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Applying Fiduciary Responsibilities in the Managed Care Context

Peter D. Jacobson† and Michael T. Cahill‡

I. INTRODUCTION

The cost containment innovations offered by managed care have been needed corrections to the excesses of the fee-for-service health care system. Yet, implementing these innovations raises inevitable questions about conflicts of interest regarding the allocation of resources under managed care. The inherent conflict faced by physicians and health plan administrators between the health care needs of individual patients and the need to preserve scarce resources for patient populations is at issue in the managed care era. The sources of the conflict are the economic incentives that underlie the managed care revolution, such as capitated funding arrangements, limitations on referrals to specialists, bonuses and withholds. In making individual clinical decisions, physicians and administrators potentially infuse their own economic interests into the process.

An additional complication is the increasing tendency of attorneys and physicians to view each other as antagonists, making it difficult to formulate policies to resolve these inherent conflicts.[1] Historically, law and medicine have been interdependent professions.[2] In the early nineteenth century, the two professions cooperated on matters of mutual interest, and there was hope that they could jointly develop a field of legal medicine. At times, however, especially during the past thirty years, that interdependence has led to considerable conflict between physicians and attorneys over the perceived intrusiveness of the legal system into the clinical domain. The conflict between the two professions has been exacerbated in recent years with the decline of physician dominance and authority over health care delivery

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[1] *See* Daniel M. Fox, *Physicians Versus Lawyers: A Conflict of Cultures*, *in* AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 210, 210 (Harlon L. Dalton et al. eds., 1987) [hereinafter AIDS AND THE LAW].

[2] *See generally* JAMES C. MOHR, DOCTORS AND THE LAW: MEDICAL JURISPRUDENCE IN NINETEENTH-CENTURY AMERICA (1993) (discussing the practice of medicine in early America).

and the rise of managed care.[3]

Two basic difficulties underlie nearly all conflicts arising under managed care. The first is the problem of forming a binding agreement while in a position of uncertainty regarding the future. At best, it is difficult to specify the future contingencies of medical care in the language of the health plan agreement. When medical needs arise, any contractual ambiguities or tensions lurking beneath the parties' various understandings of the benefit package come to the surface.

The second problem is the reality of scarce resources, which necessitated the development of the modern managed care regime in the first place. It simply is not possible to provide health care on demand without regard to cost. Cost containment is an inevitable feature of health care delivery at the Millennium; the question is not whether there will be cost containment, but how to structure and oversee the process of cost containment. Neither the courts—to whom patients frequently turn when the general need for cost containment turns into the specific need to deny treatment—nor anyone else can successfully resolve managed care disputes by ignoring or wishing away the fundamental fact of scarcity. The mission facing whoever arbitrates managed care disputes is to ensure fair, accurate and efficient administration while also preventing bias or the provision of inadequate care in the name of short-sighted profiteering.

In this Article we describe a process, based on fiduciary duty principles, for resolving potential conflicts of interest arising in managed care and for addressing the mutual antagonism between physicians and attorneys. As Part II of this Article describes, one current topic of legal debate is whether courts should analyze managed care issues under the rubric of tort or contract law. Although both tort and contract are, to some extent, necessary components of a legal regime in managed care, they are not sufficient either individually or in tandem to resolve the types of conflicts and disputes presented in managed care.

As an alternative, Part III proposes (detailed more specifically in Part IV) a regime rooted in the concept of fiduciary duty.[4] A fiduciary—literally, one who is entrusted with the power to act for the benefit of another—owes a duty of loyalty and a duty to exercise care in making decisions.[5] Fiduciary relationships are particularly important in medical care where "the parties are unable to foresee the conditions

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[3] *See* Fox, *supra* note 1, at 211 (observing that "the conflict between physicians and lawyers, though it is rooted in the modern history of the two professions, has become more intense in recent years as the authority most people accord to physicians has diminished").

[4] Norman Daniels and James Sabin have been developing a similar approach, albeit in a different context. *See generally* Norman Daniels & James E. Sabin, *The Ethics of Accountability in Managed Care Reform*, HEALTH AFF., Sept. 1998, at 50 (discussing a movement in managed care reform to increase accountability to consumers); Norman Daniels & James E. Sabin, *Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy*, HASTINGS CENTER REP., Mar.–Apr. 1998, at 27 (discussing how greater fairness in the decision-making process is needed when health plans are expanding experimental and last chance procedures); Norman Daniels & James E. Sabin, *Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers*, 26 PHIL. & PUB. AFF. 303 (1997) (discussing the shift of authority over medical care from the patients to private organizations).

[5] *See* Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1048 (1991); *see also* Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 365 (1990) (discussing the rules of fiduciary contracting); Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 242 (1995) (examining the "metaphor of physicians as fiduciaries").

under which one act produces better results than another,"[6] and where the parties lack adequate information to assess the quality of care.

The underlying justification for using the fiduciary duty model is that a patient's trust in his or her physician is the foundation of a morally acceptable health care system. Patients expect and trust that physicians have control over the resources needed for their care.[7] Many aspects of this relationship of trust—including methods of balancing social and economic concerns and the aspects of a physician's relationship to the managed care plan that must be disclosed to patients—are subjects of intense dispute.[8] The basic need for trust, though, is incontrovertible. Absent trust, managed care cannot survive.

A fiduciary model offers a framework that preserves patient trust while recognizing that changes in the marketplace, including economic incentives to limit the use of health care resources, are unavoidable, at least in the short-term. Part V concludes with a discussion of law and medicine at the Millennium, focusing on why the fiduciary approach can help resolve the tensions unsettling health care delivery.

II. THE TORT VS. CONTRACT DEBATE[9]

In the fee-for-service system, disputes regarding a patient's insurance coverage were governed by contract law. Disputes regarding the care the patient received from a provider were governed by tort law and focused on whether the provider had satisfied the standard of care. Contract analysis emphasizes that the parties have entered into an agreement and attempts to explain how that earlier agreement bears on the present situation; the contract model adopts an *ex ante*, pre-dispute perspective. Tort, on the other hand, examines the situation from the *ex post* perspective, highlighting the fact that the circumstances of a subsequent dispute usually could not have been anticipated when the parties formed the plan.

In the new managed care model, the insurance and health care delivery functions combine into one entity. This changes the litigation context in several ways. With the integration of financing and health care delivery, refusing coverage means denying care altogether. In their capacity as insurers, managed care organizations (MCOs) may deny health care recommended by the patient's physician or may only agree to provide limited funding for certain clinical interventions. If the patient suffers an adverse outcome as a result of this decision, which legal regime should govern the subsequent legal claim—tort or contract? Although contract-based solutions have greatly predominated, each legal rule has its adherents in the literature.

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[6] Cooter & Freedman, *supra* note 5, at 1048.

[7] *See* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL., POL'Y & LAW 661, 669 (1998).

[8] *See generally* CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH CARE REFORM (1995) (arguing that private contracts can be used to specify the legal rights of patients in relation to health care providers); MARC A. RODWIN, MEDICINE, MONEY, AND MORALS (1993) (examining the relationship between professional ethics and economic interests in determining medical behavior); M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268 (1999) (reviewing the conflicts between the ethic of "loyalty to patients and pressure to use clinical methods and judgment for social purposes and on behalf of third parties"); Mark A. Hall & Robert A. Berenson, *Ethical Practice in Managed Care: A Dose of Realism*, 128 ANNALS OF INTERNAL MED. 395 (1998) (examining the ethics of medical practice under managed care).

[9] This section is adapted from Peter D. Jacobson & Neena M. Patil, Managed Care Litigation: Legal Doctrine at the Boundary of Contract and Tort (unpublished manuscript, on file at *Medical Care Research and Review*).

Both regimes have features that address, and comport well with, certain aspects of managed care.[10]

The basic case for contract is that the market will provide the type and level of choices that consumers want. For Clark Havighurst and other contract proponents,[11] the rationale for the primacy of contract is that consumers can directly exercise sovereignty over cost, quality and service.[12] As an instrument of market arrangements, contractual freedom will force health care providers to compete on both price and quality to retain customers. Paul Rubin notes that purchasers have an incentive to choose an efficient plan, defined as "one that provides all cost-justified care and no more,"[13] and that contracts allow individuals to decide how much they desire to spend on health care relative to other commodities.[14] Contract proponents also argue that contracting shifts the responsibility of health care decisions back to the patient where it belongs.[15]

The most powerful argument against the contract perspective in health care is the absence of adequate patient information. Unlike most consumer contracts, where the consumer can anticipate his or her needs and assess the costs of the product being purchased, most patients cannot anticipate their future medical needs when the contract is signed.[16] It is difficult for patients to comprehend the potential risks and to bargain over them in advance. By definition, medical error is an accidental byproduct of the provider-patient relationship. The combination of "lack of information, inability to evaluate risk, and the inequality of bargaining power" is a powerful rejoinder to the pro-contract viewpoint.[17] The contractarian case assumes a separation between benefit decisions, traditionally a matter for contract interpretation, and medical treatment decisions, traditionally overseen by tort law's standard of care. In fact, most of the litigated cases depend on individual clinical decisions that are rarely influenced by the terms of the contract.[18] Since these clinical decisions do not usually depend on interpretations of available benefits, contract law may have little to say about how they are resolved.

Many advocates of a contract-based system have thoroughly presented the case against tort. In brief, these commentators believe that the tort system is inefficient and random in providing compensation, has very high administrative costs, does not deter wrongdoing, sets standards of care too high and provides benefits that consumers would generally not be willing to pay for in the market. These advocates argue that tort awards increase the cost of health care without providing

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[10] *See* Peter D. Jacobson, *Legal Challenges to Managed Care Cost Containment Programs: An Initial Assessment*, HEALTH AFF., July–Aug. 1999, at 69, 76–83.

[11] *See* HAVIGHURST, *supra* note 8, at 1–10; Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 492 (1997) (noting that various experiments offering low-cost, low-benefit plans have not succeeded in the market).

[12] *See* HAVIGHURST, *supra* note 8, at 1–10.

[13] Paul H. Rubin, *Treatment Decisions: Tort or Contract?*, REGULATION, Winter 1999, at 25, 27.

[14] *See id.*

[15] *See* E. Haavi Morreim, *Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice*, 23 J.L. MED. & ETHICS 247, 256–58 (1995).

[16] *See* Catherine G. McLaughlin & Paul B. Ginsburg, *Competition, Quality of Care, and the Role of the Consumer*, 76 MILBANK Q. 737, 739 (1998) (stating that consumers lack the information and knowledge to judge the quality of services).

[17] P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW AND CONTEMP. PROBS. 286, 295 (1986).

[18] *See* Jacobson & Patil, *supra* note 9.

commensurate benefits.[19]

Both the tort and contract regimes have considerable shortcomings in terms of their conceptual or practical ability to handle the conflicts posed by managed care. Although particular aspects of managed care seem to resemble contract-governed or tort-governed activities, "[i]t is becoming impossible to characterize components of managed care as wholly contractual or wholly tort, which makes it quite difficult to determine which body of law governs."[20] As a result, the tort-contract debate is a dead end in addressing managed care's potential conflicts.

III. AN ALTERNATIVE—FIDUCIARY DUTY

Since both tort and contract appear to be inadequate as methods for resolving potential conflicts between an individual patient and an MCO's patient population,[21] we need to develop alternative approaches.[22] The concept of fiduciary duty is one option for resolving such disputes. One reason is that the fiduciary model is already part of the managed care decision-making process through the Employee Retirement Income Security Act of 1974 (ERISA).[23] ERISA recognizes that individual clinical decisions may sometimes be made in the context of a potential conflict with the goal of preserving assets for the managed care patient population. This section sketches the contours of the fiduciary approach and describes its relation to the legal framework created by ERISA.

A. THE FIDUCIARY APPROACH

The fiduciary model delegates decision-making power to an impartial authority, called the fiduciary, to resolve conflicts arising between patient care for a single patient and the costs of that care to the plan as a whole.[24] We will refer to the "impartial" fiduciary as the plan fiduciary to distinguish him or her from individual physicians who also have a fiduciary relationship with their own patients. The plan fiduciary will bear responsibility for balancing the needs and interests of the patients who receive care, the insurers who pay for care, and the physicians who provide care. While information problems commonly prevent patients from making proper risk

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[19] *See, e.g.*, RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 382–83 (1997); Danzon, *supra* note 11, at 518–19; Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 645–46 (1997); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1525 (1987); Rubin, *supra* note 13, at 29–30. The evidence that tort law actually increases health care costs is sparse. Atiyah argues that the proper response is to reform the tort system and not allow contracting for lower than reasonable standards of care. *See* Atiyah, *supra* note 17, at 287–303.

[20] Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. CONTEMP. HEALTH L. & POL'Y, Fall 1998, at 1, 27.

[21] *See* William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 6 (1994) (illustrating the tension between the individual patient's well-being and the general population's well-being).

[22] Some scholars have proposed strategies that would bridge tort and contract. For example, Havighurst and Sage argue that enterprise liability is most appropriate, while Brewbaker argues in favor of a breach of warranty standard. *See* Havighurst, *supra* note 19, at 587; Sage et al., *supra* note 21, at 1–2. *But see* HEALTH CARE CORPORATE LAW: MANAGED CARE § 6.2.5.2 (Mark A. Hall & William S. Brewbaker, III eds., 1996) (discussing theories of managed care liability, including contractual obligations. For example, some courts will find that the insurer breached an implied covenant of good faith and fair dealing). In addition, Mariner and Morreim propose standards that would combine elements of tort and contract. For details, see Jacobson & Patil, *supra* note 9.

[23] 29 U.S.C. §§ 1001–1461 (1999).

[24] *See* Cooter & Freedman, *supra* note 5, at 1046.

calculations, and individual providers are unable to assess the impact of specific care decisions on the overall costs of a plan, a plan fiduciary is perfectly poised to make whatever tradeoffs are necessary between care and the cost of care. The United States Supreme Court has noted that the central purpose of fiduciary law is to govern the exercise of discretion in making decisions that are not, and cannot be, controlled in advance by legal means.[25]

A fiduciary relationship imposes two fundamental duties on the fiduciary: the duty to exercise prudence[26] and the duty of loyalty.[27] Courts can resolve conflicts regarding managed care decisions by focusing on whether the plan fiduciary has upheld these two duties. Both of these duties relate to process rather than outcome in that a court will not substitute its judgment for the fiduciary's where there is no showing of a failure to exercise good judgment or that an improper motivation lurks behind that decision.[28]

The duty of prudence, often ignored in health care cases discussing fiduciary duty, requires that the fiduciary exercise reasonable care and skill in making decisions affecting beneficiaries.[29] Possession or an express claim of greater-than-normal skill or judgment will raise the threshold of prudence a fiduciary must satisfy.[30] Any challenge to the plan fiduciary's decision to deny care would need to assert a breach of this duty.

The duty of loyalty demands that the fiduciary not have any conflicting loyalties that might influence his or her ability to make decisions in the beneficiaries' best interests.[31] In the managed care context, some might assume that this prohibition on conflicts would foreclose the creation of incentives to curtail costs, as these might be thought to encourage disloyalty to specific patients. The approach articulated here assumes the continued use of incentives, and does not oppose them. To the contrary, traditional medical ethics place the physician-patient relationship at the center of the clinical encounter, not at the periphery. While incentives will inevitably pose conflicts between individual patients and the patient population, the physician's initial loyalty and fiduciary duty is owed to the individual patient.[32]

Thus, there is a need for a feasible set of fiduciary duties and standards for physicians and managed care organizations that explicitly recognizes the tensions involved in simultaneously serving the patient and the patient population. Although both realms of fiduciary duties are important, this Article focuses on the plan fiduciary as the usual decision maker. The fiduciary framework offers a means of resolving patient-population conflicts without undermining the legitimate policy objectives of controlling health care costs or the physician's fiduciary duty to his patients. Fiduciary law contemplates that fiduciaries may need to balance competing

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[25] *See* Varity Corp. v. Howe, 516 U.S. 489, 504 (1996) ("Indeed, the primary function of the fiduciary duty is to constrain the exercise of discretionary powers which are controlled by no other specific duty imposed by the trust instrument or the legal regime.").

[26] *See* GEORGE T. BOGERT, TRUSTS 334 (6th ed. 1987).

[27] *See id.* at 341.

[28] *See id.* at 336; *see also id.* at 334–35, 342 (stating that the lack of good judgment or improper motivation triggers a breach of fiduciary duty).

[29] *See id.* at 335.

[30] *See id.* at 335–36 n.17.

[31] *See id.* at 341.

[32] *Cf.* William M. Sage, *Physicians as Advocates*, 35 HOUSTON L. REV. 1529 (1999) (presenting a case for doctors providing lawyer-like advocacy).

interests (such as corporate officers serving multiple constituencies).[33] In most cases involving denial of care, the correct analysis with respect to the duty of loyalty is not to ask whether the plan fiduciary has any inherent conflicts or broad incentives to minimize costs generally. Instead, the issue is whether a decision in the specific case at hand was in fact motivated by an improper conflict of interest that interfered with sound clinical judgment.

Numerous disputes regarding the plan fiduciary's satisfaction of the two duties described above arise in managed care. For example, one frequent source of litigation is the common provision that a plan will cover care deemed medically necessary.[34] This provision is devoid of meaning until it is applied to the medical needs of a specific patient with a specific condition.[35] As described below, this framework attempts to define who should decide what is medically necessary, how the fiduciary should make that decision, and what role the court system would play in reviewing that decision. Another common dispute revolves around the fact that many plans include policies restricting the use of procedures that, although they may provide substantial benefits for certain patients, have substantial costs that would exceed their benefits if made available to all patients.[36] One such procedure is the injection of more costly contrast agents for radiological procedures that provide significant benefits to high-risk groups but whose benefits do not justify the cost of using them for every injection.[37] The plan fiduciary would be responsible for determining whether the particular patient was sufficiently high-risk to justify the more expensive procedure despite the general plan policy restricting its use.

One way to give a broad sense of what a fiduciary model would entail is to briefly sketch how it would differ from the traditional contract and tort views. Unlike the *ex ante* contract perspective, the fiduciary model acknowledges the specific clinical choices involved in benefit decisions. Instead of asking the courts to apply ambiguous contract terms to a complex clinical determination, the fiduciary model would examine what factors the plan fiduciary considered in his or her decision. In contrast to the tort model's focus on causation and damages in an individual case, this model evaluates the integrity of the process governing how decisions are made and whether the challenged decision complied with that process. Instead of considering the standard of care an individual provider owes an individual patient, this model considers the standard of care (or prudence) the MCO as an institution owes to both individual patients and the total pool of plan subscribers. Simultaneously, it is more efficient and less costly than a tort-based regime because private agents, rather than the courts, would be making decisions in the first instance. And where the terms "tort" and "contract" frequently amount to little more than reductive viewpoints that systematically favor individual patients and MCOs, respectively, the fiduciary model

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[33] *See* Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 256 (1995) ("[T]he fact that physicians have obligations to third parties does not mean that they cannot be fiduciaries for patients. Obligations to third parties may merely limit the scope of fiduciary obligation. . . .").

[34] *See, e.g.*, McGraw v. Prudential Ins. Co. of America, 137 F.3d 1253, 1259 (10th Cir. 1998) (holding that a decision to deny benefits is arbitrary and capricious if it is not a reasonable interpretation of the plan's terms).

[35] *See, e.g.*, Peter D. Jacobson et al., *Defining and Implementing Medical Necessity in Washington State and Oregon*, 34 INQUIRY 143, 143 (1997).

[36] *See* Jacobson, *supra* note 10, at 69–70.

[37] *See* Peter D. Jacobson & C.J. Rosenquist, *The Introduction of Low-Osmolar Contrast Agents in Radiology: Medical, Economic, Legal and Public Policy Issues*, 260 JAMA 1586, 1586 (1988).

contains no internal bias for or against the provision of care in specific cases.[38]

B. ERISA'S FIDUCIARY RULES[39]

The concept of using fiduciary duties to make tradeoffs between individual beneficiaries and plan populations is hardly novel. Indeed, in the managed care environment, the need to balance competing interests is explicitly contemplated under ERISA,[40] which governs most employer-provided health plans. ERISA imposes a fiduciary duty requiring those who make discretionary decisions on behalf of an employee benefit plan to act "solely in the interest of the participants and beneficiaries" of the plan.[41] Unfortunately, these terms are not defined either by ERISA or by the courts.[42] Neither ERISA nor the courts are clear about which decisions are discretionary or made on behalf of the plan. Courts have held in many cases that MCOs are subject to this fiduciary duty when making certain decisions, such as reviewing the appropriateness of a physician's treatment recommendations.[43] In exercising this fiduciary duty, one obvious problem the administrator faces is that the plan's participants may not share a single interest; the clinical needs of one patient may conflict with the MCO's economic interests or the interests of other members of the patient population.[44]

To determine whether an MCO breached its fiduciary duty when denying plan benefits, courts employ different levels of scrutiny based on the amount of discretion granted to the MCO under the employee benefits plan (EBP). Generally, courts are very deferential, upholding the plan administrator's decision as long as it was not arbitrary and capricious.[45] This deference is in part due to the recognition that the plan administrator also owes a fiduciary duty to maintain plan assets for other participants.[46] Courts have most often equated compliance with the terms of the EBP as, by definition, acting "in the interest" of the plan participant.[47] In doing so, courts limit their review to ensuring that the MCO reasonably comported with the terms of

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[38] *See* Varity Corp. v. Howe, 516 U.S. 489, 514 (1996).

> [A] fiduciary obligation, enforceable by fiduciaries seeking relief for themselves, does not necessarily favor payment over nonpayment. The common law of trusts recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries.

Id.

[39] This section is adapted from Peter D. Jacobson & Scott D. Pomfret, *ERISA Litigation and Physician Autonomy*, 283 JAMA 921, 921-26 (2000).

[40] 29 U.S.C. §§ 1001-1461 (1999).

[41] *Id.* § 1104(a)(1).

[42] *See* Peter D. Jacobson & Scott Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUSTON L. REV. 985, 987 (1998); E. Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 65 TENN. L. REV. 511, 512 (1998).

[43] *See* Reilly v. Blue Cross & Blue Shield, 846 F.2d 416, 423 (7th Cir. 1988). *But see* Kyle Railways, Inc. v. Pacific Administration Servs., 990 F.2d 513, 516-17 (9th Cir. 1993). It is agreed that MCOs and employers are not considered fiduciaries with regard to establishing or changing the terms of the plan. *See id.*

[44] *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 107-08 (1989).

[45] *See* McGraw v. Prudential Ins. Co., 137 F.3d 1253, 1259 (10th Cir. 1998); Morreim, *supra* note 42, at 520.

[46] *See* Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1669 n.124 (1992).

[47] *See, e.g.*, Adams v. Freedom Forge Corp., 204 F.3d 475, 491 (3d Cir. 2000); Seales v. Amoco Corp., 82 F. Supp. 2d 1312, 1322 (M.D. Ala. 2000).

the EBP.[48] As a result, MCOs retain power vis-à-vis physicians by controlling the interpretation of EBP terms.[49] But in a case where the plan profits directly from the denial, the potential conflict of interest must be considered as a factor in deciding whether there was an abuse of the fiduciary's discretion.[50]

To date, courts have not defined the meaning of ERISA's fiduciary duty provision. For the most part, they have understood this duty only as a mandate that plan administrators avoid improper financial incentives. The precise rules governing which institutional financial structures are acceptable and which are not acceptable remain opaque, as do the standards for making tradeoffs between patients and the plan in individual cases. A more robust understanding of fiduciary duties is needed to address these concerns. We offer and defend such a definitive scheme in the following Part.

IV. THE FIDUCIARY FRAMEWORK

The fiduciary model arises from the possibilities and limitations available to the parties as they contract to form a plan. While the parties cannot decide cost-allocation issues in advance, they can decide who *will* decide. In other words, they can vest someone (the plan fiduciary) with decision-making authority and with concomitant responsibilities, including the duties to be prudent and loyal to the participants' interests. Indeed, most managed care plans do name administrators whose function is to make determinations regarding matters at the intersection of the management and care components of managed care. A managed care model centered on the organizing principle of fiduciary duty must address three sets of issues: (1) the proper *structure* for selection and oversight of the fiduciary; (2) the actual *decision rules* that will govern the fiduciary's exercise of his authority; and (3) the role of the *legal system* in adjudicating disputes with respect to the fiduciary's decisions.

A. STRUCTURAL ISSUES

The first concerns are *structural* and relate to the plan's internal mechanisms to ensure proper decisions by the fiduciary. Because a fiduciary is by definition a figure in a position of trust, institutional safeguards must assure that the fiduciary will be trustworthy. These safeguards take two forms: constraints on who may serve as a fiduciary and disclosure to plan participants of relevant information about the fiduciary.[51] The plan participants must consent to the organizational structure that establishes and monitors the fiduciary because the fiduciary is ultimately accountable to insureds as well as payors.

1. Selecting the Fiduciary

One fundamental question that this framework must answer, and that courts have struggled to answer, is who constitutes a fiduciary in managed care.[52] Broadly defined, whoever exercises discretion in determining when and whether to approve

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[48] *See* England v. John Alden Life Ins. Co., 846 F. Supp. 798, 801 (W.D. Mo. 1994).

[49] *See, e.g.*, Hall & Anderson, *supra* note 46, at 1670.

[50] *See* Killian v. Healthsource Provident Administrators, Inc., 152 F.3d 514, 521 (6th Cir. 1998).

[51] Another safeguard, *ex post* oversight of the fiduciary's decisions, is legal rather than structural in nature and is discussed *infra* Part IV.C.

[52] That issue is central to the Supreme Court's upcoming consideration of *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *reh'g denied*, 170 F.3d 683 (7th Cir. 1999), *cert. granted*, 120 S. Ct. 10 (1999).

medical intervention is acting in a fiduciary capacity.[53] Thus, either a physician or a plan administrator can act as a fiduciary if the plan delegates discretionary decision-making authority to them.

The common law duty of loyalty demands the selection of a plan fiduciary with no conflicting interests that would prevent him or her from making unbiased decisions in the beneficiaries' best interests.[54] The identification of truly relevant conflicts is more difficult than it may first appear. It is difficult to distinguish decisions motivated by conflicting loyalties from good-faith efforts to control costs in accordance with the managed care objective. Acts undertaken to benefit the plan as a whole (i.e., to reduce costs and, therefore, the premium owed by each plan participant) often look the same as acts undertaken to benefit the managed care corporate entity (i.e., to increase profits and make shareholders wealthier).[55] Ultimately, the insureds under the plan also have a decided interest in holding down costs to ensure the plan's economic viability and efficient operation. In a competitive marketplace, lower costs will result in reduced premiums or expanded benefits. At the same time, if subscribers express the desire to pay more in return for receiving more benefits, the fiduciary will have no incentive to deny care arbitrarily, because the plan participants will replace him or her with someone more responsive to their wishes. The question is not whether there are any conflicts at all, but rather what kinds of conflicting loyalties or responsibilities are acceptable, what kinds are not, and how they will be resolved.

Not all courts reviewing decisions by managed care plan administrators have understood the intimate connection between the financial interests of the corporation and those of the plan participants. Courts sometimes find conflicting loyalties improper where there are only conflicting obligations to multiple beneficiaries. By definition, conflicting obligations are inevitable under managed care because resources spent for one patient are not available for another, but these are not necessarily the types of conflicts that would violate fiduciary duty.[56] For example, in the recent case of *Herdrich v. Pegram*,[57] the U.S. Court of Appeals for the Seventh Circuit comes close to adopting a *per se* conflict of interest rule against managed care's use of financial incentives where parties with the power to make decisions about care have any direct stake in the MCO's financial performance. Judge Easterbrook, dissenting from the denial of a rehearing of the case before the full court, pointed out that if the defendant's structure violated fiduciary duties, "then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations."[58] The proper objective of the loyalty rule is to eliminate systematic bias and deter misconduct rather than to aid particular patients after the fact.[59]

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[53] *See* Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 190 (1997).

[54] *See* Varity Corp. v. Howe, 516 U.S. 489, 506 (1996).

[55] *Cf.* Hall & Anderson, *supra* note 46, at 1669 ("[T]he only conflict the [self-insuring] employer faces is that between a single claimant and a pool of beneficiaries, the very conflict that should be foremost in the insurer's mind when assessing medical appropriateness.").

[56] *See* Morreim, *supra* note 42, at 524–28 (1998).

[57] 154 F.3d 362.

[58] Herdrich v. Pegram, 170 F.3d 683, 687 (7th Cir. 1999) (Easterbrook, J., dissenting from denial of rehearing en banc).

[59] *See* BOGERT, *supra* note 26, at 343 n.11.

> In applying the loyalty rule the court of equity is not primarily concerned in preventing

Conversely, some courts have recognized that efforts to lower costs often can be interpreted either as useful attempts to benefit participants or as nefarious schemes to increase corporate profits, and have correctly suggested that the standard of review should depend on the extent to which a clear ulterior profit-making motive is present. For example, the court in *McGraw v. Prudential Ins. Co.*[60] noted that "the degree of deference to accord [a fiduciary's] decision will be decreased on a sliding scale in proportion to the extent of conflict present,"[61] recognizing the need for flexibility given that "every exercise of discretion impacts [the MCO] financially. . . ."[62] The focus on the fiduciary's general relation to the MCO is misplaced because the conflicts the courts identify are unavoidable. An inquiry directly devoted to examining the justifications behind specific administrative decisions is more appropriate.[63]

2. Informing Plan Participants

Arguably, some courts have defined the organizational structures that will create inherent conflicts of interest for the plan fiduciary too broadly. However, this does not mean the courts' role in overseeing potential conflicts should be diminished, only that it should be redirected. Courts should carefully examine whether the plan participants had proper *notice* regarding the identity and other relevant characteristics of the plan fiduciary when they entered the plan.[64] The fiduciary model presupposes that all parties to the managed care plan have voluntarily ceded decision-making authority to the fiduciary. As is generally the case in the law governing fiduciary relationships—for example, with respect to attorney-client relationships and trustee-beneficiary relationships—even where there is only an appearance or likelihood of conflict, it is critical that conflicts be disclosed.

The courts have given this issue increasing attention. In *Neade v. Portes*,[65] an Illinois appeals court held that an individual doctor could breach his fiduciary duty for failing to disclose to patients the nature of his financial relationship to the MCO and the incentives that relationship created. The court noted that "there is a potential conflict of interest, which the physician should disclose, where, incompatibly with the patient's interest, he has a financial interest in minimizing referrals or tests."[66] Although the *Neade* court broke new ground in requiring individual providers to disclose their financial interests, the underlying premise of disclosure is not novel. As *Neade* recognized, earlier cases had discussed the fiduciary duty of a plan, as opposed to an individual provider, to disclose information about its financial structure. One such case is *Shea v. Esensten*,[67] in which the Eighth Circuit noted that

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> unjust enrichment and working out the equities of the parties in the individual case. . . . It is principally desirous of procuring a result which will keep all trustees out of temptation and thus conduce to the ethical and efficient administration of trusts.

Id.

[60] 137 F.3d 1253, 1258–59 (10th Cir. 1998).

[61] *Id.* at 1258.

[62] *Id.* at 1259.

[63] *See supra* Part III.B. For a discussion of this issue at greater length see *infra* section IV.C.

[64] A full discussion of disclosure is beyond the scope of this article. For such a discussion, see generally William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701 (1999). *See also* Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 516–20 (1997).

[65] 710 N.E.2d 418 (Ill. App. 2d 1999).

[66] *Id.* at 427.

[67] 107 F.3d 625 (8th Cir. 1997).

"[t]he duty to disclose material information is the core of a fiduciary's responsibility. . . ."[68]

B. DECISION RULES

A second set of issues relates to the substantive *decision rules* the fiduciary will employ to resolve disputes. How a conflict of interest will be determined and under what circumstances a fiduciary breaches the duty of loyalty are among the questions to be addressed. Decision rules take two forms: general administrative decisions applied *ex ante* and specific care decisions applied *ex post*. These categories mirror the two types of fiduciary decisions. First, there must be a set of *policy rules*, specified in advance of specific care situations, that satisfy the general cost-benefit analysis managed care seeks to impose on spending decisions. For example, rules can be established to impose caps or outright prohibitions on types of care known to be marginally beneficial. Given the frequent need for adaptation in the face of changing technology, such rules will not be easy to draft and implement. Second, there must also be *care standards* that are more flexible and help the fiduciary make individualized determinations with respect to particular patients. For instance, the fiduciary may be called on to decide whether a particular form of care is medically necessary for a given patient. It will be impossible to create rules in advance to govern these decisions because they will depend on the facts of specific cases. Instead, the task will be to generate guidelines or principles that will assist the fiduciary in making a determination.

1. Policy Rules

Most general statements of plan policy that can be specified in advance will be expressed in the plan contract itself. The fiduciary's role with respect to policy rules will be limited to a small group of issues for which a blanket provision is appropriate, but that could not have been addressed at the time the plan was adopted. For example, as technology develops or prices change with respect to cutting-edge or only marginally beneficial procedures, the fiduciary's authority will include the power to create general rules governing the application of new procedures, or to modify existing rules to reflect the changing reality. Of course, even these rules can be overruled through modification of the plan's terms when the plan is renewed. Additionally, because the fiduciary will be directly accountable for the rules he creates, it will be in his or her interest to exercise discretion. Hard and fast rules will be created only where the proper course seems clear. For all of these reasons, the plan fiduciary will probably not create many policy rules.

With the potential exception of challenges to denials of life-saving interventions, few subscribers are likely to challenge clear benefit limitations appearing in the plan document. However, subscribers are likely to challenge benefit denials as applied to specific situations. A benefit limiting inpatient hospital stays to thirty days may not be contested until the plan fiduciary requires a hospital discharge after, for example, eight days, despite a physician's request for additional days.[69] In such a case, it is not the benefit itself but the fiduciary's response to the physician's request that is interpretation of the rule that is subject to review.

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[68] *Id.* at 628 (quoting Eddy v. Colonial Life Ins. Co., 919 F.2d 747, 750 (D.C. Cir. 1990)).

[69] *Cf.* Muse v. Charter Hosp. of Winston-Salem, Inc., 452 S.E.2d 589, 594 (N.C. Ct. App. 1995) (holding that a "hospital has the duty not to institute policies . . . which interfere with the doctor's medical judgement.").

2. Care Standards

A more significant and complex set of rules governs decisions that relate not to general plan administration, but to individualized choices about the level of care to be afforded a given patient in specific circumstances. The question to address is: what is the scope of a fiduciary's authority to make or review these decisions? Alternatively, what must a fiduciary do, or prove, to make the decisions binding and authoritative? For the decisions to have weight and survive scrutiny, the fiduciary must meet a minimum threshold in two respects. First, before coming to a decision, he or she must gather and analyze sufficient information to make a reasoned judgment. Second, after the decision, the fiduciary must be able to articulate objectively the bases for that decision. Most importantly, these decisions must be publicly accessible and transparent.[70] It is critical that the fiduciary provide fair process to benefit denials. As the court stated in *Potvin v. Metropolitan Life Ins. Co.*, "[f]air procedure comes into play where private organizations are 'tinged with public stature or purpose' or attain a 'quasi-public significance'. . . ."[71] Fair procedures, the court added, must protect individuals from arbitrary decisions.[72]

We suggest a two-part test for evaluating a fiduciary's decision to deny care. First, the fiduciary must have a *medical* reason for denying the intervention or service to prove that he has satisfied the duty to exercise prudence in making decisions affecting the patient. That reason must find support in clinical practice guidelines, the current standard of care, well-defined benefit exclusions, the medical literature, or in some other practice justification. Further, that justification must be reasonablegiven the facts of the case at hand, and because the duty of prudence embraces an "element of initiative or effort,"[73] it must be clear that the fiduciary was familiar with all facts necessary to arrive at a proper medical decision.[74]

Second, the fiduciary must have an *administrative* reason for the decision in defend against a claim that a determination breached the duty of loyalty. The fiduciary must indicate a concomitant benefit to the patient population that justifies the harm to the individual patient in the case at hand. To borrow the language of ERISA, the plan fiduciary's responsibility in each instance is to make decisions "solely in the interest of the participants and beneficiaries" of the plan.[75] The fiduciary must not be serving only personal or corporate ends. There are many tools the fiduciary might use, including cost-benefit or cost-effective analyses to demonstrate an appropriate administration reason.

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[70] *See generally* articles cited *supra* note 4 (offering an extended analysis).

[71] 63 Cal. Rptr. 2d 202, 207 (1997) (quoting Delta Dental Plan v. Banasky, 27 Cal. App. 4th 1598, 1607 (1994)), *aff'd*, 2000 LEXIS 3717 (Cal. Sup. Ct. 2000).

[72] *See id.* at 208–09.

[73] *See* BOGERT, *supra* note 26, at 335; M. Gregg Bloche, *Fidelity and Deceit at the Bedside*, 283 JAMA 1881, 1881–84 (2000).

[74] For an example of a case where a court decided, rightly in our view, that no such medical justification supported the decision to deny care, see *McGraw v. Prudential Ins. Co.*, 137 F.3d 1253 (10th Cir. 1998). In *McGraw*, the medical director charged with reviewing the decision to deny coverage did not even undertake to review the patient's medical records. Relying in part on this "egregious" failure, the court found the ultimate decision to deny coverage to be arbitrary and capricious. *See id.* at 1262–63. Under our model, the failure to review medical records would automatically preclude any ability to show a medical justification for the decision at the time the decision was made and would therefore amount to a *per se* breach of fiduciary duty.

[75] 29 U.S.C § 1104 (1994).

C. LEGAL ISSUES

The third set of concerns is explicitly *legal*, and again embraces two central issues. First, what will be the role of the courts in overseeing institutional structure, policy rules and specific decisions? Second, what legal remedies will be available to plan participants who successfully challenge a fiduciary's decision in a particular case?

1. Standard of Review

The two-part standard previously described, requiring both a medical and an administrative reason for the denial of care, takes on meaning only when one addresses the proper judicial standard of review of those justifications. Because the courts will be applying these standards and assessing the sufficiency of the reasons, what counts as a sufficient basis for the fiduciary's decision is not to be defined in terms of abstract principles or goals, but rather in terms of evidentiary requirements and the level of scrutiny the courts will apply to the fiduciary's decision. The task is not to decide what might make a fiduciary's decision right or wrong in the abstract, but to determine what will make a fiduciary's decision survive judicial review. In short, who has the burden of proof, and when is that burden met?

It is clear that some deference is due to the fiduciary's decision under the common law model of fiduciary duty.[76] Yet the court must also retain sufficient oversight to assure that the fiduciary's specific decision was not violative of the duties of prudence or loyalty, or compromised due to conflicted interests. This is part of the courts' institutional role. With respect to both elements of our standard (medical basis and population benefit), the burden should be on the fiduciary to justify the denial. But how is the fiduciary to meet that burden? One recent argument asserts that the health plan should have to present clear and convincing evidence (using clinical practice guidelines, perhaps) that the plaintiff's desired procedure is not appropriate in order to surmount a claim based on medical necessity.[77] This burden seems too stringent, although other suggestions—such as those put forward by E. Haavi Morreim,[78] Mark Hall and Gerald Anderson[79]—seem too deferential to the managed care decisionmaker.

The level of deference with which a court reviews the fiduciary's decision should vary according to the nature and circumstances of the decision. The basic factor determining the level of scrutiny a court should apply to the fiduciary's decision is the extent to which the medical and administrative aspects of the decision are "inextricably intertwined."[80] The threshold issue a court will confront before

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[76] *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111 (1989).

> [C]haracterizing a denial of benefits as a breach of fiduciary duty does not necessarily change the standard a court would apply when reviewing the administrator's decision to deny benefits. After all, *Firestone*, which authorized deferential court review when the plan itself gives the administrator discretionary authority, based its decision upon the same common-law trust doctrines that govern standards of fiduciary conduct.

Varity Corp. v. Howe, 516 U.S. 489, 514–15 (1996).

[77] *See* Sara Rosenbaum et al., *Who Should Determine When Health Care is Medically Necessary?*, 340 NEW ENG. J. MED. 229, 232 (1999).

[78] *See* Morreim, *supra* note 42, at 551–52.

[79] *See* Hall & Anderson, *supra* note 46, at 1698–1705.

[80] This phrase has been used as a legal term of art in a variety of situations. *See, e.g.*, Swint v. Chambers County Comm'n, 514 U.S. 35, 51 (1995); Atlantic Richfield Co. v. USA Petroleum Co., 495 U.S. 328, 345 (1990). In the context of ERISA preemption of state law claims, courts have held that the "essential inquiry" is whether allegedly negligent medical advice or care was inextricably

applying the two-part standard above (medical basis and population benefit) is the extent to which the decision necessitates a tradeoff between the competing claims and needs of the patient and the plan. The more a given decision implicates both the administration of the plan and the practice of medicine, the more evidence the fiduciary must show to demonstrate that these goals legitimately have been balanced, i.e., to show that the decision was motivated by good faith.

One way to demonstrate the decision's legitimacy is to provide a medical reason for the denial that would apply even if the decision were not intertwined. Thus, if the decision meets the first element of our test to such an extent that it satisfies not only the fiduciary duty of prudence but the stricter tort standard of care, the decision is clearly sound.

If such a clear medical justification is not present, the fiduciary must show that the medical needs of the individual patient remained a central concern and were not automatically sacrificed. The key evidentiary question is how much of a showing is necessary to demonstrate the fiduciary's decision-making rationale?

We propose an approach similar to the active rational-basis test employed in constitutional law.[81] The rational-basis test is used to determine the constitutionality of legislation.[82] Under the rational-basis test, courts will uphold a state's economic and social legislation as long as it serves any reasonable state interest.[83] But in an active rational-basis analysis, courts require states to provide additional justification for the legislation.[84] Applying this to the fiduciary context, the fiduciary must demonstrate the objective existence of a plausible medical reason and offer some showing that this justification actually motivated the decision. Merely stating that the care should be denied or that providing care would adversely affect the patient population would not fulfill the fiduciary's obligations. Importantly, as with review of agency determinations in administrative law, the fiduciary should not be allowed merely to provide the courts with a "post-hoc rationalization" generated after litigation has commenced, but is responsible for generating a contemporaneous record providing the basis for denial that existed at the time of rejection.[85] In fact, such an ongoing record could provide a set of precedents to guide future cases and ensure consistency. It would also make plan decisions explicit so they could be subsequently superseded by contract renewal terms.

When medicine and administration are not intertwined, there would be no deference due to the fiduciary's decision. In fact, there would not even be a proper

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intertwined with administration of plan benefits. *See, e.g.*, Schmid v. Kaiser Foundation Health Plan, 963 F. Supp. 942, 944–45 (D. Or. 1997). Thus here, as elsewhere, there is a rough correlation (though by no means congruence) between our fiduciary analysis and the ERISA regime.

[81] As Hall and Anderson note, models of judicial review based on fiduciary duties share similarities with models of review under administrative law, constitutional law and the law of arbitration. *See* Hall & Anderson, *supra* note 46, at 1696 (noting that fiduciary, administrative and arbitration models of judicial review are "somewhat competing and somewhat overlapping"). Space constraints prevent a thorough analysis of the similarities and differences of the results under our proposed standard of review as opposed to these other models, but we think the analogy to rational-basis review under constitutional law, though inexact, is useful.

[82] *See* Daniel R. Mandelker, *Housing Issues, in* AIDS AND THE LAW, *supra* note 1, at 142, 148.

[83] *See id.*

[84] *See, e.g.*, Milner v. Apfel, 148 F.3d 812, 816 (7th Cir. 1998) (explaining that in some instances a more searching "active" standard of review is used).

[85] At least one federal court of appeals has read the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), to impose such a requirement on ERISA trustees. *See* Cox v. Mid-America Dairymen, Inc., 965 F.2d 569, 574 (8th Cir. 1992).

claim for breach of fiduciary duty, but rather a standard tort claim (if the decision was medical in nature) or breach of contract claim (if the decision was administrative in nature).[86] For those decisions made in situations that truly involve the hybrid managed care decision, such as the use of a gatekeeper function to limit access to specialty care, the fiduciary model applies and the court should defer to the decision only if the fiduciary can justify the decision as indicated above.

To be sure, the process we propose will not be a panacea and will not solve problems immediately. Over time, standards and doctrine will emerge to provide stability and fairness of process that will minimize the conflicts and provide adequate redress for a breach of fiduciary duty. Our approach is consistent with M. Gregg Bloche's argument that clinical loyalties may conflict with medicine's broader social purposes (including issues of cost containment).[87] In this sense, the fiduciary duty framework we outline represents "an ongoing effort to mediate, case by case, between clinical fidelity and medicine's social purposes . . . [this] conflict [is] in need of ongoing management, rather than . . . a problem to be solved once and for all."[88]

2. Remedies for Breach of Fiduciary Duty

One advantage of the fiduciary duty approach is the flexibility it gives the court in crafting remedies where the plan fiduciary is found to have breached his or her duties. At common law, a suit against a fiduciary would lie in equity, meaning that a court could specify injunctive relief and command the fiduciary to undertake action or undo past action.[89] In addition, the court could demand restitution of any unwarranted gain to the fiduciary.[90] Violation of a fiduciary duty also gives rise to a claim in tort,[91] meaning that the plaintiff could recover monetary damages resulting from the breach where equitable relief could not remedy the injury. In many cases, however, the proper remedy would be an injunction, which grants the court greater discretion while at the same time encouraging private settlements and creative solutions between beneficiaries and plan fiduciaries.

D. JUSTIFICATIONS FOR THE FIDUCIARY MODEL

The above discussion suggests several general advantages of a fiduciary model. A more explicit consideration follows.

First, as noted in Part II, neither contract nor tort law seems to offer an adequate framework for resolving conflicts between individuals and populations. The inadequacy of these regimes demonstrates the desirability of finding an alternative method. The concept of fiduciary duty, like tort and contract, is a fundamental legal principle, underlying the law of both agency and trusts.[92] Yet the common-law principles underlying the fiduciary relationship (as opposed to the law surrounding

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[86] *See, e.g.*, Herdrich v. Pegram, 170 F.3d 683, 686 (7th Cir. 1999) (Easterbrook, J., dissenting from denial of rehearing en banc) (arguing that "[f]iduciary duties are vital when contracts are incomplete, but when a contract fully specifies proper behavior, then even a full-fledged trustee need not (indeed, must not) depart from the contractual provisions that the settlor established."); Turner v. Fallon Community Health Plan, Inc., 127 F.3d 196, 200 (1st Cir. 1997) (noting that "[t]he notion that there is a fiduciary duty on Fallon's part to expend funds for treatment explicitly excluded from the plan would be quite a stretch").

[87] *See* Bloche, *supra* note 8, at 268.

[88] *Id.* at 272.

[89] *See* BOGERT, *supra* note 26, at 549–50.

[90] *See id.* at 289.

[91] *See* RESTATEMENT (SECOND) OF TORTS § 874 (1979).

[92] *See, e.g.*, RESTATEMENT (SECOND) OF AGENCY § 13 (1958) (explaining the fiduciary responsibilities of an agent).

ERISA fiduciaries) have not received much attention from courts or commentators as a possible analytical framework for managed care law.[93]

Second, since attorneys, physicians and health care administrators are trained to understand the concept of fiduciary duty, they are more likely to be comfortable with a regime that places fiduciary duties at the core of decisionmaking. In terms of the relative ease of its implementation, a "new" alternative that is still rooted in traditional common law concepts and doctrines may be easier to implement than a truly radical or revolutionary approach. Also, the fiduciary duty concept is indifferent to how health care is organized. Much of the current debate centers on how managed care has changed the nature of the law-medicine interaction. The centrality of fiduciary duties can remain stable even if the environment changes. Fiduciary duties transcend the ways in which the health care system is organized.

Third, a model that focuses on fiduciary duty is practical because it harmonizes well with the existing statutory regime governing managed care entities. As noted above, ERISA imposes a fiduciary duty on plan administrators toward plan beneficiaries.[94] Moreover, the Supreme Court has stated its belief that the common law of trusts should inform courts' interpretation of the duty imposed by ERISA on plan administrators.[95] Certainly, a fiduciary model cannot be justified merely by relying on the fact that ERISA imposes a fiduciary duty. Indeed, we have offered a normative rather than a positive analysis of the applicability of fiduciary duty to demonstrate that a fiduciary model *should* direct the law in this area, rather than merely to discuss whether it *does*. This normative evaluation bears on ERISA in that it may highlight the advantages and shortcomings of the ERISA approach and also may usefully describe the proper implications of ERISA's undefined imposition of a fiduciary role on plan administrators.

Fourth, an analytical model rooted in an existing legal framework assures that the courts can fulfill their traditional institutional role of monitoring and facilitating social and economic arrangements. Courts have long been in the business of reconciling or balancing conflicting policy objectives, particularly in situations like managed care where an external check on free-market financial incentives is needed. The courts must mediate relationships like those presented in the managed-care situation, where the triad of providers, consumers and payors have interests that sometimes overlap and conflict. As an institution, the judiciary is also able, and likely, to establish stable doctrinal rules over time.

Equally important, a fiduciary-duty approach would enable the courts to render better decisions or at least provide better justifications for the decisions they now struggle to reach. A fiduciary-duty perspective allows courts to support the viability of managed care as a method of cost containment. This perspective also avoids the blunt instrument of contractual interpretation, which frequently produces the harsh outcome of blanket denials, or tort, which has the potential to undermine managed-care cost containment innovations. In the realm of administrative law, a similar regime of deference exists for agencies that can provide a basic record to support

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[93] Two commentators that have considered this approach are E. Haavi Morreim and Maxwell Mehlman. *See generally* Morreim, *supra* note 42; Mehlman, *supra* note 5 (discussing imposing the obligations of a fiduciary upon health care organizations for the purposes of patient-related decisionmaking and judicial review). *Cf.* Hall & Anderson, *supra* note 46, at 1697–98 (discussing, but quickly dismissing, the possibility of a "trust law model" for judicial review of decisions).

[94] *See supra* Part III.B.

[95] *See* Varity Corp. v. Howe, 516 U.S. 489, 497 (1996).

their decisions.[96] Likewise, the fiduciary model vests initial decision-making authority, and the power to create and evaluate a factual record, in a party with expertise in the area, while also retaining an oversight role for the courts.

Fifth, a successful fiduciary model will reduce litigation. While the tort and contract models rely on the courts to resolve conflicts, the fiduciary model creates a structure to resolve these conflicts within the managed care system. This approach offers the opportunity to reestablish relationships of trust between all the parties and to focus on the ethical foundations of physicians' and institutions' fiduciary duties to individual patients.[97] A fiduciary model places the physician-patient relationship at the center of the clinical encounter, not at the periphery. The fiduciary concept motivates all parties to talk about the same issue and to think about creative solutions rather than to scream past one another.

One potential drawback to this framework is that requiring a detailed record of the decision-making process will make that process itself more expensive, increasing the overall cost of the plan. As a result, the fiduciary model would work only if there was a concomitant decrease in the costs of litigation of disputed claims. This is a testable empirical issue. It is worth noting that even if requiring a fiduciary process increases administrative costs, it offers considerable public-relations benefits and may reduce litigation.

V. CONCLUSION—LAW AND MEDICINE AT THE MILLENNIUM

The antagonism between lawyers and doctors is not just about setting medical practice standards or health policy. For much of the second half of the twentieth century, attorneys and physicians vied for preeminence in social and economic status. In fact, physicians supplanted attorneys in social and economic stature after World War II, dominating health care delivery and health care policy, and achieving preeminence in social status.[98] Since that time, these two professions have often competed for position in defining the role of law in medicine and medicine in law. One consequence of this on-going battle is an increasing level of mistrust between the legal and medical professions, resulting in a dialogue that is more adversarial than cooperative. Another consequence is that too much attention is devoted to what divides the two professions, and too little reflection is dedicated to what the professions have in common. Focusing on these similarities might serve to revive better communication and cooperation.

What has been lost in recent years and must be reinvigorated, is a sense of what the two professions have in common. Physicians and attorneys share a set of core social and ethical values that help define them as professionals. For instance, they share respect for the individual, the need to make case-by-case decisions under uncertainty, and a commitment to reason, professional judgment and experience as the basis for decisionmaking.[99] Both professions are also devoted to the betterment of society, as well as the benefit of the client/patient. For the lawyer, there is a duty

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[96] *See* United States v. Nova Scotia Food Products Corp., 568 F.2d 240, 252–53 (2d Cir. 1977) (deciding that where the FDA did not cite reasons for its regulation, the regulation was arbitrary and invalid).

[97] *See* Bloche, *supra* note 8, at 268–74; Mechanic, *supra* note 7, at 661.

[98] For an excellent and comprehensive history of this transformation, see generally PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

[99] *See* David C. Hadorn, *Emerging Parallels in the American Health Care and Legal-Judicial Systems*, 18 AM. J.L. & MED. 73, 75–76 (1992) (highlighting similarities in decisionmaking that the legal and medical systems use, including structural and procedural aspects).

to uphold the law, a core value that can impede the service of a client in rare instances.[100] Physicians have corresponding responsibilities to social purposes such as public health and non-health related social goals (e.g., military readiness or criminal justice).[101] Finally, in many ways, from the legal profession's reliance on medical expertise to establish cases in the courtroom, to medicine's trust in lawyers for advice on appropriate practice, lawyers and doctors have arguably become codependent.

The concept of fiduciary duty is particularly important in understanding the professions' shared values. Perhaps the most common ethic to physicians and lawyers is dedication to the individuals who seek their services. Professional privilege, the confidentiality of a professional's relationship with patient or client, has developed beyond being legally enforceable to become etched into societal, as well as professional, expectations. The very integrity of the professions of law and medicine requires that every member of the profession be able to maintain patient trust and confidentiality. Physicians and lawyers are entrusted with protecting different spheres of a person's being, the former with bodily integrity and the latter with rights under law. These duties are elemental to the professions and are assumed with the taking of oaths, upon graduation from medical school or admission to the bar.

An important issue in the new millennium is the stimulation of a more productive dialogue between the legal and medical professions. Given the recent hostility and complexity of health care delivery, reconciliation will not be easy, even though there is no preordained reason why law and medicine must remain antagonists. To be sure, contentions over liability standards and the perceived intrusion of the law into medical practice will remain a part of the relationship, regardless of how health care delivery is organized in the future. For example, the attorney's duty to represent his client creates the very adversarial tension that animates malpractice litigation and sometimes makes it seem as though attorneys are not interested in the search for scientific truth.

Nevertheless, the shared value of fiduciary duties offers an opportunity for a mutual dialogue between the two groups. A stable health policy environment depends on effective collaboration between law and medicine. Most observers are likely to agree that continued antagonism between law and medicine is not helpful to patients nor to formulating health policy. There may well be better ways of creating an enduring dialogue than this approach, but there is no acceptable alternative to reconciliation. Whether fiduciary duties will achieve the desired reconciliation remains to be tested. At a minimum, it is a more promising approach than continued reliance on tort or contract to mediate the interactions between physicians and attorneys.

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[100] *See id.* at 79.

[101] *See* MARC A. RODWIN, MEDICINE, MONEY, AND MORALS 159 (1993); Bloche, *supra* note 8, at 269.