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MANAGED CARE AND MANAGED SENTENCING — A Tale of Two Systems

The daily injustices mount. The front line professionals who administer the system cry out for more discretion to depart from the rigid rules that bind them. Congress finally hears their call, and is poised to enact sweeping reforms.

Are improvements in federal sentencing law on the way? Probably not in the near future. But the new Congress will surely take up proposals to regulate the managed health care industry, and the impending debate over a proposed "Patients' Bill of Rights" law offers important lessons for federal sentencing policy.

At first blush, sentencing reform and health care reform have about as much to do with each other as Justice Breyer and Dr. Spock. But take a closer look and some interesting if imperfect parallels become apparent:

- The sentencing and health care systems deliver two of the most highly valued goods in American life: justice and medicine. Courtrooms and emergency rooms dominate the headlines, the congressional agenda, and even prime time television.
- Both systems are administered by highly educated professionals. Judges and doctors are prized for the wisdom and discernment that years of experience provide, although members of both professions are sometimes perceived as unaccountable.
- Both justice and health are theoretically available to all and unwarranted disparity among similarly culpable defendants or similarly symptomatic patients is an evil both systems strive to avoid. As a practical matter, however, the instruments of punishment (prisons, probation officers) and of health care (pharmaceuticals, hospitals) are finite and expensive commodities. Either explicitly or implicitly, society rations expenditures on both of these goods.
- Both the sentencing and health care systems tend to one individual at a time, but society has a huge stake in the sentence imposed on each criminal and the medical care provided to each patient. The punishment of offenders provides society with general deterrence and incapacitation of dangerous individuals in the same way that the treatment of sick people bolsters public health and contains infectious diseases. The community benefits when the fair and effective treatment of one of its members leads to rehabilitation following either wrongdoing or sickness, just as it suffers from recidivism or relapse.

Even the sentencing-related federalism issues discussed elsewhere in this Issue arise in the health care system as well. Both systems have a history of shared federal and non-federal responsibilities, but in both the federal role is expanding. Medical care for the indigent, traditionally a local concern, is now jointly subsidized by the federal and state governments through the Medicaid program, while health care for the elderly is largely carried out through the federal Medicare program. These massive federal health programs were enacted in the 1960's, just a few years before the federal government first asserted itself in street-level crime control. That's the same period in which the federal government dramatically increased its financial support to and influence over state and local criminal justice systems, as well as state and local public health agencies.

State health officials, like their law enforcement counterparts, welcome federal resources but resent federal interference. They have argued, generally with success, that the federal government is ill-suited to administer the health programs it funds. Thus, the federal government has not usurped state and local control of health care in the way that it has increasingly done so in criminal justice. When the federal government mandates Medicaid coverage of a medical condition, for example, it carries out the policy through state and local agencies.

One reason why the federal role in health care is less controversial than the federal role in sentencing is that health care is still largely — despite the advent of Medicaid and Medicare — a private sector activity, while sentencing is a purely governmental function. Criminal sentences are imposed by government officials applying a body of law. In the case of federal sentencing, Congress itself (either directly or through its agent, the Sentencing Commission) writes the rules which guide judges. In contrast, most health care decisions in the United States are made by privately employed physicians acting pursuant to rules promulgated by private insurance companies. Congress' role in the health arena is not to rewrite those rules (although, as we will see, it has sometimes done that) but rather to regulate the interaction between insurance companies and doctors in order to protect the interest of patients.

Still, today's managed care debate poses the same central question that Congress addressed in 1984 when it restructured the federal sentencing system:



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What is the proper balance between standardized decision making and individualized outcomes in a system that seeks to dispense a complex good to a large number of people in a fair, rational and cost-effective manner through professional decision makers? Whether the good is justice or medicine, and whether the decision makers are judges or doctors, Congress must resolve the inevitable tension between binding rules and professional discretion.

The Sentencing Reform Act of 1984 struck a sensible balance between the competing goals of standardized sentencing rules and individualized sentencing. Since then, federal sentencing policy has swung too far toward standardization and away from judicial discretion. Yet, even as Congress enacts more mandatory minimum sentencing laws which thwart individualized decision making, it moves to regulate managed care in order to reduce standardization and enhance the professional discretion of doctors.

Why is Congress heading in one direction on health care and the opposite direction on sentencing? Does Uncle Sam's left hand not know what his right hand is doing? Does the American Medical Association have more lobbying clout than the Federal Judges Association? Or is it just that every patient in the country is some Congressperson's valued constituent while criminal defendants are a despised minority? All of the above. But for a naively logical moment, let's examine the manner in which Congress is likely to strike a balance between standardization and individualization in the health care system in order to illustrate how it should restore that balance in the sentencing system.

I. The Evolution of Managed Care

The history of federal sentencing reform is well known to FSR readers but a brief review of the history of managed care may be useful to set the stage for a comparison of the parallel policy debates.

Most Americans obtain health insurance through their employers, and large corporations typically subsidize the purchase of health insurance as a standard employment benefit. Until recently, most health insurance plans operated on a straightforward fee-for-service basis: the employee and his or her family members utilized doctors of their choice, paid for services out-of-pocket and then submitted receipts to the employer's insurance company for reimbursement. Insurers engaged in very little cost containment; they made money simply because at any given moment they covered more young, healthy policy holders than old, unhealthy ones.

Some employers, especially in the public sector, offered their employees a choice between fee-for-service insurance and managed care. Under the managed care option, employees received services

only from "preferred providers" or were enrolled in a health maintenance organization (HMO) and required to utilize doctors employed by the HMO. Although afforded less freedom to choose their doctors, employees opting for managed care paid lower insurance premiums than those in fee-for-service plans and made no out-of-pocket payments except nominal co-payments at the time of service. HMOs made money by paying doctors lower fees in exchange for a guaranteed high volume of patients.

During the 1980's, health care costs grew dramatically due to a variety of factors, including expensive new technologies and increased specialization by doctors. Employers scrambled to contain costs by raising premiums or eliminating altogether the more expensive fee-for-service option. They also pressed HMOs to reduce costs by managing health care benefits more aggressively. HMOs began reviewing and demanding pre-approval of the treatment decisions of doctors in order to screen out "unnecessary" health care and thereby save employers money. Detailed rules were promulgated limiting the medical services eligible for reimbursement and constraining the circumstances under which patients could be referred to specialists.

Doctors naturally chafed under this new regimen of review. After all, they had traditionally exercised vast discretion to treat their patients as they saw fit and were unaccustomed to having their professional judgment subject to challenge. They saw the managed care companies as distant, green-eyeshaded, bean-counting bureaucrats. Also, managed care was accompanied by complex, burdensome paperwork; doctors complained that they were so busy complying with the new rules that they had too little time to practice medicine. Sounds familiar?

Managed care was almost reformed as part of President Clinton's ill-fated universal health care proposal. That plan would have expanded managed care and used the resulting cost savings to expand health insurance to all Americans, but it would have also instituted significant regulation of managed care. Health plans would have been subject to detailed quality controls and government oversight, and patients would have been permitted to appeal the denial of care to administrative bodies and ultimately to the courts.

Congress rejected the Clinton plan for reasons beyond the scope of this article. Since then, economic forces have caused managed care to expand throughout the health care market, but without comprehensive regulation. Managed care has become more prevalent, more rigid and more hated by doctors and patients alike.

Anecdotal evidence of specific managed care abuses have led legislatures to enact ad hoc patient

protections. For example, managed care policies calling for hospitals to discharge newborn children and their mothers from the hospital within 24 hours after birth led to an outcry against “drive-by” deliveries. A number of state legislatures passed laws mandating that insurance companies pay for no less than 48 hours of hospitalization following childbirth, and Congress soon included that requirement in federal law. Other federal statutes mandate coverage for hospitalization following mastectomies, and prohibit certain restrictions on insurance coverage for mental illness that exceed restrictions on coverage for physical illnesses.

These piecemeal reforms have led to calls for comprehensive managed care reform, including legal remedies for patients denied care they contend is medically necessary. Competing versions of the Patients’ Bill of Rights legislation have surfaced in the last two years, and there is little doubt the current Congress will tackle this red-hot issue.

II. Parallels Between Managed Care and “Managed Sentencing”

Since the movement to reduce doctors’ discretion and standardize health care decision making has come to be known as “managed care,” sentencing guidelines and mandatory minimums might well be called “managed sentencing.”

Although they both blossomed in the 1980’s, “managed care” and “managed sentencing” have different goals. Insurance companies utilize managed care to contain costs. The goals of managed sentencing are more complicated — early proponents of a sentencing guidelines system, such as Senator Kennedy, believed that the establishment of a body of sentencing law would help reduce unfair sentencing disparity, while Republican co-sponsors of the 1984 Sentencing Reform Act saw guidelines (and subsequent mandatory minimums) as a means to lengthen criminal sentences. Whether the motive is fairness, crime control, or health care cost containment, standardization is meant to trump what is perceived to be the too disparate or lenient exercise of discretion by professionals “in the field” — judges and doctors.

Advocates of standardized decision making tout the benefits of simplicity, clarity and (apparent) certainty. But attempts to impose overly rigid standards on professional decision making in complex, fact-bound fields like criminal justice and medicine are misguided. The effort often fails because sophisticated decision makers are adept at finding ways around the rules. Thus, mandatory sentencing laws are not truly mandatory, since prosecutors, judges and defense attorneys can agree to permit sympathetic defendants who have committed offenses that carry a mandatory sentence to plead guilty to lesser or

different offenses that do not carry a mandatory sentence. Similarly, doctors can evade insurance rules on behalf of their patients by falsely labeling as medically necessary procedures that are in fact elective or cosmetic, or by selecting a diagnosis that will lead to reimbursement instead of one that will not.

Still, law and conscience limit the extent to which judges or doctors will manipulate the rules that purport to bind them. When those limits are reached, standardization yields grossly unfair results in individual cases and frustration results. Judges are precluded from imposing just sentences, doctors are precluded from practicing sound medicine, and the wheels of legislative reform begin to turn.

Managed care reform, as we have seen, will never go so far as to abolish the rules that insurance companies impose on physicians. Since there is broad recognition that cost containment is a legitimate goal, reformers try to strike a balance between standardization and medical discretion. For example, some proposals rewrite those rules to make them less restrictive (e.g., women get to stay in the hospital longer after giving birth), or they encourage departures from the rules (e.g., doctors are permitted to advise patients about treatment options outside the plan’s coverage). Patients aggrieved by a decision under the rules (e.g., refusal to provide an experimental treatment) are afforded the right to appeal that decision to a higher authority.

Structurally, then, managed care reform resembles the 1984 Sentencing Reform Act. Congress established a Sentencing Commission to write standards, but explicitly permitted judges to depart from those standards upon a finding of aggravating or mitigating circumstances not anticipated by the rule makers. Then, to bolster standardization, it permitted either party aggrieved by a departure to appeal that decision to a higher court.

Unfortunately, the thoughtful sentencing structure established by the 1984 Act is crumbling from neglect. Beginning in 1986 and as recently as last October, Congress has enacted mandatory minimum sentencing laws that distort the guideline system and that are the antithesis of balance. An effort to redress the inflexibility of mandatory minimums — the 1994 safety valve amendment to 18 U.S.C. 3553 — is itself overly prescriptive and depressingly narrow. The guidelines are less rigid than the mandatories, but Congress repeatedly undermines the work of the Commission with overly specific statutory directives and by blocking Commission proposals to improve the guidelines. Meanwhile the Commission itself now has no members as a result of political wrangling between the Justice Department and the Senate.

Federal sentencing today is harsher and more unthinking than the most heavy-handed managed care rule ever imposed by an insurance company. Just like overly rigid managed care, the sentencing rules are often evaded; when they cannot be evaded, they often result in needless pain and suffering. If the pre-1984 sentencing system was, as Judge Frankel put it, law without order, the current system is order without justice.

III. Lessons

If concern about the excesses of managed care generates sensible reforms that strike a fair balance between insurance companies' legitimate need for standardization and the medical profession's right to exercise discretion in individual cases, that debate will have great relevance to the course of federal sentencing policy.

One lesson of the managed care debate is easily applied to sentencing policy: mandatory sentencing laws are wrong. They should no longer be enacted, and they should all be repealed. Just as insurance mandates that arbitrarily cut off medical care without giving doctors the chance to take account of the unique needs of individual patients are wrong, so congressional mandates that impose punishment without giving judges the chance to take account of the unique circumstances of individual crimes and individual criminals are wrong.

A second lesson is directed to the Sentencing Commission, should its new members ever be appointed. The current guidelines are too rigid, and provide for insufficient consideration of offender characteristics. The mere opportunity to depart from standards is not enough, for either judge or doctor. There must be genuine flexibility in the rules themselves, and a culture of decision making in which judicious adjustments based on unusual circumstances may occur without stigma or retribution. To be sure, there should always be an opportunity to remedy incorrect departures through appeal, but complex goods like justice or medicine cannot be dispensed in a mechanistic, cookie cutter fashion.

The lesson of managed care and sentencing reform is not unique, indeed it is at the heart of our system of government. Most disputes in our society pose mixed questions of law and fact. All laws passed by Congress are in some sense standards, yet all are applied by administrative agencies and judges in individual cases. Any law so inflexible that it cannot be applied in a rational manner by wise decision makers in individual cases should be rewritten.

Mandatory minimums, overly rigid sentencing guidelines and overly rigid managed care are all flawed because they pretend that somber and complex human decisions can be made based on law alone.

Legislatures, sentencing commissions or insurance companies that seek to deprive judges or doctors of the discretion to apply the law or the rules to the facts of the case have unwisely arrogated too much power to themselves.

Any decision making model that turns judges or doctors into mere technicians is especially foolish. The skill most prized in a judge or a doctor is sound judgment, and the essence of judgment is differentiating one set of facts from another in order to make a wise decision. To a distant rulemaking body two patients or two criminals may look alike, but the skilled professional can tell them apart on close examination. It is no coincidence that doctors are leaving the practice of medicine and judges are leaving the bench in the face of twin schemes that deprive them of the ability to use their judgment.

None of this is to deny that there are sound reasons for the rise of both managed care and sentencing guidelines. Medicine is too expensive these days for doctors to dispense without any accountability to third party payors. Well regulated managed care can help constrain health care costs without unduly compromising the quality of health care, just as guidelines can lead to more equitable and understandable sentencing decisions than the lawless "black-box" process that pre-dated the 1984 Act.

But in the final analysis, only a doctor — not an insurance company — can treat a sick patient. And only a judge — not a legislature or an overzealous commission — can sentence a criminal defendant.