“Dying to Make a Profit” Health Insurance Companies Dirty Little Secret

(SE) Chris Ryan October 07, 2010

A wise Jewish Rabbi once pointed out what seems on reflection to be stunningly obvious: “No one can serve two masters, for either he will hate the one and love the other, or he will be devoted to the one and despise the other.” [1] Yet for years public health insurance companies have convinced Americans that Jesus was simply wrong. You can have your cake and eat it, too. You can have it both ways. And yes, Virginia, you can deliver quality, affordable health care to the consumer while generating a profit for your shareholders.

The American health insurance industry may well have accomplished one of the greatest triumphs of rhetoric over common sense in recorded history. They have successfully convinced the public, and perhaps even themselves, that not even the people’s own government cares about their health as much as they do. At the same time, they express openly in the strongest terms their commitment to deliver increasing value to their shareholders. [1] They believe – and want America to believe – that they can serve two masters, and do so with integrity.

But the reality of this impossible task is finally catching up with the industry. One of the tools public insurance companies use to hide the depth of their corporate split personality crumbled under the weight of a significant Supreme Court ruling several years ago. [2] Now the Securities and Exchange Commission (SEC) rules created by the Sarbanes-Oxley Act of 2002 are forcing insurance companies to lay their cards on the table, as it were, and openly admit what common sense should have made obvious: they have been attempting for years to serve two masters. Like Archie in the classic comic book series, they must now choose between Veronica and Betty. The days of “playing the field” are coming to an end. The wife is about to meet the mistress.

The Fiduciary Duty of an Insurance Company

The trouble for health insurance companies begins with the very essence of what it means to offer “insurance.” When most people think of a business, they picture in their mind a company offering a good or service who, if they are innovative enough and committed enough, will outsell their competition. Such a company cannot rest on their past accomplishment in a capitalistic system, however. There is always another company that may be building a better product, or offering a better service for less, who may ultimately put them out of business. Such a system thrives on competition, encourages innovation, and offers good choices to the consuming public.

It is tempting to view insurance as just another good or service to be provided in the marketplace. Do insurance companies really need their own special set of rules under which they must conduct business? Why not allow insurance companies to freely compete under the same rules that apply to, say, lawnmower manufacturers? Competition between lawnmower manufacturers gives the consumer more choices and in theory encourages the manufacture of better lawnmowers; would not competition between insurance providers give consumers the same variety of choices and encourage better protection for the insured?

The analogy is flawed, however, because there is a fundamental difference between lawnmowers and insurance. The difference becomes most apparent when you consider what happens when something goes wrong with the lawnmower. Suppose you bring it home, and within days discover the engine is faulty, that the wheels fall off continually, or that the blade is about as sharp as the edge of a 2 by 4. What remedies can you pursue? You can return the machine to the store and demand a refund, or an exchange on another machine. Either way, you are out
no more money than you were before you made the purchase. You may have lost some time and suffered some aggravation, but little else.

What happens, however, if you find that you have purchased faulty insurance? What if the insurance company, for example, is not willing to fulfill the terms of the policy you purchased? You may have lost your automobile, your house, or be facing an expensive surgical procedure. You do not have the option of returning your insurance policy for a “refund.” You have done more than given them a check for $200 in return for the promise, with a little effort on your part, of a mowed lawn. You have entrusted the insurance company with money up front so that, if the unfortunate should happen, they will be there to back you up.

This is why insurance companies, under both common law and, in many cases, the law of the land, have to play by different rules than other businesses. Like banks, insurance companies are said to have a “fiduciary duty” to their clients. Fiduciary comes from the Latin word *fides*, which translates as “trust.” Those who have purchased insurance from a company have placed much more trust in that company’s promises than they would have to place in a lawnmower manufacturer. Insurance companies therefore fall under a category of businesses known as fiduciaries; they have a special trust relationship with their clients, who have entrusted them with property in return for future protection. The Random House Dictionary defines a fiduciary as “A person to whom property or power is entrusted for the benefit of another.”[ii] Webster’s Third New Dictionary explains that a fiduciary’s good conscience “requires one to act at all times for the sole benefit and interests of another with loyalty to those interests.”[iii]

The insured have done more than “purchase a service” from an insurance company. They have in fact given that company a certain power over them. An insurance policy is not a contract. Both parties to a contract are seeking their mutual benefit. Fiduciary relations, on the other hand, are designed “not to satisfy both parties’ needs, but only those of the entrustor.”[iv] In other words, the entrustor or insured is made promises by the insurance company, but not the other way around. It may seem that the premium payments that the insurance company receives from the one it is insuring is the “tit for tat” of the arrangement. But in actual fact, on closer examination, the relationship between insured and insurer is seen to be inherently unequal.

The insured, or entrustor, pays money upfront to a company with only a promise of aid in the future under specific circumstances in return. The insured are not just giving the insurance company money; they are vesting them with power. The amount of power depends on the extent which the insured, or entrustor, can leave their insurance company, retrieve their property, and choose another policy.[v] In the end, it is the entrustor or the insured that always stand to lose more in their relationship with the insurance company than the other way around.[vi]

Because of the fiduciary duties insurance companies owe their clients, they have always been the subject of special legal regulation. Those who adhere openly to these regulations, while they may find their freedom to conduct business limited, gain a reputation for honesty and trustworthiness.[vii] Unlike lawnmowers, where cost and quality may be the chief selling points, honesty and trustworthiness are what keeps insurance companies in business. Lose these in the eyes of the public, and your business could evaporate.

If all this is true of insurance companies in general, is it true of health insurance companies in particular? Do health insurance companies have, and do they recognize, a fiduciary duty to those they insure? Health insurance companies fit the definition of a fiduciary in three ways; by the way they practice and operate, by the way they portray themselves, and by the fact that the courts have concluded that they are.[viii] There is no getting around the fact that health insurance companies owe their policyholders “a high duty of care.”[ix] In Hartford Accident & Indemnity Co. vs. Michigan Mutual Insurance Co., the courts ruled that:

It is well established that, as between an insurer and its assured, a fiduciary relationship does exist, requiring utmost good faith by the carrier in its dealings with its insured. In defending a claim, an insurer is obligated to act with undivided loyalty; it may not place its own interests above those of its assured.[x]

**Enter the Mistress**

But health insurance companies are not only beholden to their policyholders. There is a mistress in the background
to whom health insurance companies also claim loyalty: their stockholders, and their bottom line. Of course many health insurance companies would suggest that the relationship is more akin to bigamy. Can a company not practice “big love?” Can it not be possible that the health insurance industry has found the secret to being able to serve two masters equitably?

First of all, there is no ignoring the fact that most insurance companies do in fact have a fiduciary duty to their shareholders. Under law, all officers of a corporation have two duties – a duty of care, and a duty of loyalty – to uphold. The duty of care refers to the officers’ responsibility not to act negligently in the performance of their duties. The duty of loyalty requires that they place the interests of the corporation – and its shareholders – above their own interests. Any officer that without thought for the corporation’s future or out of interest only for him or herself drove the business into bankruptcy would be guilty of breaching both their duty of care and their duty of loyalty.

But a corporation’s duty toward its stockholders may not be nearly as strong as an insurance company’s duties toward its policyholders. There are many examples in law of corporations overriding the concerns and desires of their stockholders – and their stock prices – to pursue more important aims for the corporation. Consider just a few examples.

First, it is in no way out of the ordinary for directors of a company to make decisions that unambiguously favor those to whom money is owed, but negatively impact stock prices. When a corporation files for bankruptcy, for example, the value of equity in the business is almost immediately destroyed, to the benefit of creditors. In this case, the duty owed the shareholders is overridden in favor of those who hold the corporation’s debt.

Second, “in a recapitalization, the board can, by creating a shell corporation with a new financial structure and then merging the old firm into the shell, eliminate a particular class of stock.” This in no way benefits the stockholders, but can benefit the firm itself.

A third case in point is the case of Shlensky vs. Wrigley, having to do with the installation of lights at Chicago’s Wrigley field to permit the playing of night games. The plaintiff argued that by not installing lights (which at this point existed at every other major ballpark), the value of the Chicago Cubs baseball team was not being maximized. Those on the board of the company who defended the inaction admitted that their decision not to install lights probably hurt stock prices. They based their decision to keep the park dark on the preferences of Wrigley’s majority owner, who believed fervently that baseball was a daytime game. The board was not in the least bothered by the fact that their decision to leave Wrigley in the dark did not maximize stock value.

In light of these and other examples, defending the notion that directors owe their duty solely to shareholders seems harder to defend today. Shareholders, in other words, are a fickle mistress. Yet many health insurance companies seem to be more devoted to this mistress than those to whom they are legally “married,” their policyholders. Note, too, that all of these examples are of regular businesses. Insurance companies, as has been pointed out, must operate differently. Their policyholders are more than mere “customers” or “clients.” They are entrusters to whom a fiduciary duty is owed.

**Having Your Cake and Eating It Too**

“But,” health insurance companies sometimes insist, “improving our bottom line benefits both shareholders and policyholders. By reducing the cost of health care we can both improve our bottom line and lower the cost of insurance to our policyholders. Everyone wins!”

On its face, this seems like a reasonable point. No one can argue that the cost of health care, apart from insurance, is increasing exponentially. The chief reason for this increase in cost is the increase in technological innovations that have made treatment for a disease vastly more effective – and expensive – than they were in the past.

The modern health insurance industry was born in the 1930s, during the Great Depression. The first health maintenance organization may well have been the managed care set up by Henry Kaiser, the industrialist, at the site of the Grand Coulee Dam in Washington State. Kaiser made arrangements with physicians to provide health care for the workers at the dam, which was located in a very remote area far from other treatment facilities.
The first fee for service (FFS) plans which followed the Blue Cross (hospital services insurance) and Blue Shield (physician services insurance) model were usually organized and run by hospitals and physicians themselves. Because payments were made relative to the number of services provided, FFS plans tended to encourage over-prescription of medical services. Doctors ordered too many tests and procedures, which in turn drove up costs. A 'do-everything' mentality, regardless of outcome or quality of care, thrived.

The steady increase in the number of tests and treatments available, especially through the 1960s and 1970s, further increased the cost of health care. Few individuals could pay for the high tech care now available to them without insurance. But at the same time, the probability that any given patient would need the new and expensive treatments was low enough that insurance costs remained low for a time.

In addition to increases in the cost of treatment options, there are two other reasons for an increase in the cost of health care which, in truth, have nothing to do with actions on behalf of insurance companies. The first is the demographics of the United States; as the population ages, and the percentage of the overall population over 65 grows, the cost of overall health care increases correspondingly. The second has to do with an increase in lifestyle and environmental diseases. The rate of obesity in the United States continues to increase, owing to a more sedentary lifestyle (less exercise) and more processed foods that lead to increased weight. Diseases associated with unhealthy living and eating such as diabetes need to be treated over a long period of time, and so in turn lead to a significant increase in treatment costs.

Having said all that, it might seem that the increase in health insurance costs is beyond the control of health insurance companies. They are simply victims of circumstance. Yet too often health insurance companies, because they choose to serve their shareholders rather than their policyholders, make a bad situation worse rather than better. In addition to the increased cost of technology, the aging of the population, and lifestyle and environmental diseases, there are three other causes for the rise of health insurance costs. Not surprisingly these all are all connected directly with the profit motive of insurance companies, and not at all with improvements in health care. They are an increase in charges for the same services, providing new but unneeded services simply to gain market share, and striving to identify more and more services as medical, rather than societal, issues.

This last deserves some explanation. Take, for example, obesity. The health effects of obesity can be lifelong, and result in a long stream of medical management costs. The issue is at heart a societal problem, and one that could be tackled through prevention initiatives. The cost savings that could result from helping just one person remain fit are significant. Yet the insurance industry often draws political and financial support away from such initiatives. Furthermore, the tendency to “medicalize” certain social problems also serves to increase health care costs for everyone. Not only do health insurance companies not help control these costs, in some cases they can play a significant role in increasing them.

What’s Good for the Mistress…

Health insurance companies still want to convince the public that they can manage their duty to their shareholders without effecting patient care, and that they are in fact a force for good when it comes to quality of treatment and increasing health outcomes. If they manage patient care properly and reduce costs, will that not help bring down insurance costs for everyone? Is not some amount of “rationing of care” necessary to keep costs under control?

This may be true, if the motive for the rationing was purely to benefit the policyholder. The rationing could then even be construed as the insurance company upholding its fiduciary duty to the insured. In fact most health insurance companies, when explaining the rationale behind rationing care, usually couch it in terms of “reducing unnecessary care” and “improving quality of care.”

If that is the case, then why has there been such subterfuge when it comes to the insured pressing insurance
companies with claims that they have breached their fiduciary duty? In other words, why have so many health insurance companies hidden behind one federal statute in particular to protect themselves from claims they have breached their duties?

That particular law is the 1974 Employee Retirement Income Security Act, also known as ERISA. The law was passed to set “minimum standards for most voluntarily established pension and health plans in private industry [and] to provide protection for individuals in these plans.” [xxv] It was a successor to the 1973 Health Maintenance Organization Act. One of the key features of that act was to recognize cost containment measures as an acceptable and appropriate part of health insurance. [xxvi] Like many laws, both the MCO Act and ERISA were enacted to serve a laudable purpose: to provide for uniform standards for health insurance plans across the nation. But in so doing, ERISA also made it impossible for states to accomplish one of their primary purposes, the regulation of the insurance industry, including health insurance. Because of ERISA, health insurance companies were able to claim they were exempt from state insurance regulations. [5]

Even worse, courts interpreted ERISA as making many health insurance plans exempt from litigation. In other words, the insured now found they had few, if any, means of addressing grievances against their health insurance companies. The end result was an increasing shift in duty within insurance companies away from care of the policyholder to the considerations of the stockholder. One legal writer has pointed out that:

…as the courts recognized ERISA preemption of both state tort lawsuits and state regulation dealing with MCO control of medical decisionmaking, ERISA MCOs became more ruthless in their cost cutting and less concerned about the quality of care. [xxvii]

One example involved a case in Lancaster involving an 11 year old child suffering from headaches. The child's parents had health insurance with the Kaiser Foundation Health Plan, a plan operated under ERISA. This particular plan provided a financial incentive to primary care physicians to not refer patients to a specialist. Over the course of five years the child was treated for headaches but without any diagnostic tests actually performed. No neurologist ever evaluated the symptoms. Finally, after five years, the parents insisted on a neurological exam, at which it was revealed that 40% of the child’s brain had been replaced by a tumor. When the parents attempts to sue the HMO, the court claimed there was no breach of fiduciary duty on the part of the insurance company. They rejected the parents claim, stating: “there is no remedy against an ERISA plan using an improper incentive plan or even hiding the incentive plan from its patients.” [xxviii]

If health insurance companies are simply trying to improve service to their customers, and the constant evasion of regulation by hiding behind ERISA is simply a misunderstanding, how do the insurance companies explain their rescission of policies? Rescission is a process whereby insurance companies purposefully seek out policy holders whose policies can be “dropped.” These policyholders are, of course, those whose medical expenses are usually growing and who have become a liability to the profit of the company. The justification for the rescission is usually found in a patient’s having neglected to disclose some previous illness, but could also be something as trivial as a form that went unsigned, or even a misreported weight or height. In June of 2009 executives of three major health insurance companies were asked by a congressman whether they would “commit…that your company will never rescind another policy unless there was intentional fraudulent misrepresentation in their application.” All three answered with an emphatic, “no.”

If health insurance companies are only trying to improve service to their policyholders when they engage in cost cutting measures, how can it be that the quality of service provided by these insurers continues to drop? Already a decade ago, a study published in the Journal of the American Medical Association reported on the quality of care provided in investor-owned health maintenance organizations vs. not-for-profit HMOs. Their conclusion was that: Investor-owned HMOs…are associated with reduced quality of care. Although total costs are similar in investor-owned and not-for-profit plans, the latter spend more on patient care. [xxix]

They were not alone in their assessment that the stockholder tends to win out over the policyholder in for-profit health insurance plans. Two other studies showed that for-profit hospitals, for example, end up charging more for treatment,
and have higher mortality rates among their patients. One possible reason given for the higher mortality rates at the for-profit hospitals was “limitations of care that adversely affect patient outcomes.” [xxx] In explaining possible reasons for the higher costs, the researchers said that:

The likely explanation is the necessity to generate revenues to satisfy investors, a requirement absent in private not-for-profit hospitals. Private for-profit hospitals are also burdened with a 6% absolute increase in the proportion of hospital spending devoted to administration as compared with private not-for-profit hospitals. Further, executive bonus incentives are over 20% higher at private for-profit than at private not-for-profit hospitals. [xxxi]

**The End of the Affair**

Despite their many protestations, it would seem that health insurance companies have clearly chosen which master they will serve, and that master is not the policyholder. In trying to conceal this fact from policyholders, they have ended up also doing a disservice to their stockholders. Perhaps more than a disservice: health insurance companies are now running dangerously close to the line of illegality, and may in fact have crossed it outright. Bigamy is, after all, illegal in this country. The current state of case law and SEC rules has now made “corporate bigamy” equally illicit.

First, the ability of insurance companies to hide behind ERISA came to an end with the 2000 Supreme Court case *Pegram vs. Herdich*. While the court decided in this case for the health insurance company, the decision greatly reduced the immunity of health insurance companies from litigation. In short, the Supreme Court decided that “an ERISA MCO is protected from liability when making a pure eligibility decision, but not in the case of a pure medical treatment decision or a mixed eligibility-medical decision.” [xxiii] According to the decision rendered by the justices, a health insurance plan is within its rights to deny coverage to a patient if – and only if – the policy explicitly states that such coverage is not included in the plan. But in every other circumstance where coverage is denied, the denial of care could be considered a breach of fiduciary duty, for which the company can now be held liable. This was, if you will, a kiss between mistress and master caught on camera.

Then came the Sarbanes-Oxley Act of 2002, which forced the Securities and Exchange Commission to enact many new reporting rules for corporations. One of these rules, seemingly innocuous, states that the financial disclosures of any public company should:

…provide investors with insight into the overall magnitude of a registrant's off-balance sheet activities, the specific material impact of the arrangements on a registrant and the circumstances that could cause material contingent obligations or liabilities to come to fruition.[xxxiii]

What does this mean? First of all, because of *Pegram vs. Herdich*, all health insurance companies can be held liable for breach of duty if their denial of care stems from a medical or mixed medical and eligibility decision. The possibility of lawsuits because of a breach of care is now a contingent liability that must be accounted for in a health insurance company’s filings with the SEC. Insurance companies must report to their stockholders as well as to the SEC their duty to their policyholders, and what that might mean for the company’s bottom line. Investors will be reminded that a health insurance company is no mere widget manufacturer: they are in a business where they owe a “high duty of care” to their clients, and have a fiduciary, and not merely a contractual, obligation to them. The affair is out of the bag, and both spouse and mistress will now meet out in the open for the first time.

This should lead stockholders and other interested parties to ask the obvious question: is this contingent liability being disclosed by health insurance companies? Are they setting aside funds off their balance sheets for the possibility of failed law suits? Are these companies realizing that policyholders may, at long last, get their day in court? A close perusal of the audited statements submitted by these insurance companies to the SEC, however, will find no such disclosures.

Should this be so surprising? No husband, confronted by his wife with evidence that he’s had a dalliance with someone else, will readily admit to the fact. He’ll do his best to hide the truth for as long as possible. The husband of the scorned wife knows that if the she discovers the full extent of his unfaithfulness, he stands to lose much: a
messy divorce proceeding where the wife can demonstrate she is not at fault can lead to hefty alimony payments, the loss of property and investments, and more. The situation is similar for the officers of health insurance companies. Their compensation packages are tied directly to their company’s profitability. [6] Their company’s profitability is, in turn, tied to keeping the true nature of the conflict in their fiduciary duties hidden.

The fact that this information is not disclosed by health companies in their SEC filings could lead to serious legal ramifications. Non-disclosure of information is serious enough. But material omission of information and conspiracy to conceal that information is quite another. This would place health insurance companies not only in jeopardy of lawsuits from their policyholders, but in danger of legal action for fraud. [7]

[1] Consider as one example Aetna, one of the nation’s leading health insurance providers. First, from their Second Quarter 2009 results: “Our second quarter results do not meet our expectations or the standards we have established over several years of strong operational execution and financial performance,” said Ronald A. Williams, chairman and CEO… “Aetna has a sound strategy. We have built a diverse portfolio of high-performing businesses; our brand continues to resonate in our key markets; and we have a sound business model. We are confident that we can achieve our goal of long-term profitable growth.” (http://www.aetna.com/news/newsReleases/2009/pr_2ndquarter2009_earnings.html, last accessed August 24, 2009).

Second, contrast these last remarks with their mission statement: “Aetna is dedicated to helping people achieve health and financial security by providing easy access to safe, cost-effective, high-quality health care and protecting their finances against health-related risks… At Aetna, we put the people who use our services at the center of everything we do.” (http://www.aetna.com/about/aetna/ms/, last accessed August 24, 2009). Aetna wants both shareholders and the insured to believe they are at the center of what they do.


[4] Most Americans live in dread of the idea of “rationed care,” which seems like such an un-American concept. The truth is that care is already rationed.

[5] ERISA applies to all employee pension and health plans established in the private sector (other than churches), including those established by employee groups like unions. ERISA does not apply to plans administered by federal, state, or local governments.

[6] In 2004, Aetna reported that the total compensation package for their CEO in 2001 was a little over $3.5 million. By 2008, total compensation for the position of CEO had grown to over $24 million, an almost seven fold increase in only seven years (information taken from Aetna’s Financial Proxy Statements).


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