1998

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THE PATIENTS' BILL OF RIGHTS: MANAGED CARE UNDER SIEGE

Michael Misocky

The primacy of the patient yields to a perverse accountability—to investors, bureaucrats, insurers, and employers. And patients worry that their physician’s judgment and advice are guided by the corporate bottom line.

INTRODUCTION

In 1791, Congress enacted the Bill of Rights to guard against the tyranny that infiltrated our nation’s early history. The first ten amendments were enacted to suppress governmental intrusion into the lives of individuals. Certain rights, such as the freedom of speech, religion, and association are deemed fundamental and guaranteed under the Constitution.

Today, institutional oppression, in the form of managed care, threatens our nation’s liberty. The tyrannical managed care organization (MCO) was developed to control skyrocketing health care costs. All

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2. See U.S. CONST. amends. I-X.
3. See id.
4. See Kenneth Pedroza, Note, Cutting Fat or Cutting Corners, Health Care Delivery and its Respondent Effect on Liability, 38 ARIZ. L. REV. 399, 400 (1996). One study accentuated rising health care costs this way: The amount of money spent on health care in the United States is staggering. In 1988, health care allotments comprised 11.2% of the Gross National Product (GNP), but only one year later, the percentage escalated to 11.6% ($604 billion), an increase of $60 billion. In 1990, the United States spent $2,511 per person on medical care, totaling $647 billion. Figures show that we spend far more on health care than other industrialized countries. The
though monetary benefits have been realized, the effect on patient health has been less than fortuitous. The MCO utilizes various cost containment mechanisms to suppress a patient’s freedom of choice, a physician’s freedom of speech, and a health care provider’s freedom of association. The following scenario provides an example of the travesty that percentage of GNP spent on health care continued to grow through 1992, reaching twelve percent by year’s end, and it is expected to swell to sixteen percent by the year 2000. In fact, the percentage of GNP spent on health care rose to fourteen percent by 1993, totaling $942 billion.

Id.

5. See Alycia Regan, Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care, 30 COLUM. J.L. & SOC. PROBS. 635, 637 (1997) (describing the exponential growth of managed care organizations). Since 1993, MCOs have dramatically grown in number and expanded into new markets. See id. In 1995, approximately 19% of Americans were enrolled in health maintenance organizations (HMOs). See id. Likewise, it is estimated that 73% of Americans who receive health insurance through their employers are enrolled in MCOs. See id. “[T]his increasing reliance on managed care may be traced to a growing belief among employers and legislators that health care costs were spiraling out of control and that the traditional medical system could not adequately contain those costs.” Id.

6. See generally Diana Bearden & Bryan Maedgen, Emerging Theories of Liability in the Managed Health Care Industry, 47 BAYLOR L. REV. 285, 294-95 (1995); Ralph O. Bischoff & David B. Nash, Managed Care: Past, Present, and Future, 80 MED. CLINIC N. AM. 225 (1996); Deven C. McGraw, Note, Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?, 83 GEO. L.J. 1821, 1825 (1995); David Orentlicher, Paying Physicians More to do Less, 30 U. RICH. L. REV. 155, 155-64 (1997); Michael Malinowski, Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics, 22 AM. J.L. & MED. 331, 331-32 (1996) (noting that health care delivery is controlled in a variety of ways such as charging patients a fixed monthly fee, called a premium, and limiting patient access to health care); Barbara Noah, The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?, 48 MERCER L. REV. 1212, 1223 (1997) (noting that MCOs can be anything from a simple association of physicians to a more complex fully integrated arrangement); Pedroza, supra note 4, at 411 (describing the cost containment mechanisms used by MCOs).
accompanies health care in our nation today.  

Jane Doe, a woman in her mid-thirties, notices what she believes to be a lump on her left breast. Concerned about breast cancer because there is a history of the disease in her family, Jane decides to seek the medical advice of a doctor. Through her employer, Jane is a member of a health maintenance organization (HMO) which provides and pays for her medical care. Jane is not permitted to see her regular doctor because the physician is not pre-approved by the HMO. Instead, Jane must consult the physician designated by the HMO.

Jane’s physician suspects that she may need to see a specialist, but he has already exceeded the maximum referrals for the month. Therefore, he elects to forego the referral. Jane is unaware that her HMO provides financial incentives to her physician to limit the number of referrals. Moreover, Jane’s physician would like to utilize a new breast cancer test, but her HMO does not cover the procedure. Pursuant to his contract with the HMO, the physician is “gagged” from even informing Jane of the existence of the procedure.  

Thereafter, Jane develops breast cancer and the cancer spreads throughout her body. Although breast cancer remains a highly treatable carcinoma, if it is left undetected and untreated, there can be irreparable ramifications. As a result of the HMO’s failure to provide quality care, Jane is left to suffer a horrible and tragic death from cancer.

7. The hypothetical was developed by reviewing some of the stories and tragedies noted in research articles cited within this text.

8. See Swanson, supra note 6, at 314 (discussing gag clauses and their impact on health care). The author notes that MCOs use a drastic mechanism known as a gag clause to preclude physicians from criticizing managed care plans. See id. at 314-16. “Gag clauses are provisions in physician contracts which prevent them, explicitly or implicitly, from giving patients information about treatment options that may not be covered by their health plan.” AMA Takes Stand Against Health Plan ‘Gag’ Rules, West’s Legal News, July 12, 1996, available in 1996 WL 382081. In essence, a gag clause constrains free and unfettered discussion between a doctor and patient. See Julia Martin & Lisa Bjerknes, The Legal and Ethical Implications of Gag Clauses in Physicians Contracts, 22 AM. J. L. & MED. 433, 434 (1996).

9. See, e.g., Darrel Rowland, Cancer Victim Says She Finds Managed Care Unmanageable, COLUM. DISPATCH, Feb. 1, 1998, at A01 (describing Linda Smrdel’s fear that her MCO is going to kill her). “Her health insurer refuses to cover a treatment she desires for breast cancer, which has ravaged her family.” Id. Both her mother and aunt died of cancer at young ages. See id. “Smrdel’s only sister was 35 when breast cancer claimed her life one year ago today.” Id. “In
In his 1997 State of the Union Address, President Clinton urged Congress to enact a patients' bill of rights. In April of 1997, Clinton appointed a thirty-four member advisory committee to address whether health care was driven by an inordinate number of cost controls. More specifically, Clinton argued that patients should have the right to choose their own doctors and be informed of their medical options. The Committee, comprised of doctors, consumer advocates, business people, and policy experts, drafted a bill in response to Clinton's call for health care reform.

Despite apparent bipartisan support, the 105th Congress failed successively to pass legislation protecting the rights of patients enrolled in managed care. However, there remains a substantial need for such legislation. Specifically, there is a need to provide safeguards against the hazards associated with the cost-control mechanisms inherent to managed care. Such safeguards should: (1) allow patients to go to the nearest hospital in an emergency, (2) guarantee access to specialists, (3) provide detailed information about the quality of care, and (4) create a system for appealing denials of care to a neutral party.

A patient's bill of November, at the age of 35, Smrdel got the news that she too has breast cancer.” Id. “Almost immediately, doctors removed her breasts one of which had a cancerous tumor the size of a baseball.” Id. Her doctor along with three other physicians agreed that such a bone marrow transplant was needed because of her family's medical history. See id. Unfortunately, her insurance company would not pay for the transplant, which cost between $75,000 and $150,000, deeming the procedure experimental. See id. All too often, the “experimental” language is being used to deny treatment.


11. See Chase, supra note 10. For instance, a number of the issues that the panel was expected to address included allowing patients greater access to hospitals, payment in emergencies, guaranteeing access to specialists, providing detailed information about the quality of care, and creating a system for appealing denials of care. See id.

12. See John F. Dickerson, Dr. Clinton Scrubs Up, His Plan For Health-Care Surgery is Less Radical this Time, TIME, Dec. 8, 1997, at 48.

13. See id. The author notes that Clinton's attempt at developing a patients' bill of rights had more support from republicans than did his national health insurance proposal three years prior. See id.

14. See id; see also Richard Acello, Kaiser in Coalition Backing Patients'
rights is necessary to ensure the safety and quality of health care delivery. Due to the increasing number of patients enrolled in MCOs, if cost-control mechanisms continue to proliferate, the result could be hazardous to our nation's health.

This article explores proposals concerning the issue of patients' rights and addresses the benefits and shortcomings that may arise if a patients' bill of rights is enacted. Part I will present a background of managed care in the United States. Part II will discuss some of the cost-containment mechanisms utilized by MCOs and the resulting liability. Part III discusses theories of liability in managed care scenarios. Finally, Part IV discusses the issues that arise under managed care systems and how those issues can be addressed through legislation.

I. THE EVOLUTION OF MANAGED CARE

A. Fee-for-Service System of Health Care

Historically, health care in the United States was provided on a fee-for-service basis. Under this system, a provider charged the patient a set fee for services rendered. The fee-for-service system gave physicians exclusive control over the diagnosis and treatment of patients. Furthermore, it afforded physicians the complete discretion to choose.

Rights in HMOs, SAN DIEGO BUS. J., Nov. 3, 1997, at 32. "[A] coalition of consumer-oriented health care advocates and San Diego’s largest HMO are teaming up to propose a comprehensive 18-point patients’ bill of rights for the millions who are HMO members." Id.

15. See Gary T. Swartz, A National Health Care Program: What Its Effect Would Be On American Tort Law and Malpractice Law, 79 CORNELL L. REV. 1359 (1994). Under the traditional fee-for-service system of health care, physicians had no incentive to contain costs. See id. Rather, the physician would often overutilize to avoid malpractice liability. See id. "If a particular test or method of treatment provides even a five percent benefit to the patient, but at a much greater cost than a more inexpensive, though possibly less effective alternative, physicians almost always provide the more expensive treatment.” Allison Faber Walsh, Comment, The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations, 31 J. MARSHALL L. REV. 207, 211 (1997).

16. See Freiburg, supra note 6, at 584. The author notes that under a fee-for-service system, the provider determines an appropriate fee and then bills the patient or insurance company directly. See id. at 584-85; see also Faber Walsh, supra note 15, at 213 (noting that under a fee-for-service system physicians exercise exclusive control over the diagnosis and treatment of patients).
the method and cost of treatment. Although the patient remained primarily responsible for payment, the patient’s insurance carrier often paid for the treatment or services. Increased utilization of medical services and treatments provided physicians with greater profits and shielded them against medical malpractice lawsuits. As a result, the fee-for-service system encouraged physicians to over-utilize treatment because they had no incentive to control costs.

B. The Advent of Managed Care

Due to escalating health care costs, Congress passed the Health

17. See Faber Walsh, supra note 15 at 213; see also Vernellia Randall, Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients For Health Care Cost Containment Injuries, 17 U. PUGET SOUND L. REV. 1, 4-5 (1993) (arguing that “utilization review and financial risk shifting create the possibility that patients may be injured in totally new ways”). The author states that:

Before the new relationships were created, the only way a patient could be medically injured was through the physician’s conduct. With the advent of the new relationships, patients may be indirectly medically injured because decisions may be made based on some statistical norm, not on the patient’s individual condition. Further, the patient may be medically injured by conduct of the physician, not because of the physician’s own decision, but because of a third-party payer’s guidelines, with which the physician is trying to comply.

Id.

18. See Randall, supra note 17, at 15. Under indemnity insurance, a patient’s insurer agrees to indemnify the physician for the expense of a patient’s medical care. See id.

19. See generally Faber Walsh, supra note 15, at 213; Randall, supra note 17. See also William Chittenden III, Malpractice Liability and Managed Healthcare: History and Prognosis, 26 TORT & INS. L.J. 451, 476 (1991) (discussing the impact fee-for-service systems had on malpractice liability and noting that a physician would overutilize treatment because he could prevent malpractice liability).

20. See Randall, supra note 17, at 15; see also Pedroza, supra note 4, at 404 (1996) (discussing defensive medicine and its impact on health care delivery). Neither physicians, nor patients, are concerned about costs under the fee-for-service system because a third party payor, who is uninvolved in the decision about treatment, ultimately pays the bill. See id. It is difficult to determine if defensive medicine has substantially affected escalating health care costs because physicians spend more money when over-treating patients as a means of avoiding liability. See id. at 401.
Maintenance Act of 1973 which promoted the growth of managed care.\textsuperscript{21} As defined by one commentator, "[M]anaged care is a comprehensive term describing a system of health care cost containment that deviates from the traditional health care delivery system by substituting pre-arranged fee structures and utilization review procedures for fee-for-service billing."\textsuperscript{22} Essentially, a managed care system attempts to provide quality health care in a cost-efficient manner, modifying the traditional fee-for-service system by involving a third party to the contract between doctor and patient.\textsuperscript{23} The new contract between the provider

\textsuperscript{21} See 42 U.S.C. § 300(e) (1994) (amended 1976, 1978, 1981, 1986, 1988). The purpose of the Federal HMO Act is to provide financial assistance to HMOs as long as they meet prescribed qualifications. See Bearden & Maedgen, \textit{supra} note 6, at 292. The federal government approves loans and grants to entrepreneurs interested in creating HMOs that meet federal requirements. See \textit{id}. In order to receive financial assistance from the government, an HMO must abide by certain requirements set forth in the Act. See \textit{id}. The rules and regulations provide a structure that the HMOs must follow to assure quality health care. See \textit{id}. The Act also requires HMOs to assume all responsibility for health care services on a prospective basis. See \textit{id}. However, the Act permits physicians contracted by the HMOs to assume financial risk for the rendering of health care services. See \textit{id}. 

\textsuperscript{22} Freiburg, \textit{supra} note 6, at 584. Managed care systems share the following characteristics:

1. a separate MCO entity that contracts for the provision of health care services to subscribers or their enrollees (e.g., employees and dependents);
2. a network of providers working for or under contract with the MCO who provide services to enrollees of the MCO pursuant to pre-determined compensation arrangements between the MCO and the providers;
3. a system of utilization management designed to ensure that services are both medically necessary and cost efficient;
4. financial incentives to the MCO's enrollees to use the MCO's provider network.

\textit{Id.} at 585 (citations omitted).

\textsuperscript{23} See \textit{id}. In the United States, the traditional reimbursement system for physicians is called fee-for-service. See \textit{id}. Under a fee-for-service system, a provider determines an appropriate fee for his services and then either bills the patient directly or his insurance company. See \textit{id}. The fee-for-service system creates two contracts, a contract between the patient and physician, and a contract between the patient and insurance company. See \textit{id}. While the insurance company may receive the bill from the physician, it cannot lower the charged fees though the insurance company may elect not to cover all the costs. See \textit{id}. The patient is then responsible for any charges not covered by the insurance company. See \textit{id}. The physician therefore always receives reimbursement for any services provided to his patients. See \textit{id}. 

and the MCO "limits the amount which the provider may receive for services and restricts ... the provider's ability to bill the patient directly." A growing belief among employers and legislators was that health care costs were spiraling out of control. As a result, this caused the increased reliance on managed care. It is now estimated that approximately seventy-three percent of Americans who obtain health insurance through their employers are enrolled in MCOs.

C. Health Maintenance Organizations

There is widespread use of HMOs in the U.S. to contain costs in the health care industry. Since 1995, nineteen percent of Americans have been enrolled in an HMO. A HMO is "an organized system of health care which provides or arranges for a comprehensive array of basic and supplemental health care services." HMOs often work on a capitation basis: participants pay for services by a lump sum per month, regardless of the actual number of services provided to each member. Under this arrangement, the financial risk of caring for the enrollees shifts to the

24. Id.
25. See Bischoff & Nash, supra note 6, at 227 (noting the dramatic rise in managed care enrollment over the last two decades and the significant increase in the cost of health care as the major reason for the proliferation of managed care).
26. See Pedroza, supra note 4, at 408.
27. See McGraw, supra note 6, at 1823 n.12. From 1970 to 1990, enrollment in HMOs escalated from 3.6 million to 35 million. See id. at 1823. HMOs were implemented as the first system to attain the goal of lowering health care costs, however, new delivery systems such as PPOs and POS plans have recently emerged. See id.
28. Bearden & Magden, supra note 6, at 289 (citation omitted). HMOs are health care systems accountable for the delivery, management, and financing of health care services to a group of covered members. See PATRICIA YOUNGER ET AL., MANAGED CARE LAW MANUAL 2 (1994). HMOs are responsible for preparing medical services and treatment through health care providers and for covering the medical costs of the treatment. See Bearden & Magden, supra note 6, at 290. For a thorough discussion of managed care see generally GORDON K. MACLEOD, AN OVERVIEW OF MANAGED HEALTH CARE 4 (2d ed. 1993). The costs of treating the subscribers are prepaid and either the HMO, the health care providers, or both are at financial risk for the overuse of medical services. See Freiburg, supra note 6, at 585 (describing the alphabet soup of managed care entities and the roles they play in health care delivery).
29. See Freiburg, supra note 6, at 585; see also Bearden & Maedgen, supra note 6, at 293.
primary care physician. When an HMO contracts with physicians under a capitated system, the HMO places a financial burden on the physician for any medical costs which exceed the capitated rate for each patient. The most distinguishing characteristic of membership in an HMO is that the enrolled member pays a periodic, prepaid, fixed fee for medical services, rather than the traditional separate fee for each medical service rendered. Thus, in an HMO arrangement, the patient pays a fixed fee, while the HMO contracts with a health care provider and pays for the services provided to the patient.

The three basic types or models of HMOs are the Staff, the Group, and the Independent Practice Association (IPA) models. In a Staff model, physicians are directly employed by the HMO, which compensates them as salaried employees. The physicians generally provide care “in one facility and receive the benefits of one administration, cen-

30. See Pedroza, supra note 4, at 412; see also Bearden & Maedgen, supra note 6 at 294-95.

31. See Bearden & Maedgen, supra note 6 at 294. The capitated rate is necessary to ensure the financial survival of the HMO. For example, “[e]xtensive referral to and the use of outside services and facilities can threaten the financial survival of the HMO.” Id. As a result, the HMO provides financial incentives to the physicians to limit his use of outside services. See id.

32. Id. at 290. “HMOs have been sponsored by physicians, consumer groups, employers, unions, insurance carriers, hospitals, universities, and community groups. No set pattern exists regarding the internal arrangements for risk sharing, utilization control, or administration of the HMO.” Id. at 291.

33. See id. at 290-91. But see Faber Walsh, supra note 15, at 208 n.3 (pointing out that under an HMO plan, enrollees are limited in their choices of physicians). Enrollees must receive health services exclusively from approved hospitals and physicians. See Malinowski, supra note 6, at 333.

34. See Pedroza, supra note 4, at 408.

35. See id; see also Freiburg, supra note 6, at 586 (“As HMO employees, the providers must render virtually all of their services at HMO facilities to the HMO’s enrollees.”). The “providers must be compensated ... on a basis other than fee-for-service (e.g., salary) and must share resources such as medical records and equipment with other HMO staff members.” Id.
centralized staffing, and equipment availability.\textsuperscript{36} In a Group model, the HMO contracts with a group of physicians to provide services for its patient enrollees.\textsuperscript{37} The physicians pool the income, share common facilities, and have access to most medical records.\textsuperscript{38} The payment arrangement in a Group model HMO is on a capitation basis.\textsuperscript{39} Finally, in an IPA model, individual doctors form a group practice that contracts with the HMO to provide health care for the subscribers.\textsuperscript{40} Rather than working on a capitated rate, physicians in an IPA model bargain with the HMO for a reduction in fees for each service rendered.\textsuperscript{41} Consequently, the HMO will provide patients with care on a discounted fee-for-service basis.

\textsuperscript{36} Bearden & Maedgen, supra note 6, at 292 ("In a staff model, physicians are employees of the HMO and a typical employer-employee relationship is established.").

\textsuperscript{37} See id. "In a group model, the HMO contracts with a group of physicians (typically an incorporated group practice), rather than individual physicians, to devote all or much of its time to providing care to HMO members at the group's clinic and facilities for a fixed monthly fee per covered individual." Id. at 292-93.

\textsuperscript{38} See id. at 293.

\textsuperscript{39} See id. at 586. "The providers must pool their HMO receipts and distribute them among members in a predetermined arrangement." Id. "They also must devote, in the aggregate, more than 35 percent of their professional time serving the HMO's subscribers, and, as in a staff model, must share medical records, equipment, [and other supplies.]" Id.

\textsuperscript{40} See id. at 586. "The individual practice association HMO model is popular with physicians because it gives them increased flexibility to choose the services they wish to provide and poses less financial risk to members than other models." Id. "An IPA is made up of individual practitioners, all of whom have their own private practices, but who organize to contract with HMOs for the rendition of health care services to HMO enrollees." Id. "An IPA generally operates on a fee-for-service basis, though there may be exceptions where capitation fees are paid for primary care services." Id.

\textsuperscript{41} See id. "Unlike a capitation fee, a discounted fee-for-service arrangement does not impose a periodic limit on the total fees that can be charged for services rendered to an HMO enrollee." Id. "The IPA must determine the method by which its members will be compensated from HMO receipts and must enter into a contract with its members describing the services to be rendered by the members and the member compensation formula." Id. "Unlike a group model, there is no minimum amount of time which IPA members are required to devote to HMO patients." Id.
D. Preferred Provider Organizations

In order to compete with HMOs, doctors and hospitals formed preferred provider organizations (PPOs).\footnote{See Bearden & Maedgen, supra note 6, at 297; see also Pedroza, supra note 4, at 409 (noting the similarities between PPOs and IPAs). In both IPA and PPO Model HMOs, the doctor contracts with the PPO to provide services to its subscribers. See id; see also Orentlicher, supra note 6, at 158 (noting that under capitation, it is advantageous for a physician to provide care for more patients to increase compensation).} A PPO is defined as a "health care delivery model in which physicians, hospitals, and/or other providers of health care contract to administer their services on a predetermined fee-for-service basis to a defined group of patients."\footnote{See Bearden & Maedgen, supra note 6, at 297-98. "The preferred provider panel is typically comprised of those physicians and hospitals that have contracted to provide services to the PPO’s subscribers at discounted rates.” Id. “PPO physicians are not salaried, but instead are reimbursed on a fee-for-service basis at a negotiated or discounted rate.” Id. at 298. Moreover, “PPO physicians usually maintain their own private practices and may participate in more than one PPO.” Id. Thus, PPO physicians are independent contractors and they retain full independence in their medical practice. See id.} The organization usually involves a core panel of physicians, strict utilization management procedures, and disincentives for patients to utilize a non-PPO physician or hospital."\footnote{See generally Freiburg, supra note 6. “PPO subscribers are not restricted in physician choice, but they have an economic incentive to select a PPO physician over a non-PPO physician.” Bearden & Maedgen, supra note 6, at 297. For example, some plans provide for lower deductibles or savings account reimbursements for selecting a preferred provider. See id. “However most PPO organizations provide at least some reimbursement for care received by subscribers from a non-PPO physician.” Id.} In exchange for lower rates, the PPO offers a participating physician a greater volume of patients.\footnote{See Bearden & Maedgen, supra note 6, at 297-98. “The preferred provider panel is typically comprised of those physicians and hospitals that have contracted to provide services to the PPO’s subscribers at discounted rates.” Id. “PPO physicians are not salaried, but instead are reimbursed on a fee-for-service basis at a negotiated or discounted rate.” Id. at 298. Moreover, “PPO physicians usually maintain their own private practices and may participate in more than one PPO.” Id. Thus, PPO physicians are independent contractors and they retain full independence in their medical practice. See id.} The list of preferred providers that the subscribers have to choose from is made up of doctors who have historically admitted fewer patients and discharged

See Bearden & Maedgen, supra note 6, at 297; see also Pedroza, supra note 4, at 409 (noting the similarities between PPOs and IPAs). In both IPA and PPO Model HMOs, the doctor contracts with the PPO to provide services to its subscribers. See id; see also Orentlicher, supra note 6, at 158 (noting that under capitation, it is advantageous for a physician to provide care for more patients to increase compensation).

See Bearden & Maedgen, supra note 6, at 297 ("The organization resembles traditional direct payment insurance plans in that consumers pay premiums to the PPO, and the PPO then reimburses physicians and hospitals for their services."); see also Catherine Butler, Preferred Provider Organization Liability for Physician Malpractice, 11 AM. J. L. & MED. 345, 346 (1985). The difference from insurance plans, however, is that "PPOs obtain discounted rates by contracting directly with physicians and hospitals." Id. Members of a PPO are free to choose physicians in or out of the PPO, but members only receive discounts from those physicians who participate in the PPO. See id.

Bearden & Maedgen, supra note 6, at 297-98. “The preferred provider panel is typically comprised of those physicians and hospitals that have contracted to provide services to the PPO’s subscribers at discounted rates.” Id. “PPO physicians are not salaried, but instead are reimbursed on a fee-for-service basis at a negotiated or discounted rate.” Id. at 298. Moreover, “PPO physicians usually maintain their own private practices and may participate in more than one PPO.” Id. Thus, PPO physicians are independent contractors and they retain full independence in their medical practice. See id.

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them more quickly. Arguably, a physician's medical judgment may be skewed in a PPO because of the underlying interest in staying a participating provider in the organization.

II. Cost Containment Mechanisms Utilized by Managed Care

A. Capitation Payments

As noted above, MCOs rely heavily on capitation payments to reduce the costs of services. Under a traditional fee-for-service system, physicians often over-utilize medical services in order to raise the amount of money they will receive from a patient. Capitation largely removes the incentive to over-utilize services because a "third party payor compensates a physician at a flat rate for each patient enrolled in the MCO." The fee is predetermined based on the number of subscribers under the physician's care. Physicians receive the same amount of money for

46. Bearden & Maedgen, supra note 6, at 297. "Where a PPO is involved, medical decisions involving hospital admissions are usually subject to strict utilization controls." Id. "Almost all non-emergency admissions must be pre-approved and the lengths of hospital stays are closely monitored." Id. "Unlike HMO physicians, fee-for-service PPO physicians do not have financial incentives to limit care." Id; see also Freiburg, supra note 6, at 587. The financial risk of over-treatment under a PPO system lies entirely with the PPO, not with the physician. See id. For example, under a PPO, like a fee-for-service arrangement, both a doctor and the patient benefit from overutilization. See id. The only difference is that the fee is discounted. See id:

47. See generally Faber Walsh, supra note 15.

48. See id. at 216-17 (stressing the lack of incentive for both doctor and patient to control costs under fee-for-service care because they both reap the benefits from increased services).

49. Id. at 217-18. Actuarial data along with consideration of patient utilization patterns in specific health care plans and in the marketplace in general are used to calculate capitated rates. See id. "Historical data or industry wide statistics are used to estimate the utilization and cost of medical services per patient." Id. at 218 n.57 (citations omitted). The MCO usually includes profits and administrative costs in the fee charged. See id. Consideration is also given to other facts such as age, gender, and the type of group benefiting from coverage. See id. Setting capitation rates and negotiating contracts under a capitated arrangement involve complicated financial analyses that include knowledge of a physician's average fees, utilization rates, and income. See id.

50. See id. at 218; see also Eleanor D. Kinney, Procedural Protections for
each patient enrolled in the MCO regardless of the services provided to the patient or the cost of these services. As a result, physicians are essentially encouraged to spend as little time with their patients as possible.

B. Utilization Review

A second cost containment mechanism incorporated by MCOs is utilization review, whereby the MCOs attempt to reduce the number of unnecessary medical procedures, hospital stays, and tests for each patient. Under this system, the MCOs appoint a board of physicians and/or nurses to review each patient’s records. The board, in turn, determines if the proffered treatment is medically necessary and thus covered by the plan. Utilization review can be performed prospectively, concurrently, or retrospectively. For instance, if the consultant finds, 

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*Patients in Capitated Health Plans, 22 AM. J. L. & MED. 301, 301 (1996).* Capitation has been regarded as the “cornerstone of the health care industry octopus of the nineties, for its presence can not be easily ignored . . . .” John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting, 22 AM. J. L. & MED. 173, 173 (1996).*

51. For further discussions on capitation arrangements as cost containment, see generally Orentlicher, *supra* note 6; Faber Walsh, *supra* note 15.


53. *See* Orentlicher, *supra* note 6, at 182-83 (describing how health care plans commonly require pre-approval of care so that they can monitor costs). Two alternatives to fee-for-service include salary and capitation. *See id.* at 158. MCOs that hire a staff of full time physicians primarily use the salary method of payment. *See id.* Whereas, health plans that utilize a physician’s services for a fixed period of time usually use the capitation method. *See id.* *See also* McGraw, *supra* note 6, at 1826 (discussing the various utilization review procedures).

54. *See* Faber Walsh, *supra* note 15, at 216; see also Randall, *supra* note 17, at 28 (noting that the review committee is referred to as “independent,” because its judgment about whether a particular procedure is medically necessary is independent of the judgment of both the doctors and the MCO).

55. *See* Randall, *supra* note 17, at 29. Utilization review reduces costs by decreasing the number of unnecessary medical procedures. *See id.*

56. *See id.; see also* David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians, 275 JAMA 1693, 1695 (1996)* (discussing the alteration of the patient-physician relationship due to utilization review procedures); McGraw, *supra* note 6, at 1826 (noting that decisions to approve or deny referrals to specialists or to admit patients for treatment are usually made concurrently); see also Faber Walsh, *supra* note 15, at 217 (discussing retrospective review).
retrospectively, that a medical service provided to a patient was unnecessary, the MCO will deny payment or coverage.\textsuperscript{57} Although capitation and utilization review are the most commonly used cost containment mechanisms, MCOs also provide payment incentives which encourage physicians to limit medical services.

\textbf{C. Payment Incentives}

In response to the nature of the capitation system, physicians practicing in the managed care context often refer patients to specialists. As a result of these referrals, the primary physician reduces the amount of time personally spent with a patient. Although these referrals relieve some of the financial strain on the primary care physician, total health care costs continue to increase.\textsuperscript{58} Therefore, MCOs often “utilize payment incentives such as risk pools, bonuses and expanded capitation to decrease a primary care physician’s use of referrals, diagnostic tests, and other services.”\textsuperscript{59} Payment incentives control physicians’ utilization of outside medical services and encourage them to deliver cost effective healthcare.\textsuperscript{60}

Under a risk pool system, a portion of the physician’s capitated payment is withheld and put into a pooled fund.\textsuperscript{61} Money deposited into risk pools is used to pay the additional expenses of specialist referrals and hospitalizations.\textsuperscript{62} At the end of an accounting period, physicians receive

\textsuperscript{57} See Wickline v. California, 239 Cal. Rptr. 810, 811 (Cal. Ct. App. 1986). In Wickline, a woman was prematurely released from the hospital which led to the eventual amputation of her leg. See id. A utilization review’s purpose is to control health care costs by reducing unnecessary services without compromising quality in the administration of medical and hospital services. See id.

\textsuperscript{58} See id.

\textsuperscript{59} Faber Walsh, supra note 15, at 219. Payment incentives are used to discourage medical treatment in one of two ways. The MCO refuses to pay additional compensation for extra treatment or the MCO rewards doctors through extra compensation for limiting treatment. See id.; see also McGraw, supra note 6 (describing managed care’s use of financial incentives as a means of limiting care); Orentlicher, supra note 6 (discussing several types of financial incentives used to limit care).

\textsuperscript{60} See Faber Walsh, supra note 15, at 219.

\textsuperscript{61} See id. For a thorough description of risk pools and other bonus incentives given to physicians, see generally Kay Stanley, Managing Managed Care in the Medical Practice: The Physician’s Handbook for Success and Survival 61-62 (1996).

\textsuperscript{62} See Faber Walsh, supra note 15, at 219-20.
any remaining funds in the risk pool. However, if no money remains in the pool due to a high referral rate or lengthy inpatient stays, physicians will suffer the loss.

Another payment arrangement, the bonus payment, is similar to the risk pool. Here, the MCO rewards the primary care physician for referring fewer patients and requesting fewer diagnostic tests. At the beginning of each year, a lump sum of money is set aside by the MCO to pay for outside medical services, as opposed to withholding a portion of each physician’s capitation payment. The physicians do not have to bear the financial burden should the pool be exhausted, however they are given an incentive not to exhaust the pool because any remaining funds may eventually be paid to the physicians in the form of a bonus at the conclusion of the fiscal year.

The final payment arrangement, extended capitation, encourages physicians to limit costly medical treatments by including ancillary services for each patient in the physician’s allocated capitated payment. The capitated payments for each patient include the physician’s own expenses, tests, referrals, and other medical services. Physicians pay for diagnostic tests and other procedures out of their own pocket, thus limiting their incentive to utilize such services. The various financial in-

63. See id. at 220; see also Jan Crawford, Tort Law: The Appropriate Vehicle to Control HMO Abuses of Gag Clauses, 29 ARIZ. ST. L.J. 1103 (1997). Financial incentives are given to physicians in the form of risk pools, whereby money is withheld from the provider and then returned at the end of the year depending on the number of hospitalizations, referrals, and medical testing procedures. See id. at 1108. Most importantly, in the risk pool arrangement, the doctor also bears the risk of overtreatment. See id.

64. See id.

65. See id.

66. See id.

67. See Crawford, supra note 63, at 1108 (stating that the physicians’ expenses in capitated payments force physicians to cut costs internally to increase their net profits); see also Jennifer L. Myron, HMOs’ Use of Gag Clauses: An Unethical Threat to America’s Health, 101 DICK. L. REV. 729, 732 (1997) (“Many doctors feel that capitation presents them with a clear financial incentive to accept more patients since many doctors are being ‘paid by the head’.”).

68. See Myron, supra note 67, at 732. If a physician ordinarily charges a referral, this will be deducted from his capitated payment; as a result, the physician is less apt to refer patients to specialists because it will cause a reduction in fees. See id.

69. See id.
centives and availability of treatment options are not disclosed to patients because the physicians are prohibited from communicating this information to the patient under their contract with the MCO.  

D. Gag Clauses as Cost Containment

Gag clauses are ethically and legally destructive to the doctor-patient relationship. Most gag clauses restrict the content of communications between physicians and patients. A typical gag clause reads as follows: "Physicians shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions or the public in . . . the quality of . . . [h]ealthcare coverage." Interpreting this language, one commentator has argued that "if a physician were to tell a patient that he felt the best treatment available was one that the HMO did not cover . . ., this could cause the patient to lose confidence in the HMO." Therefore, gag clauses prohibit physicians from communicating information to patients regarding available treatments and any financial incentives being offered to the physician.


72. For a complete discussion on the impact gag clauses have on the patient-physician relationship, see generally Malinowski, supra note 6; Swanson, supra note 6 (discussing the contradiction between gag clauses and a physician’s ethical obligations under the Hippocratic Oath).

73. Swanson, supra note 6, at 314 (citing a gag clause from a U.S. Healthcare contract).

74. Id. at 315. See also John P. Little, Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health, 49 RUTGERS L. REV. 1397, 1445 (1997).

In 1990, Basile Pappas was diagnosed with a spinal cord infection at Haverford Community Hospital. The emergency room physician determined that Pappas needed more specialized treatment and made arrangements to transport Pappas to Jefferson hospital. The ambulance service informed the physician that Jefferson was not approved by Pappas’s MCO. Despite two hours of arguing, the MCO refused to authorize the transfer and after further delay approved a transfer to another hospital. The delay exacerbated the spinal infection and Pappas is now a quadriplegic.

Id. (citing Pappas v. Asbel, 675 A.2d 711 (Pa. Super. Ct. 1996) (citations omitted)).

75. See Martin & Bjerknes, supra note 71, at 441. Arguments for and
More specifically, as perceived by the American Medical Association (AMA), gag clauses unethically interfere with the doctor-patient relationship.6 Under AMA guidelines, "the duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice."7 Moreover, another AMA guideline provides: "Any incentive against the prevalence of gag clauses in managed care contracts include:

Managed care proponents argue that these provisions are not commonplace and hence not a problem, while patient and physician advocates believe that their use is widespread and problematic. For example, Dr. Peter Kongstvedt, a physician and National Practice Leader of Managed Care Strategy and Medical Management for Ernst & Young's Managed Care Group, testified before a House of Representatives subcommittee that "there have been few concrete examples of unedited contracts that support the claim that such inappropriate 'gag' rules actually exist" and that he has never seen a gag clause in the hundreds of contracts that he has reviewed. ... Mark Sektnan, a legislative advocate for the California Association of HMOs, similarly believes that gag clauses are nonexistent: "We do not believe that our contracts (with doctors) have gag clauses."

In contrast, many physicians and consumer advocates believe that gag clauses are prevalent. For example, Dr. Christine Cassel, while president-elect of the American College of Physicians, stated that gag clauses are becoming more common. John Kaegi, a spokesperson for ChoiceCare ..., reported, "[m]y understanding is almost all, if not all, managed care firms have confidentiality clauses," a particularly far-reaching form of gag clause covering anything from discussion of unauthorized treatment options to contact with patients after a plan has deselected a physician. ... Aynah Askanas, legal counsel for the California Medical Association (CMA), reviews contracts for physicians. She claims to have found gag clauses prohibiting a physician from making negative comments about the plan in approximately twenty percent of all the contracts she has reviewed.

Id. at 441-42 (citations omitted).

76. See Swanson, supra note 6, at 318.

The nature of the relationship presents the opportunity for influence and abuse as patients rely upon guidance from their physicians. Patients neither have the skill nor the ability to fully understand and evaluate their conditions. They therefore rely upon physicians to place their interests and needs first, without the threat of compromise. When physicians are being influenced in their medical choices by an HMO and through the financial incentives that the plan provides, the patient can no longer be sure that they are receiving the best possible treatment .... These gag clauses lead to an ethical erosion of the confidence we place in physicians and an overall decrease in the quality of care so that entities can make a profit. Though these conflicts of interest have not seriously undermined the patient's trust in physicians, the potential is there.

77. Nancy J. Picinic, Note, Physicians Bound and Gagged: Federal At-
to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter. Contrary to their ethical obligation, some critics assert that physicians, in order to secure patients, are left with no alternative but to sign the contract with the MCO. A physician placed in this ethical dilemma should seek refuge under the AMA Code which "may be used in shielding physicians from termination for upholding ethical principles despite contractual provisions to the contrary."

A final attack on gag clauses may come from the doctrine of informed consent. The informed consent doctrine requires patients to be informed of all facts "which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." Physicians are under a legal duty to inform patients of the risks, benefits, and alternatives of proposed treatments. The patient is then free to choose among the alternatives.

Significant scholarly debate surrounds the question of whether the informed consent doctrine requires a physician to disclose to a patient the existence of financial incentives to limit care. In Moore v. Regents...
of University of California, the California Supreme Court utilized the doctrine of informed consent to hold that "a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment." Nonetheless, the informed consent doctrine provides an inadequate remedy, because it only grants retrospective relief.

In many cases, the patient died or was injured as a result of the physician's failure to disclose. Moreover, the patient bears the difficult burden of proving that the physician's failure to disclose the financial incentives proximately caused the harm. Due to the inherent difficulty of proof and the gravity of potential harm, many state legislatures enacted full disclosure laws. The continued use of gag clauses as a cost con-

85. 793 P.2d 479 (Cal. 1990).
86. Id. at 483; see also McGraw, supra note 6, at 1840.
87. See McGraw, supra note 6, at 1843. More specifically, the patient would bear the burden of proving:
(1) that the doctrine of informed consent has been breached because the physician did not disclose that she was compensated through a financial incentive arrangement;
(2) that the patient was harmed, and that this harm was proximately caused by this breach;
(3) that if the patient had been informed about the existence of the arrangement, he would have sought care from another provider using his own resources or that he would have actively petitioned the health plan for the treatment through its established grievance procedures.

Id; see also Picinic, supra note 77, at 391 n.132.

If informed consent can be applied to the disclosure of capitation arrangements, it must still be established not only that the patient would have chosen the other undisclosed, more costly alternative, but also that the alternative would have resulted in a more advantageous outcome and that the less costly treatment was medically inappropriate.

Id. The problems inherent in the plaintiff's burden is that it is nearly impossible to show that had the patient been informed of the physician's financial incentive to provide less care, they would have, nonetheless, sought the additional services. See id. This 'proof' is highly speculative at best. See id.

88. See id.

89. See Swanson, supra note 6, at 327-32. For example, Massachusetts enacted a law prohibiting MCOs from refusing to contract with physicians who in good faith communicated with patients regarding MCO terms or provisions. See MASS. GEN. LAWS ANN. ch. 175, § 108 (West Supp. 1996). Colorado enacted a bill attacking gag clauses by prohibiting MCOs from terminating physicians for communications with patients. See COLO. REV. STAT. ANN. § 10-16-121 (West Supp. 1995) (formerly H.B. 1216). Virginia law requires that "a contract between a carrier [MCO] and a provider [physician] shall permit and require the provider to
tainment mechanism will harm patients and encourage efforts to impose liability on the MCOs.

III. EMERGING THEORIES OF LIABILITY IN MANAGED CARE

Providing quality health care to a patient while attempting to contain costs results in expanded liability for physicians and MCOs. Injured patients claim that cost containment mechanisms influence a physician’s judgment to limit or deny treatment. Patients bring common causes of action such as negligence, breach of fiduciary duty, breach of contract, and tortious interference with the patient-physician relationship to allege that cost containment mechanisms are the cause of their injury. Difficulty arises when the MCO makes a decision to deny treatment or a physician decides to stop treating a patient. Under these circumstances, it becomes problematic to determine who is responsible for the patient’s injury. The following cases address who is liable when negligent utilization review results in injury to a patient.

A. Wickline v. California

*Wickline v. California* is the leading case on whether a primary care physician and/or MCO may be held liable for a denial of necessary medical treatment. In this highly publicized case, the plaintiff alleged

90. See generally Beardan & Maedgen, *supra* note 6 (noting the recent expansion toward liability in the managed care setting).

91. See id. at 325. As part of its efforts at cost control, an HMO typically monitors and prospectively authorizes or denies medical treatment, including non-emergency hospitalizations and lengths of hospital stays. See id. "[T]his more extensive involvement in the health care process may expose the HMO to liability on the grounds of negligent interference with the health care decision making process." *Id.*

92. See *id.* In addition, theories of liability have included breach of contract, false/misleading advertising, insurance bad faith claims, and ostensible and apparent agency. See generally Orentlicher, *supra* note 6; Faber Walsh, *supra* note 15 (noting the various claims plaintiffs have brought against insurance companies).

93. See Beardan & Maedgen, *supra* note 6, at 325. "The HMO, in its function as rationer of medical services, may refuse to authorize certain treatments or services that are medically unnecessary." *Id.* "If in hindsight, such denial of treatment results in injury to the patient, the HMO may risk liability on the basis of having negligently refused a necessary medical procedure." *Id.*


95. See *id.* at 811 (discussing the risks associated with prospective review as
that the MCO’s cost containment mechanism was the basis of the denial of treatment, directly and proximately causing her injury. The patient, Lois Wickline, was diagnosed with Leriche’s Syndrome and forced to undergo surgical treatment. Her physician concluded that due to Wickline’s unstable condition, she had to remain in the hospital. However, a Medi-Cal consultant denied the treating physician’s request for the additional hospital stay. Shortly thereafter, Mrs. Wickline developed gangrene in her leg and had to return to the hospital to have it amputated.

Wickline sued the state of California claiming that Medi-Cal was opposed to retrospective review). The court explained that “a mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment.” Id. at 811-12. An erroneous decision in a prospective review, on the other hand, results in the withholding of care, which could potentially lead to a patient’s disability or death. See id.

96. See id. at 810-11.

97. Leriche’s Syndrome is a condition caused by an obstruction of the terminal aorta, which carries blood from the heart to the arteries in all organs and parts of the body. See id. at 812.

98. See Wickline, 239 Cal. Rptr. at 812. Surgery was performed to remove Mrs. Wickline’s artery and replace it with a synthetic artery. See id. After surgery, Mrs. Wickline experienced circulatory problems in her leg. See id. She was taken back to surgery to remove a clot that had formed and the graft was resewn. See id. Mrs. Wickline’s recovery was “stormy” and she was operated on again, in order to remove a section of the chain of nerves that lie on each side of the spinal column. See id.

99. See id. at 813. Mrs. Wickline’s physician felt that it was medically necessary for her to remain in the hospital because she was at risk for blood clotting and infection. See Wickline, 239 Cal. Rptr. at 813.

100. See id. at 814. In a prospective review, an independent committee reviews the proposed treatment to determine whether it is medically necessary. See id. at 813. The physician’s request for an additional eight days was reviewed by a nurse who had the authority to approve an extension but had to seek Medi-Cal’s approval for an extension. See id. at 814. The nurse called a Medi-Cal consultant and said that in her opinion, nothing in Wickline’s case warranted an eight-day extension. See id. Subsequently, a board certified surgeon employed by Medi-Cal rejected Mrs. Wickline’s request and instead authorized only four additional days. See id.

101. See Wickline, 239 Cal. Rptr. at 816. Once Mrs. Wickline arrived home she started feeling pain in her right leg and the leg started to take a whitish, “statue-like marble appearance.” Id. Her symptoms worsened and on the ninth day following her release, she was forced to return to the hospital. See id.
negligent in denying the request for an extended hospital stay.\textsuperscript{102} A jury found for Wickline and awarded her $500,000. However, the Court of Appeals of California reversed the decision and held that Medi-Cal was not liable for medical malpractice as a matter of law.\textsuperscript{103} The court reasoned that a patient's physician is solely responsible for determining the medical necessity of a patient's treatment.\textsuperscript{104} More specifically, the court stated that "a physician is in a much better position to evaluate and diagnose a patient's condition and therefore has the ultimate responsibility for medical decisions."\textsuperscript{105}

Although the court held the treating physician responsible for Wickline's injuries, the court did not rule out third party payor liability. In fact, the court opened the door to MCO liability when cost containment mechanisms result in harm to the patient.\textsuperscript{106} Finally, the court concluded that cost containment mechanisms should not be allowed to interfere with a physician's judgment.\textsuperscript{107}

\textsuperscript{102} See id. at 811.
\textsuperscript{103} See id. at 820. Although the California Court of Appeals found in favor of the State, it opened the door to MCO liability by holding:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including when appropriate, health care payers. Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.

\textit{Id.} at 810.

\textsuperscript{104} See Wickline, 239 Cal. Rptr. at 810. However after opening the door to MCO liability, the court qualified its holding.

[The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payers as the liability scapegoat when the consequences of his own determinative medical decisions go sour.

\textit{Id.}

\textsuperscript{105} Id.; see also Jack K. Kilcullen, \textit{Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability}, 22 AM. J. L. \\& MED. 7, 34 (1996) (stressing the importance of the \textit{Wickline} decision with respect to HMO liability).

\textsuperscript{106} See Wickline, 239 Cal. Rptr. at 819. The Court essentially opened the courtroom doors to MCO liability when cost containment mechanisms influence a physician's judgment whether or not to render care to the patient and the patient is harmed as a result. \textit{See id.}

\textsuperscript{107} See id. at 820.
B. Wilson v. Blue Cross of Southern California

A later decision of the Court of Appeals of California held contrary to Wickline. In Wilson v. Blue Cross of Southern California,\(^{108}\) the plaintiff, Howard Wilson, was admitted to a hospital while suffering from anorexia, severe depression, and drug dependency.\(^{109}\) After spending eleven days in the hospital, Wilson’s treating physician determined that three to four weeks of additional in-patient care was required.\(^{110}\) However, Blue Cross refused to authorize that length of stay.\(^{111}\) Unable to afford the costs on his own, Wilson was released from the hospital. Twenty days after his release, he committed suicide.\(^{112}\) Wilson’s parents brought suit against the insurance companies for breach of the insurance contract, negligence, and wrongful death.

The trial court, relying on Wickline, concluded that Wilson’s treating physician was solely responsible for his death and granted the insurance companies’ summary judgment motions.\(^{113}\) The California Court of Appeals reversed the decision and remanded it to the trial court. The court held that the insurance companies were not entitled to summary judgment.\(^{114}\) Ultimately, Western Medical, the review entity used by Blue Cross, settled the suit with Wilson’s parents and a jury found the insurance companies liable for breach of contract.\(^{115}\) Most notably, the Court

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109. See id. at 877.
110. See id. Howard Wilson’s physician determined that he needed an additional three to four weeks of psychological assessment and care at the hospital rather than being discharged as the insurance company wanted. See id.
111. See id. Blue Cross hired Western Medical to conduct a concurrent utilization review. See id. Concurrent utilization review involves constant monitoring of the patient throughout treatment, and if any referral to a specialist, diagnostic test or treatment is deemed not medically necessary, the patient will be denied benefits. See J. Scott Anderson, Is Utilization Review the Practice of Medicine?, 19 J. LEGAL MED. 431, 434 (1998).
112. See Wilson, 271 Cal. Rptr. at 878.
113. See id. The court of appeals disagreed by holding that the physician’s failure to pursue an appeal to the denial of Wilson’s benefits did not warrant a summary judgment for the defendants. See id. The Court also emphasized that the defendants failed to prove that the request for further hospital stay would have been granted had Wilson’s physicians appealed. See id.
114. See id. The court of appeals relied on the treating physician’s testimony to hold that there was enough evidence to raise an issue of fact as to whether the defendants’ conduct was a substantial factor in Wilson’s death. See id.
115. See Wilson, 271 Cal Rptr. at 898. The defendants argued that the
of Appeals found that the language in Wickline, stating that the discharge decision was the sole responsibility of the treating physician, was dicta. Therefore, the appeals court determined that this language was unnecessary to trial court's decision.116

The court classified the language as "broadly stated" and emphasized that it did not "correctly state the law relative to causation issues in a tort case."117 As a result, the Wilson court opened the door for injured plaintiffs to sue their MCOs if the denial of benefits is a "substantial factor" in bringing about the injury and no rule of law relieves the MCO of liability.118

C. ERISA Preemption: Corcoran v. United Healthcare

Although some state courts have recognized MCO liability, most have succumbed to the preemption of state law claims by the Early Retirement and Income Security Act of 1974 (ERISA).119 Congress originally enacted ERISA to encourage employers to form employee benefit plans.120 However, employer-sponsored plans use ERISA to escape li-

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\( Wickline \) decision can be interpreted to mean that a strong public policy in favor of utilization review supports a judgment in their favor. See id. at 884. However, the court rejected this argument holding that, unlike the \( Wickline \) decision, no public policy exception applied. \( Id. \)

116. \( See \) id. at 883.

117. \( Id. \) In Wilson, one of the treating physicians testified that Wilson's inability to pay for the treatment was the sole reason for the patient's discharge, and that Wilson would probably be alive had he stayed in the hospital. See id.

118. \( See \) Wilson, 271 Cal Rptr. at 883; see also Beardan & Maedgen, supra note 6, at 328 (arguing that the Wilson court left open the question of MCO liability for adverse utilization review decisions); Pedroza, supra note 4, at 426. "[T]he Wilson decision may indicate that a change in the health care delivery system will foster change in our understanding of the different elements of causation." \( Id. \) "Third party payors will no longer be exempt from cause in fact because the physician or the patient made the final say in the treatment decision." \( Id. \) "Rather, the third party payor will be held to have satisfied the cause in fact determination any time their decision amounts to a 'substantial factor' in the injury of the patient." \( Id. \)


120. \( See \) Little, supra note 74, at 1464-65. ERISA protects employee pension plans by requiring participation (1) by an employer engaged in interstate commerce, (2) by any employee organization representing employees engaged in commerce, or (3) by both. \( See \) Kilcullen, supra note 105, at 36 (citing 29 U.S.C. § 1001 (b) (1994)). In addition to requiring participation, ERISA establishes both financial and fiduciary responsibilities. \( See \) id. ERISA also allows actions to be
ability with regard to negligent medical decisions. More specifically, ERISA protects interstate employers from being subjected to multiple state laws by preempting “any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.” Thus, injured plaintiffs bringing state law tort claims will only receive lost benefits if their claims are governed by ERISA. In essence, ERISA governs claims which relate “to an employee benefit plan.” The Supreme Court of the United States ruled that a state law “relates to” a benefit plan if the law has a “connection with or reference to” a benefit plan. Although there is no clear evidence that Congress intended ERISA to shield MCOs from liability, many state courts interpret the “relates to” language broadly.

brought in federal court to “recover benefits due [a participant or beneficiary] under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”

121. Malinowski, supra note 6, at 363 (noting that “any state legislation, common law rule, or regulation such as wrongful death liability, that ‘relates to’ an employee benefit plan is preempted.”). See Corey J. Ayling, New Developments in ERISA Preemption and Judicial Oversight of Managed Care, 31 CREIGHTON L. REV. 403, 406 (1998). Congress never intended such a broad preemption in the context of health insurance and state law claims of negligence. See id. Moreover, there is the need for change with respect to the broad preemption of ERISA. See id.

122. Malinowski, supra note 6, at 363.

123. Shaw v. Delta Air Lines, 463 U.S. 85, 97 (1983). The Court noted that “some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law relates to the plan.” Id. at 100.

124. See Little, supra note 74, at 1465 (citing Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc., 999 F.2d 298, 302 (8th Cir. 1993) (holding that ERISA preempts a wrongful death suit in which the MCO initially refused and then delayed approval for heart surgery); Tolton v. American Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) (dismissing a claim for wrongful death after a MCO denied psychiatric benefits and the patient subsequently committed suicide); Spain v. Aetna Life Ins. Co., 11 F.3d 129, 132 (9th Cir. 1993) (ruling that ERISA preempts a suit in which a MCO refused to authorize and later delayed approval for a bone marrow transplant)). But see Dukes v. U.S. Health Care, Inc., 57 F.3d 350, 351 (3d Cir. 1995) (holding that tort claim was not preempted); Rice v. Panchal, 65 F.3d 637 (10th Cir. 1995); Pacificare of Okla., Inc. v. Burrage, 59 F.3d 151, 155 (10th Cir. 1995). See also Malinowski, supra note 6, at 364 (noting that ERISA may provide some minimal relief in the context of benefit denials). “While Section 502 (a) of ERISA does provide some relief, it is limited to the value of benefits denied.” Id. ERISA, however, does not provide a remedy for “lost wages, pain and suffering, or other damages available under state tort law.” Id.
As a result, millions of Americans are left without a remedy for the negligence of their MCOs. One commentator states:

ERISA's preemption of liability of health care plans, but not the individual physician, is an outdated government incentive that disrupts competition and robs consumers of well-established remedies. It removes a powerful incentive to provide quality service at a time when the government itself has failed to shoulder that responsibility directly through a national health care program. Ultimately, coverage without quality assurance and reform without relief would mean that the health care revolution has only circled back to the status quo.125

In Corcoran v. United Healthcare,126 the Fifth Circuit held that since United Healthcare was a "plan administrator," Mrs. Corcoran's claim was preempted by ERISA.127 In Corcoran, an MCO denied an obstetrician's request to allow Corcoran to remain hospitalized. Because Corcoran was in a "high risk pregnancy" category, her physician felt that she should stay in the hospital for monitoring.128 However, United Healthcare, an independent review organization, denied Mrs. Corcoran the benefit of a longer hospital stay, and instead authorized ten hours per day of home nursing care.129 Mrs. Corcoran was discharged and, during a time when no nurse was on duty, her unborn child went into distress and died.130

Mrs. Corcoran and her husband brought a wrongful death action in Louisiana state court alleging that their unborn child died as a result of the negligence of Blue Cross and United Healthcare. The defendants removed the case to federal court, arguing that it was preempted by ERISA.131 The Court of Appeals for the Fifth Circuit held that Mrs. Cor-

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125. Kilcullen, supra note 105, at 50.
126. 965 F.2d 1321 (5th Cir. 1992).
127. See id. at 1322.
128. See id.
129. See id. at 1323-24.
130. See id. Under a portion of the plan known as the "Quality Care Program," participants were required to obtain precertification before hospital admission. See id. The quality care program was administered by defendant United Healthcare under an agreement with Bell. See id. United Healthcare performed utilization review services to reduce costs of the plan. See id.
131. See id. at 1324-25. Blue Cross was the insurance company responsible for employing United to conduct the utilization review. See id. at 1323. The plaintiffs argued that the defendant's refusal to permit the hospitalization was an erroneous medical decision. See id. at 1324. The defendant argued that its deci-
coran had no right to sue her HMO for damages because her insurance plan was governed by ERISA. As a result, when a state claim deals with a denial of benefits under a utilization review, the claim will likely be preempted by ERISA. However, other courts have held that when a claim is based on simple state common law negligence, it will not be preempted. Since this issue remains unresolved and state courts are in disarray regarding MCO liability, Congress should clarify the intentions of ERISA.

IV. MANAGED CARE UNDER SIEGE

The number of Americans enrolled in HMOs totals nearly seventy million. There has been a fifty percent increase in the number of Americans enrolled in HMOs over the last four years. Although mans-

132. See Corcoran, 965 F.2d at 1322. The Court concluded that the defendant, in fact, made medical decisions, and even gave medical advice, but it did so in the context of making a determination about the availability of benefits under the plan. See id. at 1325.


135. See Kilcullen, supra note 105, at 50.

ERISA’s preemption actually served to deprive [the patient] of a state law right: “[w]hile we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans . . . the lack of an ERISA remedy does not affect a pre-emption analysis.” The result embodies the public’s worst nightmare about managed care, where issues of cost battle issues of health. Under ERISA, the desire to prevent escalation of costs to businesses prevailed: [A]lthough imposing liability might have the salutary effect of deterring poor quality medical decisions, there is significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states. . . . [T]his would increase the cost of providing utilization review services, thereby increasing the cost to health benefit plans of including cost containment features . . . and ultimately decreasing the pool of plan funds available to reimburse participants.

Id. at 42 (footnotes omitted).

136. See Stephen Green, Congress To Focus On Health Care Reform: Key Issue Will Be Requiring Longer Hospital Stays, SAN DIEGO UNION-TRIB., Jan. 3,
aged care is somewhat effective at controlling health care costs, the overall quality of health care has diminished. "Managed care is winning in the health care marketplace but is in danger of losing the battle for public opinion." The misfortunes associated with cost containment have added fuel to the managed care fire. The public’s fear of man-

1998, at A21. See generally Picinic, supra note 77 (highlighting the dramatic rise in participation in MCOs over the last several years).

137. Green, supra note 136, at A21 (quoting Drew Altman, president of the Kaiser Family Foundation). See Neil B. Caesar, What's in Store for Physicians When a Market Enters Phase III, MANAGED CARE, Jan. 1996, at 47 ("[M]any health care physicians believe that they must go along with any managed care opportunity no matter how unattractive, and no matter how disorganized or arrogant the MCO.").

Cost containment mechanisms such as utilization review, capitalization, and payment incentives limit treatment and encourage health care providers to cut costs. A physician has an ethical and legal duty to put the patient’s needs first; however, the pressure to contain costs and the incentive to make more money by cutting treatment costs may cloud a physician’s judgment about a patient’s medical treatment. When determining medical treatment for a patient, a doctor should not consider what is best for the managed care plan. Nevertheless, through bonuses and other incentives, the MCO pressures physicians to do just that or risk personal financial ruin.

Faber Walsh, supra note 15, at 221 n.88 (citations omitted). But see Green, supra note 136, at A21. While it is true that 52% of respondents wanted the government to protect members of HMOs, it is also true that 40% were opposed if extra costs were involved. See id.

138. See generally Faber Walsh, supra note 15. U.S. Senator Alphonse D'Amato (R-New York) compiled the following examples:

In New York, a diabetic developed an infection in his foot that had become gangrenous and had spread all the way to his groin. Almost his entire leg was infected and the blood vessels clogged. The patient was admitted to the hospital where he was immediately treated with intravenous antibiotics to combat the infection. The doctor estimated that it would be medically necessary for the patient to remain in the hospital for ten to fifteen additional days. Upon learning this, a MCO official went to the patient's hospital room, and without even notifying the doctor, told the man that “he could watch Oprah and be treated as well from home with a visiting nurse.” Against the doctor’s protests and with fluid still draining from his wounds, the patient was discharged from the hospital several days early. As a result of the early discharge from the hospital and inadequate care, the patient had to postpone much needed surgery, because his blood had become too thin to perform surgery safely.

In Colorado, a 75-year old woman was diagnosed with kidney cancer, but her plan refused to authorize surgery to remove the kidney and tumor of the elderly woman. The plan only relented and allowed the surgery to be performed when a Congressman fi-
aged care, coupled with the crippling effects of ERISA on state attempts to reform managed care, have prompted a federal response.\textsuperscript{139}

President Clinton's "patients' bill of rights" attempts to bring "quality" back into health care.\textsuperscript{140} Although recent bills were defeated in Congress, provisions of the bills continue to be very important issues. These issues include:

1. Information disclosure. This requires plans to give consumers facts about benefits and exclusions, doctor credentials and hospital track records.

2. Choice of Providers and Plans. This establishes direct access to specialists for patients with serious medical conditions.

3. Access to Emergency Services. This provides coverage when lack of such care would cause serious jeopardy.

4. Participation in Treatment Decisions. This gives consumers information on treatment risks, benefits and alternatives, and any financial arrangements influencing decisions. In addition, "gag" clauses forbidding doctors from disclosing all treatment options are banned.

5. Nondiscrimination. This bars bias in health care based on race, religion, age, sex, disability, genetic risks or source of payment.

6. Confidentiality. This protects privacy of medical information.

7. Complaints and Appeals. This sets internal and external appeals processes, and requires decisions involving emergency care to be resolved in seventy-two hours, consistent with Medicare rules.\textsuperscript{141}

Members of the Democratic and Republican parties introduced bills to protect patient rights.\textsuperscript{142} Even though this session of Congress ended

\footnotesize{\textsuperscript{139} See Chase, supra note 10, at B1.\textsuperscript{140} See id. President Clinton's bill of rights was described by Robert Blendon, a health policy professor at Harvard University, as "[a] mild piece of consumer protection law that corresponds to a lot of other protections in areas such as air safety and banking." Clinton Signs Act, supra note 10, at A16.\textsuperscript{141} Chase, supra note 10, at B1. (noting the major provisions of the proposed Patients Bill of Rights).\textsuperscript{142} See 143 Cong. Rec. S3665 (daily ed. Apr. 24, 1997); H.R. Rep. No. 820 (1997); H.R. Rep. No. 1415 (1997); H.R. Rep. No. 3605 (1998); H.R. Rep. No. 6403 (1998); see also Green, supra note 136, at A21. U.S. Congressman Greg Ganske (R-Iowa), a plastic surgeon, said, "[q]uite simply, the leadership doesn't
without any movement in managed care reform, patient's rights will highlight the legislative agenda again next year. Clearly, the bipartisan support generated by the tragedies associated with managed care highlights the significance of the pending problem. It is important to speak for most Republicans on this issue." Id. Congressman Ganske also said that GOP leaders fail "to understand that an overwhelming majority of Americans favor legislation to protect them from a health care system that seems increasingly concerned with charts of the plan's financial fortunes, not charts of the patient's health." Id.

143. See, e.g., H.R. Rep. No. 3605 (1998). See also Harriet Hiland, Washington Has Choice In Managed-Care Bills, BUS. J.-PHOENIX, Feb. 13, 1998, at 20. Two republican congressmen, Rep. Charlie Norwood (Georgia) and Sen. Alfonse D'Amato introduced bills that would have regulated MCOs and would have given patients the right to sue their MCO under state laws. See Green, supra note 136, at A21. Two democratic congressmen, Sen. Edward Kennedy (Massachusetts) and Rep. John Dingell (Michigan), "have sponsored bills that would impose consumer protections on MCOs, including guaranteeing access to medical specialists." Id. A bill co-sponsored by Sen. Dianne Feinstein (D-California), D'Amato, and Sen. Olympia Snowe (R-Maine) "would require HMOs to allow a several day hospital stay for women undergoing mastectomies and reconstructive surgery." Id. Ganske and Rep. Edward Markey (D-Massachusetts) "have sponsored a bill that would prohibit so-called gag clauses, which forbid physicians from discussing with patients treatments not authorized by the MCO." Id. According to Congressman Norwood, "if the [Democrats] come out with their own bill they're going to divide the bipartisan support that we have now . . . raising the possibility that we could turn what needs to be done into a campaign commercial." Id. For a discussion about the managed care debate, see Amy Goldstein & Helen Dewar, Senate Kills 'Patients' Rights Bill; Managed-Care Measure a Victim of Partisanship, Clinton Scandal, Lobbying, WASH. POST, Oct. 10, 1998 at A1.

Weeks before the Senate killed HMO reform yesterday on a procedural vote, it had been a forgone conclusion that creating a 'patient's bill of rights' was destined to land on the stack of legislation that the 105th Congress would not pass. Remarkably, the issue collapsed even though Democrats and Republicans in both chambers declared that they would like nothing more than a new law this year to grant patients in health plans more clout—and even though the polls showed that no other action by Congress would be as welcomed by the American people.

144. See, e.g., H.R. 1415 (1997). The Patient Access to Responsible Care Act of 1997 ("PARCA") was introduced by Rep. Norwood. Id. Until recently, it was speculated that PARCA had the most momentum with as many as 219 sponsors. See Hiland, supra note 143, at 20. But see House Democrats Plan To Offer Own Managed Care Bill, CONG. DAILY, Feb. 4, 1998. PARCA was attacked by business and insurance industries that claimed it would raise costs to the point where employers would be forced to drop health coverage. See id. For these rea-
outline the major provisions that were part of recent patients' rights legislation and discuss their possible impact on health-care delivery.

A. Freedom of Information

Future legislation in the health care arena should require MCOs to disclose information to patients about health care benefits, appeals procedures, performance measures, history of patient satisfaction, as well as the number and type of physicians participating in the MCO. Full disclosure will enable a patient to become aware of the full range of available treatment options. In turn, patients will be better equipped to make informed decisions about their health care. Moreover, full disclosure of a MCO's financial incentives will help reestablish trust in the

sons, PARCA lost some of its momentum. See id. ("I've really seen a change in the atmosphere on Capitol Hill with respect to PARCA," quoting Karen Ignagni, president of the American Association of Health Plans). "A lot of individuals who have signed onto PARCA are not aware of the range of issues and full implications." See id.

145. See, e.g., H.R. Rep. No. 3605, § 121 (1998). The Patients Bill of Rights Act (PBRA) would have required health plans to disclose the following:

(1) Service area, benefits, and any exclusions;
(2) disclosure of the medical loss ratio of the plan;
(3) how the plan provides out of area coverage;
(4) the number, mix, and distribution of participating health professionals and providers;
(5) the ratio of enrollees to participating health professionals and providers by category and type of health professional and provider;
(6) the expenditures and utilization per enrollee by category and type of health professional and provider;
(7) a description of the appropriate use of emergency services;
(8) utilization review requirements of the issuer (including prior authorization review, concurrent review, post-payment review, and any other procedures that may lead to denial of coverage or payment for a service;
(9) financial arrangements and incentives; and
(10) grievance procedures and appeals rights under the coverage, and summary information about the number and disposition of grievances and appeals in the most recent period for which complete and accurate information is available.

Id.

146. See Swanson, supra note 6, at 332 (arguing that a patient has a right to know what financial incentives are being offered to physicians to reduce care and referrals to specialists, as well as what reimbursement system is being used). "Financial incentives and resource constraints utilized by MCOs and physicians must be fully disclosed to patients." Faber Walsh, supra note 15, at 243. Specifically, the author found that “patients have the right to know the financial incentives that may impact the course of their medical care and treatment.” id.
However, full disclosure of financial arrangements may aggravate a patient's existing apathy toward managed care. For example, if a patient seeking treatment for what he or she believes is a serious upper respiratory infection is sent home without a remedy, he or she will be skeptical of this diagnosis if he or she knows that the physician is encouraged to limit care. Nevertheless, a fully informed patient will be better situated to assess his or her treatment options and a physician who provides such information will be in compliance with the ethical and legal obligations of the informed consent doctrine.

B. Prohibiting the Use of Financial Incentives to Limit Care

MCOs should be prohibited from using financial incentives to influence doctors to deny or limit medically necessary health care. Many

147. See Amy Goldstein, Clinton Backs Bill of Rights for Patients; President to Seek Law to Enforce Standards, WASH. POST., Nov. 20, 1997, at A1.

148. See Swanson, supra note 6, at 318.

Patients need to have trust in their doctors, and when doctors are not allowed to tell patients candidly what they think about a particular plan or treatment, HMOs begin chipping away at that relationship. In a world where doctors are not allowed to discuss the full range of relevant treatments with their ailing patients, are unable to tell them when substandard labs are used for crucial diagnostic tests, and are unable to advise them about which health plan best suits their individual needs, it is society as a whole that suffers.

Id.

149. See Faber Walsh, supra note 15, at 221 n.8:

As the health care industry moves toward managed care and away from traditional medicine, the physician-patient relationship is altered. The physician-patient relationship is viewed as a fiduciary relationship whereby the physician owes his patient a fundamental duty to put the patient's medical needs above all other personal interests. A patient places complete trust in his doctor to care for him and provide the best medical treatment possible. A doctor takes a Hippocratic oath to provide the best possible medical care for the sick above all other interests. The relationship between the patient and physician is held in the highest regard, as the most important relationship in medicine. However, managed care introduces a third party into the previously exclusive doctor-patient relationship. As a provider in a MCO, a physician must abide by his ethical duty to the patient to provide the best medical treatment possible, and at the same time adhere to cost containment mechanisms and limitations set forth in their contracts with the MCOs.

Id. (citations omitted).

150. See id. at 242-43.

151. See, e.g., H.R. Rep. No. 3605, § 142 (1998). PBRA would have pro-
commentators criticize the use of financial incentives to limit care.152 Others argue that the financial incentives are necessary to contain health care costs.153 Without the financial restraints, physicians may revert back to their old ways of overutilization.154 This over-treatment will lead to unnecessary costs that managed care plans were designed to prevent.155

Arguably, any legislation which restricts a MCO's ability to cut costs would undermine the sole purpose of managed care, which is to provide quality health care at an affordable cost. Indeed, cost containment mechanisms are useful at minimizing soaring health care costs.156 A reward to physicians for cutting the fat out of health care is a good idea,
but a physician should not be encouraged to forego medically necessary treatments for financial reasons. As a result, future legislation should prohibit only those financial incentives that influence doctors to deny or limit medically necessary care while continuing to allow an MCO to contain costs. An important distinction between the Democratic and Republican proposals brought before the 105th Congress was who decides what is "medically necessary." Under the Republican proposal, medical necessity was defined by the health plan, whereas the Democratic proposal leaves this determination to health care professionals.

C. Granting Patients the Freedom of Choice

Patients should have increased access to doctors and specialists of their choice. Patients should no longer be forced to see a preferred provider and should, in some cases, be able to go to their family doctors. While increasing the availability of physicians may lead to increased costs, the cost of a particular patient's care would inevitably decrease as a result of enhanced quality of care. For example, patients

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157. See id. at 219-20.
158. See id.; see also, e.g., H.R. Rep. No. 3605, § 142 (1998). PBRA would have permitted financial arrangements whereby a physician could still cut utilization without jeopardizing the quality of care that is required. See id.
161. See id.
162. See 143 Cong. Rec. S3666 (daily ed. Apr. 24, 1997). Senator D'Amato noted that:
In Georgia, a 2-year old boy was suffering from a high fever that did not respond to medication. His parents followed the insurance company's instructions for pre-authorization of emergency room care and attempted to drive 42 miles to the preferred hospital. The couple passed five emergency rooms along the way. Before they could reach the preferred hospital, their son went into cardiac arrest and stopped breathing. The child slipped into coma, developed gangrene in his extremities, and subsequently lost his arms and legs to
permitted to see their regular doctors would benefit the MCO in two ways. First, the patient would be more compliant with treatment recommendations if they came from his or her regular doctor. Second, a physician who has seen a patient for years can better assess his or her present conditions and, in turn, will be able to keep medical costs to a minimum.

Most notably, patients with special conditions should have access to specialists with the requisite expertise to treat their problems. Currently, most health plans will charge patients more when they seek care outside the network without considering the patient’s problem or the provider’s particular expertise. Moreover, legislation in this area should address the special health care needs of women and children. For ex-

amputation.

Id.


164. See, e.g., H.R. Rep. No. 3605, § 103-104 (1998). PBRA’s access to specialty care provision would have established certain standards to ensure access to appropriate specialty care as follows:

Sec. 103. CHOICE OF PROVIDERS.
(a) PRIMARY CARE- A group health plan, and a health insurance issuer that offers health insurance coverage, shall permit each participant, beneficiary, and enrollee to receive primary care from any participating primary care provider who is available to accept such individual.
(b) SPECIALISTS-
(1) IN GENERAL- Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care provider who is available to accept such individual for such care.
(2) LIMITATION- Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating providers with respect to such care.

Sec. 104. ACCESS TO SPECIALTY CARE.
(a) OBSTETRICAL AND GYNECOLOGICAL CARE-
(1) IN GENERAL- If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care provider—
(A) the plan or issuer shall permit such an individual who is a female to designate a participating physician who specializes in obstetrics and gynecology as the individual’s primary care provider; and
ample, women should have direct access to ob/gyn care and the ability to designate their ob/gyn as their primary care provider.\textsuperscript{165} Likewise, children with special medical conditions should have direct access to pediatric specialists.\textsuperscript{166}

MCOs should be required to have enough doctors to satisfy the demand dictated by their patients. Moreover, health plans should maintain a sufficient variety and geographical distribution of providers to ensure that patients receive covered services on a timely basis. Giving patients the freedom to choose their medical providers will enhance the quality of health care because patients, who are limited in their choice of providers and access to specialists, will not receive the care necessary to address their medical needs. Along these lines, approximately thirty-two states have enacted some form of "any willing provider" statute to enhance the accessibility of health care.\textsuperscript{167} The state statutes have the dual purpose of promoting patient choice and securing physician access to preferred provider organizations.\textsuperscript{168} However, since many states' "any willing provider" laws were preempted by ERISA, federal legislation is necessary to enhance a patient's freedom of choice.\textsuperscript{169}

In addition, MCOs should offer patients a variety of plans from which to choose.\textsuperscript{170} The MCO could then pass the additional costs onto the

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\item[(B)] if such an individual has not designated such a provider as a primary care provider, the plan or issuer—
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\item[(i)] may not require authorization or a referral by the individual's primary care provider or otherwise for coverage of routine gynecological care (such as preventive women's health examinations) and pregnancy-related services provided by a participating health care professional who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and
\item[(ii)] may treat the ordering of other gynecological care by such a participating physician as the authorization of the primary care provider with respect to such care under the plan or coverage.
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166. For example, if a child needed a pediatric neurologist, but the plan only had an adult neurologist, that plan would refer the child to an outside specialist at no extra cost to the family. See H.R. Rep. No. 3605, § 103-104 (1998).
167. See Swanson, supra note 6, at 320.
168. See id.
169. See generally Margaret G. Farrel, ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism, 23 AM. J. L. & MED. 251 (1997) (noting that ERISA preemption has had a profound impact on the quality of health care).
170. See, e.g., H.R. Rep. No. 3605, § 102 (1998). PBRA would have required health plans of employers, who offer only a closed panel HMO, to offer the
consumers in the form of higher premiums or larger deductibles. Most importantly, the patient will be making the treatment decisions. Unlike MCOs, which operate on large-scale economics, an individual patient may not let cost factors influence his or her decision, and should be permitted to pay for the medical services on his or her own. **"The patient should be aware what his health dollar will and will not purchase; if he and his doctor decide he needs something not paid for under the HMO, it should be his option to pay for it himself."**

**D. Greater Access to Emergency Services**

Patients should be able to receive emergency medical care without the burden of seeking prior approval from their MCOs. Recent proposals employees an opportunity to purchase a point of sale option in addition to the basic plan offered through the employer. See H.R. Rep. No. 3605, § 102 (1998).


172. See id. For example, a patient suffering from chronic back pain could choose a MCO that would agree to cover preventative back therapy notwithstanding the fact that no preventative back therapy is provided by the MCO. See id. The MCO would reimburse the costs of these services based on rates consistent with those negotiated under the plan. See id. The patient would then be responsible for any remaining costs associated with treatment. See id.

173. Swanson, *supra* note 6, at 320.


Sec. 101. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES-

(1) IN GENERAL- If a group health plan, or health insurance coverage offered by a health insurance issuer, provides any benefits with respect to emergency services (as defined in paragraph (2) (A)), the plan or issuer shall cover emergency services furnished under the plan or coverage—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider—

(i) the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider, and

(ii) the plan or issuer pays an amount that is not less than the amount paid to a participating health care provider for the same services; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Reve-
assert that patients must have access to emergency care, without prior authorization, in any situation that a "prudent lay person" would regard as an emergency.\textsuperscript{175} To require pre-approval for emergency treatment is a contradiction of terms. The following real life situation affords an example. In Texas, a seventeen-year-old girl was critically injured in a head-on car crash that left her with severe head trauma, a broken back, a crushed pelvis, and numerous other injuries.\textsuperscript{176} The girl eventually survived, but her health plan refused to pay $40,000 of her hospital bill because her family had not received "prior authorization" for her emergency admission.\textsuperscript{177} Indeed, the imminence of an emergency and the dire consequences of delayed treatment necessitate emergency treatment without pre-approval.

E. Equal Protection and Discrimination

In the health care arena, MCOs should be prohibited from discriminating against patients and physicians.\textsuperscript{178} Future legislation should require health plans to have a written, objective process for provider selection and should forbid discrimination against doctors based on license, location, or patient base.\textsuperscript{179} Under the current system, MCOs are

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(2) DEFINITIONS- In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD- The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.


177. See id.

178. See, e.g., H.R. Rep. No. 3605, § 109 (1998). PBRA would have prohibited a health plan from discriminating, directly or through contractual arrangements, in any activity that has the effect of discriminating against an individual on the basis of race, national origin, gender, language, sexual orientation, genetic information, or source of payment. See id.

179. See, e.g., H.R. Rep. No. 3605, § 113. PBRA read in part as follows: Sec. 113. PROCESS FOR SELECTION OF PROVIDERS. (a) IN GENERAL- A group health plan and a health insurance issuer that offers health insurance coverage shall, if it provides benefits through participating health care professionals, have a written process for the selection of participating health care pro-
able to discriminately select only those doctors who will comply with their cost containment mandates. Thus, a physician, who puts quality above cost, is subject to a penalty for practicing "good medicine." As a result, anti-discrimination legislation will enable those physicians, who seek to improve quality, to become members of the health care team.

In addition, patients should be protected from discrimination based on their medical background or pre-existing conditions. This will ensure that the patients in the most need for care receive that care. For example, under the current system, an MCO could manufacture a utopian membership made up of only healthy individuals with no pre-existing conditions. In turn, the individuals with long-term diseases will be left without health coverage, or coverage that is too cost-prohibitive for them to

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180. See Faber Walsh, supra note 15, at 207 (discussing how MCOs influence physicians economically to institute cost containment); Orentlicher, supra note 6, at 153 (noting the various cost containment mechanisms utilized by MCOs); Regan, supra note 5, at 635.

181. See supra note 178 and accompanying text.
maintain. Clearly, an anti-discrimination provision will prevent the dictator-like MCO from eradicating sick individuals from their population.

F. Freedom of Speech: Prohibiting “Gag” Clauses

MCOs should be prohibited from limiting a physician’s ability to discuss treatment options with the patient.\textsuperscript{182} Moreover, protecting provid-

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\textsuperscript{182} See, e.g., H.R. Rep. No. 3605, § 141. PBRA reads in part as follows: Sec. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) PROHIBITION-

(1) GENERAL RULE- The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider’s patient.

(2) NULLIFICATION- Any contract provision or agreement described in paragraph (1) shall be null and void.

(b) RULES OF CONSTRUCTION- Nothing in this section shall be construed—

(1) to prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a group health plan or health insurance issuer to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

(2) to permit a health care provider to misrepresent the scope of benefits covered under the group health plan or health insurance coverage or to otherwise require a group health plan health insurance issuer to reimburse providers for benefits not covered under the plan or coverage.

(c) MEDICAL COMMUNICATION DEFINED- In this section:

(1) IN GENERAL- The term ‘medical communication’ means any communication made by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) with respect to—

(A) the patient’s health status, medical care, or treatment options;

(B) any utilization review requirements that may affect treatment options for the patient; or

(C) any financial incentives that may affect the treatment of the patient.

(2) MISREPRESENTATION- The term ‘medical communication’ does not include a communication by a health care provider with a patient of the health care provider (or the guardian or legal...
ers in these situations from retribution will foster open communications and help stabilize the patient-physician relationship. Although insurance companies deny that “gag clauses” exist and downplay their negative effects on the quality of care, Congress should prohibit them for the following reasons:

1. In accordance with the AMA’s stance, “gag clauses” are unethical and destructive to the doctor-patient relationship.
2. Since physicians are in the best position to influence treatment, they should be able to speak freely to patients regarding their alternatives.
3. While “gag clauses” may already be illegal under the common law doctrine of informed consent, it is often too difficult for a plaintiff to prove harm.
4. Even if a patient is successful in proving breach of informed consent, the inadequate remedy provided does nothing to thwart future misfortunes in the delivery of health care.
5. While many state legislatures have recognized the need for full disclosure laws, the laws are often pre-empted by ERISA.

G. Amending ERISA: Piercing the MCO Liability Shield

Finally, ERISA should be amended to force MCOs to assume responsibility for their adverse decisions. Under the current system, MCOs

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183. See Little, supra note 74, at 1474. Legislation that does not eliminate “at will” employment for physicians would be ineffectual. See id. “Because without procedural protections, forcing a MCO to provide justifiable reasons for terminating a physician, laws disallowing gag clauses and requiring full disclosure of financial incentives are powerless to protect patients.” Id. The reason they are powerless is that the termination can act as a de facto gag clause by making physicians silent out of fear that his disclosure to patients could result in his termination. See id. According to Diane Archer, executive director of Medicare Rights Center, “The ability to terminate physicians without cause has perhaps the greatest chilling effect on patient communications.” Id.


Sec. 192. PREEMPTION; STATE FLEXIBILITY;
can usually escape liability under the guise of ERISA preemption. For example, an injured person can only recover the dollar value of the benefit denied. As a result, MCOs are free to manipulate the quality of health care in the U.S. A proposal that would allow state law to determine whether a health care beneficiary can bring a state cause of action against health plans is a good solution. Amending ERISA would ensure that MCOs could be held liable for denying treatment or influencing doctors to limit medically necessary care. However, "[h]olding MCOs liable for the effects of cost-containment, defeats the purpose of these organizations.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS-
(1) IN GENERAL- Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this title.
(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS- Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.
(b) RULES OF CONSTRUCTION- Except as provided in sections 152 and 153, nothing in this title shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.
(c) DEFINITIONS- For purposes of this section:
(1) STATE LAW- The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.


187. For a full discussion of the Early Retirement Income Security Act of 1974 (ERISA), including an explanation of ERISA's broad implications on state law remedies, see generally Kilcullen, supra note 105, at 7. See also Little, supra note 74, at 1464-68 (explaining the impact of ERISA on legislative and judicial protections for physicians and patients); Faber Walsh, supra note 15, at 222 n.93.
188. See Noah, supra note 6, at 1263. Another reason why MCOs are shielded from liability is that the medical malpractice liability system was rooted in the traditional fee-for-service health care delivery system. See Pedroza, supra note 4, at 431. Under a traditional fee-for-service system, physicians were required to act as fiduciaries for their patients. See id. Moreover, the physician served as the patient's sole "gatekeeper" and it was well known that over-treatment benefited both the physician and the patient. See id. Thus, it only made sense that the physi-
Another potential problem is that the cost of defending lawsuits would result in a rise in health care costs and could eventually lead us back to the fee-for-service days of overutilization. However, the mere threat of lawsuits would force the MCOs to relinquish control to physicians for treatment decisions. Moreover, as most commentators agree, amending ERISA to extend liability to MCOs for negligent treatment decisions would ensure the quality of health care.

CONCLUSION

Under the traditional fee-for-service system, physicians over-utilized medical services to guard against medical malpractice claims and to increase the profit margin of their practices. As a result, health care costs were exorbitant and the era of managed care began. With their alphabet soup of organizations such as HMOs, PPOs, and IPAs, managed care organizations mounted an attack on the spiraling costs of health care. The MCOs utilized a variety of cost containment mechanisms to regain control of health care spending.

With economically based programs such as capitation, bonuses, risk pools, and utilization review, MCOs have transformed health care delivery into a profit making business enterprise. Meanwhile, physicians, pursuant to their contracts with MCOs, are gagged from communicating with their patients alone was liable for any negligent medical decisions. See id. But, as health care shifted to managed care, the liability system remained constant. See id. “The tort system does not merely serve as a means of compensation for the injured, it serves as a moral agent in our society, shaping peoples actions.” Id. Therefore, for liability to be effective it must not only compensate the injured it must also provide incentives to MCOs to prevent harm. See id.

More importantly, the threat of lawsuits will motivate MCOs to increasingly leave medical decisions to the medical doctors. See id. The physician will again become the sole gatekeeper. See id. The judicial system and state legislatures have failed to provide physicians with adequate protections against dangerous policies and ERISA presents an obstacle for any judicial or legislative measures. See Noah, supra note 6, at 1246-48. Comprehensive federal legislation is therefore necessary. See id. “Such federal legislation would be a major step in providing physicians with the freedom necessary to restore safety and trust in America’s health care system.” Id. However, malpractice law places an enormous burden on managed care organizations. See id. Money spent defending lawsuits could result in an overall increase in health care costs. See id. Also, the insistence on providing the best available care to every patient continually drives up costs, which correlates to increased premiums. See id.

189. See Noah, supra note 6, at 1246-48.
financial incentives and treatment options to their patients. Moreover, due to ERISA’s broad preemption of state laws that “relate to” a benefit plan, MCOs have destroyed the “quality” of health care without fear of liability. As a result, patients are defenseless in the war against destructive health care delivery.

Just as Paul Revere’s ride signaled our nation’s independence, President Clinton has declared war on managed care with his proposed Patients’ Bill of Rights. In response to Clinton’s declaration, a bipartisan effort in Congress has evolved to halt the destructive power of managed care. Despite the inability of Congress to enact a patients’ bill of rights this term, the managed care reign of terror is drawing to a close. Many managed care entities have voluntarily changed some of their policies. However, in order to promote uniformity and maintain control of this volatile area, federal action is necessary. Future legislation should foster doctor-patient communications and allow patients to make informed decisions about their health care. Legislation should prohibit financial incentives from limiting medically necessary care and allow patients greater access to services and providers. Moreover, discrimination by MCOs should be eliminated and the ERISA liability shield should be pierced to allow patients to sue their HMOs for inappropriate utilization review decisions. Indeed, appropriate managed care legislation will strike a nice balance by allowing MCOs to maintain cost control without compromising the quality of health care delivery.