Physician Financial Incentives in Managed Care

by

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INTRODUCTION

The things in life that count the most are things that can't be counted. A smile, a hug, a healthy mind and body. Employees and families depend on Foundation Health to be there when it counts. Foundation Health. When you need us, we'll be there. (quote from an advertisement for Foundation Health, a large HMO that was recently acquired by Pacificare)

A revolutionary change has occurred in the way health care is delivered in the United States. Managed care, once scoffed at by many physicians, now predominates, while traditional indemnity insurance is quickly disappearing. At the heart of the change is the goal of saving money by altering the economic incentives for physicians. In the old days of fee-for-service medicine, physicians had financial incentives to overtreat patients, but in managed care the incentives are for undertreating patients. And while the idealized physician-patient relationship (i.e., the physician doing all that is in his/her power to treat the patient regardless of cost) still remains in theory, the new financial reality of today's health care delivery systems often sullies the purity of this relationship. Physicians in many managed care settings face daily conflicts-of-interest between their pocketbooks and the treatment of their patients. Often, the more procedures and tests a physician performs, the less he/she is paid.

Unfortunately, until recently, we as a society did not consider how to deal with physicians' incentives to cut costs. Federal and state legislation did little to regulate these incentives, and the courts failed to provide guidance. The only significant thinking about the issue came from medical ethicists as well as a handful of concerned physicians, and few heeded their warnings. The common belief was that managed care was leading to huge savings in a health care system where costs were spiraling out of control, and it was providing just as many benefits as traditional fee-for-service insurance.
However, in the past few years a convergence of circumstances has caused a backlash against managed care. The press and consumer groups have jumped on so-called "HMO horror stories" which inevitably involve an HMO (health maintenance organization) enrollee who was denied care and died or suffered irreparable injury because an HMO was trying to save money. Moreover, the effects of the stories are exacerbated by the press reporting the enormous salaries of many of those very same HMOs' CEOs. Managed care has also angered a number of physicians by causing them to lose pay and autonomy, and many consumers do not like their new health plans' restrictive bureaucracies. The combination of these factors has created a number of powerful influences trying to regulate managed care via legislation and court decisions.

In this paper, I hope to answer the following question: how should our society regulate physician financial incentives in managed care? Some believe that these incentives should not exist at all due to the inherent conflict-of-interest they create. Others believe that managed care organizations (MCOs) should be able to have any kind of incentives they want because an open market will insure quality.¹ However, we as a society seem to oscillate between these two extremes.

What makes this question especially interesting is that so little is known about the effects of the incentives. Policy researchers, journalists, politicians, advocacy groups, and physician groups all put their different spins on what these incentives actually do, but there is scant research that even comes close to proving that any of their opinions are correct. Thus, with incomplete information, we must somehow weigh the potentially damaging effects of incentives versus their key role in managed care innovations and cost savings. By considering economic, ethical, and legal arguments that relate to the incentives, I hope to create a multi-dimensional approach which goes beyond the often

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¹ The term managed care organization which will be used throughout the paper includes both HMOs, preferred provider organizations, and other hybrid health care delivery systems that fall under the rubric of managed care.
superficial propositions of the aforementioned groups and helps allow for rational policy
to be implemented.

In order to understand the potential effects of these incentives, one must
understand how managed care works, and the first portion of the paper is devoted to this
subject. There are two main categories of MCOs, HMOs and preferred provider
organizations (PPOs), and within each category there are numerous permutations. The
structures of these organizations will be explained, with an emphasis on the physician’s
role in them. In addition, MCOs’ use of physician incentives will be examined in detail,
as will the limited research regarding the effects these incentives have on physician
behavior. The politics involved with the issue of regulating physician financial incentives
will then be addressed. Numerous bills at both the state and federal levels have been
proposed attempting to regulate managed care, and a number of the main causes of this
are discussed.

The next part of the paper is devoted to the Employee Retirement Income
Security Act of 1973 (ERISA). Because so many of the bills that apply to physician
financial incentives are being proposed at the state level, a number of issues surrounding
ERISA arise. ERISA is a federal bill that regulates company benefits provided to
employees. The reason it is so important when considering state health care legislation is
that ERISA often preempts the proposed legislation due to Federal law’s Constitutional
preeminence. Thus because health benefits are included under ERISA, some employers
(those who have what is called self-insurance) and their managed care plans receive court
ruled exemptions from certain kinds of state health care regulation. My analysis, using
significant judicial opinions through the years, attempts to explain ERISA’s potential
hindrance of state attempts at health care reform.

I then analyze the major types of physician incentive legislation being
proposed. There are three main categories of regulation: legislation pertaining to health
plan and physician disclosure of financial incentives to patients; legislation pertaining to MCOs' selective contracting with physicians; and legislation pertaining to the limiting or banning of physician financial incentives for low utilization rates. For each of these categories, I will try to explore the advantages and disadvantages of proposed legislation as well as its political viability. I will also look at whether the legislation can be enforced, and whether ERISA can affect its implementation at the state level. I will do this using articles, legislative bills, current legislation, public opinion polls, court cases, and quotes from major lobbying organizations on both sides of these issues.

Following my exploration of attempts to legislatively regulate these incentives, I will look at significant court rulings that relate to them. A number of courts have ruled that MCOs are potentially liable for patient injury due to the way they pay their physicians. Courts have also written significant opinions regarding the concepts of informed consent and fiduciary responsibility as they pertain to physician financial incentives. Using court cases and analyses by legal scholars, I hope to paint a picture of the court's potential influence on MCOs' use of these incentives.

Finally, I will give my recommendations for what I believe to be the most reasonable policy regarding these incentives.

THE EVOLUTION OF MANAGED CARE AND THE CHANGE IN PHYSICIAN FINANCIAL INCENTIVES

Before the advent of managed health care, the issue of physician conflict-of-interest was rarely considered, except for limited issues regarding physician profiteering.²

² Utilization rates refer to the amount of tests, referrals to specialists, patient hospitalizations and other services that a physician orders. The higher the utilization rates, the more money the managed care company spends on a patient. Thus, MCOs vastly prefer low utilization rates.
³ There was concern about issues regarding physicians referring patients to diagnostic centers and laboratories that the physicians owned as well as a number of kickback schemes. See CRS Report for Health Care: Physicians Self-Referrals. Congressional Research Service (The Library of Congress.
Physicians were paid on a fee-for-service schedule, meaning that the physician was paid a fee for each patient visit or procedure performed. The majority of insured Americans had a Blue Cross/Blue Shield or commercial indemnity insurance plan which allowed them to visit any physician they wished. Insurers tried to limit health care consumption by requiring their enrollees to pay a deductible and then a percentage (often about 20%) of all health costs after the deductible (called coinsurance) up to a limit, after which the insurance company took over payment of all costs up to a maximum benefit level. Insurance companies rarely paid attention to the bills submitted to them, and physicians were given a great deal of autonomy. Generally, the goals of both the physician and patient were "congruent" in that the patient received comprehensive, no-costs-spared care, and the physician benefited financially, though there was obviously the possibility of overtreatment.4

The problem with this arrangement was that costs were increasing at a tremendous rate. The Congressional Budget Office estimates that between 1965 and 1991, national health expenditures rose an average of 6 percent annually after adjustment for inflation.5 As traditional indemnity insurance premiums kept skyrocketing, many employers looked for less expensive ways of insuring their employees, and managed care was the answer. Since the late 1980s, the increase in employer group health care costs slowed significantly, and according to A. Foster Higgins & Co. Inc., they actually declined 1.1% in 1994.6 This decrease can be directly attributed to more and more employees moving into managed care plans. As the chart below shows, this movement has been dramatic for privately insured employees:

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Percentage of privately insured employees in the different types of Health Plans

<table>
<thead>
<tr>
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<th>1988</th>
<th>1993</th>
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<tbody>
<tr>
<td>Fee-for-Service</td>
<td>71%</td>
<td>49%</td>
</tr>
<tr>
<td>*HMOs</td>
<td>18%</td>
<td>22%</td>
</tr>
<tr>
<td>*PPOs and point-of-service</td>
<td>11%</td>
<td>29%</td>
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</tbody>
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(*Indicates a type of managed care plan)

This shift has only increased in recent years, with 71% of employees enrolled in managed care plans in 1995.\textsuperscript{8} The Federal government, also worried about increasing costs, has moved toward allowing America's elderly to enroll in managed care, and though the numbers are far less staggering, there has been a significant increase. In 1987, 3% of all Medicare beneficiaries enrolled in HMOs, while in 1995, the number jumped to 6.6%\textsuperscript{9}. In addition, states are following suit and are increasingly pushing their Medicaid beneficiaries into managed care.

In order to understand the economic pressure placed on physicians by managed care, we must understand what managed care is. Managed care has been defined numerous ways, but for the purposes of this paper, a managed care organization will be defined as any health plan that contracts with a specific group of providers. There are numerous kinds of managed care plans that fit this definition, and it is difficult to generalize about them. However, MCOs generally have one or more of the following features. First, managed care plans often do not have coinsurance. The patient, or more often the patient's employer, pays a set fee for his/her care and the only payments he/she has to make after that are small copayments for physician visits. Second, the plans limit the providers the patient can choose from or impose economic incentives favoring the use of certain physicians. Third, the plans carefully monitor provider utilization of resources.

\textsuperscript{8}Geisel. p.1.
(tests, procedures, referrals), which is called utilization review. Finally, managed care plans often provide physician financial incentives for particular practice patterns.

There are three main types of managed care plans, with numerous permutations: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and point-of-service plans (POS). PPOs are most similar to fee-for-service plans. They pay physicians a fee for each patient visit, with the patient responsible for either a small copayment or a percentage of the fee. However, they negotiate lower fees with providers to whom they allow their patients access by promising the so-called 'network providers' significant patient volume. So if a patient wants to see Dr. Smith and Dr. Smith is not in the network, the patient has to pay "out of pocket" to see him. If Dr. Smith is in the network, he receives $80 instead of his customary $100 fee for seeing the patient. In PPOs, patients can self-refer to specialists without seeing their primary care physician, but the PPO does utilization review of ordered tests and hospital stays. PPOs have similar incentive structures to indemnity insurance in that physicians have an incentive to overtreat. Yet, this incentive is blunted by the PPO’s ability to drop physicians with high utilization rates from their networks and by providing bonuses for low utilization rates.

HMOs differ from PPOs because generally each enrollee chooses a "gatekeeper" primary care physician who must approve tests, referrals to specialists, and hospital admissions. Moreover, in a typical HMO, there is a fixed group of gatekeeper and specialist physicians to choose from. There are three types of HMOs: staff model, group model, and network or IPA (independent practice association). In staff model, physicians are salaried employees of the plan, and all the physicians' patients are members of the HMO. In group model, physicians in large independent group practices contract with the HMO, and a varying percentage (in some cases all) of the physicians' patients come from the HMO. In IPA and network models (some authors make a distinction), numerous solo and group practices contract with the HMO to provide
services; the physician practices in his/her own office, and only a portion of the 
physician's patients come from a single HMO. Any of these types of HMOs can 
additionally be point-of-service plans, meaning that subscribers can go outside the HMO 
physician network if they are willing to pay a coinsurance-type percentage of the 
physician fee.

The financial incentive structure that physicians practice under in HMOs 
varies greatly, and the type of HMO does not necessarily correlate with the financial 
pressures on the physician. To understand these pressures, one must look at how the 
physician is paid and the nature of the incentives. Physicians in HMOs can be paid by 
salary, fee-for-service, capitation, or a combination. An excellent definition of capitation 
is provided by literature from the Department of Health and Human Services: "A 
capitated payment is a set dollar amount per patient per month that a prepaid health care 
organization pays to a physician or physician group to cover a specified set of services, 
without regard to the actual number of services provided to each person."10 For 
example, a physician has 500 patients and receives $20 per patient per month from an 
HMO. The physician then has to treat all of his/her patients with $10,000, and the 
assumption is that some patients will need more care and some less. The money left over 
after the cost of treating the patients is income for the physician, creating a financial 
incentive for the physician to minimize patient services. A 1995 survey estimated that 
57% of network or IPA HMOs and 34% of group or staff HMOs used capitation when 
directly contracting with physicians.11

In general, fee-for-service physicians have an incentive to overtreat, capitated 
physicians have an incentive to undertreat, and salaried physicians have neither.

10Department of Health and Human Services. Medicare and Medicaid Programs: Requirements for 
Physician Incentive Plans in Prepaid Health Care Organizations. Federal Register. December 14, 
11Gold M., et. al. Arrangements Between Managed Care Plans and Physicians: Results from a 1994 
Survey of Managed Care Plans. Physician Payment Review Commission, Washington, D.C. February, 
However, these payment schemes are complicated by what are called “withholds.”
HMOs will often withhold part of a physician’s fee, salary or capitation until the end of
the year. The aforementioned 1995 survey found that the majority of HMOs include
withholds in their contracts.\textsuperscript{12} HMOs use withholds to align the physician’s interests
with those of the administrators. Alan Hillman, a professor at University of
Pennsylvania, did a large survey of HMOs in 1987 and describes withholds this way:

"In a typical HMO, after an administrative percentage is deducted, the
premium is divided into various special-purpose funds ... to pay for the
services of primary care physicians, specialists, hospitals and for
outpatient laboratory tests. The primary care fund is used to pay the
primary care physicians although a percentage of their payment is often
withheld until the status of the other funds is determined at the end of the
year. If there is a surplus, the HMO may return the withheld amount to the
primary care physicians; if there is a deficit, the withheld funds may be
retained by the HMO."\textsuperscript{13}

HMOs use the withhold to influence physician behavior, and in most, the desired
behavior is the lowest utilization of services possible. However, MCOs can also use
withholds as quality incentives for preventative care treatment such as immunizations and
Pap smears.

An HMO’s ability to increase or decrease the financial risk it places its
physicians under is based on a number of factors. First, if physicians in an HMO have
their utilization rates judged as a group, there is far less pressure on a given physician’s
decision-making than if the physician is judged individually. Thus, the larger the group,
the less the HMO influences individual decisions. Another factor is the amount of the
withhold. The greater the withhold, the greater the pressure on the physician. U.S.
Healthcare, a prominent HMO, in some of its contracts provided for a gatekeeper

\textsuperscript{12}Gold. p. 80.
\textsuperscript{13}Hillman AL. Financial Incentives for Physicians in HMOs: Is there a conflict of Interest? The New
physician to earn between $123,984 and $230,760, depending on utilization rates.\textsuperscript{14} Obviously, an income difference of $100,000 is a very strong incentive to undertreat.

For physicians who receive capitated payments, there are other factors that may hold sway over their decision-making. For instance, HMOs can contract with physicians for a large or small number of services. One HMO may contract with a physician to provide for primary care and diagnostic tests, while another may contract a physician to provide for primary care, diagnostic tests, specialty care, and hospital charges. The first physician has far less money to gain or lose than the second, and thus he/she has far less financial risk resting on clinical decisions. A similar factor is something called stop-loss or reinsurance. HMOs generally limit the amount of money that a physician has to pay out of his/her capitated payments in order to treat a patient. For instance, a patient needs coronary bypass surgery (a procedure that can cost tens of thousands of dollars) and a physician has agreed in his/her contract to pay for hospital care with the capitated payment. The HMO will stipulate that if the physician spends over $3,000 (a common amount) on the patient's care, the HMO will take over expenses. The lower the stop-loss amount, the less the financial risk, and accordingly the less the influence on the physician.

For all physicians dealing with managed care, including PPOs, there is another level of pressure, especially in regions where managed care is beginning to predominate. This is the ability of managed care organizations to drop providers from their physician networks. Most HMOs and PPOs have information systems to monitor the practice patterns of physicians.\textsuperscript{15} If a physician is not providing cost-effective care, he/she may be dropped from a plan.\textsuperscript{16} A particularly egregious case in point is the story of Gordon

\textsuperscript{15}According to the Gold survey, 76\% of group/staff plans use it, 86\% of network/IPA, and 52\% of PPOs profile their physicians or physician groups. Gold, p. 115.\textsuperscript{16}Gray BH. \textit{The Profit Motive and Patient Care} (Cambridge, MA: Harvard University Press, 1991), p. 223.
Sack, a Houston physician contracting with Aetna Health Plans. In July 1993, Dr. Sack was named the Houston area's primary care physician of the month by Aetna. A few months later he was dropped from the plan because he had excessively high utilization rates compared to other regional physicians. Today, some plans pro-actively scrutinize the practice patterns of those they allow into their networks. A recently formed Blue Cross-Blue Shield PPO in Washington, D.C. invited only those physicians who fit a certain "Pro/File (i.e., practice pattern)." 

The discussion of incentives up to now has dealt with what is called a two-tiered system, where the MCO contracts directly with individual physicians. However, more and more physicians are joining large medical groups which then contract with HMOs in so called three-tiered arrangements that include the HMO, the intermediate entity, and the physicians. A survey done in 1994 found that 67% of MCOs contracted with intermediate entities. Medical groups are often given a flat capitation by an HMO to treat a certain number of patients. The administrators of the medical groups can then exert the same financial pressures on their physicians that HMOs do. At times an HMO may capitate all its patient care with a large physician group, but then the physician groups may pay their providers fee-for-service or by straight salary. Alternatively, an HMO may have the same contract with the physician group, but the providers in the group may be subject to capitation, withholds, or bonuses for low utilization rates. Moreover, this situation can be even more complicated if the HMO contracts some aspects of patient care out to physician groups, and others directly with physicians. Thus to truly understand the financial pressures physicians are under, one must look at the

\[17\text{Hilzenrath, D. In Managed Care, Some Doctors Trip on Bottom Line. The Washington Post. August 8, 1994.}\]
\[18\text{Iglehart, p. 1169.}\]
\[19\text{A good discussion of the concept of three-tiered HMOs can be found in Hillman A, Welch P, and Pauly M. Contractual Arrangements Between HMOs and Primary Care Physicians. Medical Care. 1992;30:136-148.}\]
\[20\text{A 1994 survey found that 73% of group/staff model HMOs paid intermediate administrators by capitation and 77% of network/IPA model HMOs did so. See Gold. P. 82.}\]
different levels of administration they deal with. HMOs and medical group administrators both must be examined. For simplicity’s sake, when MCOs are referred to, physician groups with physician financial incentives can be lumped with them unless they are specifically mentioned as being distinct.

How do these incentives affect physician performance? Do they cause physicians to treat their patients efficiently and eliminate unnecessary procedures or do they cause physicians to withhold necessary care? No one knows. However, numerous studies have reached similar conclusions on certain issues when comparing MCOs and fee-for-service organizations. One obvious distinction between the two is that MCOs practice a less expensive form of medicine. Several studies, the most famous of which is the Rand study, have found this to be true, and they claim that MCOs achieved their savings through shorter hospital lengths-of-stay and less use of expensive procedures and tests.21 Most studies have also agreed that there is not a discernible difference in the health of enrollees when comparing managed care and traditional fee-for-service.22

Unfortunately no one has proven that the health of enrollees in a health care plan is at all correlated with the quality of their care. Furthermore, researchers have not yet found a way to accurately gauge the performance of health care plans.23 A number of commentators have also brought up the concern that physicians working with financial incentives to lower costs primarily work in the patient’s interest except, as ethicist David

22 See Miller and Luft. A recent four year observational study modified these past studies slightly for certain populations. It found that chronically ill patients who were either poor, elderly, or both had significantly better health outcomes in fee-for-service than in HMOs. See Ware et. al. Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems. JAMA. 1996;276:1039-47.
23 Comprehensive report cards assessing performance will not be ready for many years, though there are some crude report cards out there. Some of the best known are from the National Committee on Quality Assurance. See Thomas P. Quality of Care: Getting the Best. Harvard Health Letter Special Supplement. January, 1995: pp. 9-12.
Mechanic states, "at the margins, or in situations of uncertainty" where there are numerous alternatives and no one correct treatment. They worry that patient care could be compromised in those gray areas.24

THE POLITICS OF MANAGED CARE

Due to its ability to control costs, people looked at managed care as the salvation of our health care system. Many believed, and still believe, that MCOs provides just as good health care for significantly less money. Moreover, a majority of people report being happy with their HMOs. However, although no significant research has shown discernible differences in the quality or health of enrollees when comparing managed care and fee-for-service, there is mounting criticism of the managed care industry. There are a number of factors leading to this criticism, and although these factors are not very substantive, they have motivated people to clamor for reform. First and foremost are the so called “HMO horror stories” that are being publicized by the press and anti-managed care advocates. There is no proof that MCOs have any more horror stories than fee-for-service, but that is not often mentioned in these stories. One of the most famous horror stories is the case of Joyce Ching. Ching was a 32 year old woman living in southern California who began experiencing abdominal pain and rectal bleeding. She went to her assigned primary care physician, who was being paid by capitation to treat her. The pain and rectal bleeding went undiagnosed for three months during which multiple visits to the doctor along with multiple requests by Ching for a referral to a specialist occurred. Finally the physician referred Ching to a

gastroenterologist and she was diagnosed as having colon cancer. She died a year and a half later. The contract the primary care physician had with Ching's health plan stipulated that tests and specialist referrals had to be paid for by the physician out of the capitation payments made to him. Many believe the incentive to make more money caused the physician to treat Ching less aggressively and might have shortened her life.  

Another story involves a woman named Vicky Collins. Collins, a woman who worked for a Congressman in Washington, began feeling very dizzy while at work. She went to the nurses station and then to see her physician at her HMO. She was diagnosed as having a pinched nerve and sent home. During the following weekend, numbness began to spread down the left side of her body. Her fiancé repeatedly called the HMO, but a nurse kept telling him to call back Monday. Late Sunday afternoon, Collins tried to stand up and collapsed. She had had a stroke and is now wheelchair bound. Numerous stories like these are showing up on television, and in magazines and newspapers. These stories are the mother's milk for consumer groups trying to regulate managed care. In fact, a consumer lobbying organization called the Coalition for Health Care Choice and Accountability has something called "Project Soundoff" which is trying to gather HMO horror stories, and they have even set up a World Wide Web page to further their cause.

Feeding more fuel to fire is the fact that while HMOs are perceived to be shortchanging patients, their executives are earning very large paychecks. According to the California Medical Association, the six largest HMOs in California earned profits or $1.13 billion in 1995 and have a combined cash reserve of $5.6 billion. Moreover, the CEOs of many of the large HMOs are taking home huge salaries. Especially galling to consumer advocates is the $1 billion dollar profit (based on stocks and stock options)

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Leonard Abramson, founder and CEO of U.S. Healthcare, made as a result of his company's merger with Aetna Life & Casualty Co. Other CEOs are paid handsomely as well: William Wayne McGuire of United Healthcare Corp. earned $4.3 million in 1995 and David A. Jones of Humana Inc. earned $2.2 million in 1995.\textsuperscript{28}

Many physicians are not happy with managed care. They see their incomes leveling off or in some cases declining. They feel a loss of autonomy, and they feel that they are being placed in an unfair conflicts-of-interest. As physician Carole E. Horn states, "I don't want to be put in the position of feeling that every time I make a referral I believe one of my patients needs, I'm taking reimbursement out of my own pocket."\textsuperscript{29} Ironically, the biggest push for regulation is coming from the American Medical Association (AMA). Historically, the AMA has been loathe to have the health care business regulated by government, and has done little to impose rules of ethics on its members.\textsuperscript{30} However, the HMO squeeze has caused them to change their thinking. As Steve Thompson, vice president of the California Medical Association (a state branch of the AMA) states, "Most physicians don't believe that medical decisions should be legislated. But to the extent those decisions are being made in corporate boardrooms, without any physician involvement, legislation -- where physicians at least have a chance to have input -- is preferable to a corporate mode of decision making."\textsuperscript{31} While that is a valid point, a less noble motivation might be that they see an opportunity to get back some of the lost job and income opportunities that managed care has taken from physicians. The AMA behaves as if they are defending the patient against HMO monsters, but perhaps they are really protecting themselves. As Don White, spokesman for the American Association of Health Plans (AAHP), the largest managed care

\textsuperscript{29}Hizenrath. p.A1.
\textsuperscript{31}What's a Government to do? California Journal. April 1, 1996.
lobbying organization, states, "There are people with vested interests in keeping things the way they've been since World War II."\textsuperscript{32}

The combination of media horror stories, HMO salaries, and physician unhappiness with managed care has created a legislative juggernaut. Media horror stories are especially influential according to Charles Calderon, chairman of California's Senate Judiciary Committee. "The anecdotal stuff is what drives legislators. [It gives the public] the notion they're not getting proper care."\textsuperscript{33} Consumer groups, the AMA, and state medical societies are pushing hard for legislation. Moreover, groups like nurses and hospital workers that are also losing jobs and income due to managed care are at it as well. This has led to the proposal of a huge number of laws that would regulate managed care. At the Federal level four or five major pieces of legislation have been proposed every year for the past few years, and at the state level, the numbers have been mind boggling. AAHP reports tracking 75 bills pertaining to managed care in 1993, 90 in 1994, 175 in 1995, and as of May 1996, they were tracking 325.\textsuperscript{34}

Why has so much legislation been proposed at the state level rather than federal? Prior to Clinton assuming office, most health care reforms were taking place at the state level. This subsided to a certain degree when the Clinton administration tried to push through comprehensive reform. The Clinton plan's failure combined with the 1994 midterm elections -- where the Republicans took majorities in the House of Representatives and the Senate -- were basically the death knell for comprehensive reform at the federal level. This left more incremental reform to occur at the state level where there were still consumer groups and medical societies that were fighting for it. Both houses of Congress are currently considering managed care reform measures that

\textsuperscript{33}Kertesz L. Managed Care; HMOs Battling Horror Stories. \textit{Modern Healthcare}. 1996;26:44.
\textsuperscript{34}Bitchik G. Under Scrutiny Consumer Groups Begin to Act against Health Care Providers \textit{Hospitals and Health Networks}. 1996;70:p. 24.
call for incremental reform of the industry, but chastened by the Clinton plan fiasco, they are far less ambitious. By far, the more radical proposals are at the state level currently, and this brings up the rather hefty issue of a federal law called ERISA, which may preclude some of the state laws from taking effect due to federal precedence.

ERISA AND MANAGED CARE LEGISLATION

The Employee Retirement Income Security Act of 1974 (ERISA) was originally written so that employer-provided pension and welfare benefits could be federally regulated (health care benefits were included in this legislation). A primary reason for doing this was so that companies with employees in many states did not have to deal with different benefits regulation in each state. The most important part of the legislation as it relates to health care is something called the preemption clause. This clause preempts state laws "which relate to any employee benefit plan."\(^{35}\) However, this is complicated by that fact that ERISA also states that the preemption clause does not apply to "any law of state that regulates insurance."\(^{36}\) So basically, state governments can regulate insurance companies, but not employee benefits. Unfortunately, because insurance companies are the providers of health care benefits to numerous employees, interpretation of ERISA has become a legal nightmare or as one jurist called it a "Sargasso sea of obfuscation."\(^{37}\) Worst of all, there are almost no rules within ERISA to regulate health benefits. So employers are left with practically no federal regulation of their health benefits and significant protection from state regulation.

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\(^{35}\) 29 U.S.C.A. & 1144(a).
\(^{37}\) Travelers Ins. Co. v. Cuomo, 14 F.3rd 708, 717 (2nd Cir. 1993)
Interestingly, the framers of this legislation, who were drafting it in the days before managed care, had no idea that it would impact health care so significantly. In fact, the preemption clause was put in at the request of both big multistate employers and the AFL-CIO. The multistate employers saw it as a way to simplify benefit writing and not be subject to states with tendencies towards heavy regulation. The AFL-CIO wanted it primarily so that when they were in the stages of collective bargaining with employers, they could trade certain benefits for increased wages or vice versa. The drafters of the legislation were not terribly concerned about the lack of specifics concerning health benefits because they believed that there would be comprehensive federal regulations written imminently.38

What has resulted since is a law that some contend has "been used to eviscerate state attempts to regulate both health care financing and health delivery."39 Because the law is so vague, it has been left up to the courts to determine when state laws regulate insurance and when they regulate employee benefits. A very important distinction came in the Supreme Court ruling concerning Metropolitan Life Ins. v. Massachusetts.40 In this ruling, the court made a distinction between health benefits that were paid for through an insurer by the employer versus what is called self-funding. Self-funded plans use their own assets to pay for employees' health care rather than pay premiums to an insurance company or MCO to provide health care benefits. With managed care and all the permutations of health insurance, the ruling's real distinction was whether the employer or the insurer assumed the financial risk regarding the patient's care. This ruling has motivated numerous businesses to self-fund their health benefits. Currently, of the 114 million people who receive their health care benefits through their

employer, the federal government estimates that 44 million (40%) are in self-funded
plans, and that the number is increasing rapidly.41

A number of other important court rulings have helped to define how states
can and cannot legislate self-funded plans. Broad state laws mandating certain employee
health benefits are almost certainly preempted (see Shaw v. Delta Airlines).42 Moreover,
because there are no defined federal standards for health benefits, a self-funded company
can change its benefits at will. A particularly shocking case is McGann v. H & H Music
Company where a self-funded employer was allowed to significantly reduce its benefits
for patients with AIDS after an employee was diagnosed as having AIDS.43 What
becomes more complicated however are laws such as a New Jersey law regulating
hospital rates which included extra charges to pay for uncompensated care (i.e., hospitals
would add fees to the bills of those insured to pay for the uninsured, see United Wire,
Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital).44 Some
jurists have opined that because these charges "relate to" employee benefits in that the
benefit plans will have to pay for other peoples' health care, ERISA preempts the rate
setting. Others argue that ERISA was never intended to have such a broad interpretation
and that laws like this are not preempted. Most recently, the latter jurists appear to hold
the upper hand due to the U.S Supreme Court ruling in New York State Conference of
Blue Cross & Blue Shield Plans v. Travelers Ins. Co.45 In this case, the court ruled that
the state of New York was allowed to include extra charges on hospital bills paid for by
commercial insurers and self-funders while not adding the charges to Blue Cross & Blue
Shield plans so that Blue Cross & Blue Shield, which includes many more high risk
patients, could better compete in the market place.

41Jaggar S. Employer-Based Health Plans - Issues, Trends, and Challenges Posed by ERISA. GAO Report.
43946 F.2d 401, 403 (5th Cir. 1991)
44793 F. Supp. at 527-8. For a discussion of this case, see Parmet W. Regulation and Federalism: Legal
Many argue that Congress should change ERISA so that such a broad and vague law stops impeding states from improving their health care systems. However, the business community, a well-funded and well-organized political entity, is strongly opposed. Employers have multiple motivations to self-fund and thus avoid state regulation. First, if they are a multistate employer, they can have a single health benefits package for all their employees instead of the cost and bureaucracy of different benefits in each state. Second, they believe that they can better contain cost and improve quality if they are not overly regulated because they will have greater flexibility to innovate. Third, they are able to avoid expensive lawsuits based on health plan enrollees being denied benefits. Finally, if they choose, they can provide no benefits at all, and with the cost of health insurance, that is an important option for many employers.

FINANCIAL INCENTIVES ADDRESSED BY STATUTORY LAW

Because so many laws are being proposed in so many legislatures, the bills discussed will no longer be current by the time this paper is finished. However, as long as managed care and physician financial incentives exist, the fundamental issues brought up by these pieces of legislation will remain relevant for consideration. There are three main categories of legislation that have either been made into law or are currently being proposed: physician and MCO (managed care organization) disclosure laws; due process and "any willing provider laws"; and laws to ban or limit physician incentives. Each of these categories of laws will be analyzed using the same criteria, which include:

1) Why is the law being proposed?
2) How will it be enforced?
3) What are the advantages?
4) What are the disadvantages?

5) Is it politically viable?

6) Can ERISA preempt it?

DISCLOSURE OF PHYSICIAN FINANCIAL INCENTIVES

Many doctors and medical ethicists believe that physicians and MCOs have an affirmative duty to disclose financial incentives to patients. This belief comes not only from a commonsense perspective, but also from the medical ethical principles involved with the concept of informed consent. This term will be discussed in greater length later in the paper, but suffice to say that it relates to the idea that the patient should be informed of any information pertinent to making a personal health care decision. This broad principle includes many aspects of the physician-patient relationship, and many believe that when it is applied to the concept of physician financial incentives, it necessitates full disclosure of them to the patient in order for there to be full informed consent to any kind of procedure or surgery. In part due to the belief that certain parts of managed care contracts violate the principle of informed consent as well as the more general belief that physicians and patients should be allowed to freely communicate, two types of laws have come forth: anti-gag laws and mandatory disclosure laws.

The primary force behind anti-gag law proposals has been physicians' interpretations of certain clauses in their contracts with MCOs that they believe prohibit particular kinds of communication with patients. A number of physicians contend that not following these prohibitions can lead to warnings from the MCOs and even to termination of provider contracts. According to the AMA, different gag clauses have included: gags on discussing treatment options with patients unless the plan has authorized payment for them; gags on criticizing the plan and its policies; and, most
important to this paper, gags on discussing physician financial incentives for low utilization rates.⁴⁶

Although physician-MCO contracts are generally confidential, some of these "gag" clauses have been published. For example, a previous U.S. Healthcare (a large HMO) contract stated: "Physician 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 U.S. Healthcare or the quality of U.S. Healthcare coverage ... Physicians shall keep the Proprietary Information [payment rates, utilization review procedures, etc.] and this Agreement strictly confidential."⁴⁷ Another example is a clause HealthNet (another large HMO) formerly used, "Physician agrees not to disparage plan or its processes, programs or policies to any persons, including members or other participating providers. Disparagement of the plan will be treated as an administrative compliance failure."⁴⁸ Many feel that these clauses pit the physician's ethical duty of informed consent against his/her contractual responsibility. Managed care organizations say that these clauses are not trying to prevent communication between physicians and patients but simply prevent physicians from criticizing health plans and from divulging proprietary information. As Susan Pisano, a spokesperson for the American Association of Health Plans (AAHP) stated, "There has been a great deal of mythology and confusion surrounding this issue."⁴⁹

Wherever the truth lies, many states have decided to enact legislation to affirm the physician's ability to communicate with his/her patients. Massachusetts was the first to do so early in 1996. The key clause of House Bill 5347 reads: "An insurer shall not

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refuse to contract with or compensate for covered services with an otherwise eligible provider or nonparticipating provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding to provisions, terms or requirements of the insurer's products as they relate to the needs of such provider's patients. The federal government is currently considering similar legislation that sponsors have named the "Patient Right to Know Act of 1996." The act was introduced with a great deal of fanfare by Representatives Greg Ganske (Republican-Iowa) and Ed Markey (Democrat-Massachusetts), who introduced the legislation wearing surgical masks and gags around their mouths. The legislation affirms the physician's ability to communicate with his/her patient even more specifically than the Massachusetts law. It states that MCOs may not take any retaliatory action against a provider for communication involving: the risks and benefits of clinical options; variation among providers; utilization review decisions; and "any financial incentives or disincentives provided by [MCOs] to a health care provider that are based on service utilization." Unfortunately neither law directly addresses the relationship between the physician and his/her physician group. The Massachusetts law does not mention it. The Ganske-Markey bill states that it would apply to a “third party administrator or other person with responsibility for contracts with health care providers.” However, this is mentioned in the context of employee welfare benefit plans, and may not apply to physician group administrators.

The Massachusetts law has no specific enforcement mechanism written into it, but presumably it would be enforced by the government agency that regulates and licenses MCOs. In contrast, the Ganske-Markey bill (which would be administered by the Department of Health and Human Services) includes significant penalties for each

50 Massachusetts House Bill 5347. Section 2.
51 Managed Care: Anti-Gag Clause Bill Introduced In House. Health Line. February 27, 1996.
infraction. It allows for fines of up to $25,000 dollars for each violation, and up to $100,000 for each violation if “the Secretary determines that the entity has engaged within the 5 years immediately preceding such violation, in a pattern of such violations.”

What are the benefits of such legislation? Obviously, it would erase any doubt about what physicians are allowed to communicate to patients, especially when the law is written very specifically like the "Patient Right to Know Act." As Joseph Heyman, MD, president of the Massachusetts Medical Society states, anti-gag legislation allows physicians to "freely discuss insurance plan restrictions and medical care options without worrying about retaliation from those insurers." With such legislation, physicians can more easily uphold their ethical duty of informed consent. Moreover, patients can be safe in the knowledge that their physician will have the ability to communicate any information pertinent to treatment options and clinical decision-making.

There are some criticisms regarding this type of legislation. One is that it is unnecessary. MCO representatives contend that the supposed “gag” clauses do not inhibit physician-patient communication. Karen Ignani, President and CEO of AAHP, states, "Despite all the recent headlines and news articles, available information suggests that health plans rarely -- if ever -- use provider contracts to restrict communications on patient care." Moreover, such legislation may just add unnecessary regulation and bureaucracy to an area where contracts are constantly changing, sending government, according to Ignani, down "the long and unprecedented road of deciding what private contracts may and may not contain."
Even more troubling are the issues of plan disparagement by physicians and physician disclosure of MCOs' proprietary information. The managed care industry avers that much of the language in so called gag-clauses is meant to keep physicians from criticizing health plans. They argue that if physicians disagree with a health plan's policy, they should take it up with the plan administrators and not patients. Moreover, managed care plans do not want physicians with multiple health plan contracts to encourage patients to switch from one plan to another that is more financially advantageous to the physician. The only problem with this argument is that information relevant to the patient's welfare may be prohibited by such a clause. If a physician believes a new MCO policy regarding financial incentives is improper, he/she is not allowed to discuss it with patients. The Massachusetts law mentions "good faith," and perhaps that is the way to distinguish gratuitous criticism from pertinent physician-patient communications.

Health plans are businesses, and they have operational secrets that they deserve to keep, especially in regards to subjects such as payment rates and utilization review methods. Often plans will include clauses to protect proprietary information because in a competitive marketplace, according to Ignagni, "the release of such information about one plan can give its competitors an advantage." However, a physician is certainly able to talk non-specifically about all aspects of a health plan, including his/her financial incentives without giving away trade secrets. Physicians can say they receive significant bonuses for low patient use of emergency rooms without saying they receive $X for certain utilization rates. Even the AAHP agrees that a physician can describe his/her financial arrangements with a health plan in "general terms." So, any law of this sort, should allow a proprietary

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58 Ignagni Testimony (see above).
59 Massachusetts H.B. 5347.
60 Ignagni Testimony (see above).
61 Ignagni Testimony (see above).
information clause, but at the same time should define what is and is not proprietary
information. Neither the Massachusetts law nor the "Patient Right to Know Act" does
this.

Mandatory disclosure laws are more interventionist than anti-gag laws. Many
factions, including the AMA, consumer groups, and a number of ethicists believe that the
physician incentives that managed care organizations use should be included in the
information given to prospective and active enrollees about a health plan. Physician
Douglass F. Levinson argues, "All health insurance plans should be required to provide
formal disclosure statements to prospective subscribers concerning restrictions on the
choice of service and capitation payments and financial incentives for reduced use. These
statements should be simple and concise."62 Advocates of disclosure believe that this
information would greatly benefit health care consumers who would be able to
distinguish among health plans based on facts far more substantive than the
advertisements that crowd the air waves during health plan enrollment time. Some even
push the idea of disclosure a step further, advocating mandatory financial incentive
disclosure by the physician to the patient.

The Federal government as well as most states have laws and regulations
pertaining to MCOs. However, until recently none have mandated disclosure of financial
incentives to health plan enrollees. An example of a state with rigorous MCO regulation
is California. All MCOs have to be licensed by the Department of Corporations in order
to legally operate in California, and potential applicants have to submit numerous items:
organizational documents (i.e., articles of incorporation, partnership agreements, etc.),
corporate bylaws, significant shareholders and names of top management, a statement
describing the MCO and its function, a financial statement from the MCO, and many

other items. In addition, all provider contracts have to be submitted. Unfortunately, the Department of Corporations does not make the contracts or even the types of contracts available to the public. The regulation states, "The payment rendered or to be rendered to such provider of health care services shall be deemed confidential information that shall not be divulged by the commissioner, except that such payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry."  

A number of states have rectified this type of situation by mandating disclosure. One state that has enacted such a law is Georgia. The Georgia Patient Protection Act (PPA) states that among other things, health plans must disclose "the existence of any limited utilization incentive plans." It then goes on to say that "disclosure of information ... shall be readable, understandable, and on a standardized form," and that "such information shall be disclosed to each enrollee ... at the time of enrollment and at least annually thereafter." Similarly, at the federal level, there is a bill proposed by Representative Charles W. Norwood (Republican-GA) called the "Family Health Care Fairness Act of 1995" which also mandates that "a Network plan provide enrollees and prospective enrollees with truthful, accurate, and easily understandable marketing materials and information about ... financial arrangements and incentives that may (A) limit the items and services furnished to an enrollee, (B) restrict referral or treatment options, or (C) negatively affect the fiduciary responsibility of a health professional or provider to an enrollee." Unfortunately, neither law explains how it would apply to disclosure by a physician group that had utilization incentives in its contracts with physicians.

63California Codes: Health and Safety, section 1351.
64California Codes: Health and Safety, section 1351.
66Georgia H.B. 1338, 33-20A-2 (a) and (a)(B).
67U.S. House of Representatives H.R. 2400, sec. 207(a) and sec. 207(a)(9).
Both the Georgia law and Representative Norwood’s bill have specific, though slightly different enforcement mechanisms. The Georgia PPA would be enforced by the Commissioner of Insurance, and he/she would be armed with two main mechanisms of punishment: the ability to revoke a health plan’s license to operate in the state and the ability to impose significant monetary penalties. Representative Norwood’s bill orders the Department of Health and Human Services to create “regulations as are necessary and appropriate to provide for the enforcement of the requirements of this act.” Both of these bills would be relatively simple to enforce. Since they mandate disclosure of incentives to enrollees, they could be monitored by the Department of Health and Human Services or a state insurance commissioner. Moreover, physician organizations and consumer groups would probably be watching carefully for violations as well. The only area that might be complicated is defining what proper disclosure is and whether a particular health plan is guilty of not properly disclosing information. However, clearly written guidelines from HHS or a state insurance commissioner would probably avoid that problem.

The benefits of such legislation are obvious. The patient would be armed with information that helps him/her to better make medical decisions and perhaps inculcate him/her with a healthy bit of cynicism. Moreover, by having the health plans disclose such incentives, it may, to a certain degree, take the pressure off of the physician who would not be as obligated to talk about them. In a sense, this kind of legislation would allow the physician to uphold the responsibilities of informed consent without having to directly tell the patient that he/she gets paid more for lower utilization rates.

Some believe that health plan disclosure alone is not enough, and that the physician should have to disclose the incentives to the patient directly, especially when the patient has to make a medical decision based on information provided by the

68 See 61. 33-20A-4.
69 See 63. sec. 301.
physician (i.e., a man with chest pains calls his physician asking whether he should go to the emergency room, and if he goes, the physician could potentially lose income). As medical ethicist Paul S. Applebaum states, "Disclosure at the time of enrollment ... is unlikely to leave subscribers meaningfully informed about the way in which their doctors' recommendations are being affected by concern over costs."\textsuperscript{70} He advocates physician incentive disclosure whenever the physician or patient has a decision to make that could involve these incentives. However, while he and others believe that the physician's ethical duty requires this disclosure, there are no laws to date mandating it.

Mandatory disclosure legislation has its critics. MCOs, as with the anti-gag legislation, are concern about proprietary information. However, as long as the legislation is not unnecessarily specific about contractual aspects such as payment rates and withhold percentages, this should not be a problem. There are two criticisms that are more troublesome. First, some are concerned that active disclosure of these incentives in marketing material will, as Robert Hughes, president of the Massachusetts Association of HMOs, states, "make it all the more likely that people will feel doctors check their ethics at the bank."\textsuperscript{71} The more these incentives are disclosed, the more suspicious the patient becomes, and misperceptions can abound. Second, MCOs have asserted that these disclosure laws are unilateral. As George Strumpf, vice president of H.I.P Health Plan, states, "We're going to have, on one side, 'everything you ever wanted to know about H.M.O.'s but were afraid to ask,' but nothing about fee-for-service practitioners."\textsuperscript{72}

As for all the managed care legislation being considered in this paper, there are two main factions on opposite sides of anti-gag and mandatory disclosure laws: the

\textsuperscript{70}Applebaum PS. Informed Consent and Health Care Costs. \textit{The Millbank Quarterly}. 1993;71:669-76.
\textsuperscript{71}Campagne H. Bill simplifies Managed Care Disclosures. \textit{Massachusetts Lawyers Weekly}. May 13, 1996, p.33.
managed care industry (most prominently represented by AAHP) which generally opposes this type of legislation, and the AMA (as well as state medical societies) and consumer groups which generally support it. Both of these sides expend huge amounts of time and money advocating for their side before legislators, and they both have significant influence on the fate of bills. Even more influential, but harder to determine is the opinion of the American people. These types of laws are often complex and most Americans do not understand them or do not care to because they are not as apparent in their every day psyche as something like taxes. However, high profile media stories as well as the public posturing of the managed care industry and the AMA can leave an impression, and instruments such as surveys can be used to gauge public sentiment.

The AMA's Council on Ethical and Judicial Affairs issued guidelines pertaining to financial incentives to reduce utilization in managed care. It said that, "obligations of disclosure [of incentives] always apply to the physician practicing in managed care," and "any incentives to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter." 73 Consistent with these beliefs, the AMA has been a strong proponent of both anti-gag clause laws and disclosure laws. In January of 1995, the AMA demanded that "managed care plans immediately cancel 'gag' clauses in their contracts or policies with physicians," and during the previous year they were prominent backers of the "Patient Protection Act of 1994," sponsored by Senator Paul Wellstone (Democrat-Minnesota), which mandated disclosure and prohibited "gag" clauses. 74

The AAHP has consistently opposed both kinds of legislation, though their opposition has only been emphatic in regards to disclosure of proprietary information. Their primary defense against anti-gag legislation is that it is unnecessary because the

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“gag” clauses are only meant to protect proprietary information and prevent physicians from criticizing plan administrators. This assertion has been supported by a number of MCOs publicly affirming that they allow unrestricted communication between physicians and patients. The California Association of HMOs released a statement regarding their "Principles of Patient-Physician communication," which states, "Physicians should be free to discuss with patients how a health plan reimburses their affiliated physician groups or how the physician group reimburses individual physicians." Although it does not cede control completely, adding, “If physicians, physician groups and health plans enter into agreements to maintain the confidentiality of specific reimbursement rates, the agreement should be respected." In addition, U.S. Healthcare as well as other HMOs, whose gag clauses were particularly maligned, voluntarily dropped their gag clauses.

However, while making some concessions, the AAHP has opposed the Markey-Ganske bill because they believe it is too much governmental intrusion and that it does not prevent plan disparagement or disclosure of proprietary information. Currently, it appears that MCOs will not fight to prevent an anti-gag bill from being passed if they feel it is written appropriately. For example, the Massachusetts Association of HMOs found their state’s anti-gag legislation "perfectly appropriate," and the organization was mollified that it did not eliminate non-disparagement clauses.

The managed care industry's view of mandatory disclosure is more difficult to evaluate because the topic of disclosure has only been addressed as part of far more comprehensive legislation. Publicly, managed care has voiced support of disclosure. Karen Ignani, president of AAHP, stated that patients should be informed "in general terms what the plan's financial arrangements are with the health professionals who

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77 Ignani Testimony (see above).
provide patient care."\textsuperscript{79} However, they are concerned about being forced to disclose proprietary information.

Part of the reason that managed care advocates have not vociferously opposed either type of legislation is that they have difficulty selling their criticism to the public. Americans have been bombarded with pictures of physicians with gags in their mouths on covers of magazines and are being told that their physicians may be limited in what they can say regarding treatment options and how they are paid. How can managed care publicists respond? They cannot openly argue that full communication between a physician and a patient should be inhibited. Nor can they reasonably argue that they should not disclose how their physicians are reimbursed. Logically, they accede. There is little to no financial cost in following such laws. Moreover, as long as proprietary information is kept confidential and physicians are not allowed to gratuitously disparage health plans, the industry's only possible fear is that disclosing these incentives could lead to greater scrutiny of them, and that is a risk they have to take.

ERISA would not preempt either anti-gag laws or mandatory disclosure laws because neither directly or indirectly affects employee benefits.

DUE PROCESS LEGISLATION AND "ANY WILLING PROVIDER" LEGISLATION

Managed care's ability to offer provider contracts to physicians with low utilization rates, and to terminate contracts with physicians who have high utilization rates is a powerful method of controlling physician behavior. Currently, MCOs can terminate contracts without any explanation or warning, and they can reject physicians' applications to be considered as providers without explanation as well. Many ethicists,\textsuperscript{79}

\textsuperscript{79}Ignani Testimony(see above).
physicians and consumer advocates believe this to be wrong. While not a direct financial incentive, the power to terminate a provider contract at will could mean a significant loss of income for physicians who have a number of patients enrolled in a particular health plan. Some believe that this could influence physician behavior to the point of potentially compromising patient care. Moreover, physicians feel that they are being unfairly judged by business executives who do not know anything about medicine. These factors have lead to what are called due process and "any willing provider" legislation.

The goal of due process legislation is to provide guidelines which allow for fairness when physicians apply to contract with MCOs or have their contracts terminated. Two prominent federal bills which include very similar due process language are the previously mentioned "Patient Protection Act of 1994" and "Family Health Care Fairness Act of 1995." The latter bill is especially thorough in its approach to due process. It stipulates that network plans must allow a physician in a plan's service area to apply to become a provider at least once a year, and that plans must select physicians using "objective standards of quality" that are available to physicians, health plan purchasers, and enrollees. Moreover, if physicians are "profiled", the "profiles" must be made available to all these groups as well. If a physician is denied a provider contract based on these standards, the physician is given an explanation as to why he/she did not meet these standards and is allowed a chance to submit supplemental or corrected information. If the physician is still denied a contract, he/she can appeal the decision in a manner which "conforms to the process specified in section 412 of the Health Care Quality Improvement Act of 1986," which involves a hearing before an arbitrator, or panel in which the physician can have legal representation. These rules would also apply to a physician whose contract is being terminated. He/she would have to receive an
explanation regarding why he/she no longer meets the plan's standards, and he/she would have the same right to appeal.\textsuperscript{80}

These two bills have essentially the same enforcement mechanism. Both would give authority to the Department of Health and Human Services (HHS) to make sure that MCOs do not violate the bills' stipulations. As mentioned in the previous section, Representative Norwood's bill mandates that HHS create regulations to do this. The "Patient Protection Act" is a little more specific. It mandates that all MCOs must be certified by HHS, and that there would be periodic review and recertification.\textsuperscript{81}

This legislation provides significant benefits to physicians and patients. One benefit is that it would require that managed care plans explain what physician practice "profiles" they use for deciding whom to offer provider contracts. This, hopefully, would lessen the pressure on the individual physician. The physician would understand the health plan's use of utilization rates, and would also know that he/she would have a chance to appeal any contract terminations that he/she thought were unfair. Currently, some physicians fear accepting new patients with significant medical histories because they believe that this could increase their utilization rates which could lead to contract termination with no recourse. When the health plan spells out its standards, the physician no longer has a fear of the unknown. A further benefit is that if a patient's employer switched health plans and the patient wanted to continue seeing his/her current physician, he/she could ask the physician to try to contract with the patient's new health plan, and the health plan would have to provide for due process when reviewing the physician's application.\textsuperscript{82}

\textsuperscript{80}H.R.2400. Family Health Care Fairness Act of 1995. sec. 206. And Health Care Quality Improvement Act of 1986 (42 USCS @ 11112 (1996)).
\textsuperscript{81} S.2196. The Patient Protection Act of 1994. sec. 4(a).
\textsuperscript{82} If the physician was in a physician group, the situation would be more complicated because a physician group would probably not decide to contract with a MCO based on the request of one physician.
Mandatory disclosure of MCOs' criteria for contracting with providers would allow consumer groups and potential enrollees access to more information about how MCOs work. As Lonnie Bristow, chair of the AMA board of trustees, states "[such legislation would] expose insurance companies and managed care plans to the bright full light of patient and public scrutiny."\(^{83}\) People could judge plans based on whether or not they seem to emphasize low cost over quality of care when contracting with physicians. Perhaps this type of legislation might even provoke MCOs to consider more rationally how they decide with whom to contract.

The main criticism of such legislation is that it is so burdensome for the MCOs to not contract with a physician or to terminate his/her contract that it becomes in effect "any willing provider" legislation. As Mary Nell Lehnhard of Blue Cross/Blue Shield states, "If you scrutinize every single physician, it ties you into years of litigation. It's [the "Patient Protection Act"] not a direct 'any willing provider' law but it has the exact same effect of putting you into the legal system that you never get out of."\(^{84}\) Basically, those who criticize comprehensive due process legislation, such as the "Patient Protection Act" and the Norwood bill, lump it with "any willing provider" and see no difference. This, however, is simplistic. Granted, very detailed and onerous due process legislation, with multiple bureaucratic levels, approaches "any willing provider," but, as we will see below, it is not the same thing. Another criticism is that it may be difficult to make contracting criteria public without releasing proprietary information -- even more so than with anti-gag or mandatory disclosure laws -- since physician "profiling" is a very sophisticated process.

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“Any willing provider” (AWP) legislation is simpler than due Process, basically stating that if a doctor is licensed, he/she must be admitted by a health plan as a network physician. Many physicians favor this type of legislation which allows them more autonomy and lessens the power that the health plans can wield. Moreover, patients have a greater range of physicians to choose from and do not have to be concerned about keeping their physician if they change plans. No major federal health care proposal has included an AWP provision. However, a number of states have passed this type of legislation. In 1995, Arkansas enacted the "Patient Protection Act of 1995." The key clause states that a health plan shall not "prohibit or limit a health care provider that is qualified [i.e., licensed by the state of Arkansas]... and is willing to accept the plan's operating terms and conditions, its schedule of fees, covered expenses, utilization regulations and quality standards, the opportunity to participate in that plan."85 The law does not specifically address whether it would apply to physicians trying to join physician groups.

Enforcement of this law would occur in the courts. The law states, “Any person adversely affected by a violation of this act may sue in a court of competent jurisdiction for injunctive relief against the health care insurer and, upon prevailing, shall, in addition to such relief, recover damages not less than one thousand dollars ($1,000), attorney fees and costs."86

AWP legislation has similar benefits to due process legislation, but often to a greater degree. Because health plans would not be able to offer and terminate contracts on the basis of low utilization rates, physicians would practice under significantly less financial pressure when treating patients. MCOs would still be able to give bonuses and use withholds to influence physician utilization, but they could not terminate contracts based on utilization rates alone. In addition, patients could have greater continuity of care.

85Arkansas Senate Bill 299. Patient Protection Act of 1995. Sec. 4 (a)(3)
86Sec 82. Sec. 6.
because if they switched health plans, they could simply ask their provider to apply to contract with their new health plan.

However, there are two vociferously argued criticisms of AWP legislation, quality and cost. By allowing any licensed physician into a health plan, how can quality be kept high? As Brookings Institution health care scholar Henry Aaron states, "Can you imagine any law firm being required to pay 'any willing lawyer.'?"\(^7\) Obviously, some doctors are better than others, and many believe that health plans should have the right to distinguish among them. Some argue the plans are doing this currently, citing the fact that 85% of HMO physicians are board certified versus 60% of physicians in the United States.\(^8\) Moreover, different types of health plans may want different types of doctors. Some may want very cost-efficient practitioners while others may want to enroll doctors on the cutting edge of technology. AWP legislation would not allow this type of selection.

Cost is called into question even more than quality when AWP legislation is discussed. Many believe that AWP legislation destroys MCOs’ ability to try to lower costs, and the reason for this is multifactored. First, a significant method that MCOs have used to decrease costs is to offer patient volume to physicians in return for discounted fees. With AWP legislation, this can no longer occur because if any physician is able to be a provider, MCOs no longer have the bargaining tool of patient volume. Second, MCOs claim to save money by excluding physicians with questionable practice patterns, opting instead to contract with physicians who demonstrate high quality, low cost care. AWP legislation would no longer allow managed care plans to do this. Finally, because each physician a plan contracts with costs a certain amount of money administratively,


\(^8\)Atkinson & Company. The Cost Impact of "Any Willing Provider" Legislation. Sponsored by Group Health Association of America (now part of AAHP)
especially if there is significant "profiling" done, AWP legislation could drive up the cost of health care due to increased administrative costs.

Managed care advocacy groups have funded studies of whether AWP legislation would increase costs. Although these studies must be taken with a grain of salt because of their sponsors, their conclusions are interesting. The Group Health Association of America (which recently merged with another organization to become the AAHP) funded a study by the actuarial firm Atkinson & Company, which used staffing and resource utilization models to try to predict the cost impact of AWP legislation. They created different scenarios that could occur as a result of such legislation, and tried to predict provider behavior in such scenarios. Their scenarios ranged from a given plan contracting with 35% of all physicians in the plan's service area (best case) to contracting with 80% (worst case). The reason 35% would theoretically be better than 80% is the plan could negotiate fee-discounts more effectively and would have fewer administrative costs (theoretically, the more physicians an MCO contracts with, the greater the administrative costs). They concluded that the best case scenario would result in a 9% increase in managed care premiums while the worst case would result in a 29% increase in premiums. Furthermore, they concluded that these premium increases would increase the uninsured population by anywhere from 3.4 to 10.7 million people.

The Healthcare Leadership Council, the Alliance for Managed Care, and the Health Insurance Association of America sponsored a different study by health care research firm Lewin-VHI, Inc. to determine the cost of AWP legislation. Lewin-VHI accomplished this by using regression models based on states that have some type of AWP in place already. Like the Atkinson & Company study, they found that AWP

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89 Atkinson & Company. The Cost Impact of "Any Willing Provider" Legislation. Sponsored by Group Health Association of America (now part of AAHP)
legislation would increase costs significantly. They estimate that this type of legislation will increase total health care expenditures approximately 74.7 billion dollars for the combined years of 1996 through 2002. Moreover, they believe that the data limitations in their model suggest that they may have "underestimated the cost impacts" of this type of legislation.91

The AMA aggressively supported due process law, especially Senator Paul Wellstone's "Patient Protection Act of 1994." However, it has been careful to distinguish its support for due process legislation from that of supporting AWP legislation, specifically saying that the "Patient Protection Act" was "not a national 'any willing provider' bill."92 The AMA argued that "Patient Protection Act" type legislation was necessary because physicians' ability to "exercise their clinical judgment is being compromised."93 They also tried to portray the "Patient Protection Act" as a bill defending the patient from, as Lonnie Bristow, chair of the AMA board of trustees, states, the "MBAs whose bottom line is 'caveat emptor.'"94

While MCOs have been relatively quiet in their opposition to anti-gag and mandatory disclosure legislation, they have been vocal in their opposition to due process and AWP legislation. They have repeatedly asserted that most due process bills, though significantly different from AWP legislation in language, give the physician so many rights that for all intents and purposes they are AWP legislation in disguise. As Karen Ignani, President of the AAHP said of Senator Wellstone's bill, "By any other name, this is an 'any willing provider' proposal."95 Managed care lobbyists have not directly criticized the concept of due process, they have simply categorized all due process bills as

91Steils J. see above. Executive Summary. P. XI.
94see footnote 83.
back door attempts at AWP, and they have blasted AWP legislation, or as they call it, "any living provider," at every turn.96

MCOs have portrayed the "Patient Protection Act" as purely being in the interest of preserving physician incomes. As Jennifer Leaning, MD, a physician with Harvard Community Health Plan (a large Boston HMO), stated, "There are those in the medical community who do not want to go forward. Not long ago they were firm believers in the free market. Today they want special protection against the consumer-driven, market-driven reforms that HMOs have established."97 In addition, MCOs commissioned the aforementioned studies by Atkinson & Company and Lewin-VHI to show how much this type of legislation theoretically could add to the nation's health care costs. They have also asserted that AWP legislation would compromise their quality of care, forcing them to keep providers that they know are doing a poor job.98

What do Americans think about due process and "any willing provider" legislation? First Choice Health Network Inc., the largest PPO in Washington state, commissioned GMA Research to survey 401 Washington residents on their feelings about AWP legislation, and GMA produced the Washington Health Care poll.99 The results of this poll demonstrate the ambivalence health care consumers have towards this type of legislation. Of those polled, 34% said AWP legislation, if enacted, would increase the cost of health care (29% said it would not affect cost, 8% said it would reduce cost, 29% said they did not know). In addition, 50% said they would oppose AWP legislation if it increased the cost of health care (24% said they would support it and 26% said they did not know). However, when those polled were asked if they would rather keep their ability to choose their own doctor or keep health costs as low as

97 See Culhane
98 See Culhane
possible, 72% wanted to be able to choose their own physician (vs. 28% who wanted low cost). So, basically patients want the freedom to choose their physician and have low cost health care, and it is unclear which is more important to them.

AWP and due process legislation are very contentious issues in the Capitol and in State Houses across the country, and while the AMA and managed care lobbyists might argue about them on ethical grounds, the reason they are so contentious is primarily economic. The AMA sees this type of legislation as a way of wrestling power from managed care and giving greater autonomy to physicians. If it is passed, physicians would not have to feel the pressure to reduce utilization rates for fear of being dropped from a network or take significantly discounted fees to insure a full patient load. Managed care, on the other hand, sees this type of legislation as a significant road block to their goal of efficiency and low cost. They want to be able to influence physician behavior and only contract with cost-efficient physicians. This type of legislation would prevent them from doing so. Both physician lobbying organizations and MCOs are spending significant amounts of money on lobbying and public relations in order to argue their cases. So far, at the national level, due process and AWP legislation do not look like they will pass any time soon. However, at the state level, a number of legislatures have passed AWP laws of one sort or another, and sometimes quite convincingly. In fact, in Arkansas, the AWP bill passed with 100 in favor and 2 against.

MCOs feel that they have so much to lose with this type of legislation that in some of the states where it has passed, namely Louisiana and Arkansas, they have taken it to court contending that AWP violates ERISA. While the Arkansas case remains in court, the Louisiana decision came down in favor of managed care. In CIGNA Healthplan v. Louisiana, the court found that ERISA pre-empted the state’s AWP legislation. It based this decision on two reasons. First, the Louisiana AWP law specifically mentions that self-funded employers must adhere to the AWP law, and
according to ERISA, these employers are exempt from state regulation. Second, the law relates to the employee benefits by mandating that all PPOs have to accept any licensed physician. The court contends that this is limiting the self-funded employers' options when setting up employee benefits which violates the "relates to" clause of ERISA. The case is currently on appeal.

Many legal scholars think this ruling to be an aberration rather than significant precedent. They contend that the previously mentioned U.S. Supreme Court ruling in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. (which rejected the indirect economic argument) allows states significant discretion in regulating health care plans and that the Louisiana AWP was found in violation of ERISA because of the particular way it was written. The current thinking is that a properly conceived AWP law, that regulates HMOs and insurance companies but not employers would probably be allowed under ERISA. According to lawyer Jessylen Alica Brown, cases such as Stuart Circle Hospital v. Aetna Health Management, which held that ERISA does not preempt a Virginia law that prohibits PPOs from unreasonably discriminating against physicians, show this to be the case (the court reasoned that the law regulates insurance companies rather than employers). As Brown states, "One can credibly argue that 'any willing provider' laws govern the business of insurance, not employee benefit plans."

Due process legislation seems even less likely than AWP legislation to be preempted by ERISA. As long as the due process laws are not written in a way that directly affects employers, the only way they could be pre-empted is the aforementioned indirect economic argument which is even more difficult to show than with AWP legislation since it is theoretically far less intrusive in the operation of MCOs.

LIMITING OR BANNING PHYSICIAN FINANCIAL INCENTIVES FOR DECREASED UTILIZATION

Surprisingly, most of the proposed legislation at both the state and Federal level concerning physician financial incentives has not addressed what many consider to be the most fundamental issue: should these incentives be limited or even banned completely? Many physicians and ethicists believe these incentives present a conflict-of-interests that physicians should not engage in. Former editor of the New England Journal of Medicine, Dr. Arnold Relman, said of the incentives: "Often the effect has been bad for the doctor and bad for the patient... The financial arrangements often make the doctor a double agent. The ethics of the doctor-patient relationship historically require the physician to put the patient's interest first."102 Yet, few people have even considered trying to ban them. They are a key component of managed care, and any fear of physician conflicts-of-interest has been overwhelmed by managed care's success in capping skyrocketing health care costs. Moreover, the trend toward physician financial incentives for low utilization appears to be accelerating. Alan Hoops, CEO of PacifiCare (a large HMO), stated, "Given the right structure, doctors need to bear most of the [financial] risk."103

One significant law that almost bucked this trend was part of the Omnibus Budget Reconciliation Act of 1986. It stated that hospitals and MCOs contracted with Medicare or Medicaid beneficiaries were prohibited from using financial incentives that induced physicians to reduce services.104 The law was to be put into effect in 1989, but was then delayed until 1991. At some point before 1991, the bill was gutted and much less stringent requirements of MCOs and hospitals replaced the original language so that

the incentives were allowed to remain. However, the legislation had one restriction: MCOs and hospitals could not give physicians incentives to reduce treatment costs on a particular patient, only groups of patients. Some commentators believe that the weakening of the legislation was due to the lobbying efforts of MCOs.

Recently a number of more modest pieces of legislation have been proposed that attempt to put some limits on physician financial incentives, though none ban them outright. There are basically two types of legislation that have been offered: legislation that bans certain kinds of financial incentives and legislation that limits the financial risk under which physicians can be placed. In the former category are two failed referenda on the ballot of the November, 1996 elections: the California Nurses Association sponsored Patient Protection Act and the Service Employees International Union's HMO Patients' Rights Initiative. They both have identical language regarding incentives, stating, "No health care business shall offer or pay bonuses, incentives or other financial compensation directly or indirectly to any physician, nurse or other licensed or certified caregiver for the denial, withholding, or delay of safe, adequate and appropriate care to which patients are entitled. This section shall not prohibit a health care business from using capitated rates." Both of these propositions also have identical language regarding enforcement mechanisms. They each state, "The provisions of this Act shall be administered and enforced by the appropriate state agencies, which shall issue regulations, hold hearings, and take any other administrative actions that are necessary to carry out the purposes and

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106 See Rodwin, p. 166.
107 The Patient Protection Act Article 4, Section 1796.04 and The Health Care Patient Protection Act of 1996. Section 4. Georgia’s government has already enacted very similar legislation which reads "A managed care plan may not use a financial incentive program that directly compensates a health care provider for ordering or providing less than medically necessary and appropriate care to his or her patients. Nothing in this Code section shall be deemed to prohibit a managed care entity from using a capitated payment arrangement consistent with the intent of this Code section." (Georgia H.B. 1338, 33-20A-6.)
enforce the provisions of this act."\textsuperscript{108} The HMO Patients' Rights Initiative also includes a clause allowing health care consumers to go to the courts "to enforce any provision of this Act individually or in the public interest."\textsuperscript{109}

The California referenda certainly make a moral statement, i.e., physicians should not be remunerated for giving sub-optimal care to patients. Moreover, the referenda could potentially prevent HMOs from using certain types of incentives. However, the language of the referenda is so vague that it is difficult to determine its potential effect. In the California Ballot Pamphlet, the legislative analyst states, "It is not clear whether the measure prohibits any financial incentives that are not already prohibited under federal restrictions that apply to providers who serve Medicare or Medi-Cal patients."\textsuperscript{110} Although the referenda ban incentives for "the denial, withholding or delay" of proper care, no HMO currently engages in this kind of overt behavior. It would be gross negligence. Most physician incentives are based on things such as utilization rates which may be related to but are not specifically responsible for denying or withholding care. And even if one argues that such incentives could indirectly lead to physicians denying proper care, it could just as easily be argued that the incentives are for preventing unnecessary care. Moreover, who is to determine what proper care is? Is it anything that is not malpractice? The vagueness of the language makes it very difficult to implement.

Weakening the referenda even more is the clause each contains stating that they will "not prohibit a health care business from using capitated rates." Capitation is a form of payment where the physician receives a set amount of money from the HMO depending on the number of patients in his/her practice. Whatever the physician has left

\textsuperscript{108}The Patient Protection Act Article 17, Section 1796.17 and The Health Care Patient Protection Act of 1996. Section 13(a).
\textsuperscript{109}The Health Care Patient Protection Act of 1996. Section 13(b).
\textsuperscript{110}California Ballot Pamphlet. August 12, 1996. P. 54. Presumably, the analyst is referring to the aforementioned HCFA ban on physician incentives to reduce care for individual patients.
over after treating their patients is his/hers to keep. This is as much a financial incentive as bonuses or withholds. It is just a different payment structure. In fact, in this arrangement, the physician feels that any dollar spent on patient care is a dollar out of his/her own pocket. How can the writers of these referenda exclude capitation? Under their scenario, certain small bonuses could be banned while a capitated physician with high deductible stop-loss insurance, who is at far more financial risk, would be allowed.

Because of the vagueness of the referenda, it is very difficult to analyze benefits and costs of such legislation due to the fact that they could vary so significantly depending on interpretation by the California government and courts. However, one can analyze generally the benefits and costs of a law that would outlaw these incentives completely. The main benefit is that the physician will no longer be a “double agent.” Depending on his/her remuneration, he/she may have incentives to overtreat, but the patient would no longer have to worry about undertreatment. The big problem is cost. Many argue that these incentives have contributed a great deal to the decrease in health care inflation and that taking them away would cause health care costs to again rise out of control.

The other approach to regulating physician financial incentives is to limit the financial risk HMOs can place physicians under. The idea behind limiting the incentives is that if they are kept at a relatively small size, they will not negatively affect physician behavior too much. By far the most sophisticated example of this type of regulation has been implemented by the Health Care Financing Administration (HCFA) for Medicare patients enrolled in HMOs. In 1992, HCFA proposed comprehensive rules, the most important of which limited the amount of risk a health plan could place a participating physician under. The rules were shelved by HCFA and reintroduced in 1996 in a slightly

111 HCFA is the division of the federal Department of Health and Human Services that administers Medicare and Medicaid.
modified form only to be shelved again. Finally, they were put into effect January 1, 1997. The heart of the regulation stipulates that physicians are at “significant financial risk” if their income could vary by 25% or more based on withholds, bonuses, and other factors when they are paid out annually. If the payments (withholds, bonuses, etc.) are made more often, the risk limit is 15%. The rationale behind the higher percentage allowable for annual incentive payments is that the risk is spread over a year's worth of patients, and less of the incentive payment would depend on a clinical decision with a single patient. In other words, the longer the period between incentive payments, the greater the volume of patients and the less influence the incentives have on the physician. If an MCO places a physician at “significant financial risk,” it then has to provide significant stop-loss protection.\textsuperscript{112} Risk contracts in the relationship between physicians and physician groups are included in this regulation as well, meaning that a physician group is considered to be placing its physicians at “substantial financial risk” if it surpasses the 25% mark.\textsuperscript{113}

HCFA apparently arrived at these percentages in two ways. First, they looked at the ranges of withholds that HMOs currently use, and determined the upper range to be 25% to 30%. Second, they reasoned:

"Financial incentive plans that place physicians or physician groups at risk for 25% of their payments from prepaid health care organizations would appear to be of the same magnitude as the reduction in payments many physicians voluntarily accept in return for increased volume and protection against bad debt, and in response to marketplace competition."\textsuperscript{114}


\textsuperscript{113}The most recent version of the regulations state “Section 417.479(b) is revised to clarify that the physician incentive plan requirements also apply to subcontracting arrangements.” Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations. Federal Register. Sect. V, Volume 61, No. 60, December 31, 1996.

In other words, because physicians in PPOs take reduced fees in order to have greater volumes of patients and no bad debt, they have similar earnings to those in HMOs with withholds.

These percentages apply to all types of physician payments, including withholds, bonuses and capitation. Moreover, they apply to any combination of the three. For instance, say a physician has 20% of his/her payments withheld by an HMO and could potentially receive bonuses that add up to 10% of total possible income (including withholds). This physician would have income risk greater than 25% and would be at “significant financial risk.”

The aforementioned stop-loss protection for physicians is intended to limit physician financial risk in these “significant financial risk” contracts. Many believe that if stop-loss protection (whereby the physician is only responsible for sick patients up to a certain amount of money) does not cover the physicians enough, then physicians will feel pressured to use low cost treatments for very sick patients so that they do not lose too much money. An example of this would be a physician who receives capitated payments for all of his/her patients’ care and has a patient with AIDS. If the HMO does not take over paying for the patient until $40,000, the physician could lose a huge amount of income. However, if the HMO takes over at $1,000, the physician does not have to worry so much about expensive treatments. The HCFA regulation allows for two methods of stop-loss coverage, aggregate (the amount of money a physician can be held responsible in his/her entire practice) and individual (the amount of money a physician can be held responsible for with an individual patient, like the example mentioned above). With aggregate coverage, MCOs must cover 90% of the costs of referral services that are in excess of 25% of potential physician income. With individual coverage, there is a sliding scale so that the smaller the number of patients in the physician or physician group practice, the lower the limit. The idea behind this is that a few sick patients in a very small practice could upset the practice’s finances significantly, but would not in a larger
practice. So a practice with less than 1,000 patients would have a stop-loss of $10,000; a practice with 1,000 to 10,000 patients would have a stop-loss of $30,000; and a practice with greater than 25,000 patients would not have to have any stop-loss insurance.\footnote{Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations. Federal Register Volume 61, No. 60, March 27, 1996. I(g)(2)(i) and (ii).}

The rules are enforced by HCFA and include three levels of punishment: civil money penalties not to exceed $25,000 per occurrence of non-compliance, intermediate sanctions, and contract termination.\footnote{Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations. Federal Register Volume 61, No. 60, March 27, 1996. Section F.}

HCFA has created rules that are comprehensive and demonstrate a sophisticated understanding of the managed care industry. They limit the amount of risk the physician can take on, and MCOs cannot skirt around them by reconfiguring their payment methods. These rules are especially well written because they cover the relationship between the physician and the physician group so that there is not a loophole allowing physician groups to place the physician at risk in lieu of the MCO. Moreover, the rules cover both the overall salary risk for the physician and, in some cases, the financial risk that a single patient poses to the physician (i.e. stop-loss coverage). As Bruce Fried, director of HCFA's office of managed care states, "It's a proxy for quality and a safeguard against underreferrals."\footnote{Weissenstein E. The Week in Healthcare; HCFA Ruling Requires Physician Disclosure. \textit{Modern Healthcare}. 1996;26:12.}

However, the decision to consider physician income risk of 25% to be "significant financial risk" seems arbitrary. Touting these new rules, Secretary of Health and Human Services Donna E. Shalala stated, "No patient should have to wonder if their doctor's decision is based on sound medicine or financial incentives. This regulation should help put Americans' minds at rest."\footnote{Pear R. U.S. Shelves Plan to Limit Rewards to H.M.O. Doctors. \textit{The New York Times} (National Edition). July 8, 1996, A1,C10.} How can she be so sure? As mentioned above, HCFA justifies these levels two ways. First, they looked at the upper range of
risk placed on physicians in managed care, which turned out to be around 25% to 30% of salary. Then they estimated that physicians in PPOs give up about that much in order to increase patient volume and avoid bad patient debt. The problem with this justification is that it does not address whether risk levels this high affect physician behavior. It simply validates the status quo. HCFA cites no studies that try to determine the effects of such risk levels. Moreover, the argument that fee-for-service physicians reducing fees in PPO arrangements is analogous to a withhold of 25% is illogical. Reduced fees have nothing to do with financial incentives that attempt to manipulate physician behavior. It has also been argued that such rules make it more difficult to control costs and add cumbersome bureaucracy that involves the rewriting of numerous physician contracts. In addition, in a system where physicians and physician groups are attempting to take on more risk, the rules, according to Karen M. Ignani, president of the AAHP, "do not reflect recent developments in the market."^{119}

Other than by certain physicians and ethicists, there has been little public advocacy of the complete banning of physician financial incentives. Although at the superficial level the California initiatives may have appeared to do so, they did not really ban them outright. However, there has been a fair amount of discussion regarding regulation of these incentives. Not surprisingly, the AMA generally supports regulating incentives while MCOs are vehemently opposed. The CNA and SEIU both worked very hard to get their initiatives passed, and they argue that they were simply advocating for quality patient care. Although a number of consumer groups also supported the California initiatives, the AMA did not, but the reason for the AMA's lack of support probably had little to do with the financial incentives clauses and more to do with other parts of the referenda. In fact, the financial incentives clauses were actually quite similar

^{119}Pear. C10.
to the guidelines written by the AMA Council on Ethical and Judicial Affairs, which state, "Financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care." Both consumer groups and the AMA have actively supported the rules proposed by HCFA. The rules are in accordance with the AMA Council on Ethical and Judicial Affairs guidelines which state, "Limits should be placed on the magnitude of fee withholds, bonuses, and other financial incentives to limit care. Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged." 

One is hard pressed to assess managed care's opinion of the financial incentives clause in the California initiatives because the initiatives had other clauses that MCOs find even more odious. For instance, both of the referenda mandate certain staffing levels in hospitals, and MCOs argue that this could greatly increase premiums. Kirk West, president of the California Chamber of Commerce states, "These measures are really nothing more than full employment acts that will benefit union members [SEIU and CNA] and cost the rest of us a fortune." Although the financial incentives clause may not have been their main reason for opposing the initiative, the initiative were all or none and MCOs spent a significant amount of money to fight them. They even hired the public relations and consulting firm Goddard-Claussen/First Tuesday, which ran the "Harry & Louise" ad campaign that helped defeat the Clinton health care reform proposals.

Voters ended up defeating the referenda resoundingly. However, one cannot infer the public's opinion of the financial incentives clause from their opposition to the

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120 Council on Ethical and Judicial Affairs, AMA. Ethical Issues in Managed Care. JAMA; Jan 25, 1995; vol 273. 330-5.
121 Same as above footnote.
122 Initiatives to Curb Alleged HMO Abuses Qualify for Ballot, Pick up Endorsement. BNA Health Care Daily June 14, 1996.
referenda in general. In fact, bills that have easily passed through legislatures in other states such as Georgia have included very similar language.

MCOs' displeasure with the HCFA rules is obvious. The rules were proposed in 1992, and HCFA received numerous comments from MCOs and the public which they tried to address in their final rules issued in March 1996. HCFA also allowed for a final period of public comment before the rules were to take effect on May 28, 1996. During this period they were severely criticized by many of the largest MCOs who claimed that the regulations would force them to rewrite thousands of physician contracts. And although no MCO publicly states that they oppose the rules because their contracts with physicians often include payment risk greater than the rules allow, one is hard put to avoid that conclusion. For instance, when Lyle S. Swallow, a lawyer for Healthnet, a large HMO says the rules "will affect our contracts," and that physician groups have accepted "more and more financial risk," the implication is that the risk in many of their physician contracts exceed the HCFA "significant financial risk" percentages. In addition, at a meeting between HCFA and MCO representatives on May 1, 1996, HCFA officials had trouble answering questions pertaining the rules' impact on very complex physician contracts.123 Feeling pressured by the managed care industry, in July, 1996, the Clinton administration decided to delay implementation of the rules until 1997. Finally, on January 1, 1997, the rules were implemented with almost no changes from the May 1996 version.

It is difficult to assess the public's opinion of HCFA's rules. They are complex and are really the domain of government officials, MCOs and policy researchers.

123HCFA: Physician Incentive Pay Rules Won't Take Effect Until Next Year. Managed Care Week. May 13, 1996.
Since the HCFA rules only apply to Medicare and Medicaid recipients, ERISA has no influence on them. As for the California initiatives' financial incentive clause and other state laws limiting or banning physician financial incentives, the same argument applies as with the AWP and due process laws. An argument could be made that by removing the incentives, the cost of employee health benefits will increase due to less cost-conscious physician behavior, but that only involves indirect economic impacts that such regulation might have on employers. And as was said before, it appears that recent court rulings do not favor the indirect economic argument for laws being preempted by ERISA.

SIGNIFICANT JUDICIAL RULINGS RELATING TO PHYSICIAN FINANCIAL INCENTIVES IN MANAGED CARE

Although the explosive growth of managed care is a relatively recent phenomenon, there have already been some notable judicial cases that have shown that MCOs and physicians may have certain responsibilities under common law when engaging in these types of arrangements.

Until recently, MCOs had been virtually immune from liability in regard to medical malpractice. They were treated as third party payers, and since the physicians ultimately made the medical decisions -- or so MCOs claimed -- MCOs had no legal responsibility for patient treatment. This simplistic assumption was challenged in the Wickline v. State of California ruling.124 In this case, the plaintiff, Lois Wickline, was admitted to a hospital for vascular surgery. She was a Medi-Cal patient, and Medi-Cal reviewers determined that she should be discharged on a certain date following surgery based on their length-of-stay guidelines. Numerous problems developed after the surgery

that required further surgical treatment. Wickline's physician asked Medi-Cal reviewers for an eight-day extension to the original discharge date. However, the reviewers only agreed to pay for a four-day extension, and the physician did not appeal the decision. After being discharged from the hospital, Wickline developed an infection that required amputation of her leg, and in the opinion of the physician she would not have lost her leg had she stayed in the hospital for the full eight-day extension.

Wickline's suit contended that Medi-Cal "negligently discontinued [her] Medi-Cal eligibility, causing [her] to be discharged ... prematurely."125 The court stated that "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."126 However, because the discharge was within the "standards of practice of the medical community," there was no perceived negligence, and the court never had to apply its statement about third party payers to the Wickline case.127

Another case that holds third party payers potentially liable for negligence is Wilson v. Blue Cross.128 Howard Wilson was admitted to a hospital for depression, anorexia, and drug dependency. His treating physician believed that Wilson needed to spend 3 to 4 weeks at the hospital. However, a utilization review organization said it would pay for ten days. Wilson was discharged after ten days and subsequently committed suicide. Wilson's mother brought suit against the insurer and the physicians with whom it contracted. The court found that there was a "triable issue of material fact as to whether Western Medical's [the utilization organization contracted by Wilson's insurer] conduct was a substantial factor in causing the decedent's death."129 This

125Wickline. p. 662.
127Wickline. p. 667.
opinion, according to legal scholar Frances Miller, "affirms the Wickline rationale concerning potential liability for insurers who design and impose cost-containment requirements."\textsuperscript{130}

These cases, though not directly involving physician financial incentives, paved the way for cases which did. One such case is \textit{Bush v. Dake}.\textsuperscript{131} Sharon Bush consulted Dr. Paul M. Dake (her primary care physician) concerning symptoms of vaginal bleeding and mucous discharge unrelated to menstruation. Dake prescribed medications for what he believed to be an infection. The symptoms did not abate and Dake referred Bush to Dr. Frederick W. Foltz, a gynecologist. Foltz did a vaginal smear to test for chlamydia, which was negative, but advised her to return if the bleeding persisted following her next menstrual cycle. The bleeding persisted, but Dake refused to refer her back to Foltz, and without the referral, the insurer, Group Health services of Michigan, Inc. (GHS), would not pay for the appointment. Bush did not return to see Foltz. A few months later Bush went to a local hospital's emergency room complaining of the same symptoms, a biopsy was taken, and she was diagnosed with cervical cancer. The court concluded that if a pap smear had been done earlier, the diagnosis of cancer could have been made earlier.

Dr. Dake was part of a physician network contracted with GHS that received capitated payments for patient treatment. Furthermore, GHS set up pools of money that were used to cover any specialist referrals or hospitalization costs. Any left over money in these pools at the end of the year was divided between the network of physicians and GHS. In other words, the physicians financially benefited from low utilization rates. Bush claimed that "there is a jury question presented as to whether the system [of


financial incentives] ... contributed to the malpractice in this case."\textsuperscript{132} The court, in denying the defendants' motion for partial summary disposition, agreed, stating, "There is a genuine issue of material fact presented as to whether GHS's system in and of itself proximately contributed to the malpractice in this case."\textsuperscript{133} However, GHS's financial incentive system never came under the scrutiny of a jury because before trial, the parties settled out of court.\textsuperscript{134}

Other cases such as \textit{Boyd v. Albert Einstein Medical Center} and \textit{Sweede v. Cigna} are similar to \textit{Bush v. Dake} in that they involve HMO liability for physician malpractice based on financial incentives. However, they are equally uninstructive because they were also settled out of court.\textsuperscript{135} Although the issue of risk sharing and managed care liability is not resolved in the courts at this point, these cases demonstrate that the antiquated belief that third party payers have no influence over physician decision-making is no longer accepted. Moreover, these suits, according to health policy scholar Marc Rodwin, "may encourage HMOs to limit the financial pressures placed by HMOs on physicians."\textsuperscript{136}

Another area where the courts have become involved is in an MCO's ability to terminate a provider without cause. Most, if not all, MCO-provider contracts include a clause that allows the MCO to summarily drop a physician from its network without giving any reason. As mentioned above, this puts the providers under pressure to have low utilization rates due to fear of being dropped. Courts until recently have unanimously upheld these provisions, and physicians have often appealed MCO decisions to no avail. However, a recent New Hampshire Supreme Court ruling in the case of

\textsuperscript{132}\textit{Bush v. Dake.}
\textsuperscript{133}\textit{Bush v. Dake.}
\textsuperscript{134}Rodwin, p. 171.
\textsuperscript{136}Rodwin, p. 175.
Harper v. Healthsource New Hampshire Inc. may be a harbinger of change to come.\textsuperscript{137} In this case, Paul Harper, a primary care physician and surgeon, was re-enrolled as a primary care physician but not as a surgeon by Healthsource (a large HMO) during the HMO’s annual re-enrollment period. Healthsource initially gave as a reason his less than optimum credentials as a surgeon, but when he protested, they simply cited a clause in Harper’s contract which stated, “This agreement may be terminated by either party without cause upon six months prior written notice.”\textsuperscript{138} Since Healthsource provided approximately a third of Harper’s patients, this was a large piece of his business, and he appealed Healthsource’s opinion again and again to no avail. Moreover, they would not give him access to the documents (primarily patient records) they used to analyze his utilization rates.

Harper sued, and the case ended up in the state Supreme Court. He had a number of causes of action, the most important being that the termination clause violated public policy.\textsuperscript{139} The court in its opinion in favor of the plaintiff stated, “The public has a substantial interest in the relationship between health maintenance organizations and their preferred provider physicians … As Harper correctly notes, the termination of his relationship with Healthsource affects more than just his own interest.”\textsuperscript{140} It then concluded that “the public interest and fundamental fairness demand that a health maintenance organization’s decision to terminate its relationship with a particular physician provider must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy.”\textsuperscript{141} This ruling opens the door for physicians to take MCO contract terminations to the courts. The ruling does not

\textsuperscript{138}Harper.
\textsuperscript{139}In Harper, the court states, “An agreement is against public policy if it is injurious to the interests of the public, contravenes some established interest of society, violates some public statute, is against good morals, tends to interfere with the public welfare or safety, or, as it is sometimes put, if it is at war with the interest of society and is in conflict with the morals of the time.”
\textsuperscript{140}Harper.
\textsuperscript{141}Harper.
completely forbid terminations without cause, but it does allow physicians to protest if they feel the termination was in bad faith or in some way counter to public policy.

The courts have also begun addressing the physician's role in disclosing financial incentives to patients. Two interrelated principles of common law have been invoked in regard to disclosure: informed consent and fiduciary responsibility. Informed consent is based on the principle that, as Justice Benjamin Cardozo stated, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." Originally informed consent mandated that the physician receive permission from the patient before performing a procedure or surgery. This idea was based in battery (defined as the unlawful physical assault of a person) law and necessitated that the physician explain the inherent risks associated with the procedure or surgery. From these relatively narrow roots, the application of informed consent has expanded a great deal. Though the definition of informed consent is not completely agreed upon, medical ethicists Edmund D. Pellegrino and David C. Thomastra define it this way:

The physician must provide the patient or his or her proxy with the information necessary to make an informed and competent choice [regarding medical decisions]. Suffice it to say that the information should be provided without deception, coercion, or manipulation. The information also must be presented sensitively, in a way geared to the patient's capacity for understanding, to his education, and to his linguistic, cultural, and social milieu.


\[^{143}\text{For an explanation of the evolution of informed consent, see Shultz MM. From Informed Consent to Patient Choice: A New Protected Interest.} The Yale Law Journal. 1985;95:219-99.\]

This definition has recently begun to apply to a physician recommending against a surgery or procedure, i.e., informed refusal. However, there is still significant argument about what aspects of the physician-patient relationship informed refusal encompasses.

A fiduciary relationship occurs when one party has superior knowledge or technical skill and the other is vulnerable. Because the physician has vast knowledge and training and the patient is not only lacking this knowledge but often lacks his/her full mental faculties due to pain or sickness, the relationship is considered to be a fiduciary one. This relationship is in stark contrast to that of many common consumer relationships. Legal scholar Frances Miller makes an apt comparison, stating, "The physician's conduct is not measured by that of ... the used-car salesman, because the principle of caveat emptor appropriate to arms-length bargaining has no place in the doctor-patient relationship." Courts have concurred with this statement; in Cobbs v. Grant, the California Supreme Court stated, "The patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arm's-length transactions."

Fiduciary rules prohibit the person in the superior position (the fiduciary) from taking advantage of the other party. This is partially achieved, according to medical

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145See Truman v. Thomas. 611 p.2nd 902 (Cal. 1980). In this case, Dr. Claude Thomas repeatedly recommended that his patient, Rena Truman have a pap smear test; she refused. She eventually contracted and died from cervical cancer which could have been diagnosed from the pap smear. Her family sued the physician because he did not disclose the risks of refusing the test. The court found that there was a cause of action for physician negligence.


ethicist E. Haavi Morreim, by "keeping [the patient] as well-informed as possible." Moreover, the rules require the fiduciary to act in the other party's best interest at all times. If the fiduciary does not do so, courts impose severe penalties. So the overall effect of applying fiduciary rules to the physician-patient relationship, according to legal scholar Maxwell Mehlman, is "to permit the patient to entrust her welfare to a party with greater knowledge and expertise, while at the same time minimizing the need to monitor the physician's behavior to ensure that the physician acts in the patient's interest." An important court case that cited both fiduciary responsibility and informed consent doctrine as mandating disclosure of economic incentives is Moore v. Regents of The University of California. In this case, the plaintiff, John Moore, was being treated for leukemia by Dr. David Golde, and eventually, based on a recommendation from Dr. Golde, had a splenectomy. Before the surgery, Dr. Golde had arranged to obtain portions of Mr. Moore's spleen and develop a cell-line from it which could be sold for biological research. And while he received informed consent for the splenectomy, he did not explain to Mr. Moore his plans to develop a cell-line. After the surgery, Golde repeatedly withdrew blood, skin, bone marrow aspirate, and sperm from Moore's body, and, while continuing to develop the cell-line, told Moore nothing of his economic interests. Moore sued based on conversion (stealing of property) and "breach of a fiduciary duty to disclose facts material to the patient's consent." While the court rejected the conversion claim, it found there was a cause of action with regard to the physician's failure to disclose pertinent facts:

"We hold that a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the

151 Moore v. Regents of The University of California. 51 Cal.3d 120, 271 Cal Rptr. 146, 793 P.2d 479. I am using a reprint from Furrow, so any page numbers refer to Furrow.
152 Moore. p. 361.
patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment. 153

Although no court case has done so to date, this ruling can easily be applied to physicians practicing in MCOs with financial incentives. The language implies that if a physician benefits financially from performing a procedure (generally a fee-for-service arrangement) or not performing a procedure (capitation or withholds), he/she has a duty under informed consent doctrine and rules of fiduciary responsibility to disclose this information to the patient. Basically, while the definitions of informed consent and fiduciary responsibility are not completely agreed on by the courts, there is a movement towards patient autonomy in medical decision-making, and economic information is increasingly believed to be significant in the decision-making. 154

HOW SHOULD OUR SOCIETY DEAL WITH INCENTIVES TO REDUCE TREATMENT

There are some people in the fields of health policy, law and ethics, who believe that the market can take care of itself and that reforms regarding financial conflicts-of-interest are unnecessary. However, with researchers' difficulties in assessing health plan quality and the corresponding imperfect information consumers use to choose plans, that seems a specious argument. Others believe reform is needed, and existing proposals vary from limited intervention to a restructuring of how physicians are paid. The least intrusive reform that is discussed is health plan disclosure of physician financial incentives. There seems to be widespread support for the idea, and one is hard pressed to find a down side to it. This information would greatly benefit health care consumers, who would be able to distinguish among health plans on information that is far more

154 See Miller FH. Denial of Health Care.
substantial than what they often use now -- brochures and advertisements. The main question though is how much information should have to be disclosed. Obviously trade secrets should not have to be disclosed, but how much information should be made available and in what way? Should all MCOs’ marketing material include the amount of income their physicians are at risk for and their stop-loss limits? Should there just be some very general information concerning the types of incentives in place between providers and MCOs? How often should enrollees be reminded of these incentives and who should do the reminding?

I believe that MCOs should have to disclose their incentives in a pamphlet comprehensible to the lay person. This disclosure should include incentives found in MCO-physician contracts and physician group-physician contracts. It should generally state what the plan gives physicians financial incentives for, including: low utilization rates, referral rates, immunization rates, etc. Moreover, there should be a scale determined by the government that measures the general level of financial risk providers are placed under. Factors would include withholds, stop-loss coverage, bonuses, size of risk pool, and other related issues. Consumers would be given report cards for each health plan assessing the plan’s risk, and the methods of assessment would be made available to the public. With this type of system, the specifics of each MCO’s operations would be kept secret while a potential enrollee would have some idea of the financial incentives a plan uses.

This method could have a few problems theoretically. First, government organizations may have some trouble assessing risk. In simple provider-MCO contracts, there would be little difficulty; however, the contracts can be quite complex. For example, in MCO-physician group contracts where the MCO pays a fixed fee to the physician group, and the group pays the physicians fee-for-service or a salary, it is difficult to assess the risk placed on the physician versus the risk placed on the group. However experts in the field of risk assessment would hopefully be able to effectively
compare the risks of different contracts. What may be potentially more problematic is the number of different kinds of contracts each MCO has. A given MCO may have hundreds of different contracts, including those with individual providers, specialty groups, and multispecialty groups which are updated and rewritten annually. Moreover, these contracts may vary geographically as well, depending on population density and managed care penetration. The risk assessors might have great difficulty evaluating all the different contracts in an MCO to determine an overall risk estimate.

Physician disclosure of financial incentives is more problematic because of the complexity of the physician-patient relationship. There should be no gag rules on physician-patient communication. If a physician feels that as part of informed consent and fiduciary duty he/she is obliged to inform patients of his/her financial incentives when he/she deems appropriate, no contract should interfere with the communication. However, anti-gag laws should be written with some sensitivity to MCOs in that they should not allow blatant disclosure of trade secrets by physicians nor irresponsible criticism of health plans by physicians. Achieving these objectives is not terribly difficult and a number of states are in the process of enacting such laws.

The more daunting question is, should physicians be required to disclose their financial incentives to patients, and if so, when? Ethicists disagree about how physicians should disclose incentives to patients. Some argue that disclosure should be made whenever the patient has to make a decision about his/her treatment. Others argue that health plan disclosure at the time of enrollment is sufficient. The former group believe that there is no way that a patient will understand the disclosure if it is made only at the time of enrollment, especially if the first significant medical decision a patient has to make comes years after enrolling in a particular health plan. The latter group’s argument is twofold. First, they believe that this kind of disclosure would be incredibly time consuming. As health policy scholar Mark A. Hall writes, “[mandatory disclosure] would require physicians to engage their patients in elaborate explanations for each
discrete step in a complex tree of diagnostic and treatment options for even the most minor of ailments."\textsuperscript{155} Second, they believe the patient may lose confidence in the physician's decision-making if confronted with a barrage of information demonstrating the physician's potential conflict-of-interest.

Even if there were agreement about what should be disclosed in the physician-patient relationship, legislators would be hard pressed to write statutory disclosure requirements that would take into account all the different circumstances that could be involved in the relationship. Moreover, the strictness of statutory law would probably cause a protocol of disclosure that neither the physician nor the patient would want. Because of this strictness, as well as the lack of agreement about what constitutes good disclosure, statutory law's applications do not seem useful. Legislators probably should leave these decisions to the courts. The courts, armed with the common law principles of informed consent and fiduciary responsibility, can adjudicate conflicts in this relationship without taking it over. As medical ethicist E. Haavi Morreim writes, "Common law ... can be flexible to pursue a fundamental principle across a variety of individual circumstances because a judge is not obligated to settle anything more than the case at hand."\textsuperscript{156} However, leaving this type of decision to the courts is not without problems. Certain socio-economic groups have far greater access to our legal system, and the weakest in our society would have fewer defenses against the unscrupulous physician.

Health policy scholar Marc Rodwin argues that "full disclosure in obtaining informed consent does not always give the patient understanding or control," citing studies demonstrating that patients often do not understand the information presented or its significance.\textsuperscript{157} Even if patients do understand the incentives, should physicians

\textsuperscript{155}Hall, p. 654.
\textsuperscript{156}Morreim EH. Conflicts of Interest. p. 392.
practice under their potential influence? The two levels of incentives managed care exerts over physicians that have been discussed in this paper are the ability of MCOs to drop providers without cause, and financial incentives for particular practice patterns. In an era of increasing physician supply and demand that is not increasing at the same rate, it seems particularly dangerous to give MCOs carte blanche in adding and dropping providers, which potentially places tremendous pressure on the physicians. Currently, MCOs can push a provider more and more to decrease utilization rates with the knowledge that they will almost certainly have no liability in a malpractice suit and that they can always drop a provider if he/she is sanctioned or develops a poor reputation. Legislators should level the MCO-provider relationship by passing a due process law that has two requirements: MCOs have to disclose their criteria for adding or dropping a physician, and they have to give a reason to any physician who is either dropped from a plan network or whose application to join is denied. In addition, the law should allow for an appeal process. This would not only decrease the pressure that physicians feel from MCOs, but would open up the whole profiling process for both physicians and consumers to see.

There should be limits placed on such legislation so that it does not become ridiculously difficult for an MCO to prevent a physician from becoming a provider. The "Patient Protection Act of 1994" and the "Family Health Care Fairness Act of 1995" have many good aspects to them and appear to open up the process. However, they both have one major flaw: there is no provision for MCOs that have enough providers already. One of the main ways MCOs have begun to rein in health care costs is by trading with physicians significant patient volume for decreased fees. If, as these bills mandate, each health plan has a periodic open enrollment period for all the physicians in a given area, the MCO would be obligated to allow all those physicians to join who qualify under the MCO’s criteria, even if the MCO feels that they have enough physicians already. That, in turn, would significantly hinder the MCOs’ ability to negotiate reduced fees with
physicians. MCOs should not have to have open enrollment periods if they have enough physicians (although, if they opt to add physicians to their networks, it should be done in an equitable way). In addition, MCOs should be allowed to drop physicians if they no longer need them. A bill recently passed in Rhode Island states that plans can terminate contracts if there is a “lack of need due to economic considerations.” 158 This statement needs to be clarified, but a just way of dropping physicians from plans due to lack of need should be put in place. However, it should not be a back door way of dumping physicians whom the health plans do not want for other reasons.

“Any willing provider” legislation is a poor idea. Granted there are some benefits to such legislation: it significantly reduces the pressure MCOs can exert over providers, and it allows patients to more easily stay with the same physician over long periods of time. However, if one believes that competition among MCOs leads to innovations which could increase quality, this type of legislation is extremely problematic. MCOs would lose the aforementioned ability to negotiate reduced physician fees return for patient volume, and they would not be able to weed out physicians who do not meet their standards. The negatives outweigh the positives, and the main backers of “any willing provider” legislation appear to be physician groups who want to protect their incomes rather than improve health care.

Regulating financial incentives for certain practice patterns is a more complicated issue. Fee-for-service medicine gives the physician too much incentive to overtreat, and some financial incentives used by MCOs have obvious benefit, e.g., bonuses for high immunization rates and regular Pap smears. Moreover, no study has shown that financial incentives decrease the quality of care. However, many believe that our ability to estimate the ‘quality’ of health care is so unsophisticated that these studies are unreliable. They certainly motivate physicians to perform cost-effective treatment on

patients, but how do we know when the physician crosses the line and compromises the patient’s care? Some are absolutely opposed to these incentives. Former editor of the *New England Journal of Medicine*, Arnold Relman, writes, "Regardless of the employing organization, no physician should enter into an arrangement offering rewards for withholding services or for decreasing the use of services."\textsuperscript{159} The dilemma is how to balance cost and quality. Banning these incentives completely is one approach. A strong argument can be made that the physician is placed in such a significant conflict-of-interest that he/she is in a morally untenable position. Moreover, while studies have not demonstrated that that the incentives cause patient care to be compromised, there is significant risk that it could be. The ramifications of banning incentives are difficult to foresee, but the big fear is that there could be a significant increase in the cost of health care.

A less extreme position has been suggested by HCFA. HCFA’s new rules are an attempt at limiting the physician’s overall financial risk. The rules assess risk with a sophisticated methodology, looking at not only absolute risk of income, but also how many providers the risk is spread over as well as stop-loss insurance. It is comprehensive and is an example of thoughtful policy-making. My only concern with it is that it bases its upper limits of physician financial risk on the status quo, i.e., the highest risk of income MCOs currently place physicians under. Without good studies considering the impact of different risk percentages on physician behavior, how can HCFA so readily accept the status quo? I would argue that more studies of physician behavior under different levels of financial risk are warranted. Then, based on these studies, HCFA could change their definition of “significant financial risk” as would be appropriate.

If we are going to continue to allow these incentives, legislation should be passed which mandates that MCOs can be found liable for damages caused by such

incentives. So far no court has implicated an MCO, but some have come close. The “Family Health Care Fairness Act” requires that health plans be legally responsible for their incentives. It states:

“No health plan may engage in any activity that has the effect of inappropriately limiting or denying care to any individual enrolled in such a plan through any utilization review or cost containment technique. Any such individual who alleges an injury caused by the application of a clinically or medically inappropriate decision resulting from defects in the design or application of any utilization review or cost containment technique by a health plan may commence a civil action against the health plan…”160

I am not a lawyer, and I do not know how much a clause such as this would actually affect the common law courts, but the idea is important. If we are to have these incentives and we do not know their exact effects, patients should be able to try them before a jury. Then the incentives can be looked at on a case by case basis, and if MCOs fear law suits, they might just voluntarily remove those that seem particularly inappropriate. It is naïve to believe that MCOs have no effect on physician behavior, and allowing these incentives to be judged in a court of law may be a sufficient way of dealing with them until more is known about their effects.

Managed care companies are not evil; they -- especially those traded on Wall Street -- are simply capitalistic. Moreover, one could argue that physicians in fee-for-service arrangements are equally capitalistic. Unfortunately, applying capitalism to health care is problematic because the economics of health care differ from many other sectors of business in our society. The consumer is often a sick patient who is in no position to effectively find the best health care for the lowest price, and even if he/she were, the information he/she would be able to gather is far from perfect. A balance needs to be found between keeping health care costs under control and safeguarding patient welfare.

I would argue that both legislation and the courts are needed to do this. The combination of HCFA type rules, free physician-patient communication, mandatory health plan disclosure of incentives, and increased potential for MCO liability would hopefully protect the patient while at the same time allow for managed care innovation. Because we do not know enough about physician financial incentives, this is only a temporary and imperfect solution. Further research on their effects is needed if we are ever to reach the goal of high quality, cost-efficient health care delivery.