Bargaining With Hippocrates: Managed Care and the Doctor-Patient Relationship

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BARGAINING WITH HIPPOCRATES:
MANAGED CARE AND THE DOCTOR-PATIENT
RELATIONSHIP

TIMOTHY S. HALL*

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I. INTRODUCTION

Health care is one of the most expensive goods in the American economy, comprising 13.2% of the American Gross Domestic Product (GDP) in 2000 and projected to reach 17% of the GDP by 2011. As health care becomes more expensive relative to other goods and services, health policymakers are increasingly aware that the method of payment for health care services is inextricably related to the manner in which those services are provided. In other words, there is an ethical component to health care finance. This increasing awareness can be credited to, among other things, the overwhelming influence of managed care on the American health care system. The success of managed care in penetrating the American market for health care services has led to a host of new techniques and devices for the management of health care expenditures, and implementation of these techniques and devices has led to a reconsideration of some of the fundamental ethical tenets of medicine.

In order to reduce the instance of unnecessary, and potentially even harmful, medical interventions, managed care imposes oversight on health care expenses. Oversight includes external controls on physician spending and internal financial incentives intended to bring the self-interest of the individual physician in line with the fiscal goals of the managed care organization (MCO). This Article will focus on the financial incentives provided to physicians by MCOs in order to change physicians' practice methods and patterns, and the conflicts of interest caused by those financial incentives.

3. Health spending is expected to grow 2.5% faster than the GDP during the period 2001-2011. See id.
4. Peter Schwartz, Medical Ethics Under Managed Care, 41 INT'L J. FERTILITY AND MENOPAUSAL STUD. 124, 124 (1996) ("[H]istory may view the impact of managed care on medical ethics within the physician-patient relationship as the greatest revolution of managed care.").
5. The debate over the role of profit in American medicine and the "new ethics" of managed care are examples. See generally MARY R. ANDERLIK, THE ETHICS OF MANAGED CARE: A PRAGMATIC APPROACH (2001) (discussing some of the ethical issues facing doctors); E. HAAVI MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS (1995) (discussing physicians' changing duties to patients as a result of changing economics). However, some commentators insist that managed care must not be allowed to change the ethical duties of physicians. See, e.g., Gregory Luke Larkin, Ethical Issues of Managed Care, 17 EMERGENCY MED. CLINICS OF N. AM. 397, 399 (1999) ("The ethical obligations of emergency physicians do not change when practicing in a managed care or any other environment. The physician's primary responsibility remains with the patient.").
7. There is some debate in the literature over whether and to what extent various financial incentives actually affect physician behavior. See infra note 29 and accompanying text.
The rise of managed care in the American health care system has been described as a “clash of cultures.” Drawing on the metaphor coined by C.P. Snow in his famous “Two Cultures” lecture describing the gulf between scientists and humanities scholars, a 1997 article published in the Journal of the American Medical Association identified “two distinct cultural traditions” in American health care—the commercial culture and the professional culture. The professional culture is characterized by the traditional Hippocratic notion that the individual patient’s welfare is the primary ethical principle of medical practice and that the patient is owed undivided duties of fidelity and loyalty by the physician. The commercial culture is characterized by the intrusion of the market domain and the profit motive into the physician-patient dyad—by the elevation of commercial interests alongside interests of patient welfare—and the commercial culture is believed to be in the ascendency. It is this market-oriented vision of health care that imposes financial incentives to alter the behavior of physicians—physicians being treated for this purpose as primarily economic actors rather than professionals with ethical obligations to the individual patient—and that presumes that patients can negotiate with physicians and other actors in the health care system for their desired mix of fidelity and cost-savings, if only the playing field is leveled through appropriate disclosures. This Article briefly describes the existing managed care financial incentives and the system within which they operate. Part II will describe the use of financial incentives in managed care and the resulting popular backlash against the perceived abuses of the current system. Part III describes the piecemeal regulation (and attempts at regulation) of these financial incentives, and demonstrates that regulation generally operates by requiring disclosure. Part

10. McArthur & Moore, supra note 8, at 985.
13. Relman, supra note 12, at 22 (“[P]rofessionalism in medicine seems to be giving way to entrepreneurialism.”).
15. Of course, the paradigmatic regulatory system dependent on disclosure is the regulation of the securities industry. In that field, regulation of the content of a public offering has been subordinated to regulation of the disclosures made about that offering; the operation of market forces then are able to set an appropriate price, assuming complete transparency of information. See, e.g., Santa Fe Indus., Inc. v. Green, 430 U.S. 462 (1977) (finding that disclosure to shareholders gave fair information and, therefore, was not deceptive). However, it is worth noting at this point that such a system has recently been painfully shown not to protect against the temptations presented by systemic conflicts of interest. Examples include the Enron and WorldCom scandals. Disclosure is also the paradigm used in campaign finance regulation, a system not noted for its ethical purity. See, e.g., Editorial, State of the Sleaze, N.Y. TIMES, Jan. 28, 1997, at A20 (“We can thank the financial disclosure laws passed during the 1970s for documenting the corruption of the system. They are good laws, but flawed in their presumption that disclosure would lead to self-restraint by politicians.”).
IV proposes a new way of thinking about regulation of financial incentives, a paradigm of respect for the personhood of patients and their unique position within the health care system, and proposes that the traditional physician-patient relationship be protected by insulating the central features of the doctor-patient relationship from the operations of the health care marketplace.

II. THE MANAGED CARE BACKLASH

Until relatively recently, most Americans purchased medical care through a fee-for-service system.\(^{16}\) Either the patient paid the physician directly for services performed, or the patient purchased insurance (or the patient’s employer purchased insurance on his behalf) and the insurance company paid the physician’s charges without substantive inquiry into the reasons for those charges. As is well documented elsewhere, the growth, for tax and other reasons, of employer sponsorship of health insurance, combined with advances in medical technology after World War II,\(^{17}\) resulted in exponential increases in the cost of health care.\(^{18}\)

The dramatic rate of increase in medical expenditures came to the attention of the nation during the 1992 presidential election. Bill Clinton strongly campaigned on the need for management of health expenditures and increased access to health care services.\(^{19}\) However, after his election, his plans for comprehensive health care reform failed.\(^{20}\) In the absence of governmental reform or regulation, employers, insurers, and others with an interest in health care costs were left to fashion a private system which would curb the excesses of traditional fee-for-service medicine.\(^{21}\) This led to the rise of modern managed care.

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17. See Timothy S. Hall, Third Party Payor Conflicts of Interest in Managed Care: A Proposal for Regulation Based on the Model Rules of Professional Conduct, 29 SETON HALL L. REV. 95, 99 (1998); Barbara Ross-Lee et al., Skewed Incentives in Our Healthcare Delivery System, 94 J. AM. OSTEOPATHIC ASSOC. 849, 854 (noting that technology is potentially responsible for up to fifty percent of the rise in health costs).

18. See Elena A. Gates, Reproductive Health Under Managed Care: Expanding Provider Obligations, 22 SEMINARS IN PERINATOLOGY 233, 234 (June 1998).


Although health maintenance organizations (HMOs) have been in existence since the early 20th century, it is in the last decade that these and other forms of managed care organizations have come to dominate the American health care system. The American health care marketplace embraced managed care on the promise that it would provide cost containment, but recent data raise serious doubts whether managed care can sustain early cost savings. It is clear that managed care has not delivered true long-term cost reduction. Managed care did provide a temporary reduction in the rate of increase of health care expenses; however, that deceleration may have been provided by one-time efficiency gains, by artificial “proverse selection” into managed care plans, or a combination of such effects. Recent data show a return to significant health care inflation, returning in 2001 to double-digit inflation of the magnitude that sparked the managed care revolution in the first place, with continued double-digit inflation forecast for the foreseeable future.

Managed care is characterized by increased oversight by the payor (insurer) of the expenditures ordered by the provider (physician). Under a fee-for-service system, there was traditionally little if any oversight or questioning by a payor of treatment decisions made by a physician. This lack of oversight led to well-

22. Early HMOs were founded on the principle that regularly scheduled preventive care produces better outcomes and a healthier population. Cost containment was originally merely a side effect of the intended purpose of HMOs, which was improvement of the quality of health. Blum, supra note 12, at 604. Of course, cost containment has come to be the sine qua non of managed care, or at least of popular perceptions of managed care. McArthur & Moore, supra note 8, at 987 (“[Managed care] is increasingly interpreted as meaning ‘managed costs’...”); Ross-Lee et al., supra note 17, at 849 (“Although cost, access and quality are partners in the healthcare reform debate, there is no question that cost-control is the senior partner.”). Contra David A. Hyman, Do Good Stories Make Good Policy, 25 J. HEALTH POL., POL'Y & L. 1149 (2000), available at http://muse.jhu.edu/journals/journal_of_health_politic_policy_and_law/v025/25.hyman.html (challenging popular assumptions about the frequency and severity of managed care abuses).


24. Robert O. Morgan et al., The Medicare-HMO Revolving Door—The Healthy Go In and the Sick Go Out, 337 NEW ENG. J. MED. 169, 169 (1997) (“[T]he assumption has been that [MCOs] could help slow the growth in the costs of health care for the elderly.”) (emphasis added).

25. Margaret G. Farrell, Consumer Class Actions Challenging Managed Care Practices, SG013 ALI-ABA 517, 529 (2001) (“The advent of managed care is credited by some with at least one-time lowering of health care costs.”); Ross-Lee et al., supra note 17, at 849 (“The crucial question...is how to achieve dramatic and sustained cost reductions over time.”).

26. See, e.g., Morgan et al., supra note 24, at 174 (stating that enrollment bias in Medicare HMO enrollment leads to a false picture of savings generated by HMOs); Steffie Woolhandler & David U. Himmelstein, Extreme Risk—The New Corporate Proposition for Physicians, 333 NEW ENG. J. MED. 1706, 1707 (1995) (criticizing financial incentives for physicians by HMOs).


28. Warren Lee Holleman et al., Are Ethics and Managed Care Strange Bedfellows or a Marriage Made in Heaven?, 349 THE LANCET 350, 350 (1997) (“Many who hold the view that managed care is unethical overlook the moral problems of the fee-for-service system that managed care systems are replacing. ... ”); Adam Yarmolinsky, Supporting the Patient, 332
documented overutilization and widely divergent and scientifically unsupported practice patterns. So long as a physician's orders are not subject to significant review, and so long as she is virtually guaranteed payment for her services without significant oversight, the physician will tend to order medical services past the point of utility to the patient. In order to reduce the instance of unnecessary, and even harmful, medical interventions, managed care imposes oversight on health care expenses in at least two ways.

Managed care characteristically imposes external controls on physicians' spending decisions. These controls take the form of credentialing, utilization review, and pre-authorization requirements for costly medical interventions.

NEW ENG. J. MED. 602, 602 (1995) ("[P]atients fortunate enough to be insured treated their insurance policies as open accounts.").

29. The patient, being understandably risk-averse in health matters, has an incentive to agree to additional services which come at no direct cost to himself, even if those services are of no established benefit, so long as those services do not cause him harm or inconvenience. Ross-Lee et al., supra note 17, at 851 ("Most patients have little incentive to seek cost-effective healthcare under either managed care or fee-for-service care."). Moreover, there are serious information asymmetries preventing the patient from making treatment choices from a position of full information. See Yarmolinsky, supra note 28, at 602 ("No plan for health care reform has been proposed, or could be proposed, that would enable patients to determine all the medical services they might need . . . .") The physician has an incentive to order all services to which the patient will consent, as long as the insurer is willing to compensate her for those services. Alan L. Hillman, Health Maintenance Organizations, Financial Incentives, and Physicians' Judgments, 112 ANNALS OF INTERNAL MED. 891, 893 (1990) ("Traditional fee-for-service settings influence physicians' decision making as well, albeit in the opposite direction, an approach that may harm patients through greater use of unnecessary medical interventions."). The physician also may have incentives to order more services in response to actual or perceived threats of malpractice litigation—so-called "defensive medicine." Ross-Lee et al., supra note 17, at 852 ("Although recent measures indicate that the direct cost of defensive medicine accounts for no more than 1% of total health care expenditures, the threat of malpractice may indirectly affect costs by coloring physicians' judgment.").

30. Chervenak et al., supra note 6, at 524 (explaining that fee-for-service incentives to perform more services may cause harm to the patient); William S. Parmley et al., Task Force I: Background and General Principles, 16 J. AM. COL. OF CARDIOLOGY 7 (July 1990) ("[T]he physician has a duty . . . . refrain from interventions that would be futile.").

31. At least one commentator has argued that one way to help ensure the ethical palatability of financial incentive structures is to make sure that those who are in charge of drafting and imposing the incentives be subject to the physician's professional and ethical duties to the patient. Yarmolinsky, supra note 28, at 602 (proposing legislation prohibiting ownership of MCOs by for-profit entities).

32. Marshall B. Kapp, Can Managed Care be Managed?: Some Agnostic Reflections, THE PHAROS, Spring 1998, at 15 ("The concept of managed care is premised on the fundamental world view that the conduct of people and institutions may be influenced by financial incentives.").

33. Credentialing is choosing physicians based on a scrutiny of existing practice patterns and cost-effectiveness of care provided. See John D. Blum, The Evolution of Physician Credentialing into Managed Care Selective Contracting, 22 AM. J. L. & MED. 173 (1996). Recently, doctors have been working due process rights in the credentialing process, restricting the ability of MCOs to terminate providers in an arbitrary and capricious way. Lowell C. Brown & Elizabeth Jagla, Credentialing, Peer Review, and Provider Deselection in Managed Care: Providers in the Crossfire, 20 WHITTIER L. REV. 375, 376 (2001).

34. The external control on physician behavior is typified by external utilization review of individual physicians' medical decisions, often before payment is authorized by the MCO. Ross-Lee et al., supra note 17.

Utilization review arrived in the healthcare system as a quality-control and cost-containment strategy. However, allowing this function to exist as the creation of, or off-shoot to, the insurance industry, compromises its quality-of-care intent and realigns its incentive to specifically promote cost-savings for the industry that it serves.
such as surgery and referrals to expensive specialty services.\(^{35}\) Although these external controls may be effective in reining in medical expenditures,\(^{36}\) they are not accepted graciously by many,\(^{37}\) and have been criticized as taking medical authority out of the hands of treating physicians and allowing utilization reviewers and other bureaucrats, who may or may not be physicians,\(^{38}\) to exercise inordinate control over physicians’ medical judgment.\(^{39}\)

In addition to external controls, managed care also seeks to encourage physicians to internalize the ethos of cost-cutting and cost-effective medical practice. To accomplish this end, MCOs have sought financial means to align the self-interests of individual physicians with those of the insurer. Payment structures, such as capitation,\(^{40}\) bonuses and withholds,\(^{41}\) and provider selection and retention based on economic criteria,\(^{42}\) all tend to cause physicians to consider economic factors in their medical decisionmaking to an extent they would not under a pure fee-for-service regime.\(^{43}\)

The increasing penetration of managed care into the American health market,\(^{44}\) together with the pervasive implementation of cost-cutting financial incentives for physicians,\(^{45}\) have led to a popular backlash against many managed care practices.\(^{46}\) While early protests against managed care tended to focus on particular limitations on care allegedly imposed unilaterally by MCOs,

\[^{35}\text{Id.}\]

35. Managed care often relies on primary-care physicians to perform a “gatekeeper” function within the health care system by regulating beneficiaries’ access to more expensive surgical and specialty care and by discouraging beneficiaries from seeking specialty care for treatments which can be performed in the lower-cost environment of the primary care office.

36. See supra notes 24-27 and accompanying text.

37. Farrell, supra note 25, at 529 (“[T]wenty seven years [after the Federal HMO Act], we know that reversing fee-for-service medicine’s incentives to provide too much care has produced incentives to provide too little care.”).


39. Id. at 1350 (“U]nder a managed care system, doctors find themselves relinquishing much of their professional autonomy.”).

40. See infra notes 60-61 and accompanying text.

41. These may place from ten to thirty percent of a physician’s income at risk. BEAUCHAMP & CHILDRESS, supra note 11, at 318.

42. See supra note 33.

43. Jensen, supra note 21, at 1349 (stating that incentives “aligned doctors’ financial interests with those of employers rather than with those of patients”).

44. See supra note 16; BEAUCHAMP & CHILDRESS, supra note 11, at 318 (“The patient is in a different position when the physician has incentives to restrict needed treatment than when the physician has incentives to provide unnecessary treatment. In the latter situation, patients can obtain another opinion. In the former situation, patients may not be aware of a needed treatment.”) (citation omitted).

45. See, e.g., Debra S. Feldman et al., Effects of Managed Care on Physician-Patient Relationships: Quality of Care, and the Ethical Practice of Medicine, 158 ARCHIVES OF INTERNAL MED. 1626, 1628 fig. 6 (1998) (showing that fifty-six percent of surveyed physicians believed that managed care made it difficult to avoid conflicts of interest between the patient’s interest and the physician’s financial interest).

46. The increase in litigation against MCOs may have structural causes as well. See Farrell, supra note 25, at 519 (“By bringing together in a single entity, insurance and service delivery (risk and the ability to control loss), [MCOs] have provided a legal body to which regulatory and judicial challenges can be addressed.”). The “managed health care as villain” syndrome has also penetrated American pop culture. See John Q. (New Line Productions 2002) (casting Denzel Washington as a parent struggling to obtain treatment for his child from an MCO).
including "gag" clauses,\textsuperscript{47} "drive-through" deliveries,\textsuperscript{48} and others,\textsuperscript{49} recent commentary has taken a broader view of managed care financial incentives, arguing that such incentives undermine patients' trust in physicians\textsuperscript{50} and the therapeutic doctor-patient relationship necessary for effective treatment,\textsuperscript{51} as well as undermining the physician's ethical duty to act in the best interest of her patients\textsuperscript{52,53} without regard to personal welfare or social cost.\textsuperscript{53}

In this Article, the term "conflict of interest" will generally refer to ethical conflicts of interest presented by the double agency\textsuperscript{54} aspect of practice within a managed care system, particularly the double agency incentivized by forms of payment embraced by managed care. All methods of payment create their

\begin{footnotesize}
\textsuperscript{47} Although all states now specifically ban the use of "gag" clauses, or contractual provisions prohibiting physicians from discussing particular treatment options with patients, there is considerable debate in the literature whether such clauses ever existed in the first place. Compare Warren Lee Holleman et al., Continuity of Care, Informed Consent, and Fiduciary Responsibilities in For-Profit Managed Care Systems, 9 ARCHIVES OF FAM. MED. 21, 23 ("Over the years, managed care companies have instituted 3 types of gag clauses . . . . Prior to the new laws, [a gag clause] was present in nearly every physician contract."); and Woolhandler & Himmelstein, supra note 26, at 1706 (quoting a restrictive clause from authors' contract with an MCO, with David A. Hyman, Managed Care at the Millennium: Scenes from a Maul, 24 J. HEALTH POL., POL'y & L. 1061, 1063 (1999) (denying systemic use or enforcement of gag clauses)). However, even given the legal ban on gag clauses, MCOs still have practical power over physicians' speech. See Bryan A. Liang, The Practical Utility of Gag Clause Legislation, 13 J. OF GEN. INTERNAL MED. 419, 419 (1998) (stating that the presence of termination clauses in provider contracts gives MCOs another device for policing the speech of physicians).

\textsuperscript{48} Gates, supra note 18, at 235.

\textsuperscript{49} BEAUCHAMP & CHILDRESS, supra note 11, at 318 ("On the whole, the medical profession has attempted to address specific conflicts of interest . . . without attending to general and systemic issues of conflicts of interest.") (footnote omitted).


\textsuperscript{51} Feldman et al., supra note 45, at 1630 ("Most [physician] respondents indicated that patient trust in the physician is diminished under managed care."); Stephen M. Shortell et al., Physicians as Double Agents: Maintaining Trust in an Era of Multiple Accountabilities, 280 JAMA 1102, 1103 (1998).

\textsuperscript{52} Leonard M. Fleck & Harriet Squer, Just Caring: Facing the Ethical Challenges of Managed Care, FAMILY PRACTICE MANAGEMENT, Oct. 1995, at 48 ("A physician in a MCO cannot be an unrestricted advocate of each patient's best interest. That is, a physician's advocacy can never ignore the needs of the rest of the MCO's members."); see also Feldman et al., supra note 45, at 1628 fig. 2 (showing that fifty-three percent of surveyed physicians believed that managed care makes it more difficult to place patient's interests first).

\textsuperscript{53} Although the primary ethical duty of the physician is owed directly to her patient, there is no longer any serious doubt that physicians also have social duties to safeguard scarce healthcare resources. See, e.g., COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, THE ETHICAL ISSUES OF CAPITATION 2 (1997) [hereinafter CEJA Capitation Report] ("It is entirely appropriate for physicians to feel some obligation to safeguard broader health care resources . . . .") (citing AMA Principles of Medical Ethics, Principle VII), available at http://www.ama-assn.org/amal/upload/mm/369/report78b.pdf. However, the primary ethical obligation is still to the patient. Id. ("Adopting dual roles is only cause for concern when the roles are given equal or nearly equal status and the primacy of individual patient care is threatened."). Some commentators hold that, although a physician can be a valuable voice in setting societal health policy, the physician cannot be both social planner and patient advocate within the same relationship. See, e.g., Schwartz, supra note 4, at 126 ("The care giver can sit on organizational panels, can help to set organizational policy, etc., but within a patient-care giver relationship the physician must be an unashamed advocate for his or her patient.").

\textsuperscript{54} See Shortell et al., supra note 51, at 1102. "Double agency" refers to the supplanting of the traditional patient-centered ethic of the physician with another duty: whether to the managed care organization, other patients who potentially are competing for scarce health care dollars, or the physician's own economic or other interests. See Hall, supra note 17, at 105-07.
\end{footnotesize}
own incentive structures.\textsuperscript{55} Certainly, the fee-for-service system, with or without private insurance, carried with it the incentive to do more even in the absence of a clear medical rationale for additional intervention.\textsuperscript{56} However, the conflicts of interest created by managed care payment systems are different in character than the conflicts presented by fee-for-service medicine,\textsuperscript{57} and a legal and regulatory approach designed to minimize the impact of fee-for-service incentives\textsuperscript{58} cannot be expected to perform the same task under a managed care system. In any case, the mere existence of conflicts of interest under fee-for-service medicine is not, in and of itself, an adequate response to calls to regulate the conflicts generated by managed care financial incentives.\textsuperscript{59}

Physicians delivering health care services under a managed care system are generally paid through one of three mechanisms—salary, fee-for-service, or capitation.\textsuperscript{60} Of these, capitation represents the fundamental innovation of managed care in aligning the physician’s financial incentives and goals with those of the managed care industry. Capitation has accordingly received the most attention and criticism in the literature of managed care ethics and practice.\textsuperscript{61} Capitation systems pay the physician a fixed amount of money in

\textsuperscript{55} Even a supposedly “neutral” payment method such as salary, advocated by some managed care commentators as a means to avoid the evils of financial conflicts of interest, carries with it the incentive to maximize the worker’s effective hourly compensation by minimizing the time spent discharging one’s duties. See Hall, supra note 17, at 103; see also Relman, supra note 12, at 22 (“[The] double role of physicians as purveyors of services and patient counsellors has always raised questions about conflict of interest . . . .”); Shortell et al., supra note 51, at 1102 (“There have also been other factors [motivating doctors], principally the financial reward.”).

\textsuperscript{56} Fee-for-service medicine, of course, carried its own set of unpalatable incentives. See Jensen, supra note 21, at 1336-37 (“A plaintiff victory [against MCO incentive structures] would . . . be truly ironic because the removal of incentives that keep doctors from overtreating their patients will return Americans to the system of health care that they rejected just twenty years ago.”) (footnote omitted); Relman, supra note 14, at 1150 (suggesting new practice strategies for physicians); Winters et al., supra note 50, at 14.

\textsuperscript{57} Arnold S. Relman, Dealing with Conflicts of Interest, 313 NEW ENG. J. MED. 749, 750 (1985); see also Woolhandler & Himmelstein, supra note 26 (criticizing financial incentives for physicians by HMOs).

\textsuperscript{58} Prior to the managed care backlash, many of the principal regulations governing health care providers were aimed at reducing incentives to overspend or overbill. See MARC A. RODWIN, MEDICINE, MONEY, & MORALS (1995). Thus, federal law and regulations forbid many types of physician self-referral, fee-splitting or “kickbacks,” and overbilling the Medicare and Medicaid programs (fraud & abuse).

\textsuperscript{59} Dennis F. Thompson, Understanding Financial Conflicts of Interest, 329 NEW ENG. J. MED. 573, 573 (1993) (explaining that existence of one type of conflict of interest does not eliminate the need or desirability of regulating another type).

\textsuperscript{60} See Alan L. Hillman et al., HMO Managers’ Views on Financial Incentives and Quality, HEALTH AFFAIRS, Winter 1991, at 207, 208. Although these three payment systems constitute the bases for most compensation in MCOs, the marketplace has been prolific in devising variations and combinations on these three major themes. See Hall, supra note 17, at 101-05.

\textsuperscript{61} See, e.g., CEJA Capitation Report, supra note 53 (discussing capitation and how it operates in the medical community); Frances H. Miller, Foreword: The Promise and Problems of Capitation, 22 AM. J. L. & MED. 167 (1996) (same); Andrew Ruskin, Capitation: The Legal Implications of Using Capitation to Affect Physician Decision-Making Processes, 13 J. CONTEMP. HEALTH L. & POL’Y 391 (1997) (same); Woolhandler & Himmelstein, supra note 26, at 1706 ("The new risk-sharing arrangements are not simply the inverse of fee-for-service. Instead, they are the inverse of fee splitting."). Fee splitting is the practice of accepting fees in exchange for referral of patients and is generally considered unethical. See, e.g., Relman, supra note 12, at 23 (discussing the "traditional ethical rule against earning professional income by referring patients"); Special Article, The American Academy of Neurology Code of Professional Conduct, 43 NEUROLOGY 1257, 1258 rule 2.5 (1993) [hereinafter Neurology Code of
exchange for a contractual agreement to provide a defined set of medical services to an insured population. The fixed payment is defined in terms of an amount "per member, per month," and this amount is paid regardless of the actual amount of care demanded by the insured population in any given time period. In a purely capitated system, the physician or provider group remains solely financially responsible for costs of care exceeding the capitation payments. Thus shifting risk for catastrophic illness from the insurer/MCO to the provider, and forcing the provider to consider global resource allocation issues as well as issues of individual benefit from medical spending. Because of this potentially large downside risk, many commentators have singled out capitation as potentially unethical or risky for physicians, and some have attempted to articulate guidelines for ethical use of capitation incentives. In fact, the risk of severe financial losses through capitated contracts is managed through several devices (many of which were admittedly absent or lacking in early capitation transactions), including informed negotiation by physician groups of adequate monthly payments to cover expected medical expenses plus an adequate profit margin, negotiation of appropriate limits on the medical care covered by the capitation contract, judicious use of stop-loss insurance as a protective device for participating physicians, limiting capitation contracts to large groups of physicians to reduce the risk that any one physician's overly generous use of resources or any one patient's unusually expensive medical needs could bankrupt the practice, and calculating capitation rates from cost data acquired over a period of time in order to minimize the effect of periods of inordinately heavy or light resource usage. In addition to capitation, MCOs often use bonus and incentive payments to change physician behavior. The

Professional Conduct] (discussing professional fees).
63. Shortell et al., supra note 51, at 1103 ("Capitation forces the physician to pay attention to the denominator of all enrollees in the plan . . . and not just the numerator of the individual patient receiving treatment.").
65. See, e.g., CEJA Capitation Report, supra note 53, at 6-7 (outlining the Council's recommendations for applying capitation in an ethical manner).
66. This negotiation was made all the more difficult because of the difficulty that any but the largest and most diverse physician groups have in obtaining adequate cost and usage data on the patient population presented by the MCO. Shortell et al., supra note 51, at 1103 ("[W]ithout detailed information concerning the patients in their care, . . . the ability of physicians to deal with risk is severely compromised.").
67. Although the paradigmatic capitation contract transfers all risk of medical losses to the physician or physician group in exchange for fixed payments per member, per month, this arrangement was probably never common, and is today rare or nonexistent.
68. These are among the ethical safeguards recommended by the American Medical Association in 1997. See CEJA Capitation Report, supra note 53, at 6-7.
69. Id.
amount of personal income dependent on bonus or contingent payments varies widely, but can be considerable.\textsuperscript{70}

The practice of using financial incentives to limit care, combined with widespread reporting of managed care abuses and denials of needed services, have lessened the trust that the American public holds for physicians and the medical industry.\textsuperscript{71} In response to perceived abuses, the federal and state governments have stepped into the managed care marketplace with a host of regulatory devices. The next section describes several of these regulatory mechanisms and the current legal structure for claims against MCOs for denial of care.

III. REGULATORY RESPONSES

The legal system’s response to the conflicts of interest presented by managed care systems is a relatively recent development. It consists of a mixture of federal and state legislation and regulation, together with private and public litigation seeking to apply a wide variety of laws, some drafted for the purpose and some applied to the problem by analogy, to the problem of physician conflicts of interest in managed care.\textsuperscript{72} The next section reviews the current state of regulation of managed care physician financial incentives and concludes that, with few exceptions, disclosure is the predominant regulatory device, whether that disclosure is obtained through legislation, litigation, or regulation.\textsuperscript{73}

A. ERISA

The Federal Employee Retirement Income Security Act of 1974 (ERISA)\textsuperscript{74} regulates “employee benefit plans,”\textsuperscript{75} and health care plans provided by employers to employees come within the statutory definition of employee benefit plan.\textsuperscript{76} ERISA is intended to create a uniform federal jurisprudence governing employee benefit plans,\textsuperscript{77} and thus preempts most state laws relating to such plans.\textsuperscript{78} However, the managed care backlash has brought with it

\textsuperscript{70} Woolhandler & Himmelstein, supra note 26, at 1706 (“An internist with 1500 . . . patients might take home more than $150,000 from bonuses and incentives, or nearly nothing.”).

\textsuperscript{71} See supra note 46 and accompanying text.

\textsuperscript{72} Litigation challenging practices of MCOs is increasingly framed as class actions. See Maio v. Aetna, Inc., 221 F.3d 472 (3d Cir. 2000); In re Managed Care Litig., 185 F. Supp. 2d 1310 (S.D. Fla. 2002); Farrell, supra note 25; Jensen, supra note 21, at 1337 (arguing that class actions against unpopular industries serve as a dubious legal “front” for political pressures and “for[e] . . . the judiciary branches into the unwise and improper role of policymaker”); see also Kathy Cerminara, The Class Action Suit as a Method of Patient Empowerment in the Managed Care Setting, 24 AM. J. L. & MED. 7 (1998) (discussing the use of the class action device in health care litigation).

\textsuperscript{73} Disclosure is seen as curative of conflicts of interest in other healthcare settings as well. In 1995, a pharmaceutical benefits management company entered into a settlement with seventeen states in which it agreed to disclose to physicians that it provided financial incentives to physicians to recommend less expensive drug alternatives to prescribed drugs. See Milt Freudenheim, Drug Makers’ Managed-Care Ties Questioned, N.Y. TIMES, Nov, 10, 1995, at D1.


\textsuperscript{75} 29 U.S.C. § 1002(3).

\textsuperscript{76} 29 U.S.C. § 1002(1), (3).


\textsuperscript{78} 29 U.S.C. § 1144(a).
judicial\textsuperscript{79} and popular outrage over the perceived immunity granted to MCOs by ERISA, leading to a string of cases limiting the scope of ERISA's preemptive reach. To the extent that states enact laws purporting to govern health care plans, an analysis of the efficacy of such laws must begin with a consideration of the requirements of the ERISA statute and the shifting sands of the ERISA preemption doctrine.

Most commentators agree that under the current gloss of Supreme Court rulings on the subject, ERISA preempts claims relating to the administration of employee benefit plans, including health care plans, but that claims arising from the medical services provided by a health care plan are not preempted under ERISA.\textsuperscript{80} The Supreme Court has not yet definitively answered the question of whether state laws purporting to govern managed care financial incentives are preempted by ERISA. Although cases decided in 2000 and 2002 shed some light on the subject, many unanswered questions remain.

We begin our consideration of the requirements of ERISA in the context of managed care financial incentives with \textit{Shea v. Esensten}.\textsuperscript{81} Mr. Shea consulted his primary care physician complaining of chest pains. He related to the physician his family history of cardiac disease and his history of hospitalization for chest pains during a recent business trip out of the country.\textsuperscript{82} However, Mr. Shea's physician was of the opinion that Mr. Shea was too young and his symptoms not severe enough to justify a referral to a cardiologist.\textsuperscript{83} Mr. Shea's physician was also subject to a provision in his contract with Mr. Shea's MCO, Medica, intended to reduce the number of referrals to specialists. The physician could receive a year-end bonus for limiting such referrals and would suffer a reduction in his income for over-referring.\textsuperscript{84} Neither of these incentives were disclosed to Mr. Shea, who reluctantly accepted his primary care physician's advice.\textsuperscript{85} After Mr. Shea died of a heart attack, his widow sued Medica, claiming that Medica's failure to disclose the financial incentives contained in its provider contract materially affected her husband's decision not to seek a second opinion.\textsuperscript{86} Had the Sheas been aware of their physician's conflict of interest, the lawsuit averred, Mr. Shea would have been more skeptical of his advice and would have sought a cardiologist's opinion at his own expense, which follow-up care would have in all likelihood discovered his heart disease and enabled him to receive timely treatment.\textsuperscript{87} Mr. Shea argued that this failure to disclose constituted a violation of the MCO's fiduciary duty to its enrollees under ERISA.\textsuperscript{88}

\textsuperscript{79} See Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 53 (D. Mass. 1997) ("[T]his court had no choice but to pluck [plaintiff's] case out of the state court ... and then, at the behest of [defendant], to slam the courthouse doors in her face and leave her without any remedy.").

\textsuperscript{80} See, e.g., \textit{In re United States Healthcare Inc.}, 193 F.3d 151 (3d Cir. 1999), cert. denied, 530 U.S. 1242 (2000) (finding that a negligence claim based on MCO policy of discharging newborns from hospital within twenty-four hours was not preempted by ERISA to the extent it relies on MCO's actions in arranging for treatment rather than MCO's role as plan administrator in determining what benefits are appropriate).

\textsuperscript{81} 107 F.3d 625 (8th Cir. 1997).

\textsuperscript{82} \textit{id}. at 626.

\textsuperscript{83} \textit{id}.

\textsuperscript{84} \textit{id}. at 627.

\textsuperscript{85} \textit{id}. at 626.

\textsuperscript{86} \textit{id}. at 627.

\textsuperscript{87} \textit{Shea}, 107 F.3d at 627.

\textsuperscript{88} \textit{id}. 

https://scholarcommons.sc.edu/sclr/vol54/iss3/6
In the Eighth Circuit, ERISA fiduciary duty requires disclosure of "material facts which could adversely affect a plan member's interests." 89 The court concluded that "a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information." 90 After Shea, in the Eighth Circuit, 91 MCOs are thus under a duty to disclose the existence of financial incentives intended to influence a physician's treatment decisions. 92

Other courts have not followed the reasoning of Shea or have chosen to distinguish it. In Weiss v. Cigna Healthcare, Inc. 93 the court refused to impose a duty under ERISA to disclose financial incentives, holding that any action by the physician in limiting the care provided to the beneficiary is not legally attributable to the ERISA plan. 94

In the Fifth Circuit, Mary Ellen Ehlmann brought an action against the Kaiser Foundation Health Plan of Texas alleging that Kaiser's failure to disclose its financial incentives in physician contracts, coupled with allegedly misleading information in its plan materials made available to beneficiaries, constituted a breach of its fiduciary duties under ERISA. 95 The Fifth Circuit rejected the claim that ERISA imposes a broad duty to disclose financial incentives, reasoning that, had Congress or the Department of Labor wanted to impose such a duty, a specific requirement would have been written into the statute or regulations. 96 The Fifth Circuit distinguished Shea on the basis that Mr. Shea had made a specific request of his doctor for a referral to a heart specialist and had been advised that such care was not necessary without disclosure of the financial incentives discouraging such a referral. 97 Perhaps, then, the Fifth Circuit would countenance a claim for breach of fiduciary duty on facts similar to Shea, although the court expressly declined to articulate the contours of such a duty. 98

Even in circuits where ERISA has been interpreted to require disclosure of financial incentives, the question whether the mere existence of financial incentives can constitute a breach of the ERISA fiduciary duty remained

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89. Id. at 628 (citing Varity Corp. v. Howe, 36 F.3d 746, 754 (8th Cir. 1994), aff'd, 516 U.S. 489 (1996)).
90. Id.
91. The Shea holding has not been met with unanimous approval in other courts. See, e.g., Weiss v. Cigna Healthcare, Inc., 972 F. Supp. 748, 754-55 (S.D.N.Y. 1997) ("CIGNA ... ha[s] no duty to disclose the nature of its compensation agreements with its physicians .... ").
92. There is no guidance in Shea as to a threshold of the severity of the financial incentive before the disclosure requirement is triggered. Although arguably some financial incentives could be regarded as so minimal that they would not trigger the materiality standard, in practice, all managed care financial incentives are intended to influence the physician's treatment decisions in order to counteract the perverse incentives of fee-for-service medicine. See supra notes 39-45.
94. Id. at 753-54.
96. Id. at 555. Although the court recognized that ERISA imposes a duty to disclose "material provisions of a plan," it made no analysis of the materiality of physician financial incentives except to note that such incentives are not required to be disclosed under relevant regulations. Id. Although the plaintiff attempted to answer this reasoning by arguing that, at the time the statute and regulations were drafted, such MCO incentive plans did not exist and thus could not have been contemplated by Congress or the Department of Labor, the court did not find this argument persuasive. Id. at 555 n.3.
97. Id. at 556; Shea v. Esensten, 107 F.3d 625, 626 (8th Cir. 1997).
98. Ehlmann, 198 F.3d at 556 ("We do not pass on what sort of disclosure, if any, that Section 404 might require given a specific inquiry from a plan member or given some other special circumstance.").
unanswered until recently.\textsuperscript{99} In \textit{Pegram v. Herdrich},\textsuperscript{100} the Supreme Court decided for the first time the question of whether a physician who provides services under an ERISA plan is a “fiduciary” for purposes of ERISA regulation and can thus be held liable under ERISA for breach of fiduciary duty for her actions under a financial incentive structure which arguably led to inappropriate denials of care.\textsuperscript{101}

On March 1, 1992, Cynthia Herdrich, a beneficiary of an ERISA plan sponsored by her husband’s employer and administered by Carle Health Insurance Management Co., Inc. (Carle), sought medical care from Dr. Lori Pegram. On March 7, Dr. Pegram discovered a mass in Herdrich’s abdomen.\textsuperscript{102} After this discovery, but before further diagnostic testing to determine the nature of the mass, Herdrich’s appendix burst, necessitating emergency surgery.\textsuperscript{103} Dr. Pegram’s decisions to have both the scheduled diagnostics and the surgery performed at a Carle-owned, and thus cheaper, facility, despite the delay and inconvenience to Herdrich, were arguably influenced by a direct relationship between the cost of out-of-network referrals authorized by Pegram and the size of her year-end bonus from Carle.\textsuperscript{104}

Herdrich filed a lawsuit against Dr. Pegram and Carle, alleging negligence in delaying the needed diagnostic procedure, as well as breach of fiduciary duty under ERISA, in that the cost-containment incentive plan created an impermissible conflict of interest between Dr. Pegram’s duties to Herdrich as a plan beneficiary and Pegram’s financial self-interest.\textsuperscript{105} The district court dismissed Herdrich’s ERISA claim,\textsuperscript{106} but the Seventh Circuit reinstated it, holding that Carle met the statutory definition of a “fiduciary” due to the owner-physician’s control over the governance of the HMO and over the coverage decision process.\textsuperscript{107}

Carle sought and was granted certiorari to the Supreme Court.\textsuperscript{108} Writing for the unanimous Court, Justice Souter held that Carle was not acting as an ERISA fiduciary when it, through Dr. Pegram, determined (incorrectly) that Herdrich’s condition was not an emergency, and that she was thus not entitled under the Plan to immediate treatment at a non-Carle owned facility.\textsuperscript{109} Under ERISA, unlike the common law of trusts, a single entity can permissibly “wear two hats,” acting as fiduciary as to certain of its decisions and actions, but acting out of self-interest as to others.\textsuperscript{110} The Court noted that all of Pegram’s decisions arguably affected by the financial incentive—whether to order an immediate ultrasound and whether Herdrich’s condition constituted an

\textsuperscript{99} Although, in \textit{Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.}, 958 F. Supp. 1137 (E.D. Va. 1997), the district court for the Eastern District of Virginia held that plaintiff’s state law claims of negligence and fraud for the establishment and nondisclosure of financial incentives were preempted by ERISA, the court did not have occasion to consider whether ERISA itself imposed any duties regarding the scope or disclosure of such incentives.


\textsuperscript{101} The following description of the \textit{Pegram} case was published in Timothy S. Hall, \textit{Pegram v. Herdrich}, \textit{14 HEALTH LAW NEWS} 15, 15-16 (Sept. 2000).

\textsuperscript{102} \textit{Pegram}, 530 U.S. at 215.

\textsuperscript{103} \textit{id.} at 215.

\textsuperscript{104} \textit{Id.} at 216 n.3.

\textsuperscript{105} \textit{Id.} at 217.

\textsuperscript{106} \textit{Herdrich v. Pegram}, 154 F.3d 362, 365 (7th Cir. 1998).

\textsuperscript{107} \textit{Id.} at 369-71.


\textsuperscript{110} \textit{Id.} at 225.
“emergency”—contained a strong element of medical judgment or "treatment" in addition to their effect on the administration of Plan benefits, or "eligibility" decisions. The Court characterized these decisions as "mixed" treatment and eligibility decisions, and concluded that "mixed" decisions are not within the definition of "fiduciary" intended by Congress.

Herdrich claimed at oral argument that the mere existence of the incentive, independent of any particular act by Dr. Pegram, constituted a breach of fiduciary duty. Herdrich asked the Court to distinguish between the incentive plan used by Carle, which rewards a physician for her own decisions to deny care, and other incentive plans which base bonuses on the performance of a large group of physicians or the utilization of a population of patients. Although this distinction has support among both medical and legal commentators, the Court expressly declined the invitation to directly regulate physician incentives. Justice Souter claimed an inability to distinguish the "not . . . subtle" financial link between treatment and payment in the Carle network from any other compensation structure used by HMOs and concluded that since Herdrich sought disgorgement of part of the HMO's profits, recognition of this suit "would be nothing less than elimination of the for-profit HMO." Since Congress has encouraged the formation and operation of HMOs since passage of the Federal HMO Act in 1973, this result was unacceptable.

In addition to the slippery-slope argument, the Court rested its holding on doubts as to the courts' institutional competency to resolve disputes over the proper scope and structure of managed care incentives. While conceding, arguendo, that the Carle incentive may not be "as socially desirable" as other possible incentives, the Court deferred to the judgment of Congress on this matter. "The . . . difficulty of these policy considerations, and Congress' superior institutional competence . . . suggest that legislative not judicial solutions are preferable." If there are incentive structures which impede the effectiveness of the doctor-patient relationship, the Court here gives a clear statement that Congress, or perhaps state legislatures, must be the source of legal distinctions between permissible and impermissible incentives.

Although the Court clarifies that mixed treatment and eligibility decisions are not decisions for which a physician wears a fiduciary hat under ERISA, the consequences of the Court's decision for health plans and beneficiaries remain unclear. Although the Court clearly signals that ERISA will not be the

111. Id. at 228.
112. Id. at 231.
113. Id. at 227 n.8.
114. Id.
116. Id. at 233.
118. Pegram, 530 U.S. at 221.
119. Id. at 222 (quoting Patsy v. Bd. of Regents of Fla., 457 U.S. 496, 513 (1982)).
120. But see In re Managed Care Litig. 135 F. Supp. 2d 1253, 1257-58 ("[T]he Court in Pegram did not fashion an all-encompassing cloak of immunity for the health care industry.").
121. Hall, supra note 101, at 16; Pegram, 530 U.S. at 228 n.8. (leaving open the issue of whether MCOs are "fiduciary[s] insofar as [they have] discretionary authority to administer the plan, and so . . . [are] obligated to disclose characteristics of the plan and of those who provide services"). MCOs may have ERISA obligations to disclose, if not to forbear from using, managed care incentives. The extent to which this represents an adoption of Shea's holding that ERISA contains an affirmative duty to disclose remains unclear.
source of judicial regulation of physician financial incentives, plaintiffs will now look to state laws to support claims such as Herdrich’s. Many states have passed or are considering laws which prohibit MCOs and physicians from entering into contracts which contain incentives to deny or delay care. In addition, state tort law may be invoked in cases when physicians fail to provide adequate care, whether that failure was caused by negligence or by financial incentive. In rejecting ERISA fiduciary status for Carle’s physician owner/employees, the Court sends a signal that ERISA may no longer bar the use of such state laws to regulate “mixed” treatment and eligibility decisions made by ERISA health plans. As state tort damages are generally regarded as much more generous for individual claimants than ERISA remedies, Carle’s victory may be a “Pyrrhic” one as state courts expand their tort doctrines to encompass physician incentive structures adopted by MCOs, and federal courts increasingly limit the scope of ERISA preemption.

Another question of state versus federal regulation is raised, and only partially resolved, by the recent Supreme Court case of Rush Prudential HMO, Inc. v. Moran. Moran involved a challenge to a state law requiring that MCOs allow disputed denials of medical services to be reviewed by an independent physician. When Rush refused to comply with the state law, Moran sued in state court. Rush argued that Moran’s state claim was completely preempted by ERISA, because it involved the determination of eligibility for services, not the quality of the services rendered. The district court eventually agreed, but the Seventh Circuit held that the Illinois law was not completely preempted. The Supreme Court, in a 5-4 decision, agreed with the Seventh Circuit, holding that the independent review provisions of the Illinois law could coexist with ERISA. The Court reasoned that since under ERISA “laws that ‘regulate insurance’ are saved from preemption,” then the threshold question was whether the state law in question “regulates insurance.” Using both a “commonsense” approach as well as the traditional Royal Drug – Pireno test for the “business of insurance” under the McCarran-Ferguson Act, the Court concluded that the independent review law regulates insurance, and therefore is

122. Hall, supra note 101, at 16; Gary M. Ford & Jennifer E. Eller, Managed Care Litigation Review, 583 ALI-ABA 571, 574 (2001) ("[C]laims that mere use of managed care techniques violated ERISA were largely silenced by the Supreme Court’s decision in Pegram v. Herdrich . . . ").
124. Hall, supra note 101, at 16; see also infra notes 140-41 and accompanying text.
125. Hall, supra note 101, at 16; McLean & Richards, supra note 123, at 4.
127. Hall, supra note 101, at 16; McLean & Richards, supra note 123, at 32-33.
129. Id. at 2156; see 215 ILL. COMP. STAT. 125/4-10 (2000).
130. Moran, 122 S. Ct. at 2157.
131. Id.
132. Id. at 2158.
133. Id.
134. Id. at 2171.
not preempted by ERISA. In response to Rush’s argument that the Illinois law impermissibly infringes on the policy of uniformity expressed in ERISA, the Court stated that the independent professional review provided for in Illinois’ law did not “supplement or supplant” ERISA’s remedies, and that any lack of uniformity in laws applicable to MCOs from state to state is “the inevitable result of the congressional decision to ‘save’ local insurance regulation” from preemption.

Moran represents further erosion of the oft-quoted doctrine that ERISA represents a complete insulation of MCOs from accountability for their decisions. However, just how far that erosion reaches is unclear. Moran did not involve a state law which imposed independent state liability upon MCOs for their decision-making or for their imposition of improper incentives on physicians. In the Fifth Circuit, the case of Corporate Health Insurance, Inc. v. Texas Department of Insurance held that a Texas law creating a state law cause of action against MCOs for negligence in delivering medical services was not preempted by ERISA. The court specifically excluded the possibility that the Texas law could result in liability for “denial of coverage for a medical service recommended by the treating physician.”

Remaining questions include whether Moran supersedes Lancaster v. Kaiser Foundation Health Plan, which held that state claims of negligent establishment of a financial incentive plan and nondisclosure of that plan were completely preempted. That determination, and others, will depend on case-by-case analysis of state laws regulating managed care insurance plans, in light of the “regulation of insurance” savings clause analysis adopted by the Court in Moran.

Even though ERISA has produced perhaps the most voluminous judicial pronouncements on the relationship of managed care to the doctor-patient dyad, ERISA clearly has not been and is not likely to be a panacea for the doctor-patient relationship. ERISA has been used primarily as a shield for MCOs, and the Supreme Court has clearly signaled its unwillingness to allow the statute to be used as a sword by managed care plaintiffs, except in extraordinary circumstances. Pegram clearly shows that the Supreme Court will not consider managed care financial incentives per se illegal. Even in the absence of per se illegality status for managed care conflicts of interest, ERISA is not likely to even produce a uniform federalized doctrine of disclosure of financial incentives post-Pegram, given the conflicting interpretations in the circuits of the requirements of ERISA fiduciary status. If Pegram is taken to allow state experimentation without preemption, some states may enact full disclosure laws, but it is by no means certain that any will, or that disclosure laws, once enacted, would be enforced or enforceable.

137. Moran, 122 S. Ct. at 2163.
138. Id. at 2166 (citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987)).
139. Id. at 2168 (quoting Metro. Life Ins. Co. v. Mass., 471 U.S. 724, 747 (1985)). This reasoning is not unlimited, as the Court points out that “a State might provide for a type of ‘review’ that would so resemble an adjudication as to fall within” the preemption doctrine. Id. at 746 (quoting inv. Montemayor v. Corporate Health Ins., 215 F.3d 526 (5th Cir. 2000), vacated sub nom. Montemayor v. Corporate Health Ins., 122 S. Ct. 2617 (2002)).
140. Id. at 540.
141. Id. at 534.
143. See supra notes 43-45, 92-127 and accompanying text on the multiple difficulties of enforcing disclosure requirements.
B. RICO

In light of restrictive ERISA rules and extensive ERISA preemption of state claims, litigants are increasingly turning to the Federal RICO statute. The Racketeer Influenced and Corrupt Organizations Act (RICO) was enacted as an anti-organized crime initiative. Despite this origin, the language of the statute was intentionally drafted broadly to apply to "any person meeting the statutory elements of the crime. RICO has been suggested as a potential adjunct or alternative to ERISA in the managed care plaintiff's arsenal.

Civil RICO damages are much more generous than ERISA remedies. In order to recover statutory treble damages and attorneys' fees, a plaintiff must establish (1) conduct of an "enterprise" (2) through a "pattern of racketeering activity" that causes (3) damage to the plaintiff's business or property.

Few reported cases have applied RICO to the managed care industry. Those cases which have do not present a unified approach or hold out much promise for regulation of managed care conflicts of interest. The first significant managed care litigation to rely on RICO as a theory of recovery arose in Nevada. A class of employers and employees sued Humana Health Plans, alleging violations of, inter alia, ERISA and RICO in Humana's dealings with its insureds and providers. Plaintiffs had insurance contracts with Humana that required the insured pay twenty percent of incurred costs for hospital health care, up to a defined cap (usually $5,000) on annual health expenses. The plaintiffs alleged that Humana negotiated discounts from the usual, customary, and reasonable rates charged by an affiliated hospital, but failed to take those discounts into account in calculating plaintiffs' co-payment obligations, resulting in the plaintiffs paying more than twenty percent of the cost below the cap. The district court entered summary judgment for Humana on the grounds that RICO was preempted by the McCarran-Ferguson Act. This Act establishes that regulation of the "business of insurance" is a matter of state law and preempts any federal law to the extent that federal law "invalidate[s], impair[s], or supersede[s] any law enacted by any State for the purpose of regulating the business of insurance... unless such Act specifically relates to

145. Farrell, supra note 25, at 521 ("To file[sic] the regulatory vacuum created by ERISA, consumers have asserted federal causes of action such as RICO... ").
149. Since RICO is a federal statute, its use in managed care litigation arguably does not interfere with the goals of ERISA in the same way that state regulation of managed care would. ERISA contemplates a uniform federal regulatory scheme and is intended to protect employee benefit plans from the burdens of compliance with a patchwork of state laws. Both of these goals are consistent with the use of RICO against managed care abuses.
150. 18 U.S.C. § 1964(c).
152. 18 U.S.C. § 1964(c).
154. Id. at 1503.
155. Id. at 1501.
156. Id. at 1522.
the business of insurance." Noting that RICO does not "specifically relate to" the "business of insurance," and that Nevada has in place a regulatory scheme which regulates unfair trade practices by insurers, the district court entered summary judgment for Humana.

The plaintiffs appealed to the Ninth Circuit, which reversed the district court's grant of summary judgment. The United States Supreme Court unanimously affirmed, stating that RICO acts as a mere "aid or enhancement" to the Nevada regulation; thus, application of RICO does not "invalidate, impair, or supersede" Nevada law. Although Federal RICO damages potentially greatly exceeded available remedies under Nevada's regulatory scheme, this did not "impair" the State law. As a result of the Supreme Court's affirmation that the plaintiffs' RICO claim was, at the least, not preempted by the McCarran-Ferguson Act, the litigation has now been settled, with Humana agreeing to pay approximately $16,000,000 to the employer purchasers and the employee insureds combined.

Not all RICO managed care litigation is as successful. In 1999, plaintiffs Joseph and Mary Ann Maio and Gary Bender filed a class action lawsuit against Aetna, Inc. and affiliated entities (Aetna), alleging that defendants had engaged in a pattern of misrepresentation of its health insurance products. Specifically, plaintiffs alleged that Aetna, while representing to enrollees that its goal was to raise the quality of health care delivered by its providers, was simultaneously imposing financial incentives and contract terms on its providers solely to limit the quantity of care delivered and to hold down costs; such cost-containment efforts, the plaintiffs alleged, were undisclosed to them. The plaintiffs' RICO claims were dismissed on a summary judgment motion by defendants.

On appeal to the Third Circuit, the dismissal was affirmed. The court found that, even assuming the truth of plaintiffs' factual allegations, plaintiffs had not pled sufficient injury to sustain a RICO cause of action. RICO requires that plaintiffs show "injury to business or property" in order to prevail, and the plaintiffs' allegations of diminution in quality of health services provided due to the operation of managed care physician conflicts of interest did not constitute "injury to business or property." Such a showing would require "proof of a concrete financial loss and not mere injury to a valuable intangible property

158. *Id.* § 1012(b).
160. *Id.* at 1521. In fact, the Nevada state law in question was preempted by the provisions of ERISA. *Id.* at 1522. However, the district court did not allow this fact to save the plaintiffs' RICO claim. *Id.*
161. *Id.* at 1522.
162. *Forbush v. Humana, Inc.*, 114 F.3d 1467, 1482 (9th Cir. 1997).
164. *Id.* at 308.
165. Edith M. Kallas et al., *Class Actions In Healthcare Context*, 1216 PLI/Corp 9, V(A)(1(a) (2000) ("Humana agreed to pay the co-payor class $11,986,200 and the premium payor class $4,113,800.").
167. *Id.* at 474-79.
168. *Id.* at 474.
169. *Id.* at 502.
170. *Id.* at 482.
171. *Id.* at 501.
interest."172 Since the property plaintiffs claim was impaired was a contract right—the right to covered health services—the court reasoned that the only way the plaintiffs could show injury to that property right is by showing that the defendants failed to perform their contractual duties.173 In order to make out a showing of failure to perform, the court states, plaintiffs would be required to introduce evidence of plaintiffs' "receipt of inadequate, inferior or delayed care, personal injuries resulting therefrom, or Aetna's denial of benefits due under the insurance arrangement."174 However, plaintiffs in Maio expressly disclaimed actual diminution in the health care provided as a basis for their RICO claim; they asserted that the mere existence of undisclosed provider incentives and conflicts of interest constituted cognizable injury.175

While the Maio court based its holding solely on the lack of a RICO injury to "business or property,"176 the district court articulated other hurdles that a successful plaintiff must overcome to apply RICO to managed care conflicts of interest. First, a plaintiff must establish the existence of a RICO "enterprise."177 Second, the district court stated, and the Third Circuit reiterated, that it is "highly doubtful that advertising one's commitment to 'quality of care' can serve as the predicate for a fraud claim."178 Finally, the district court articulated legal process concerns similar to those articulated by Justice Souter in Herdrich v. Pegram:179 "[P]laintiffs' expression of dissatisfaction with defendants' plans—indeed, with HMOs in general—is more appropriately directed to the legislatures and regulatory bodies of the several states.1780

Despite the hurdles identified by the Maio court, and that court's dismissal of the plaintiffs' RICO cause of action, plaintiffs in other circuits have pressed ahead with their RICO-based managed care litigation. As of this writing, multiple class actions against MCOs including Aetna, CIGNA, Health Net, Humana, Prudential, and United,181 are pending in the Southern District of Florida. Similar to Maio, these suits allege, among other causes of action, violations of ERISA and RICO.182 However, unlike Maio, the federal district court hearing these cases has refused to hold that the injury inherent in "paying more for insurance coverage than they would have"183 necessarily fails to establish a RICO injury to business or property. The district court, rather than accept the plaintiffs' invitation to distinguish Maio on the facts before it, chose

172. Maio, 221 F.3d at 483 (quoting Steele v. Hosp. Corp. of Am., 36 F.3d 69, 70 (9th Cir. 1994)).
173. Id. at 490; see also Dornberger v. Metro Life Ins. Co., 961 F. Supp. 506, 521 (S.D.N.Y. 1997) ("Case law does indicate that a plaintiff who is fraudulently induced to enter into a transaction does not suffer injury within the meaning of [RICO] until the defendant fails to perform.").
174. Maio, 221 F.3d at 490.
175. Id. at 478-79.
176. Id. at 482 ("While appelletes argue that we may affirm the district court's order ... on a variety of grounds, we need address only one issue ... ").
177. Id. at 480 (discussing alternative grounds for the lower court's grant of summary judgment).
179. See supra notes 109-21 and accompanying text.
182. Id. at 1314.
183. Id. at 1318.
to explicitly disagree with and not adopt the reasoning of *Maio*.\(^{184}\) If the Eleventh Circuit agrees with the district court, the disagreement will have to be resolved by the Supreme Court.

While RICO may be a useful tool in the managed care plaintiff’s arsenal, it does not constitute adequate regulation of managed care conflicts of interest.\(^{185}\) The statute clearly was not drafted to accomplish such a goal. The requirement of injury to “business or property,” borrowed from the antitrust laws, will bar recovery for many plaintiffs. The use of the mail fraud predicate offense as the route of entry into RICO may prevent widespread use of RICO to challenge physician financial incentives (as opposed to external review procedures and determinations), since denials of treatment caused by physician financial incentives may not be communicated through the mails, but instead face to face in the physician’s offices. Indeed, denials of treatment caused by financial incentives may never be communicated at all, but rather may be implemented without the patient’s knowledge or consent.\(^{186}\)

C. 42 C.F.R. § 417.479

In 1997, the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) addressed the issue of physician financial incentives in its regulation of MCOs contracting with the Medicare and Medicaid systems. Under current regulations, MCO contracts may not contain provisions for any “specific payment . . . made directly or indirectly . . . as an inducement to reduce or limit medically necessary services furnished to an individual . . . .”\(^{187}\) In addition to this dubious prohibition, MCOs also may not enter into contracts with providers that place physicians at “substantial financial risk” for services not provided directly by the physicians (i.e., for physicians’ referral patterns and hospital utilization rates)\(^{188}\) without providing specific mandated protections for the physicians and patients under such a contract. “Substantial financial risk” is defined by the regulations as more than twenty-five percent of the physician’s income at risk for overuse of referral services.\(^{189}\) Plans which place more than twenty-five percent of the physician’s income at risk must provide stop-loss insurance protection against catastrophic medical

\(^{184}\) Id. at 1318. Nonetheless, the court dismissed the majority of plaintiffs’ RICO claims for failure to plead the predicate criminal acts with sufficient particularity. Id. at 1324.

\(^{185}\) At least one writer has called into question the appropriateness of using civil RICO in the managed care litigation field, arguing that this litigation is merely a sham and a cover for inappropriate political pressures to force a lucrative settlement, modeled on the recent multistate settlement of class actions against the tobacco industry. *Jensen, supra* note 21, at 1364 (“[E]xtrajudicial tactics available to plaintiffs and their attorneys . . . may bring the litigation to a premature [settlement], denying courts the opportunity to scrutinize the plaintiffs’ recovery theories.”).

\(^{186}\) See infra Part IV.

\(^{187}\) Medicare Contract Requirements, 42 C.F.R. § 417.479(a)(1) (2000). Similar language has been adopted by a number of states. For a critique of this language, see infra Part III.E.

\(^{188}\) Payment methods which address only the services provided by the physician or physician group are not applicable. See Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 61 Fed. Reg. 13,430 (March 27, 1996) (to be codified at 42 C.F.R. pt. 1003). Thus, a contract which pays a physician a capitated rate per month for a fixed patient population, but which does not require the physician to bear any of the cost of referral or hospitalization services provided to her patients, would not be regulated by this provision.

\(^{189}\) 42 C.F.R. § 417.479(e).
expenses and must conduct periodic enrollee satisfaction surveys. Finally, under this regulation, plans must disclose to Medicare beneficiaries upon request the type of incentive used, whether stop-loss protection is provided, and the results of any required enrollee satisfaction surveys. This limited disclosure requirement clearly falls far short of meeting the ethical requirements of informed consent. MCOs are not required to inform beneficiaries that they have a right to even the limited information required to be provided upon request; only those beneficiaries sophisticated enough and sufficiently informed to know that they have the right to the information, and sufficiently motivated to request it, will receive it. Existing regulations are thus flawed on both procedural and substantive grounds: they fail to provide enough information to enrollees to satisfy the demands of informed consent doctrine and also fail to provide enough substantive protection to enrollees from financial conflicts of interest.

D. Fiduciary Duty

Although the literature is replete with references to physicians as "fiduciaries" on behalf of patients, the precise legal status of physicians as fiduciaries is not clear. Courts have been more reluctant than commentators to label the physician-patient relationship a fiduciary one. In fact, the term "fiduciary" is not a monolithic one and can mean different things, and imply different duties, depending on the context. The Pegram case limited MCOs' ERISA liability for the imposition of financial incentives by deciding that the ERISA definition of "fiduciary" did not apply to MCO officers making determinations involving, at least in part, decisions about eligibility for benefits under an ERISA health plan.

190. This insurance may be provided by purchasing insurance from a commercial insurer, or by self-insuring through protecting the physician contractually from such losses. However, the cost of such insurance may not be charged to the physician. 42 C.F.R. § 417.479(g)(2).

191. 42 C.F.R. § 417.479(g)(1).

192. 42 C.F.R. § 417.479(h)(3).

193. See infra Part IV.

194. See Hall, supra note 17, at 113-14.


197. In Batas v. Prudential Insurance Co. of America, 724 N.Y.S.2d 3 (N.Y. App. Div. 2001), the New York Supreme Court Appellate Division refused to characterize the relationship between an MCO and a beneficiary as fiduciary, reasoning that the insurer had not “sought to gain [the beneficiary’s] trust and confidence,” id. at 5, and that an insurance contract alone is not thought to give rise to fiduciary duties. Id. at 7.

198. See, e.g., In re Hanft, 274 B.R. 917 (Bankr. S.D. Fla. 2002) (finding that debtor physician had a fiduciary relationship with patients sufficient to trigger state duties requiring that he set aside assets or procure medical malpractice insurance to satisfy any malpractice claims); Neurology Code of Professional Conduct, supra note 61, at 1257 rule 1.2 (“As a fiduciary, the neurologist has an ethical duty to consider the interests of the patient first.”).

199. See supra notes 100-27 and accompanying text.
ERISA is not the only potential source of fiduciary responsibilities for physicians. State law has recognized a fiduciary relationship between physician and patient for at least some limited purposes. A physician may have a duty to disclose the fact that the physician’s negligence has caused the patient’s injury. In 2002, in the context of a professional malpractice case, the Supreme Court of Arizona stated that “[w]e long ago held that a patient and a doctor were in a fiduciary relationship ‘calling for frank and truthful information from’ doctor to patient.” Fiduciary duties, if recognized, may have components of both fidelity to patients and advocacy for patients, but clearly, managed care practice stretches the limits of the fiduciary label.

Despite limited recognition of a fiduciary component to the physician-patient relationship, physicians’ alleged status as fiduciaries has not been a fruitful ground for litigation over managed care conflicts of interest. At least one reason for this may have been the existence of ERISA preemption of state law claims against MCOs involved in ERISA plans, and to the extent that the Pegram decision represents a lifting of that preemption doctrine for this purpose, litigation on this theory may increase. One scholar has suggested that the fiduciary status of physicians might provide a robust doctrine to regulate the physician-patient relationship. Writing in 1990, before the managed care backlash (indeed, arguably before the managed care revolution), Professor Maxwell J. Mehlman suggested that the fiduciary status of health care providers could act as a limiting factor in the wholesale application of market-based doctrines to the purchase and sale of health care services. Mehlman argued that, under a contractarian approach, actually very little disclosure is required of the seller; contract law assumes that the buyer’s responsibility is to acquire information as desired before making a bargain. Mehlman argues that recognition of a fiduciary relationship will both increase the amount and type of disclosure that must be made by the health care provider in order to justify entering into a particular bargain with a consumer and provide an underlying “safety net” proscribing certain types of transactions, regardless of the amount of disclosure that has been made.

Time will tell whether the partial rejection of ERISA preemption in the context of managed care incentives will lead to a revitalization of state doctrines of fiduciary status in the physician-patient relationship. As the ERISA shield has slipped in recent years, several states have passed laws purporting to specifically regulate the use of managed care financial incentives. The next section will survey some of those state laws. However, in light of the overwhelming reliance

201. Neurology Code of Professional Conduct, supra note 61, at 1259 rule 5.1 (“The patient’s interest is paramount.”).
202. Id. at 1259 rule 5.4 (“The neurologist generally should support the patient’s medical interests when they are compromised by policies of a health care institution or agency. Physicians ... should represent their patients’ medical interests and serve as their medical advocate to the institutional administration.”).
203. Bloche, supra note 196.
204. See McLean & Richards, supra note 123, at 19.
206. Id. at 374-86 (“Disclosure in fact is quite distasteful to the law of contracts.”).
207. Id. at 388-93.
208. Id. at 392-99.
on disclosure as a means of curing the ethical problems with managed care incentives, it seems unlikely that state laws, including existing fiduciary doctrines, will provide sufficient protection to health care consumers in the managed care marketplace.

In response to perceived abuses by MCOs, health care providers have also attempted to rely on fiduciary duties to hold MCOs accountable. In Humana Health Plan, Inc. v. Heritage Indiana Medical Group, a medical group contracting with Humana attempted to force Humana to provide an equitable accounting of its performance under the contract. Under Illinois law, in order to maintain an action for an equitable accounting, a plaintiff must show that ordinary breach of contract remedies are inadequate to make the plaintiff whole and “either a breach of a fiduciary relationship, a need for discovery, fraud, or the existence of mutual accounts which are of a complex nature.” Heritage attempted to show that the relationship between the MCO and the medical practice amounted to a fiduciary relationship or its equivalent. The court rejected Heritage’s claim on Humana’s motion for summary judgment, relying on the rule of law that a contractual relationship ordinarily is one of arm’s length bargaining, not a relationship of trust and confidence that would give rise to fiduciary duties, and that Heritage had asserted no facts which would support a finding of such a relationship of trust and confidence. Thus, Heritage was unable to obtain the equitable remedy of an accounting and was forced to rely on standard breach of contract doctrine to proceed against Humana.

E. State Statutes

In response to the managed care backlash and increasing patient awareness of and dissatisfaction with physician financial incentives, many states are considering, or have passed, laws which purport to regulate the financial incentives contained in physicians’ contracts with managed care companies. These laws are not uniform, and their diversity is no doubt related to the speed with which they have been enacted. There is no national model for such regulation, so states are forced to reinvent the wheel each time one seeks to enact such legislation. Nonetheless, there are strong similarities among many of these laws. Although the relationship between these state laws and ERISA is still not entirely clear, they have recently received a strong boost from the Supreme Court in light of the Pegram and Moran decisions.

210. Id. at *4 (citation omitted).
211. Heritage actually claimed that the relationship was “similar to that of a fiduciary duty,” but the court treated it as if a fiduciary duty were claimed, reasoning that there is no “similar to” status in Illinois law. Id. at *9-10.
212. Id. at *8.
213. Id. at *9.
214. Kapp, supra note 32, at 15, 17 (criticizing “inconsistent, uncoordinated, piecemeal legislative intrusions resulting from separate legislatures hastily succumbing to the most politically powerful lobbying forces of the moment . . .”).
215. See Pegram v. Herdrich, 530 U.S. 211 (2000); supra notes 100-27 and accompanying text.
At one end of the regulatory spectrum, many states have no statute governing physician incentives in managed care contracts. These states may have not yet considered the issue legislatively or may believe that the issue is already adequately regulated by existing laws at the federal or state level. In the alternative, a state may have made the political determination that governmental regulation of managed care contracting is not desirable from a public policy viewpoint. However, the number of states adopting such laws is ever-increasing. Several states mandate disclosure of financial incentives, either to a state regulatory agency or to consumers. In some states, the state regulator takes on the responsibility of ensuring that the financial incentives used reflect an appropriate mix of concern for cost containment and protection of the physician-patient relationship.

Other states have responded to the growth and increasing criticism of managed care financial incentives by attempting to ban such incentives, or at least certain features of such incentives. For example, an Alaska statute provides that "[a] health maintenance organization . . . may not cause, request, or knowingly permit . . . financial incentives to be given or offered to a provider for denying or delaying health care services." Although perhaps well intentioned, this formulation is ultimately unhelpful. Managed care arose as a response to perceived abuses in the fee-for-service marketplace, including the incentive under a fee-for-service payment system to overutilize medical services. In an

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217. Even if a state has no law generally applicable to physician financial incentives, it may have passed a law addressing physician financial incentives in a particular area which the state has chosen to regulate. See, e.g., ALA. CODE § 27-48-3 (1996) (barring "any financial incentive or disincentive . . . of any kind or nature . . . to encourage or cause early discharge of a hospital patient from postpartum care . . .").


219. VA. CODE ANN. § 38.2-5802 (Michie 2002) ("A health carrier, when applying for initial licensing . . . shall identify generally the arrangements that the health carrier has with providers . . . Descriptions . . . shall include compensation methodology and incentives."); W. VA. CODE ANN. § 33-25D-10 (Michie 2000) ("MCOs shall file with the commissioner any contracts made with providers . . .").

220. VT. STAT. ANN. tit. 18, § 9414 (1999) ("A managed care organization shall, in plain language, disclose to its members . . . the financial inducements offered to any health care provider or health care facility for the reduction or limitation of health care services."). Not all disclosure requirements are universal. See, e.g., WASH. REV. CODE ANN. § 48.43.510(2) (2003)

Upon the request of any person, . . . a carrier must provide written information regarding any health plan it offers, that includes the following . . . (d) A written description of any reimbursement or payment arrangements . . . (e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists . . . .

221. In fact, some states seem to positively require financial incentives to limit care. See, e.g., W. VA. CODE ANN. § 33-25D-10(a) (2000) ("The commissioner may require the immediate cancellation . . . or the immediate renegotiation of a contract . . . if he or she determines that a contract . . . fails to include reasonable incentives for cost control . . .").

222. ALASKA STAT. § 21.86.150(0)(4) (Michie 2002).
ideal market for health services, the provider will recommend additional services until the marginal cost of the additional service exceeds the benefit to be obtained from that service by the patient. In a fee-for-service system, a provider has an incentive to continue providing services as long as payment for those services is forthcoming, regardless of the benefit to the patient. If the patient does not bear financial responsibility for payment, the incentive to overutilize is exacerbated unless either the insurer exerts some authority over utilization or the patient suffers other costs (such as inconvenience or discomfort) and questions the utility of the services being provided. As a response to this known perverse incentive, a managed care system must impose some limitations on the extent of care provided. These limitations may be external to the provider, such as utilization review and pre-authorization procedures. However, external review systems alone may be insufficient if the providers of services still have an incentive to game the system so as to increase the amount of services provided. In addition to external review, most MCOs find it desirable to try to change the practice patterns of physicians conditioned by decades of fee-for-service incentives. In order for a managed care incentive to have the desired effect, and in order for it to counteract the perverse incentive of the fee-for-service system, it must by definition provide an incentive to perform fewer procedures, and provide fewer medical services, than the physician would have provided under fee-for-service. If the incentive is properly structured, this is a positive change, as it eliminates the excess services which would have been provided in a fee-for-service system. Ideally, the physician now has an internal, self-policing incentive to provide only that care which is both beneficial to the patient and cost-effective. Seen in this light, the Alaska statutory mandate that financial incentives must not cause a provider to deny or delay any medical services, no matter their practical utility to the patient, is a meaningless limitation which, taken seriously, would limit managed care companies to external checks and reviews of providers’ behavior.

Many state statutes regulating physician financial incentives modify the Alaska approach by narrowing the field of forbidden financial incentives. Typical of these statutes is that enacted in Idaho, which provides that "[n]o managed care organization shall offer a provider . . . any incentive plan that includes a specific payment made . . . to the provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered by the health care contract . . . ."\textsuperscript{223}

This formulation is different from the Alaska approach in several respects. It is narrower in that it applies only to specific payments made in exchange for specific delays or denials of services. This raises a serious question about whether any alternative payment system adopted by an MCO with the intent to generally affect physician’s referral, hospitalization, or treatment patterns, but which does not tie specific inducements, such as bonuses or withholds, directly to specific treatment decisions would be regulated under this statutory language.\textsuperscript{224}

\textsuperscript{223} Idaho Code § 41-3928 (Michie 1997).

\textsuperscript{224} In addition, many of these statutes expressly exempt from their reach certain types of payment systems, such as capitation. See, e.g., Idaho Code § 41-3928(2) (Michie 1997) ("Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are not tied to specific medical decisions . . . . ").
These state statutes may be useful, but require some judicial gloss on the statutory language to provide a meaningful reform of MCO contracts. Any and all managed care incentives encourage physicians to limit the care they would have ordered under a fee-for-service regime. Managed care reformers hope that incentives are strong enough to prevent physicians from undertaking treatment which is of no benefit to the patient, but not so strong that they provide an irresistible incentive to deny care which is of great marginal value. However, at present there is no calculus to determine the point at which the marginal benefit to the patient outweighs the cost of the treatment, and consequently, there is no consensus on the proper strength of these incentives. The only clear thing is that a managed care incentive, by definition, must affect physician behavior. If it did not, then there would be no reason for a MCO to implement the incentive, as it would improve neither outcomes nor financial performance. Given that all managed care incentives must encourage physicians to deny some care, the question remains: What is the proper line of demarcation between those incentives which encourage fiscal prudence, and those which lead to unethical and impermissible denials of care? The statutes, standing alone, do not tell us. If they prohibit all incentives which lead to denial of care, they are meaningless, as noted above. If they prohibit only those incentives which lead to denial of medically necessary care, then the question turns on the definition of "medical necessity," itself a contested concept. Absent a statutory definition of medical necessity, plaintiffs will invite courts to expand the concept to cover any case in which care was denied and a bad outcome resulted. Courts will face the challenge of balancing the interests of plaintiffs, who might well have paid for more treatment under a self-paid system, or certainly demanded more treatment under an indemnity fee-for-service insurance contract, against the interests of the collective pool of insured lives and the interest of society in affordable health care with adequate coverage and services. However, the difficulty of the task does not justify avoidance of it. Courts will need to rise to the challenge of providing a reasonable common-law gloss on the statutory prohibition.

Finally, these state statutes purporting to regulate physician financial incentives are not yet out from under the threat of potential preemption under ERISA. Although the ERISA shield enjoyed by MCOs is weakening, states do not have free rein to regulate. Under the recently-announced Moran decision, state laws providing for independent review of MCOs' administrative denials of coverage were denominated the "regulation of insurance" for purposes of ERISA's savings clause. However, unlike an independent review, direct regulation of physician financial incentives might be seen to affect the content of an ERISA plan, and thus "relate to" an employee benefit plan for purposes of


226. Arguably, cost containment should be subjugated to quality as a measure of incentives' impact. Cf. Ross-Lee et al., supra note 17, at 831 ("Physicians should not pursue less costly treatment without evidence that the health outcomes or the quality of life will be at least equal to those achieved with more costly treatment.").

227. See, e.g., 215 ILL. COMP. STAT. ANN. 134/45 (West 2002) (providing for mandatory external review of MCOs' determinations that care is not "medically appropriate").

228. See supra notes 74-144 and accompanying text.
preemption analysis. Definitive determination of this point must await further elaboration of the *Moran* ruling.

In addition to state statutes purporting to directly regulate the content of managed care contracts with physicians, some plaintiffs are seeking to rely on other state laws to regulate managed care financial incentives. In light of the diminishing force of ERISA preemption, this state avenue may bear fruit in the near future. Perhaps the most famous state law case holding that a physician has a fiduciary duty to disclose financial incentives to the patient is *Moore v. Regents of the University of California*.

*Moore* was a patient of the University of California at Los Angeles Medical Center. In treating Moore for hairy-cell leukemia, the physicians treating Moore became aware that Moore's tissues had unique characteristics giving them commercial value. The physicians arranged for Moore's repeated visits to UCLA, assuring him that the visits were necessary for his treatment, while in fact they were for the benefit of the physicians and the University who stood to gain from the commercial development of products derived from Moore's cells and tissues. Upon discovery of this duplicity, Moore sued on myriad causes of action, including conversion of his tissues and breach of fiduciary duty for failing to disclose to him the true nature of his extratherapeutic visits to UCLA.

While the court dismissed Moore's conversion claim, holding that Moore had no cognizable property interest in his bodily tissues, the court held that he had stated a claim for breach of fiduciary duty. In discussing the contours of the physician's fiduciary duty in this context, the court stated 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 patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment." The potential applicability of this holding to managed care financial incentives is obvious; however, few courts have accepted Moore's invitation to extend such liability.

In *Neade v. Portes* the Illinois Appellate Court relied in part on Moore in holding that the plaintiff could maintain an action against his physician for breach of fiduciary duty arising from a failure to disclose managed care incentives. Dr. Portes practiced medicine in a group practice which had a contract with a Chicago HMO. This contract provided for a capitated payment as well as a "Medical Incentive Fund." The Medical Incentive Fund would be used to pay for certain supplemental services and, at the end of the year, any surplus would be divided among the HMO and the physicians. When Neade complained of repeated episodes of chest pain, Dr. Portes repeatedly refused to authorize diagnostic testing, relying on earlier testing to conclude that Neade's

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231. *Id.* at 481.
232. *Id.* at 482.
233. *Id.* at 488-89.
234. *Id.* at 497.
235. *Id.* at 485.
237. *Id.* at 427.
238. *Id.* at 421.
symptoms were not related to heart disease. When Neade died of myocardial infarction caused by coronary artery blockage, his estate sued, claiming that Dr. Portes’ judgment was affected by his interest in the Medical Incentive Fund and that, as in *Shea*, Neade would not have relied on his physician’s reassurance that more services were not needed had he known of the existence of the incentive. The court of appeals, relying in part on *Shea v. Esensten* and *Moore v. Regents of the University of California*, held that a fiduciary relationship existed, and that a cause of action for breach of that fiduciary relationship existed independently of any cause of action for malpractice.

In *Hill Physicians Medical Group v. Pacificare* a group of physicians sued an MCO under California consumer protection law, alleging that “certain of Pacificare’s business practices . . . are unfair business practices . . . [and] ‘are likely to harm consumers (patients) in that said practices lead to unreasonable and inappropriate economic pressures on the medical groups . . . to limit the amounts and types of services provided to . . patients . . . ’" Pacificare attempted to remove the case to federal district court under the ERISA statute, claiming that under ERISA’s total preemption doctrine, plaintiff’s state law claims were preempted by ERISA’s civil enforcement provisions. The district court disagreed, holding that matters which relate solely to the contract between physician and MCO could not be asserted by individual beneficiaries of an insurance plan, do not involve interpretation of an ERISA plan, and do not “relate to” an ERISA plan so as to trigger preemption and removal. In *Ouellette v. The Christ Hospital* a federal district court determined that a malpractice claim, which rested in part on the defendant hospital’s alleged financial incentive, under its contract with an MCO to limit care provided, was not completely preempted by ERISA. The court reasoned that the claim, as a malpractice claim, “[would] not require review of [the MCO’s] utilization review or otherwise demand construction of the . . plan.”

**IV. ECONOMIC INFORMED CONSENT**

As shown in the last section, many of the regulatory responses to physician conflicts of interest in MCOs rely on mandatory disclosures to “cure” the conflict of interest and allow the relationship to legally and ethically continue. This approach reflects the market view of health care in which patients and physicians are seen as primarily arm’s length economic actors. This section

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239. *Id.*
240. *Id.* at 422.
241. 107 F.3d 625 (8th Cir. 1997); see *supra* notes 81-92 and accompanying text.
242. 793 P. 2d 479 (Cal. 1990); see *supra* notes 230-35 and accompanying text.
245. *Id.* at *3 (citations omitted).
246. *Id.* at *6-7.
247. *Id.* at *9-10 (relying on Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc., 187 F.3d 1049 (9th Cir. 1999)).
249. *Id.* at 1165.
251. See *supra* notes 8-15 (discussing the “two cultures” of health care).
will critique the market approach and suggest an alternate view of the regulation of physician financial incentives.

A. The Theory of Economic Informed Consent

One important thread of scholarship on the physician-patient relationship in managed care focuses on the doctrine of informed consent and applies it to the health insurance context. In this view, disclosure of the existence of physician conflicts of interest at the time of formation of the insurer-insured relationship allows the consumer of health care services to make a rational choice whether or not to enter into a relationship characterized by those conflicts. If the consumer decides that the cost-benefit trade-off justifies the use of physician financial incentives, then the consumer reaps the benefit of that bargain and cannot be heard later to complain about the compromises inherent in it. This section will briefly summarize the reasoning of this theory, which, borrowing a well-turned phrase from Professor Mark Hall, a leading proponent of this theory, I shall call “economic informed consent.”

The fundamental problem answered by economic informed consent is that of scarcity. Since society cannot afford to provide all marginally beneficial services and treatments to all patients, some form of cost control must be imposed. This theory calls for use of informed consent and patient choice as legal and ethical techniques to manage the conflicts of interest created by managed care practice. Since financial incentives show promise in affecting physicians’ practice patterns learned under fee-for-service medicine, these incentives are acceptable so long as they are consented to by individual enrollees. In addition, disclosure of the types and operation of financial incentives at the time of enrollment constitutes legally and ethically defensible advance consent to individual rationing decisions, which may be adverse to a specific beneficiary, and waiver of the right to complain of such decisions. Such a theory authorizes physicians to make cost-conscious decisions “at the bedside,” that is, to take global resource allocation issues into account when making choices about how or whether to treat an individual patient.


253. See Economic Informed Consent, supra note 252. This brief synopsis necessarily simplifies and streamlines the robust arguments offered by these scholars, and collapses distinctions among them. Note that some of those who agree with the thesis will no doubt disagree with some of the details as I present them.

254. Bloche, supra note 196, at 271.


256. Id. at 211 (“[E]nrolling with an HMO constitutes blanket advance consent to the subsequent denials of marginally beneficial care brought about by the rules . . . . disclosed at the outset.”).

257. Making allocation decisions “at the bedside” is a controversial practice disfavored by many commentators, who insist that although a physician may engage in policy-making global resource allocation debate (and, indeed, that medical expertise is valuable to such a debate), her clinical responsibilities must be to the individual patient before her. See Robert M. Veatch, DRGs and the Ethical Reallocation of Resources, 16 Hastings Ctr. Report 32, 37-39 (1986); Daniel P. Sulmasy, Physicians, Cost Control, and Ethics, 116 Annals of Internal Med. 920 (1992).
The use of informed consent or contractarian doctrine to provide the impetus for cost consciousness in clinical decision making relies on predicates that are not present in the managed care market at the present time and do not appear likely to be adopted, either through legal mandate or voluntary industry action, in the foreseeable future. These predicates are disclosure of the nature and effects of the proposed financial incentives and consumer choice among a full range of health insurance products. Disclosure and consumer choice are necessary in order for consumers' decisions to subscribe to a particular managed care plan, with its attendant restrictions and incentives, to be both fully voluntary and informed and to represent a bargained-for exchange of lower premiums and other benefits of the managed care program for acceptance of those restrictions and incentives.

("[B]oth bedside rationing and restrictive gatekeeping are morally illegitimate roles for the physician."); Shorrell et al., supra note 51, at 1103 (noting that historically, physicians have been "relatively isolated from the examination of" the tension between social welfare and individual patients' welfare, "being asked to be an individual patient advocate rather than a social planner"); Schwartz, supra note 4, at 126 ("[W]ithin a patient-care giver relationship the physician must be an unashamed advocate for his or her patient."); Winters et al., supra note 50, at 11; Woolhandler & Himmelstein, supra note 26. Alternatives which remove allocation decisions from the individual bedside are use of professional practice guidelines and community-based decisionmaking, both of which are considered and rejected by Professor Hall. See Medical Spending Decisions, supra note 252, at 122-24 (discussing the practice of the rationing of medical resources "at the bedside").

258. Sage, supra note 250, at 1720 ("Despite the theoretical appeal of using disclosure to improve transactional efficiency, several ways in which health care differs from other purchases belie the apparent simplicity of this regulatory mission.").

259. Below, I argue that even if full disclosure of financial incentives is made, it would be insufficient to cure the ethical problems with such incentives for several reasons. See infra Part IV.A.4.


261. Bloche, supra note 196, at 271 ("[W]hether a woman who joins an HMO thereby consents to her physician's subsequent refusal to approve a mammogram cannot be answered without prior moral judgments about the adequacy of her health insurance options and the minimum acceptable level of subscriber knowledge about the HMO's coverage policies.").

262. Kapp, supra note 32, at 15, 16 ("Valid informed consent . . . depend[s] on the patient being adequately told relevant details pertaining to reasonable alternatives."). Interestingly, in another context, the Supreme Court has held that valid "[c]onsent . . . can happen without knowledge of the available options." Marc L. Miller & Ronald Wright, The Right to Refuse Searches Is in Danger, L.A. Times, Apr. 15, 2002, at B11 (citing Schneckloth v. Bustamonte, 412 U.S. 218 (1973) (holding no federal constitutional requirement to inform citizens of the right to refuse consent for a requested search)). Although the Fourth Amendment does not apply to the physician-patient relationship, cases such as this one raise interesting questions about the lengths to which courts might go to enforce the health care consumer's right to full information before consenting to a limitation on the physician-patient relationship.

263. Medical Spending Decisions, supra note 252, at 193 ("If patients are not informed of these incentives, or are given no choice over whether to accept them, the foundational consent is . . . undermined."); Farmley et al., supra note 30, at 8.
1. No Disclosure

Disclosure is a prerequisite to economic informed consent. Without full disclosure of the nature of the physician-patient relationship presented by the managed care bargain, the choice of that bargain by the health care consumer cannot be said to be fully informed and cannot represent a free choice and conscious bargain. An example of such a managed care bargain could improve less physician advocacy in cases of denial of care by the third party payor in exchange for lower premiums and deductibles. Industry and government data clearly show that the disclosures, if any, made in the current market do not rise to the level of informed consent. Current regulations do not require adequate levels of disclosure, and the industry has not voluntarily provided adequate disclosure. Further, there is little likelihood of legal reform to implement disclosure. The best chance of regulation to implement widespread disclosure would be by means of the “Patients’ Bill of Rights” legislation currently under consideration by Congress. Unfortunately, there are at least two problems with that avenue of reform. First, as of this writing, it is unclear when, if ever, decisive action will be taken on any federal patients’ rights legislation. Although this legislation has from time to time captured the mind of the public and passage has appeared imminent, the current status is very much unclear. Patients’ rights were understandably far from Congress’s immediate agenda after the terrorist attacks of September 11, 2001, and despite murmurs from Capitol Hill, there has been no concerted effort to return to this issue in the near future. Second, even if Congress did once again take up patients’ rights legislation, broad-based disclosure is unlikely to be part of the mandate contained in that bill.


265. Parmley et al., supra note 30, at 9 (“Patients cannot express truly informed preferences or informed refusals until they are provided with sufficient information . . . .”).

266. Holleman et al., supra note 28, at 351 (noting informed consent under managed care requires at least that “patients . . . understand the limited nature of the options available to them under the plan and the conflicts of interest facing physicians . . . .”). The authors’ view of the appropriate scope of disclosure to satisfy this requirement is unclear, since they continue that “patients who ask [should] be told the financial and other non-medical incentives to limit or control their care . . . .” Id. (emphasis added).

267. See Clarence H. Braddock, III et al., Informed Decision Making in Outpatient Practice, 282 JAMA 2313 (1999); Khanna et al., supra note 225, at 291.

268. GENERAL ACCOUNTING OFFICE, CONSUMER HEALTH CARE INFORMATION: MANY QUALITY COMMISSION DISCLOSURE RECOMMENDATIONS ARE NOT CURRENT PRACTICE GAO/HEHS-98-137, at 3-4 (1998) [hereinafter GAO REPORT] (“[I]nformation that the Commission recommended be provided about the business relationships and financial arrangements among health professionals, health care facilities, and health plans . . . are among the items not routinely reported to consumers.”); Blum, supra note 12, at 605 (discussing that MCOs have implemented patient rights only as a result of governmental regulation).

269. See Deputy Secretary of Health and Human Services Claude Allen, Address at the American Association of Health Plans, 2002 Policy Conference (Feb. 26, 2002).

270. The Senate version of the current patients’ rights bill does not mention physician incentives as information that must be disclosed to beneficiaries, either sua sponte (section 121(b)) or upon request (section 121(c)). See Patients’ Bill of Rights Act of 2001, S.889, 107th Cong. (2001). The House version, H.R. 2315, contains substantially the same disclosure
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2. Insufficient Choice

A second barrier to economic informed consent is the lack of actual choice available to American health care consumers. Realistic choices available to American consumers under managed care are shrinking rather than expanding. A full panoply of insurance options would be necessary in order for consumer choices to be good evidence of preferences and thus binding on an advance consent theory; unfortunately, this is not likely. Employers are placing an increasing share of the premium burden on employees and are tending to offer only one or a limited palette of insurance options. Even if non-MCO options were available to health care purchasers, their price alone might make their purchase prohibitively expensive, thus providing the consumer with a Hobson’s choice rather than a meaningful choice. As long as this trend continues, it is impossible to say that a health care consumer’s choice of plan represents a reasoned bargain to accept economic incentives and conflicts of interest in exchange for lower premiums.

The lack of choice as to fundamental aspects of one’s health care leads to “clinical captivity” and can amplify both the patient’s transference reactions to the physician and the physician’s countertransference reactions to the patient. Even if certain employers do offer a relatively complete palette of health insurance options to their employees, those employees are often not in a position to effectively exercise the choices open to them. Although there has been advocacy for consumer choice as a cost-containment mechanism, the current state of the health care system does not appear to offer sufficient avenues for consumer choice to satisfy this requirement for a contractarian, choice-based approach to regulation of physician financial incentives.

In addition to the problems of lack of disclosure and choice, which are admitted by proponents of economic informed consent, disclosure and contract as tools to cure physician conflicts of interest also suffer from other potential problems, including issues of formalism, timing, scope, and effectiveness. The next section will consider these problems.

provisions as the Senate version and contains a provision calling for study on the effects of physician payment mechanisms “on physician behavior with respect to the provision of medical care to patients, including whether and how such arrangements affect the quality of patient care and the ability of physicians to provide care that is medically necessary and appropriate.” Patients’ Bill of Rights Act of 2001, H.R. 2315, 107th Cong. § 122(a)(2)(B) (2001).

271. MEDICAL SPENDING DECISIONS, supra note 252, at 248 (“[A]ssumptions of free and informed insurance selection are undermined by large and obvious defects in insurers’ actual disclosure practices . . . and the range of actual choice available in existing . . . insurance system.”); Harold J. Bursztajn & Archie Brodsky, Captive Patients, Captive Doctors: Clinical Dilemmas and Interventions in Caring for Patients in Managed Health Care, 21 GEN. HOSP. PSYCHIATRY 239, 240–41 (1999) (finding a lack of choice of plan for many and a lack of choice of provider as part of managed care cost-containment protocols).


274. Ross-Lee et al., supra note 17, at 851 (“When patients do have a choice between plans or providers, they often lack relevant information about quality measures . . . .”).

3. Formalism and Informed Consent

A difficulty with the use of informed consent as a cure for financial conflicts of interest in managed care is the danger of formalism in informed consent procedures. Although much of the medical literature emphasizes the need to engage in an ongoing informed consent dialogue in order to ensure the patient’s understanding and participation and to preserve the patient’s autonomy interest, the financial pressures of managed care tend to reduce the time available for this informed consent dialogue. The informed consent process is reduced to a rote signature on a form, which is usually pre-prepared by MCO executives or lawyers and is neither read nor understood by the patient or the physician. 276

Formal procedures have their benefits. Formal procedures in the medical encounter can reassure worried patients, as a form carries with it the assurance of certainty and repeatability. A formal requirement of informed consent could serve as a signal to the patient that her consent is significant and could encourage closer attention to and participation in the informed consent process. 277 Certainly the formality of a signed informed consent document removes some uncertainty over exactly what was disclosed to the patient in the unfortunate event of litigation over an unexpected bad outcome. However, in order to capture the benefits of formality, the system must take care to avoid a procedure which reduces the formality to a mere rote act, devoid of substantive meaning for the participants, particularly the patient. 278

4. Limitations of Scope

When a physician discloses a known complication of a proposed procedure or course of treatment to a patient, the patient then has the authority and, by virtue of the legal effect of the disclosure, the responsibility to determine whether or not to accept the proposed procedure or course of treatment, presumedly weighing in the balance both the benefits to be gained and the risks

276. Warren Lee Holleman et al., Continuity of Care, Informed Consent, and Fiduciary Responsibilities in For-Profit Managed Care Systems, 9 ARCHIVES OF FAM. MED. 21, 22 (2000) ("Contrary to a common misconception, the requirements of informed consent are not met by having the patient sign a paper authorizing a test or treatment."); Jan Marta, A Linguistic Model of Informed Consent, 21 J. OF MED. & PHIL. 41, 46 (1996) ("Most research on informed consent... has largely ignored the problem of a hollow consent, one that may lack meaning for the persons involved, even while retaining medicolegal validity."); Vida Foubister, Physicians Seldom Tell Patients Enough, AM. MED. NEWS, Jan. 17, 2000, at 9, 9 ("Even though there may be a signed consent form, ... the process that leads up to [consent] may be inadequate.").

277. Marshall B. Kapp, Managed Care and Mandatory Movies, 276 JAMA 1023, 1023 (1996) (expressing that educational informed consent requirement of MCO "improve[d] my sense of medical well-being, my feelings of autonomy and control, and the strength of my relationship with my physician").

278. Foubister, supra note 276, at 10 ("Doctors tend to think of informed consent in legal, rather than ethical, terms."). Further, the prerequisites of informed consent are lacking. As noted above, supra notes 264-70 and accompanying text, patients currently do not have access to full information regarding their medical care. Further, even when engaged in obtaining informed consent, physicians may not provide ethically optimal levels of disclosures. Wu & Pearlman, supra note 264, at 11 fig. 1 (Physicians provide the rationale for the proposed treatment only 43% of the time and disclose the risks and alternatives to the proposed treatment only 14% and 12% of the time, respectively.).
which must be accepted in order to realize those benefits. However, a physician's economic conflicts of interest do not relate to a specific proposed treatment or procedure, but rather to the physician-patient relationship as a whole. If a particular economic incentive does in fact have an effect on the physician's judgment with respect to a particular patient's treatment, that incentive must be taken into account by the patient with respect to every recommendation made by the physician. The ultimate effect of the conflict of interest may not be apparent to the patient at the time informed consent disclosure is given.

Ordinarily, when a patient is given informed consent disclosure, the patient has a choice whether or not to accept the proposed procedure, with its attendant risks, in order to attain the desired benefit. If the physician's economic incentives are treated as an informed consent problem, the patient may not have this choice for at least two reasons. First, the patient may have no meaningful choice among providers. If all providers in a particular managed care network are subject to the same economic conflict of interest, there can be no meaningful choice among them based on this factor. If all insurers in a particular market employ the same or similar economic incentives to control health care costs, the patient's meaningful choices are reduced further. The patient may be faced with a limited choice of insurers, as for example when a limited number of insurers or a single insurer provide health coverage for all employees of a large employer. As employers continue to shift more and more of the costs of health insurance onto the worker, workers are potentially forced into lower-cost, incentive-laden health plans. Second, as noted above, the economic incentive, assuming its efficacy at controlling health care costs and thus implicitly at controlling the behavior of the physician, colors all choices made by the physician on behalf of her patient. This may mean that higher cost choices are simply never recommended to the patient. The choice of whether or not to accept a lower-cost treatment option is not a fully informed choice unless the patient is made aware of all treatments that the physician would ordinarily recommend, in the absence of the economic incentive. If the physician would ordinarily recommend a higher-cost treatment, but neglects to do so in the face of a particular economic incentive, the patient ordinarily has no way of adequately evaluating the physician's advice, even if the patient is fully aware of the economic incentive under which the physician is operating.

279. But see Robert T. Brodell, Ethics and Micromanaged Care, 132 ARCHIVES OF DERMATOLOGY 1013 (1996) (describing a situation in which a patient was forced by a managed care pharmaceutical formulary to endure a four month trial of a covered medication, which the treating physician knew to be ineffective, before the MCO would pay for treatment with a noncovered medication which was effective, and questioning the appropriateness of this treatment, even in the presence of clear and unequivocal informed consent from the patient).

280. Thompson, supra note 59, at 575 (A patient receiving disclosure "may not ... have reasonable alternative courses of action."); Jeffrey Brainard, The Ties That Bind?, CHRON. OF HIGHER EDUC., Sept. 8, 2000, at A31.

281. Employees are receiving fewer choices in health coverage. See infra note 283 and accompanying text. But see Khanna et al., supra note 225, at 292 (discussing that disclosure helps even those with limited choice of health plan, since it gives them an incentive to negotiate with their employers for a better plan).

282. Reuters Health, supra note 27 (stating that workers are being asked to shoulder a greater than proportional increase in health insurance costs).

283. Marc A. Rodwin, Conflicts in Managed Care, 332 NEW ENG. J. MED. 604, 605 (1995) ("Implicit methods of restricting services . . . hide from patients their limited choices.").
5. Limitations of Timing

Must informed consent disclosure be given at the beginning of every physician-patient encounter or is one blanket disclosure, given at the beginning of the physician-patient relationship, sufficient to cure the conflict of interest?284 If disclosure is given at the beginning of every physician-patient encounter, the disclosure may become a routine part of the physician office visit and lose whatever warning power it may possess.285 Excessive repetition of a warning will dilute the effectiveness of the warning. On the other hand, a blanket disclosure given at the beginning of the physician-patient relationship may be insufficient286 for both timing and structural reasons. With respect to timing, the patient may not be in a position to appreciate the nature and the fact of the physician’s economic incentive or its effect on the physician-patient relationship.287 Since most health insurance is provided through employers, unions, or other large groups, a blanket disclosure would likely not come from the physician herself, but would be provided as part of a package of documents provided by the insurer (or, more likely, by the employer, union, or other group representative acting as agent of the insurer), and thus might lack the moral authority of a warning coming directly from the physician.

6. Limitations of Effectiveness

“The greatest problem in communication is the illusion that it has been accomplished.”

-George Bernard Shaw

Scholars have raised serious questions about the efficacy of informed consent even in its ordinary manifestations.288 These questions must be asked again when proposals are put forward to expand the doctrine of informed consent to cover physicians’ economic incentives. If patients tend to unconsciously discount disclosed risk factors and focus solely on the perceived benefits of the recommended course of treatment, will this defect in informed consent not be all the more pronounced when, as is true in the case at hand, the risks are theoretical and abstract rather than physical and concrete?289 Will a patient, at the time treatment is required, be in an appropriate frame of mind to perform the required balancing of costs and benefits when weighing the advice

284. Khanna et al., supra note 225, at 293 (suggesting that consent must be obtained at the time of purchase of insurance, as disclosure at the point of care is too late, but that “general disclosures by MCOs . . . do not discharge physicians from their duty to ensure an informed consent process at the point of care . . . ”).
285. See supra notes 276-78 and accompanying text (discussing formalism in informed consent).
286. Rodwin, supra note 283, at 605 (“Unless they are already ill, . . . most people are unable to predict what services they will need—a fact that undermines meaningful choice . . . ”).
287. Thompson, supra note 59, at 575 (“A deficiency of disclosure is that those who receive [it] may not know how to interpret it . . . ”).
288. Marta, supra note 276, at 42 (arguing that the disclosure model of consent “fails to consider the complexity of any act of communication, and the potential for misunderstandings . . . ”).
289. Bloche, supra note 196, at 273 (“Expectations engendered by bedside empathy persist despite cognitive input to the contrary, especially when anxious patients yearn to believe.”); Shortell et al., supra note 51, at 1102 (stating that trust in one’s doctor is needed by a patient because of a relative lack of medical knowledge).
of a physician operating under an economic incentive? Will widespread disclosure of the use of economic incentives to manage physician behavior lead to an impairment of the therapeutic relationship of trust between physician and patient, and result in a lower level of patient compliance with physician instructions and thus a reduction in the quality of health care outcomes? Dr. M. Gregg Bloche argues that the "message of fidelity" inherent in the doctor-patient relationship means that consent to breaches of that fidelity is problematic, given that patients simultaneously receive other, perhaps non-verbal, information that leads them to expect fidelity from their physician.

B. Inadequacy of Litigation as a Vehicle for Regulation

Even if mandated disclosure were enough to cure the conflicts of interest generated by managed care, litigation is an inappropriate vehicle for imposition of that mandate. Litigants often ask for mandated disclosure of financial incentives as a remedy. This quest for court-imposed mandated disclosure requirements has been at best partially successful. However, even when successful, questions remain about the efficacy of court-imposed mandated disclosure requirements. Although litigation may have benefits for patients in the managed care experience, the courts ultimately may not be the best vehicle for regulation of physician financial incentives.

1. Compliance Concerns

It is important that a mandatory disclosure requirement be readily enforceable without undue burden on the beneficiaries of a managed care contract. A disclosure requirement imposed as a function of state common law will require enforcement by litigation if managed care companies fail to disclose voluntarily or if the content, form, or timing of the disclosure fails to meet minimum acceptable standards. Adoption of a disclosure requirement by a state supreme court is no guaranty of immediate adoption of disclosure practices by all of a state’s MCOs, and repetitive and expensive litigation would be necessary to bring stragglers into compliance, even if the precedent requiring disclosure is clear and binding. There would be no effective way to sanction those MCOs who choose not to comply with the law until forced to do so by patient litigation; a civil judgment is not binding on nonparties, and so contempt citations would

290. See infra notes 314-17 (patients must trust their doctors due to patients’ vulnerable and desperate state when ill).
291. Shortell et al., supra note 51, at 1103.
292. See, e.g., Feldman et al., supra note 45, at 1628 fig.5 (reporting that forty-nine percent of surveyed physicians believed that managed care infrequently achieves improved patient outcomes, as opposed to thirteen percent believing that managed care frequently achieves improved outcomes.) But see Economic Informed Consent, supra note 252, at 546-49 (arguing that, empirically, disclosure seems to have no effect on or enhance trust).
293. Bloche, supra note 196, at 273 ("The promise of fidelity signaled by sustained, empathetic engagement is painfully at odds with the reality of a double agenda... Disclosure of this dual role... hardly dispenses with the problem of infidelity.").
294. See supra notes 230-49 and accompanying text.
295. See Cerminara, supra note 72, 9-10.
296. Kapp, supra note 32, at 15 ("Litigating substantial numbers of individual... claims in multiple jurisdictions, probably with inconsistent results, would be an... unsatisfactory way to establish policy guidelines for patient rights and provider responsibilities.").
not be available for failure to comply with an articulated disclosure requirement. The remote threat of punitive damages might provide some incentive for compliance, but it is far from certain. Without an effective scheme of sanctions, and depending on private litigation for enforcement, MCOs might choose to delay compliance until forced to comply by the threat of litigation. The burden of enforcement would then rest solely on the individually wronged patient, who might have neither the resources nor the inclination to fight protracted litigation in order to secure her rights. Since research shows that few injured patients actually bring negligence actions, one might reason by analogy that few patients wronged by MCO nondisclosure practices will sue, even if there is clear precedent giving them the right to do so.

2. Legal Process Concerns

Some courts have been reluctant to address the issue of mandatory disclosure of physician financial incentives due to legal process concerns. These courts have articulated the belief that the court system is not the proper forum for resolution of the policy debate over mandatory disclosure and have suggested that litigants who seek this relief should address their concerns to Congress rather than to the courts. The highest court to express this concern is the U.S. Supreme Court. Justice David Souter, writing for the unanimous Court in Herdrich v. Pegram, based the Court’s holding, limiting the role of the federal judiciary in deciding managed care benefit cases, in part on the argument that decisions about the proper scope of physician incentives should not be made in the courts.

3. Political Concerns

To the extent that litigation to establish or enforce a mandatory disclosure requirement is conducted by state attorneys general under their parens patriae power to protect the interests of the citizens of the state, some of the concerns about the cost and undue burden of litigation may be ameliorated. However, enforcement by state attorneys general brings with it other concerns. Different state attorneys general may have different levels of expertise, funding, and desire to carry out this sort of consumer protection litigation, and these factors may be subject to dramatic change. In Texas, Attorney General Dan Morales, a Democrat, filed landmark actions against several MCOs operating in Texas, alleging that their practices violated a Texas state law against financial incentives that induce physicians to deny needed care. While the litigation was pending, Morales lost an election and was replaced by John Cornyn, a Republican. Shortly thereafter, the litigation was transferred from the Consumer Protection division of the Attorney General’s office to the Financial Litigation division. The action against two of the MCOs was settled on terms which are

298. Id. at 221 ("[S]uch complicated factfinding and such a debatable social judgment are not wisely required of courts unless for some reason resort cannot be had to the legislative process, with its preferable forum for comprehensive investigations and judgments of social value . . . .").
arguably less than favorable to the state’s consumers of health care, and the pending litigation against the remaining MCO defendants has been suspended indefinitely by agreement between the parties.

C. The Argument from Personhood

1. Informed Consent, Market Inalienability, and Physician Incentives

If health care can be understood alternatively as a marketplace and as an ethical profession, the managed care revolution, as well as the current scholarly trend towards economic informed consent and contractarian approaches to patient protection, reflects the market concept of the health care system. That is, it is assumed that the physician, patient, and MCO are each free to enter into or to reject any proposed transaction, and that no party has the ability to exercise effective coercion or power over any other. In this idealized marketplace, exchanges are made that maximize the value received by all parties, and the sum of all healthcare transactions result in the highest possible utility to society. This section will suggest an alternative conception, grounded in the competing vision of health care as an ethical profession. If, as I suggest, disclosure and bargaining alone cannot cure managed care conflicts of interest, how do we justify regulatory limits on the rights of patients and providers to contract among themselves for the appropriate level of care to be delivered? I suggest here that one possible answer is found in the doctrine of partial non-commodification, or market-inalienability, articulated by Professor Margaret Jane Radin. For Professor Radin, market-inalienability means that a thing should not be sold or bargained away in the marketplace, that is, it should not be reduced to a commodity.

In our capitalist society, the marketplace is a primary metaphor by which we understand the world. How, then, do we justify removing a thing from the operation of the marketplace? Professor Radin argues that the answer is related to the nature of the thing itself. A marketplace operates by reducing the value of things to a common denominator, usually monetary worth. Commodification inherently assumes that a thing’s value can be calculated in money to facilitate evaluation of particular exchanges. However, some things may be incommensurate with monetary value; that is, their worth cannot, or should not, be expressed in dollars and cents. Professor Radin holds that things which are

299. George Lardner, Jr., Aetna Settles Managed-Care Lawsuit in Texas, WASH. POST, Apr. 12, 2000, at E1 (noting that the settlement “imposes no fines or sanctions” on the insurers).
300. See supra notes 8-15 (discussing the “two cultures” of health care).
301. Blum, supra note 12, at 605 (“[G]overnment has been replaced in some areas as the primary force in shaping . . . health markets by dominant managed care plans . . . whose policies . . . are motivated by the demands of purchasers . . . .”).
303. Id. at 1853 (“[N]onsalability is what I refer to as market-inalienability.”).
304. Examples used by Professor Radin are human sexuality, which under current law cannot be the subject of explicit market transactions, but may be freely exchanged, and the adoption market, in which human children cannot be bought and sold, but may be freely given for adoption. Id. at 1921-36.
305. Commodification includes not only the practice of “buying and selling, but also market rhetoric, the practice of thinking about interactions as if they were sale transactions, and market methodology, the use of monetary cost-benefit analysis to judge these interactions.” Id. at 1859.
inextricably related to our humanity – our personhood – should be outside the scope of the market.\textsuperscript{306} Thinking about our humanity in market terms produces, in Radin’s words, an “inferior concept of human flourishing” and therefore causes injury to our concepts of ourselves\textsuperscript{307} and our society.\textsuperscript{308}

If the managed care industry is a true marketplace, what is being traded? We can think of the managed care financial incentives “deal” as a tradeoff of lower health premiums (and, perhaps, increased attention to preventive care) in exchange for limited choice of provider and imposition of oversight and cost control mechanisms, potentially including physician rationing of medical resources at the bedside.\textsuperscript{309} In other words, patients are giving up their traditional expectation under a fee-for-service medical system that their physician will provide care with an eye to the patient’s benefit alone, in exchange for lower cost and, depending on the specific managed care plan and representations made, increased quality of care. However, as we have seen, in this health care transaction there is no realistic right to refuse the bargain offered.\textsuperscript{310} There may be no other meaningfully distinct insurance options offered by one’s employer, and going outside the group health market to the individual insurance market may be prohibitively expensive. Even if options are available, the difference between those options and the lower-cost options may not have been adequately explained.

Although the market has failed to adequately regulate the physician-patient relationship under managed care, for Radin, removal of a thing from the market does not depend on a conclusion that the market has failed to effectively allocate that thing.\textsuperscript{311} It is enough that the thing in question is closely related to our concept of ourselves as persons. In the case of the physician-patient relationship, both conditions are satisfied. The provision of health care services, and in particular the doctor-patient relationship, is related to our conceptions of personhood in important ways.\textsuperscript{312} Health care, indeed health itself, is regarded as a basic human right by the Constitution of the World Health Organization.\textsuperscript{313} The doctor-patient relationship is fundamentally a relationship of trust and confidence,\textsuperscript{314} not a business or commercial transaction.\textsuperscript{315} Since our physician

\textsuperscript{306} Id. at 1885.
\textsuperscript{307} Id. at 1884. “Systematically conceiving of personal attributes as fungible objects is threatening to personhood, because it detaches from the person that which is integral to the person.” Radin, supra note 302, at 1881.
\textsuperscript{308} Radin, supra note 302, at 1879 (using the example of discussing the criminality of rape in terms of a “marriage and sex market”).
\textsuperscript{309} See, e.g., Morreim, supra note 5, at 80-81; Medical Spending Decisions, supra note 252, at 122-24.
\textsuperscript{310} See supra note 262 and accompanying text.
\textsuperscript{311} Radin, supra note 302, at 1863-70. Market failure is a precondition for inalienability for many theorists. Id.
\textsuperscript{312} See generally Personhood & Health Care (David C. Thomasma et al. eds., 2001) (providing a variety of discussions on the nature of the human person as related to health care, medicine, and mental health).
\textsuperscript{313} “Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.” Const. of the World Health Org. pmbl., available at http://policy.who.int/cgi-bin委v_l5api.dll?Infobase=Basicdoc&softpage=Browse_Frame_Pg42 (last visited Jan. 20, 2003).
\textsuperscript{314} Hammonds v. Aetna Cas. & Sur. Co., 243 F. Supp. 793, 801 (N.D. Ohio 1965) (“When a patient seeks out a doctor . . . he must admit him to the most private part of the material domain of man.”)
\textsuperscript{315} Ralph Crawshaw et al., Patient-Physician Covenant, 273 JAMA 1553, 1553 (1995).
sees us at our most vulnerable, and since complete honesty and candor is necessary for successful treatment, a successful relationship with our physician is necessary for our self-actualization as persons.

Although not easily quantified or measured, trust is essential to the physician-patient relationship. Trust requires that the patient believe that “her health is the primary concern of the health care professional caring for her.” However, managed care financial incentives threaten to raise issues of cost containment or limitation of care to a level equal to or higher than the health of the individual patient in an individual clinical encounter. Although traditional statements of physician ethics clearly place the patient at the center of the physician’s ethical obligations, we cannot rely solely on aspirational ethical goals to regulate the physician-patient relationship in managed care. Although many commentators state that the physician’s ethical duty is to avoid or reject unacceptable managed care contract terms, the vulnerability of individual physicians to the market power of managed care organizations makes it untenable to expect physicians to refuse to participate on less than ethical terms, at great personal loss to themselves. The recognition of the physician’s duty to refuse unethical contract terms implies that consent is insufficient to cure certain conflicts that there are conflicts that raise sufficient doubt about the physician-patient relationship, and that the better course of action is to avoid the conflict altogether, by prohibition if need be.

Given the importance of a doctor-patient relationship characterized by trust, honesty, and beneficence, should that relationship, or certain incidents of it, be market-inalienable? In particular, should patients be permitted to “sell”

316. Shortell et al., supra note 51, at 1102 (“[The] trust[] relationship arises from the relative disparity in medical knowledge . . . and the psychological vulnerability of patients concerned about their illness or health status.”); Bloche, supra note 196, at 272 (“[T]he physician's infidelity violates another, often when the other is most vulnerable. The ethic of clinical fidelity safeguards an intimate sphere of personality against such violation.”)


319. See, e.g., Winters et al., supra note 50, at 11 (finding that the physician's primary ethical obligation is to her patient); AM. MED. ASSOC. COUNCIL ON MED. SERVS., PRINCIPLES OF MANAGED CARE 7 (4th ed. 1999) (“The first duty of physicians must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives . . . .”). Even certain of those commentators, who argue that some level of cost-consciousness “at the bedside” is desirable, often re-state the obligation to advocate on behalf of specific patients. Cf. Kapp, supra note 32, at 15, 17.

320. Holleman et al., supra note 28, at 351 (“Individual physicians should refuse to join managed-care organizations if these contracts include unethical gag orders.”).

321. Gates, supra note 18, at 234 (“Physicians . . . find themselves increasingly vulnerable to financial pressure as reimbursements decrease and job security wanes.”); Chervenak et al., supra note 6, at 524 (arguing that economic self-interest forces physicians to sign contracts containing conflicts of interest due to the oversupply of physicians).

322. See, e.g., Neurology Code of Professional Conduct, supra note 61, at 1259 (Rule 5.2 requires both disclosure of financial interests that “might conflict with” the duty to patients and avoidance of interests “would, solely because of personal gain,” influence the physician).

323. Rodwin, supra note 283, at 605 (arguing that prohibition is one method of regulating conflicts). Contra AM. MED. ASSOC. COUNCIL ON MED. SERVS., supra note 319, at 8 (“Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary . . . .”)

324. Holleman et al., supra note 47, at 23 (“We believe that the practice of medicine should not be reduced to a business transaction governed by . . . market principles . . . .”). Contra Jeffrey M. Sconyers, 330 NEW ENG. J. MED. 640 (1994) (“Relationships with physicians are not an absolute good; they are weighed against many other factors, each determined by individual
through a process of disclosure and bargaining, their expectation that their physician will act solely in their best interest and will not be subject to a hidden cost-cutting financial incentive to deny care in exchange for lower-cost managed healthcare?326 We will look first at the potential harms of such a sale.

2. Coercion

We are rightly concerned that patients might be tricked or coerced into entering into a bargain without a full understanding or weighing of the costs and benefits.327 Although proposals for a consent-based waiver of a physician’s sole agency contain mechanisms intended to deal with this problem, others argue that these mechanisms are insufficient and that we cannot be certain that individuals, particularly the poor and others without the means to select more expensive alternatives, will not be forced into this bargain against their will. As a result, we might forbid the bargain altogether as a precautionary measure to ensure that coercion is not used. However, this rationale is troubling to the extent that we recognize that the bargain does have very real benefits that, for some, may outweigh the costs and make such incentives a rational choice. Highly educated patients, or patients with medical training themselves, may feel competent to act as their own advocates in the health care process or may feel that they can afford to obtain second opinions in the event of a questionable recommendation from their primary physician. The presence of financial incentives may not seem as threatening to such individuals as to those with less education, with less knowledge of the healthcare system, or who do not have the resources to obtain second opinions. Further, financial incentives may lead to very real cost savings

customers who make these hard choices every day.”). Of course, this argument presupposes, as do other market-based arguments, that the prerequisites of information and choice are present to enable rational decision making to take place. See infra note 330; Ezekiel J. Emanuel & Allan S. Brett, 330 New Eng. J. Med. 641 (1994) (“Many of the problems ... may not be obvious to patients when they select health plans. ... Whatever health care reform is adopted, it must be evaluated in part according to its ability to strengthen the physician-patient relationship.”).

325. Of course, the term “sale” here is used metaphorically. This is consistent with Professor Radin’s assertion that “commodification includes not only actual buying and selling, but also market rhetoric, the practice of thinking about interactions as if they were sale transactions, and market methodology, the use of monetary cost-benefit analysis to judge these interactions.” Radin, supra note 302, at 1859.

326. Suggestions have been made in the literature that market mechanisms are inappropriate to regulate managed care financial incentives. See Senco of Fla. v. Clark, 473 F. Supp. 902, 908 (M.D. Fla. 1979) (holding that since the original intent of ERISA was to prevent employees from bargaining away benefits in employee benefit plans, this clearly shows that some things are being removed from the bargaining table by governmental regulation, if they are considered important enough); Beauchamp & Childress, supra note 11, at 318 (“Society and the health professions need to address conflicts of interest ... by eliminating some conflicts as well as by requiring disclosure of conflicts ...”).; Brander, supra note 280, at A31 (“[Disclosure] merely passes the buck to the [patient], who is left to wonder how the investigator will balance the competing interests ... Caveat emptor is simply not adequate in this setting.”) (discussing research conflicts rather than MCO conflicts); Rodwin, supra note 283, at 605 (“Public policy should restrict physician risk-sharing and manage care in other ways.”); Thompson, supra note 59, at 573, 574 (“Conflict-of-interest rules ... regulate the disclosure and avoidance of [conflicts] ... [I]t is ... ethically more responsible to decide in advance to remove insofar as possible factors that tend to [create conflicts].”) (emphasis added).

327. Parmley et al., supra note 30, at 7 (“The ideal of ethical medical practice is reflected in establishing voluntary and uncoerced physician-patient relations”); id. at 8 (“Principles of ethical behavior must stress ... the patient’s right of free choice.”).
for the entire health care system, since enabling basic health services to be provided to more individuals who otherwise would be unable to access these services. We do not serve the low-income uninsured well if we deny them access to any healthcare at all in order to protect them from a less than ideal physician-patient relationship. Since we know that the number of uninsured in this country is at a staggering level, provision of basic healthcare services for all must play a large role in our reasoning. Because of this "double bind," the anti-coercion rationale for market-inalienability cannot alone justify imposition of an absolute ban on physician financial incentives to deny care.

3. Damage to the Relationship

Some commentators have argued that to allow MCOs to impose financial incentives on the physician-patient relationship will cause damage to that relationship. Since trust is a necessary adjunct to a therapeutic relationship, the patient should not fear that his physician is making specific recommendations, not for his benefit, but in order to increase her compensation. Some commentators argue that improperly strong or individualized managed care incentives necessarily impair the physician-patient relationship, and that the sorts of incentives which accompanied the fee-for-service market are fundamentally different and less harmful to the physician-patient relationship than the common managed care incentives. Others argue that imposition of managed care incentives increasingly commodifies the services provided by the physician, which leads to diminished trust. To the extent that managed care

328. Bloche, supra note 196, at 269 ("[E]vidence suggests that putting physicians at risk for the cost of their decisions . . . restrains medical spending more effectively than do other methods used by payers.") (citations omitted); Brian S. Armour et al., The Effect of Explicit Financial Incentives on Physician Behavior, 161 ARCHIVES OF INTERNAL MED. 1261, 1261 (2001) (stating that incentives placing physician resources at risk are effective in reducing resource usage). But see supra notes 2-3 (showing data suggesting that cost savings produced by managed care were transitory and American health care is returning to double digit inflation). 329. See Sharona Hoffman, Unmanaged Care: Towards Moral Fairness in Health Care Coverage, 78 Ind. L.J. (forthcoming May 2003); Parmley et al., supra note 30, at 9 (discussing the ethical principle of distributive justice).

330. In 2000, there were 38.7 million Americans, or fourteen percent of the population, without health coverage for the entire year. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 2000 1 (Sept. 2001), available at http://www.census.gov/hhes/hlthin00/hlt00asc.html (last visited Jan. 12, 2003).

331. Radin, supra note 302, at 1915.

332. See, e.g., Bursztajn, supra note 271, at 241 (absence of meaningful choice in the health care context leads to diminution of trust and therapeutic potential of the doctor-patient relationship); Schwartz, supra note 4, at 127 (addressing the potential for lost trust); Relman, supra note 12, at 24 ("The risk is that professional autonomy and professional values may be subordinated to business interests and that the ethical basis of the doctor-patient relationship may erode."). But see Mark A. Hall et al., How Disclosing HMO Physician Incentives Affects Trust: Not All Cost-Minimizing Physician Incentives Are Ethically Troubling to Patients, HEALTH AFFAIRS, March/April 2002, at 197, 200 (stating that disclosure of physician incentives resulted in 1.4% increase in physician trust compared to lack of disclosure).

333. Schwartz, supra note 4, at 127 ("[A] person is much more prepared to utilize autonomy in refusing health care from a provider than in demanding health care that has not been offered and about which she may know nothing.").

334. Feldman et al., supra note 45, at 1630 ("[P]hysicians may come to see themselves more as economic commodities and less as professionals with obligations to uphold. Such a diminished sense of obligation to professional mores could eventually undermine physician-patient trust."); Edmund D. Pellegrino, Words Can Hurt You: Some Reflections on the
incentives damage those physician-patient relationships in which they are present, then, this may justify market-inalienability.

4. Damage to All Relationships

A further strand of commentary argues that managed care incentives do not only impair those relationships in which they are present, but rather impair all physician-patient relationships. Patients may enter their physicians’ offices with foreknowledge of the widespread existence of incentives to restrict care and may even overestimate the strength of such incentives in light of horror stories reported in the news. To the extent that managed care incentives are the subject of popular reporting (and misreporting), popular knowledge of the presence of such incentives in the marketplace may lead to decreased public trust in physicians and in the health care system generally, eliminating or diminishing the necessary element of trust even in those physician-patient relationships free of improper managed care incentives. Reports of successful plaintiffs in managed care litigation may lead to an increased willingness to threaten legal action in an attempt to protect one’s health. This “domino effect” can partially respond to the criticism of the coercion justification discussed above; to the extent that the existence of managed care incentives drives the existence of therapeutic physician-patient relationships out of the market, their market-inalienability is justified.

One might argue, from these three justifications, that market-inalienability is the answer to regulation of managed care financial incentives and that they should be barred from the market to preserve the physician-patient relationship necessary to successful medical outcomes. However, there is more to the analysis. One criticism of the noncommodification proposal outlined here might be that it violates the patient’s autonomy interest. By removing certain aspects of the physician-patient relationship from the bargaining table, we limit the scope of choices available to the patient, choices which he might find personally attractive. In addition to the autonomy argument, Dr. Bloche reminds us that we must take care to avoid the utopian fallacy—measuring our proposed solution

Metaphors of Managed Care, 7 J. AM. BD. OF FAM. PRAC. 505, 505 (1994); David Blumenthal, Effects of Market Reforms on Doctors and Their Patients, HEALTH AFFAIRS, Spring-Summer 1996, at 170, 179-80. Commodification may entail other effects of managed care as well, such as the impact of constantly shifting managed care panels on continuity of care. See, e.g., Holleman et al., supra note 276, at 21-22 (describing the impact of lack of continuity of care has on the doctor-patient relationship and the potential effect on health outcomes).

335. Radin, supra note 302, at 1912-13 (describing “a slippery slope leading to market domination. . . . [in which] [t]o commodify some things is simply to preclude their noncommodified analogues from existing.”); see also Robert L. Lowes, Explaining Things to an Angry Managed-Care Patient, 74 MED. ECON. 143 (1997) (presenting issues involved in doctor-patient discussions about managed care and treatment options).

336. Ellyn E. Spragins, Beware Your HMO, NEWSWEEK, Oct. 23, 1995, at 54; David A. Hyman, Regulating Managed Care: What’s Wrong with a Patient Bill of Rights?, 73 S. CAL. L. REV. 221, 222 (2000) (“In just a few short years, managed care has gone from the darling of health policy wonks to the moral equivalent of the tobacco companies.”).

337. Lowes, supra note 335, at 143, 144 (reporting that twenty percent of managed care patients believe that MCOs pressure physicians to put “wealth before their health”).

338. Winters et al., supra note 50, at 15.
339. Lowes, supra note 335, at 143.
against a vision of an ideal world rather than our existing world, marred as it is by injustice, inequality, and disempowerment. In light of the difficulties facing us, Professor Radin suggests market-inalienability may in reality move us further from our ideals. We should consider whether there is a compromise between absolute market-inalienability and full commodification of the physician-patient relationship that will address the worst effects of managed care incentives while preserving their benefits in light of real-world economic and other pressures.

5. Autonomy and Inalienability

The proposal to prohibit consent on certain economic conflicts would narrow the theoretical range of choices available to patients and, in that sense, would prevent them from exercising the full range of autonomous choices the market would otherwise make available. However, we have seen that in many cases, patients or beneficiaries of managed care plans in fact are not free to choose from the entire theoretical spectrum of health care options, but are presented with a narrow range of health care choices. In many cases, a beneficiary of an employer-sponsored health plan has only one plan sponsor to choose, although there may be more than one “style” of plan offered. In many cases, the employer’s contribution to health care costs may only cover the cost of the cheapest and most restrictive health plan or may not even completely cover that, and the additional costs of a plan with fewer or less onerous cost controls prohibitive may be for many employees. In such cases, the Hobson’s choice offered to employees is a poor substitute for the autonomy principle. In fact, by removing the worst cost-containment strategies from the managed care marketplace, a more robust regulatory system would allow beneficiaries more meaningful choices among the remaining options, including options which hold down costs by implementing reasonable and rational cost-containment strategies.

6. Avoiding The Utopian Fallacy—A Rule of Reason

The utopian fallacy remains a real pitfall for a noncommodification proposal. Professor Radin admonishes us that we must take care, in envisioning

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341. Bloche, supra note 196, at 269 (“[A]n absolutist approach [to divided clinical loyalties] is open to the charge that it takes a penurious view of the medical profession’s public responsibility.”); Chervenak et al., supra note 6, at 525 (arguing that elimination of physician conflicts of interest is not realistic).

342. Radin, supra note 302, at 1917.

[T]he double bind means that if we choose market-inalienability, we might deprive a class of poor and oppressed people of the opportunity to have . . . a better chance to lead a humane life. Those who gain from the market-inalienability, on the other hand, might be primarily people whose wealth and power make them comfortable enough to be concerned about the inroads on the general quality of life that commodification would make.

Id.

343. See infra notes 348-50 and accompanying text (rejecting full noncommodification in favor of a reasonableness analysis). Professor Radin suggests further that the autonomy or paternalism criticism may be answered by appeal to “a positive view of liberty that includes proper self-development as necessary for freedom . . . .” In that view, “inalienabilities needed to foster that development will be seen as freedom-enhancing rather than as impositions of unwanted restraints on our desires . . . .” Radin, supra note 302, at 1899.
an ideal state, not to create more problems than we solve. For the involuntarily uninsured, imperfect health care is superior to no health care at all.344 One response to this criticism would be to demand that society reengineer itself to provide health care to all, in order to remove the potential coercive effect of lack of insurance.345 Given the recent failures of attempted large-scale health care reforms,346 this response can be dismissed as unlikely.

There is another approach to noncommodification that takes account of both the dangers of the marketplace and the realities of a predominantly market-driven industry.347 For Professor Radin, commodification is not an all-or-nothing doctrine.348 We can choose incomplete commodification in order to avoid a solution that would "accord with our ideals but cause too much harm in our nonideal world."349

What might an incomplete commodification of the physician-patient relationship look like? Although there are many possible answers to that question, any answer depends on the values we seek to preserve from the marketplace. The key attributes of the doctor-patient relationship, it seems, are the duty of the physician to place the patient's welfare above her own, the related duty to advocate for the best interests of her patient, and the concomitant therapeutic trust in the physician by the patient that is made possible by secure knowledge of the physician's loyalty to him. Any regulatory system which seeks to preserve these attributes strikes a balance of incomplete commodification of the physician-patient relationship.350

D. Incomplete Commodification in Practice

This Article has argued that the law of managed care regulation should avoid an uncritical embrace of the "commercial culture"351 of modern medicine and should instead actively seek to promote the "professional culture" in order to protect the patient from undue overreaching by commercial interests, as well as to protect the physician's ability to advocate for, and take therapeutic action based on, the patient's best interest. Such an approach would address the criticism that the current system of health care regulation focuses too simplistically on whatever problem has captured the attention of the public, the news media, and thus the politicians.352 Rather than a fragmented approach to fixing the shortcomings of our health care system, a regulatory system which

344. Id. at 1911 ("It is as if, when someone is coerced at gunpoint, we were to direct or moral opporobrium at the victim ... and our enforcement efforts at preventing the victim from handing over her money ...").
345. Id. ("[T]his aspect of liberal prophylactic pluralism is hypocritical without a large-scale redistribution of wealth and power that seems highly improbable.").
346. See supra notes 19-21 and accompanying text (discussing the failed Clinton health care reform plan).
347. Radin, supra note 302, at 1915 ("[J]ustice under nonideal circumstances ... consists in choosing the best alternative now available to us.").
348. Id. at 1855 ("[M]any things can be described as incompletely commodified ... [t]hus, we may decide that some things should be market-inalienable only to a degree, or only in some aspects.").
349. Id. at 1918.
350. Id. at 1857 (arguing that in a market-dominated, laissez-faire environment, regulation may equate with noncommodification).
351. See supra notes 8-15 and accompanying text on the conflict between the commercial and professional cultures in modern medical practice.
352. See supra note 49.
maintains at its core a focus on the preservation of the physician-patient relationship from the worst excesses of the marketplace has the potential to produce a more coherent and orderly system of regulation. Although a systematic articulation of the effects of implementation of partial decommodification of the physician-patient relationship is beyond the scope of this Article, this section will sketch the contours of what such a principle might mean in the context of three current health policy debates.

1. Managed Care Financial Conflicts of Interest

A main focus of this Article has been the direct and indirect conflicts of interest created by MCOs through the design of their reimbursement mechanisms for physicians. These incentives are designed to align the interest of the physician with those of the MCO and to alter physicians’ practice patterns in order to induce medical practice that maximizes the MCO’s economic efficiency. 353 A system of incomplete commodification recognizes that there is no realistic way to completely eliminate financial considerations from the practice of medicine. Indeed, from the beginning, medicine has recognized and sought to ameliorate the difficulties inherent in the juxtaposition of the helplessness of the ill and the superior knowledge and bargaining power of the healer. For most of medical history, these issues have been dealt with through systems of professional ethics. 354 Self-regulation is the hallmark of a profession, and, until recently, American physicians have been remarkably free of oversight in the manner and mode in which they practiced their art. In the past decade, oversight has been imposed not only by the government, but by the insurance companies and MCOs that hold the nation’s medical care purse strings. Because these organizations are constrained by neither the professional ethics of the physician nor by the public accountability of government, we should be skeptical of their ability to adequately protect the interests of patients. Careful regulation can enhance both the power of managed care to deliver medical services more efficiently and of physicians to work within an efficiency-driven system to advocate for patients’ best interests, both individually and collectively.

In a previous article, 355 I have advocated an emphasis on the professional duty of the physician to place the interests of the patient first. Analogizing the physician’s relationship to the patient with that of the lawyer to her client, I proposed that states adopt a rule of professional regulation for physicians that mirrors that widely adopted for attorneys—that the physician be ethically and legally prohibited from entering into any relationship with an MCO that

353. See discussion supra Part II.
354. The Hippocratic Oath contains an injunction stating, “Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief . . . .” See Oath of Hippocrates, in 4 ENCYCLOPEDIA OF BIOETHICS 1731 (Warren T. Reich ed., 1978). The American Medical Association speaks to this matter in Section 8.03 of its Code of Medical Ethics: “Under no circumstances may physicians place their own financial interests above the welfare of their patients . . . . If a conflict develops between the physician’s financial interest and the physician’s responsibilities to the patient, the conflict must be resolved to the patient’s benefit.” AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS, reprinted in MEDICAL ETHICS: CODES, OPINIONS and STATEMENTS, at 35 (Baruch A. Brody et al. eds. 2000).
355. Hall, supra note 17.
unreasonably interferes with the physician's ability to act in her patient's best interest.\footnote{Id. at 138-39.}

Such a rule would constitute a partial noncommodification of the physician-patient relationship. It would restrict the range of choices that would be available to physicians and MCOs and limit the availability of "incentives to deny care." At the same time, it would preserve the essentially self-regulated nature of medical practice and avoid unnecessary imposition of specific rules on an ever-changing medical marketplace. It would allow state regulatory agencies to develop a sense of reasonableness of incentives on a case-by-case basis and in a quasi-judicial "common-law" process.\footnote{Id. at 142.} Finally, such a regulatory approach would protect patients from overreaching incentives imposed by MCOs and would give doctors a noneconomic bargaining chip in negotiations with MCOs to avoid those incentives which physicians believe will be detrimental to patient care. Finally, it would avoid the "piecemeal" approach to regulation of managed care in the state legislatures.\footnote{Id. at 140, 142.} Imposition of a reasonableness standard, coupled with a legislative endorsement of the principle of the paramount importance of the physician-patient relationship in the therapeutic process, would provide state regulators with a framework for deciding whether new forms of incentives or reimbursement are in fact unreasonable, which would free state legislators from the need to respond legislatively to each new market innovation.

Although the financial arrangements and incentives contractually agreed to by MCOs and physicians are an important part of the incentive structure created by modern managed care, they are not the whole picture. The remainder of this section will examine two other areas in which health care law and practice create undesirable incentives for physicians, leading to incentives to breach the duty of trust and loyalty contained in the physician-patient relationship.

2. Medical Privacy

A system of regulation that focuses on the preservation of the therapeutic physician-patient relationship will take seriously the protection of physician-patient communications and the concomitant problem of protection of medical information. This requires a careful balancing of interests since both expanded access to medical information has great potential to enhance the therapeutic relationship and the outcomes of treatment.\footnote{See e.g., PocketScript Enables Physicians to Execute Secure Electronic Prescriptions Using Their Blackberry Wireless Handhelds, PR NEWSWIRE, Jan. 7, 2003; Maura Lerner, Private Records, Public Benefit, MINNEAPOLIS STAR TRIB., Dec. 15, 2002, at 1A (describing the use of medical data to improve health outcomes).} With the expansion of information-sharing technologies, physicians and hospitals can now share relevant medical information over great distances in order to tailor medical care to the needs of an individual patient.\footnote{Nicolas P. Terry, Forward: E-Health: Perspective and Promise, 46 ST. LOUIS U. L.J. 1, 1 (2002).} However, the ease of information sharing, coupled with the great potential commercial value of individual medical
data, can lead and has led to abuses. In one widely publicized instance, patients who were prescribed the antidepressant Prozac were surprised to receive in the mail unordered free samples of a new, extended-release form of the drug. The mailing came from the drug’s manufacturer in an attempt to generate patient desire to switch their treatment plan from the short-acting drug to the new, more convenient (and presumably more profitable) extended-release form.

Clearly, this sort of use of private medical data was an abuse of patients’ privacy interests as well as an abuse of the physician-patient relationship, and media commentary quickly focused on the fact that, under the then-pending regulations of the Health Insurance Portability and Accountability Act (HIPAA), such marketing would be unlawful without the express consent of the individuals. However, less dramatic commercial uses of individual medical information are more routine. A regulatory system which values and seeks to preserve the physician-patient relationship would try to prevent physician participation in a direct marketing campaign to patients, particularly when disclosure of a patient’s treatment might be stigmatic or embarrassing to a patient. Failure to adequately protect personalized medical information from inappropriate disclosure and commercial abuse can have a negative impact on patients’ willingness to participate in treatment. Fear of disclosure leads to an unwillingness on the part of patients to accurately and completely disclose their own health status and risky behaviors and may also lead to physicians’ unwillingness to accurately and completely document the patient’s medical history and health status in medical records. Although a system which values the personhood of patients would provide patients with choices as to their

363. See Liptak, supra note 361. It is not clear precisely how prescriptions covering these mailings were obtained. See Glenn Singer, Prozac Maker Suspends Workers Over Free Samples, ORLANDO SENTINEL, July 9, 2002, at C1 (reporting company’s belief that “doctors’ offices generated lists of patients taking Prozac, wrote prescriptions and send [sic] them directly to Walgreens”). The exact number of unsolicited mailings is not known.
364. See Liptak, supra note 361 (“[T]he form letter that accompanied the Prozac was apparently prepared by a sales representative for Lilly; it was signed by the [patient’s] doctor and two other local doctors.”).
365. Id. (“Lilly’s patent for Prozac expired [in August 2001], and the drug’s sales have dropped more than 80 percent as generic equivalents have become available. But Prozac Weekly is still under patent.”).
366. The drug manufacturer in question, Eli Lilly, quickly suspended several of its employees who were involved with the promotion. Singer, supra note 363.
368. 45 C.F.R. § 164.506 (2002). However, it is important to note that even this consent requirement suffers from potentially coercive exceptions—a “covered health provider” can condition provision of services, and a health plan may condition enrollment, on consent to the disclosure of health information. § 164.506(b)(1),(2).
369. See Liptak, supra note 361. (noting that mailing of drugs is “one step beyond” normal pharmaceutical promotional practices, but is “part of the increasing trend for the commercialization of health care information . . . being bought, sold and used like any other commodity”).
370. Goldman, supra note 362, at 399.
371. Id. at 396 & n.11.
medication and therapeutic options, such decisions are best made in direct consultation with a physician, not through commercial solicitations devoid of meaningful physician-patient interaction. In particular, individualized patient medical data should not be in a position to be “bought, sold and used like any other commodity.”

3. Patient Protection Acts

Part of the “backlash” against managed care practices nationwide is the proliferation of “Patient Bills of Rights” or “Patient Protection Acts.” Although such legislation has been stalled in the Congress since the events of September 11, 2001, there has been much activity both before and since then in state legislatures. Because of the potentially sweeping nature of ERISA preemption, and because of the complexity of the Supreme Court’s gloss on ERISA preemption analysis, many of these state protection measures have been, and continue to be, tested in the courts against challenges from MCOs claiming that state patient protections are preempted by ERISA’s limited remedies. Although many patient protection measures have yet to be finally resolved by the courts, recent Supreme Court ERISA jurisprudence suggests a strong disinclination to leave managed care regulation to Congress, and thus a strong desire on the part of the Court to allow states leeway in fashioning regulatory strategies for the managed care industry.

In Pegram the Court refused to hold that an MCO’s financial incentive arrangements were a violation of ERISA’s fiduciary duties imposed on a plan’s administrators. While this denied the plaintiff in Pegram an ERISA remedy, it strongly suggested that the Court would not consider state laws regulating managed care financial incentives to be preempted by ERISA. In Moran the Court held that Illinois’ law mandating external review of an MCO’s decision to deny access to care as “medically unnecessary” was not preempted by ERISA. As of this writing, the Supreme Court is considering a challenge by a managed care industry group to a Kentucky law which mandates that an MCO allow any physician willing to conform to that MCO’s rules and regulations access to the MCO’s network and patient population. These laws, which have been enacted in several states, are generally referred to as “any willing provider” or “AWP” statutes. Managed care organizations oppose these laws because they

372. See David Fassler, Letter to the Editor, Erosions of Privacy and Free Prozac, N.Y. TIMES, July 10, 2002, at A20 (“[P]hysicians should never access or use identifiable clinical information about specific patients for commercial or marketing purposes . . . . [A]ppropriate treatment involves a comprehensive evaluation by a trained and qualified mental health professional.”). For another view, see Liptak, supra note 361, quoting a spokeswoman for one of the defendants in the Prozac lawsuit that “[t]his particular effort . . . . was the result of well-intentioned, respected physicians being given an opportunity to arrange for some of their patients to receive sample medications, at no cost, through proper, licensed pharmacy channels.”

373. Liptak, supra note 361; see also Marsha Austin, Health Care Invasion? Concept Saves Employers Money at Expense of Privacy, DENVER POST, Nov. 10, 2002, at K1 (detailing efforts by employers to gain access to employees’ medical data in order to identify “consumers who may be at risk for developing expensive . . . . medical conditions and pairing them with nurse managers . . . .”).

375. The plaintiff had already won a remedy for medical malpractice in the state court.
interfere with the MCO’s ability to engage in “economic credentialing,” which is, to select for participation in the network only those physicians who have proven an ability to practice cost-effective medicine. In contrast, consumer advocates and other proponents of AWP laws argue that the statutes ensure that an MCO provide sufficient physicians to fulfill its members’ needs, both for a full complement of specialty care and for full geographic coverage of the relevant population.

A regulatory system which is committed to the physician-patient relationship would look favorably on AWP state legislation. One of the “bargains” in the subscriber-MCO contract has been the subscriber’s agreement to give up free choice of physician in exchange for the benefits of MCO coverage. However, this bargain has led to widely reported dissatisfaction, as MCOs change their physician networks frequently and patients have been forced to discontinue longstanding doctor-patient relationships in order to preserve affordable health care. A well-crafted AWP law can address both the needs of the MCO and those of the patient. AWP laws typically require an MCO to permit physicians willing to adhere to the MCOs rules and regulations to participate in that MCO’s provider network. They do not require an MCO to provide network access and reimbursement to any physician without regard to the physician’s cost-effective practice of medicine, nor do they require any particular physician to participate in any particular MCO panel. However, these laws do provide a valuable “safety valve” for patients and physicians in long-term treatment relationships. Ultimately, it is up to the individual physician’s professional ethics and judgment whether to seek inclusion in a managed care panel, and whether a particular MCO’s terms and conditions are ethically and financially acceptable, in order to benefit a patient or group of patients. In many cases, the burden of seeking participation in a new managed care panel and complying with its terms and conditions may not outweigh the benefits to be gained for the patient. However, this decision ultimately should rest with the physician, in consultation with the patient or group of patients affected, not with the MCO. AWP laws protect the patient by allowing her to maintain important doctor-patient relationships, while protecting the interests of the MCO by requiring that any participating physician comply with the terms and conditions established by the MCO for all its participating physicians.

380. See, e.g., Holleman et al., supra note 47, at 22 (describing a case in which “the efforts of physician and patient to cultivate a successful therapeutic relationship ... were undermined by a series of business decisions viewing money, not health, as the bottom line”).
381. See, e.g., Ky. REV. STAT. ANN. § 304.17A-270 (Michie 2001) (“A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer ....”).
382. Holleman et al., supra note 47, at 24.
V. CONCLUSION

Managed care has served a useful purpose in American health law by bringing the shortcomings of the fee-for-service system to the attention of consumers, physicians, policymakers, and others. As the cost savings realized by managed care wane and the political backlash against many MCO practices continues, many have begun to wonder whether the managed care revolution is effectively over and, if so, what sort of health care system will replace managed care. One of the most telling criticisms of managed care is that it has allowed its cost-control function to override, at least in some ways and for some consumers, the fundamental truth of the physician-patient relationship—that the physician’s ultimate responsibility must be to the individual patient. In other words, the market orientation of the MCO has in part supplanted the patient care ethic of medical professionalism. The goal of this Article has been to demonstrate that the market paradigm is ill suited to the physician-patient relationship, and that the relationship between doctor and patient should not, in the final analysis, be one of arm’s length bargaining but of trust and responsibility. Partial decommodification of the physician-patient relationship would be a step toward restoration of patient trust in the health care system as well as in individual physicians, and toward restoration of the satisfaction of physicians in the practice of medicine. We would do well, as we design and implement the next generation of American health care delivery, to keep in mind these goals.

383. Relman, supra note 57, at 750 (“[T]here can be no really satisfactory solution until the medical profession itself faces up to the threat of entrepreneurialism and decides to take a firm stand in defense of professional ethics.”).
384. Id.