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MEDICAL NECESSITY DETERMINATIONS: THE NEED FOR A NEW LEGAL STRUCTURE

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I. INTRODUCTION

A CORE PRINCIPLE UNDERLYING THE U.S. legal structure for health care delivery and finance is being challenged by a new value. That principle is the supremacy of individual patient interests in medical decisions. The challenging value is a societal interest in conserving resources expended on health care. The societal interest has arisen from efforts by managers of health plans to reduce health care costs incurred by their beneficiaries. One of the cost reduction techniques used by health plans is refusal to cover, meaning pay for, medical services deemed to be unnecessary.

Because of the importance of controlling health care expenditures, our legal system has sought to facilitate the exercise of the societal interest in cost reduction. However, our system has also sought to maintain the supremacy of the patient interest in medical decisions. This has been accomplished by treating medical decisions for patients and health plan coverage decisions for plan beneficiaries as independent activities. Coverage decisions are considered to be transactions between the patient and the health plan, and medical decisions are viewed as transactions between the physician and the patient. The two transactions are considered independent because the coverage decision is not supposed to affect the physician’s judgment in medical decisions.

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about what is best for the patient, and a refusal to cover treatment recommended by a physician does not bar the patient from obtaining the services with the patient's own funds.

In many respects, coverage decisions and medical decision making are in fact independent efforts. The range of medical services covered by a health plan is a contractual issue determined by negotiations between the plan managers and the beneficiaries. Disputes between the plan managers and a beneficiary over the extent of coverage are resolved by contract law or, in many but not all states, by the common law or statutory tort of bad faith insurance settlement. The obligation of a physician to provide the medical care that is best suited to the needs of an individual patient is a duty inherent in the physician/patient relationship. Disputes about whether the physician provided appropriate care are resolved by the tort law of malpractice.

However, there is an area where coverage decisions and medical decisions merge. When a health plan agrees to cover health care services, the contract with the beneficiary generally specifies that the services must be paid for when they are reasonable and necessary for the diagnosis or treatment of an illness or injury suffered by the beneficiary. In the event of a dispute between the health plan and the beneficiary about whether covered services should be paid for, a determination about whether the services were reasonable and necessary must be made. This determination, while a coverage decision, is also a medical decision.

As a practical matter, the medical decision made as a part of a coverage decision is not independent from the medical decisions made by the physician and patient. Because medical care can be very expensive, many patients cannot afford to purchase care that a physician recommends but the health plan will not cover and therefore, they have to accept the medical decision of the health plan. The coverage decision becomes the treatment decision. Accordingly, health plans use a variety of techniques to influence or control medical decisions made by physicians.

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1. A health plan is a contract that entitles the beneficiary to payment for liabilities that are covered risks under the policy. See generally 43 AM. JUR. 2d Insurance §§ 187-218 (1982). In about half of the states, the breach of contract remedy that is inherent in contractual relations is supplemented by a common law or statutory tort of bad faith insurance settlements. J. BERTRAM HARNEIT & IRVING I. LESNICK, THE LAW OF LIFE AND HEALTH INSURANCE 1401 (1995).
Determinations about whether medical services are necessary for a patient are often not clear-cut. Medical science is not precise enough to determine exactly what services are reasonable and necessary for the diagnosis or treatment of an illness or injury for every given patient. Given the core principle of supremacy of the individual patient interest, physicians traditionally have been biased towards providing services that might help a patient, especially if the risk of iatrogenic injury has been small or nonexistent. Health plans are now seeking to change the bias towards providing services to a bias towards withholding services unless there is a strong showing of necessity.

This Article argues that treating coverage decisions and medical decisions as independent transactions ignores these realities, and therefore, fails to place appropriate restraints on the trend towards requiring more rigorous showings of necessity. This lack of restraint may cause harm to individual patients who are denied coverage for medical care, and could lead to an overall lower level of quality of care than we as a society may be comfortable with. To prevent this, it is necessary for the law to recognize the true role that health plans play in medical decision-making, and to develop mechanisms to appropriately balance the societal interest in conserving resources with the individual patient interest.

II. THE TRADITIONAL MEDICO-LEGAL SYSTEM FOR HEALTH CARE DELIVERY AND FINANCE — A PATIENT-CENTERED SYSTEM

Under the traditional health care delivery system, health care providers were expected to act in the best interests of the patient, delivering whatever care would be most beneficial to the patient. Insurers paid for such care without question. Three interrelated structures supported this system: (1) professional self-regulation, including ethics and quality assurance, where the guiding principle was supremacy of the patient interest; (2) the not-for-profit orientation of the majority of medical institutions, which was meant to keep patient interests paramount by eliminating profit as a motive; (3) legal doctrines which tended to adopt physician ethics and make the interests of the patient paramount; and (4) health plans that deferred to physician recommendations about what medical care was necessary for patients.
Patient-centered professional ethics, legal doctrines, and not-for-profit medical institutions developed together with health plans, but widespread use of health plans did not take place until after World War II and modern managed care health plans did not become widely used until recent years. Until that time, the patient and physician controlled medical decisions. The malpractice laws and laws governing the physician-patient relationship gave the physician a duty to keep the interests of the patient paramount. Other laws, such as the bar on the corporate practice of medicine, were designed to protect the independence of the physician's judgment. For a century, health plans operated within the context of these principles, and did not attempt to interfere with them.

2. The first insurance policy for medical expenses to treat bodily injuries that did not result in death was written in 1850 by the Accidental Death Association of London, and later that year by the Franklin Health Assurance Company in the United States. By 1860, the Travelers Insurance Company of Hartford was writing policies similar in nature to modern indemnity plans, and 60 other companies joined by 1866. The first employee health benefits may have been a program by Montgomery Ward and Company to provide weekly benefits for sick or injured employees. Health Ins. Ass'n of America, Source Book of Health Insurance Data 1994 1 (1995).

The modern prepaid health plan dates back to the late 1920s. In 1929, school teachers in Dallas, Texas contracted with Baylor Hospital to provide services at a monthly rate. This arrangement is generally acknowledged to have evolved into the Blue Cross and Blue Shield plans. Id. at 2. Health maintenance organizations date back to 1927, when a prepaid plan started as a cooperative in Elk City, Oklahoma. Additional plans evolved around major construction sites. However, as of 1972, fewer than 40 health maintenance organizations were in existence. The trigger for their growth was the Health Maintenance Act of 1973, Pub. L. No. 93-222, Dec. 29, 1973, most of which is codified at 42 U.S.C. 300e, et seq. By 1992, the number of HMOs had grown to 610. Tom James, III & David B. Nash, Health Maintenance Organizations: A New Development or the Employer's Old Clothes?, in Future Practice Alternatives in Medicine 203, 208 (David B. Nash ed., 2d ed. 1993) (noting that while health insurance has existed for over a century, it is generally believed that it did not become widely used until after World War II). See, e.g., Michael G. MacDonald et al., Health Care Law: A Practical Guide § 6.04[2] (1985); Susan M. Browning, Forces for Reforming the U.S. Health Care System: A Review of the Cost and Access Issues, Health Econ., Oct. 1992, at 174. The events which sparked its growth are believed to be favorable tax treatment, substitution for wage increases during World War II, and incorporation into labor management bargaining just after World War II. During the 1970s and 1980s, self-insurance became the dominant kind of health plan used by employers, and managed care became prevalent. Health Ins. Ass'n of America.

3. In fact, many of the first health plans were Blue Cross and Blue Shield plans developed by hospital associations and medical societies and were controlled by leaders in organized medicine. Clark C. Havighurst, Are the Antitrust Agencies Overregulating Physician Networks? Address at Symposium, Consumerism & Competition: Striking A Balance, Loyola University of Chicago, School of Law 304 (Oct. 12, 1995). Therefore it was natural for these health plans to defer to physicians and hospitals in medical decisions.
A. Origins of the Legal Structure — Physician Ethics

Laws designed to keep patient interests sacrosanct evolved out of physician ethical codes, which stretch back for thousands of years. Eight of the 282 Sections of the Babylonian Code of Hammurabi, the first recorded set of laws dating back to 2000 B.C., refer to medical practice.\(^4\) Subsequently, Greeks developed the Hippocratic Oath, which sets forth a statement of ethical ideals to be upheld by medical practitioners.\(^5\) The Oath was incorporated into a code of medical ethics published early in the eighteenth century by Thomas Percival, a physician and philosopher in England.\(^6\) This code served as the foundation for the code of medical ethics developed by the American Medical Association shortly after its formation in 1847.

When the AMA was formed, medicine was not a well-regarded or well-paid profession. Allopathic physicians competed with all sorts of practitioners who were not competent. Some of these incompetent practitioners applied healing techniques that were not based on the scientific method, others were poorly educated, and still others were frauds. In addition, the quality of allopathic physicians was uneven. Competition among all of these healers was fierce.\(^7\) The AMA was established to distinguish al-

\(\text{\textsuperscript{4}}\) Bernard D. Hirsh, Medical Ethics, Law and Economics in HISTORY OF THE JUDICIAL COUNCIL 1 (1985) (on file with the American Medical Association).

\(\text{\textsuperscript{5}}\) Portions of the Oath of Hippocrates, which emphasizes the obligation of the physician to put the patient's interest first, are as follows:

\begin{quote}
I swear by Apollo, the Physician, by Aesculapius, by Hygeia, by Panacea, and by all the gods and goddesses, making them my witnesses, that I will carry out according to my ability and judgment, this oath and this indenture. I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. Neither will I administer a poison to anyone when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein. Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me.
\end{quote}

\(\text{\textsuperscript{6}}\) Thomas Percival's Medical Ethics (Chauncey D. Leake ed., 1927).

lopathic physicians from other healers and gain the confidence of patients. The goal was to implement programs designed to assure patients that physicians were competent and could be trusted to put the interests of patients first.  

The initial program for differentiation was establishment of an ethical code in 1847 that held physicians to a high standard of conduct in the care of patients. Successful lobbying for licensing laws followed during the latter part of the nineteenth century to assure a minimum level of competence among allopaths. At the turn of the century, a system for accrediting medical education was established to weed out poor quality medical schools. These programs successfully established high standards of conduct and quality, and enabled allopathic medicine to become the dominant form of medical practice. The code and the other programs formed the basis for society’s expectations of physicians.

One of these expectations was the supremacy of the individual patient interest in medical decisions. The AMA’s Code of Medical Ethics, revised a number of times over the past 150 years, states that “[a] physician has a duty to do all that he or she can for the benefit of the individual patient” and “[p]hysicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health resources.” Ultimately this
principle was given judicial and legislative recognition in the traditional legal structure for health care delivery and finance.

B. Evolution of the Tort of Malpractice

Over time, courts implied the existence of a contract between physician and patient. The contract is triggered by the establishment of the physician-patient relationship. The elements of this contract are based on physician ethics, as physicians held themselves out to the public as professionals who would behave according to the code. One of the elements of this contract is a fiduciary duty that runs from the physician to the patient. The origin of this duty is the ethical obligation of the physician to make concern for the patient the physician's first consideration, and the obligation of the physician to do all that is possible to benefit the patient.

Malpractice originated as a contract remedy based on the implicit contract inherent in the physician-patient relationship. Failure to exercise the care and skill expected of a physician was considered a breach of the implicit contract and entitled the patient to collect damages. Ultimately, this contract remedy developed into the malpractice tort. This tort is the foundation for the principle that the patient's interest is supreme.

According to Prosser’s treatise on the Law of Torts, the physician is expected to place the interests of the patient above deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Id. at xiv.
14. JOSEPH M. TARASKA, LEGAL GUIDE FOR PHYSICIANS § 2.01 (1994).
15. Id.
17. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 186-
90 (5th ed. 1984) (discussing the liability of physicians).
18. Id.
all other considerations. The standard of care in malpractice litigation enables the court to assure that physicians abide by that principle. It allows the court to second guess the value judgments made by physicians when treating patients, and to impose the court's own value judgments on the profession if appropriate. This power of the court is especially germane to determinations about the necessity of medical care for a given patient, therefore the Article digresses here to give a short explanation of how this works.

The standard must be proven in each case, following the broad guideline that the physician apply the care and skill commonly possessed by a member of the profession in good standing. Each side introduces competing evidence regarding the standard, and the court decides. In a case where the issue is whether the physician failed to provide all necessary care, there are two dimensions to the standard: (a) determining what medical care would have benefitted the patient, and (b) making a value judgment about whether the benefits would have been significant enough to provide in light of all other considerations. Determining the benefits of medical care is handled by physicians — no one else has the knowledge to do so. The value judgment is made by the court.

This was illustrated in *Helling v. Carey*, a case in which a twenty-nine-year-old patient was not tested for glaucoma, but subsequently was found to have the disease and was harmed due to the late diagnosis. The national standard among physicians at the time was not to test for glaucoma in twenty-nine-year-old patients because of the low incidence of the disease in that age group. The court found that the national standard was wrong, and that the patient should have been tested. It made a value judgment in reaching this decision that the consequences to the individual patient of failure to detect the disease were so grave that even young patients should be tested. This case clearly illustrates the ultimate power of the court to make the value judgment about what constitutes necessary care.
C. The Bar on the Corporate Practice of Medicine

Malpractice laws were not considered sufficient to assure the supremacy of the patient interest. Other laws meant to prevent the physician’s judgment from being influenced were also developed. One of these was the bar on the corporate practice of medicine.

As mentioned above, by the end of the nineteenth century, physicians had successfully lobbied for statutes requiring that physicians be licensed in order to practice medicine. Most states required that physicians graduate from a recognized medical school and pass a licensing exam in order to be licensed.

At the same time, certain industries, including railroads, lumbering, and mining, were hiring physicians to treat employee populations. This practice was opposed by leaders of organized medicine, as they feared that working directly for corporations would influence physicians’ treatment methods, diagnoses, incomes, and relationships with patients. Arguments were made that corporate employment of physicians meant that the corporations were actually practicing medicine; since state licensing statutes required licensure of an individual, not a corporation, such employment should be barred.

The courts adopted the position of organized medicine and banned the corporate practice of medicine as violative of state licensing statutes. Much of the rationale for the bar was based on the different fiduciary duties of the corporation and the physician. Courts pointed out that the fiduciary duty of the directors, officers, and managers of the corporation runs to the shareholders, whereas the duty of the physician is to the patient. The corporation, therefore, had a conflict of interest when it attempted to practice medicine while physicians did not. Therefore, corpora-

23. Fishbein, infra note 8 and accompanying text.
25. Id. at 456-57.
26. See Berlin v. Sarah Bush Lincoln Health Ctr., No. 95-MR-7, slip op. at 7-8 (5th Cir. Ill. June 15, 1995) aff’d 664 N.E. 2d 337 (Ill. 1996) (stating that to permit a corporate entity not organized under the Medical Practice Act to enforce a contract against a licensed physician would be contrary to Illinois legislation); see also Dr. Allison, Dentist, Inc. v. Allison, in which the Illinois Supreme Court stated:
To practice a profession requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by a duly qualified human being, and to qualify something more than mere knowledge or skill is essential. The qualifications include personal characteristics, such as honesty, guided by an upright conscience and a sense of loyalty to clients or patients, even to the extent
tions were prohibited from practicing medicine through licensed employees or from realizing profits from a physician’s professional ministrations.\(^{27}\)

Eventually statutes passed in virtually every state allowed physicians to form professional service corporations to gain the benefits of limited liability afforded by the corporate form of business organization.\(^{28}\) However, this limited liability was found by the courts not to extend to malpractice liability.\(^ {29}\) The rationale is that physicians have a special and confidential relationship with their patients, the consequences for negligent or wrongful acts by physicians towards their patients can be very serious, therefore physicians should be held to high standards of conduct and made vulnerable to personal liability.\(^ {30}\) In other words, the courts felt that it was so important that physicians put the interests of the patient first that they should not be personally shielded by the corporate form.

D. Development of the Autonomous Hospital Medical Staff — Hospital Licensing Laws and Deeming of JCAHO Accreditation

While the medical profession was developing, hospitals were evolving as well. Hospitals developed a corporate legal structure that had the potential to remove the ultimate power over medical decision making of patients staying in the hospital. The same concerns that were raised about other corporations were raised about hospital control over physicians. These concerns were resolved by requiring hospitals to have a separate, organized medical staff responsible for the medical management of patients in the hospital.\(^ {31}\)

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29. 18A A.M. Jur. 2d Corporations § 854.

30. Id.

31. This requirement, established in 1919 by the founders of the hospital accreditation
The hospital medical staff controls the review and credentialing of each physician by his or her peers. Review of physician behavior and satisfaction of professional standards, therefore, is made by the physician's peers, not by lay persons, including judicial lay persons. So long as physicians follow the medical staff bylaws, including any procedural requirements, courts will not second-guess the professional analysis performed by physicians upon their peers.\footnote{Rao v. St. Elizabeth's Hosp., 488 N.E.2d 685 (Ill. App. Ct. 1986) (upholding right of hospital to use peer review rather than judicial review).}

Physician self-governance is based on the belief that "[P]hysicians' fiduciary responsibility extends to ensuring that other professionals or organizations to which the physician refers patients are worthy of their trust. This includes responsibility for the quality of the care in hospitals or other institutions to which their patients are admitted."\footnote{INSR. OF MNL. NAT'L ACAD. OF SCI., FOR-PROFIT ENTERPRISE IN HEALTH CARE 182 (1986).}

E. The Bar on Fee Splitting

The bar on fee splitting is designed to protect the physician's judgment from corrupting influences. It is based on an ethical rule that fee splitting violates public policy because the public is best served by recommendations uninfluenced by financial considerations.\footnote{See O'Hara v. Ahlgren, Blumenfeld & Kempster, 537 N.E.2d 730 (Ill. 1989) (holding that fee sharing arrangement between attorneys and non-attorneys is against public policy).}

The danger inherent in fee splitting is that it may motivate individuals to recommend the services of a professional out of self-interest, rather than out of the competence of the physician.\footnote{Morelli v. Ehsan, 756 P.2d 129 (Wash. 1988).} Accordingly, statutes have been adopted that prohibit dividing any fee or commission received from provision of professional services by a physician with anyone other than physicians with whom the individual practices.\footnote{See, e.g., ILL. ANN. STAT. ch. 225, § 60/22(A)(14) (Smith-Hurd Supp. 1995).} This means physi-
cians may not share, pool, or divide fees unless the arrangement falls within a specific enumerated exception, such as shared practice or concurrently rendering patient care (when the patient has full knowledge of the fee division).

F. Fraud and Abuse in Medicare and Medicaid

Bars on fraud and abuse are also meant to prevent the physician from being corrupted by financial considerations. They are intended to discourage over-treatment or inappropriate care and to safeguard the physician-patient relationship. The federal fraud and abuse statute applies only to the Medicare and Medicaid programs; nevertheless, it is quite broad. A violator is anyone who "knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind . . . in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service." If even one purpose of a payment can be inferred to be the inducement of referrals, then a violation of the law has occurred.

1. Statutes Barring Self-Referral

To further protect the public from cost overruns and overtreatment, Congress in 1989 passed a bill prohibiting physicians from referring Medicare patients needing tests to clinical labs in which the physicians had a financial interest. This law was expanded in 1993 to cover Medicaid patients and to cover ten additional service categories, including physical therapy services, radiology services, durable medical equipment, prosthetics, home health services, outpatient prescription drugs, and the like. Known as Stark I and Stark II, the laws subject violators to fines

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38. 42 U.S.C. § 1320a-7b (1994). Penalties for violation are both civil — fines of up to $25,000 — and criminal — up to five years of imprisonment — in nature and can include suspension of a provider from the Medicare and Medicaid programs.
42. Id. § 1395nn(b)(6).
of up to $15,000 per prohibited referral. In addition, some states have also enacted self-referral bans.

2. Economic Structures

The traditional indemnity health insurance system developed in the context of the law and ethics described above. Under that system, patients had the freedom to choose any physician or other provider. Any physician or provider could participate and receive payment from the insurer. The insurance company, or payor, had an obligation to pay for all health care that was reasonable and necessary for the diagnosis or treatment of an illness or injury. Except in unusual circumstances, judgment of the treating physician was the accepted standard for establishing that a treatment was medically necessary; no utilization review existed. Payors did not have an obligation to furnish care or to assure the quality of care. Non-profit institutions such as Blue Cross and Blue Shield adopted and supported this system, and this structure was also adopted by the Medicare and Medicaid programs.

III. THE EMERGENCE OF THE SOCIETAL INTEREST AND THE CONFLICT WITH THE PATIENT INTEREST

The traditional medico-legal structure worked well for decades. However, advances in medical technology have made health care substantially more expensive relative to when our traditional medico-legal structure was first developed. Today, fi-

43. A model group health indemnity insurance plan and discussion about the provisions thereof may be found in 2 HARNETT & LESNICK, supra note 1, at 6A-1. A review of this model and the annotations shows that the only obligation of the plan is to pay for covered care incurred by the beneficiaries.

44. See ROBERT D. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 10-28 (1963) (tracing the development of Blue Cross and Blue Shield's medical care coverage from 1929 to 1962).

45. The "traditional" Medicare program operates much like a traditional indemnity insurance health plan. It allows patients free choice of providers anywhere in the United States, physicians are paid on a fee-for-service basis, and there are few prospective utilization controls. See MACDONALD ET AL., supra note 2, § 7.03, at 7-23.

46. There is growing recognition that advances in technology are a primary reason for the rapid increase in health care expenditures. William B. Schwartz, The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief, 257 JAMA 220, 222 (1987). See also Richard A. Rettig, Medical Innovation Duels Cost Containment, HEALTH AFF., Summer 1994, at 7, 8-9; Alan M. Garber, Can Technology Assessment Control Health Spending?, HEALTH AFF., Summer 1994, at 115, 117.

47. At one time, most Americans could afford treatment for even serious illnesses or injuries, simply because there were so few adequate solutions for health care problems.
nancing the treatment of a serious illness or injury from one's own resources has become difficult or impossible for most Americans.\textsuperscript{48}

Over the past fifty years, most Americans became reliant on health plans to finance their health care. Health plans solve the affordability problem by enabling individual Americans to finance the treatment of serious illnesses or injuries.\textsuperscript{49} However, this solution causes health plan participants to become interdependent. A conflict emerges between the interests of an individual plan participant and the interests of the participants as a group, for as the amount spent by the health plan on the care of one participant increases, the amount left to pay for the care of other participants decreases.\textsuperscript{50}

One way of resolving this conflict is to fund the coverage pool with enough money to pay for all the care that is needed. However, conflicts then emerge over uses for money. As the amount of money needed from a participant to fund the pool increases, that participant has less money available for other desirable or necessary purposes. At some point individual participants become unwilling or unable to sacrifice expenditures for other purposes in order to contribute enough money to the pool to pay for the care that is desired by other participants. A participant seeking to draw money from the pool then comes into conflict with other participants who have other uses for the money that could be paid into the pool.

\begin{footnotesize}
\textsuperscript{48} It is still possible for most Americans to afford care for simple health care problems, although many have lost the habit of budgeting for it due to the existence of health insurance. See Center for Health Policy Research, American Med. Ass’n, Socioeconomic Characteristics of Medical Practice 1995, 96-97 (Martin L. Gonzalez ed., 1995) (illustrating the average cost for a visit to a physician in the United States).

\textsuperscript{49} Health plans have also been the source of funds necessary to fuel rapid advances in technology that, in turn, have caused rapid increases in health care expenditures. Garber, supra note 46, at 116-17.

\textsuperscript{50} If it were always possible for the individual to solve a serious conflict with the group by paying for the health care involved, the existence of this conflict would not be a great concern. However, when the conflict is greatest, it is the least likely that the individual can pay. In the context of government health plans, the issue is the provision of care for the poor, the disabled, and the elderly. Matthew Menken, Caring for the Underserved: Health Insurance Coverage Is Not Enough, 48 ARCHIVES NEUROLOGY 472, 472 (1991).
\end{footnotesize}
When this conflict is viewed in aggregate, it can be seen as a conflict between the interests of the individual and the interests of society. At any given point in time, there is a finite amount of resources available in society as a whole. Many uses compete for the available resources.\textsuperscript{51}

This conflict always existed. However, the conflict did not emerge as a serious issue for many years because the cost of health care was low enough that it could be absorbed with affordable contributions to the pools. But now health care costs are increasing faster than the ability or will of Americans to pay for health plans,\textsuperscript{52} and health care is accounting for a larger and larger share of the society's resources.\textsuperscript{53} As a result, health plan managers are seeking ways to rein in health care expenditures. The search for cost controls has sharpened the conflict between the needs of individual patients and the group.

Some methods used by health plan managers to reduce costs compromise the needs of an individual patient in favor of preserving the pool of funds available to pay for care for the rest of the beneficiaries. Some of these methods, such as limitations on the kinds of illnesses or injuries that will be paid for, or limitations on the amount of money that will be paid for the care of a beneficiary, do not challenge the core values of our legal structure for health care delivery and finance because they do not concern medical decision making.\textsuperscript{54} They are strictly a matter of


\textsuperscript{52} Id.


\textsuperscript{54} Health plan managers generally try to find ways to reduce costs that preserve the core value of placing the interests of the individual patient first. Edward B. Hirshfeld, The Health Care Industry's Transformation and the Antitrust Laws in ANTI TRUST AND THE EVOLVING HEALTH CARE MARKETS 9-16 (Edward B. Hirshfeld et al. eds., 1995). For example, rather than cutting back on necessary medical services, managers try to eliminate fraud and encourage providers to form networks that operate more efficiently. The drive for efficiency has resulted in fundamental changes in the way that health care delivery is organized. The industry is rapidly moving from an atomized "cottage industry" format to aggregations of providers.
insurance contract about the extent of insurance coverage that an individual is willing to buy.

Other methods do challenge the core values of our legal system. One of these is the elimination of unnecessary care. The object is to prevent expenditures on health care that are not necessary for the diagnosis or treatment of an illness or injury. However, to eliminate unnecessary care requires that the difference between necessary and unnecessary be defined. That ultimately involves weighing the interests of the individual against the interests of the group.

IV. DEFINING THE CONCEPT OF MEDICAL NECESSITY

The concept of controlling costs by eliminating unnecessary medical care arose from research performed by physicians about the comparative rates at which the same medical services were provided to comparable populations in different geographic areas. These studies revealed that different populations received services at different rates, but the overall health of the populations did not differ. From this empirical evidence it was inferred that the populations receiving medical services at higher rates were receiving a certain amount of unnecessary care, meaning services that did not improve the health of the population. It was also inferred that the volume of unnecessary care was significant.

This research was borne out by further studies which compared medical records for patients receiving certain kinds of medical services with a list of symptoms and conditions that indicate when those services should be provided. It was found that the services were being provided to some patients who did not display the indicated symptoms and conditions. From this evi-


56. Id. at 42-43 (analyzing the use of practice guidelines as a tool to reduce inappropriate care and to help control costs). See generally William L. Roper et al., Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice, 319 NEW ENG. J. MED. 1197, 1200 (1988) (reviewing patient outcome studies and the line to practice patterns); but see John T. Kelly & Shirley E. Kellie, Appropriateness of Medical Care: Findings, Strategies, 114 ARCHIVES PATHOLOGY & LABORATORY MED. 1119, 1119-20 (1990) (summarizing current literature concerning inappropriate medical services that questions whether a significant proportion — up to 20% — of medical care is actually unnecessary, even though only 2% of claims reviewed by Medicare Peer Review Organizations were found unnecessary).

57. Constance M. Winslow et al., The Appropriateness of Performing Coronary Artery Bypass Surgery, 260 JAMA 505, 507 (1988) (arguing that inappropriate surgeries are some-
It was inferred that significant numbers of patients who did not display the indicated symptoms were receiving the services unnecessarily.\(^5\)

This research raised the question of why physicians were providing significant amounts of unnecessary care, and whether that phenomenon could be corrected. One possible explanation for the provision of unnecessary care was fraud and self-interest, as under the traditional health plan, physicians make more money if they provide services than if they do not. Certainly that does occur, and the amount of unnecessary care provided due to fraud or self-interest is significant. But, according to the researchers, that is not the primary reason for the provision of unnecessary services. They concluded that the primary cause is lack of knowledge.\(^5\)

There is lack of knowledge for two reasons. One is that much of medical science is based on the collective experience of physicians and has never been subjected to rigorous analysis with outcomes studies. Such studies attempt to measure the extent to which a service helps a patient return to normalcy after an illness or injury. Therefore, the real benefits of many services are uncertain.\(^6\) Second, there is a huge base of medical knowledge available in medical literature, and that base of knowledge is expanding at a prodigious rate. The vehicles for disseminating that knowledge are poor, and even if better disseminated it would be impossible for physicians to master all of the data.\(^6\)

These conclusions led to a movement to develop practice guidelines for physicians. Practice guidelines are intended to be statements about the best medical practice for handling a given illness or injury that are distilled into a form that is easy to disseminate and easy to use. The purpose of the guidelines is to

\(^{58}\) Leape, supra note 55; Roper et al., supra note 56; Kelly & Kellie, supra note 56.

\(^{59}\) Leape, supra note 55, at 43 (concluding that physicians may provide inappropriate and unnecessary medical care when they base their decisions on inadequate information).

\(^{60}\) Id. (mentioning the numerous factors that are used to assess the benefits of clinical services).

\(^{61}\) Id. (assessing the difficulty in sorting out useful information from an overwhelming volume of clinical irrelevancies).
eliminate unnecessary care and to enhance the quality of care by improving the medical knowledge that is readily available to practicing physicians. Guidelines are created by subjecting the services available to diagnose or treat an illness or injury to rigorous analysis. This is done by conducting outcomes studies and/or evaluating all available medical knowledge about the subject. This information is then distilled into the guideline.62

Many organizations are attempting to draft practice guidelines, including an agency of the federal government.63 However, the movement is still in its early stages, and many problems need to be resolved before practice guidelines will be widely used to guide the treatment of most medical conditions. One of the most serious practical problems is the lack of an adequate base of outcomes studies to determine the benefits of many health care services.64 These studies are time-consuming and expensive to conduct, and it may not ever be possible to have all of the studies that are needed to answer questions about the benefits of medical services.

Another problem is the enormous variability in patients. Different individuals react differently to illnesses and injuries and the treatments available to resolve them. It is extremely difficult


63. The Agency for Health Care Policy and Research (AHCPR) and a unit of AHCPR called The Forum for Quality and Effectiveness in Health Care joined forces to pursue the development of practice guidelines, among other matters. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 § 6103, 103 Stat. 2106, 2189 (codified at 42 U.S.C.A. §§ 299, 299b-1 to -3) (1991 and Supp. 1995). Other organizations that are involved in the development of practice guidelines include the AMA Practice Parameters Partnership (comprised of 14 of the largest medical specialty societies, the AHCPR, the JCAHO, and the AHA) responsible for coordinating the activities of the medical profession with regard to practice parameters, and the AMA Practice Parameters Forum (comprised of more than 80 physician organizations and others), which provides the scientific expertise and broad-based clinical representation necessary to ensure the development of scientifically sound, clinically relevant practice parameters.

64. Alice G. Gosfield, Clinical Practice Guidelines and the Law: Applications and Implications, in HEALTH LAW HANDBOOK 65, 86 (1994) (discussing the increased scrutiny on clinical providers due to health care reform and the implications of the policies instituted due to the increased scrutiny).
to account for this variability in developing practice guidelines. As a result of the lack of outcomes studies, the variability of individual patients, and other problems, substantial uncertainty about the benefits of proposed medical care for a given individual still exists. That raises the question of whether it is possible to draft practice guidelines with a high degree of precision about what medical care is necessary.

V. HEALTH PLANS ARE ENGAGED IN MAKING VALUE JUDGMENTS IN THEIR NECESSITY DETERMINATIONS

Health plans are aware of the research into medical necessity and the practice guidelines movement. The cost problem is so great that they have applied procedures designed to determine the necessity of medical care recommended for their beneficiaries. The goal of these determinations is to provide the minimum amount of health care necessary to resolve a health care problem and to pay for those services, and for only those services. If the provision of a medical service will not improve the outcome, then health plan managers consider that it is not necessary, and should not be covered. However, making necessity determinations requires that health plans engage in making value judgments that weigh the needs of the individual against the needs of the group.

Health plans have tried to define the necessity determinations in a way that avoids value judgments. They have done so by arguing that the minimum amount of health care necessary to resolve a health care problem is the optimal amount of health care that a patient should receive. It is argued that if the provision of an additional unit of health care does not improve a patient's outcome, then the provision of that unit of health care actually harms the patient. Harm allegedly occurs because the patient is exposed to the risk of iatrogenic injury without any commensurate improvement in outcome. It is theorized that the relationship between the provision of additional medical services and outcome is a curve, whereby the provision of additional medical services improves the outcome until an optimum point is reached, after which the provision of still more services ad-

Use of this analysis reconciles the needs of the individual with the needs of the group. It makes efforts by payers to determine medical necessity a process to find the optimal amount of health care for a patient and prevent the patient from being harmed. Instead of being a process where the individual patient who might be denied care is put at risk, necessity determinations are defined as a process that protects patients.

However, this way of defining necessity is based upon fiction. Medical science is not nearly precise enough to determine the optimal point for a given patient in most cases. There simply is not enough accumulated medical knowledge about either the benefits or the risks of most medical care to make that determination. It also does not appear likely that the science of medicine will advance enough in the foreseeable future to achieve that kind of precision. For now and the foreseeable future, medical

decisions involve a substantial amount of uncertainty about what will help and what may actually harm a patient. When health plans make or influence necessity determinations, they are engaged in making value judgments that weigh the interests of the individual against the group.

VI. THE VALUE JUDGMENTS INHERENT IN NECESSITY DETERMINATIONS — WEIGHING THE SOCIETAL INTEREST AGAINST THE PATIENT INTEREST

There are several kinds of value judgments that have to be made in necessity determinations. Examples are described below.

While some medical services clearly benefit patients by resolving their health care problems, and others clearly do nothing to resolve the same problems, still others provide a marginal benefit, meaning that they are of some help but do not cure the illness or heal the injury. The question arises when the benefit is too small to be worth the expense of providing it. This kind of value judgment pits the needs of the individual against the needs of the group or society.

Some medical services yield dramatic benefits to certain individuals but none to others, and it may not be possible to know who will benefit until the services are provided. For example, mammography is a diagnostic test used to detect breast cancer. The benefits of early diagnosis are dramatic — survival rates increase significantly. However, it is not possible to know who will benefit from the test before it is given since its purpose is detection. It is possible to identify women more at risk for cancer than others, but even some women without the risk indicators get the disease. The value judgment is whether it is worth the expense of providing mammography to low-risk women. Deciding on a threshold is a value judgment that pits the needs of the individual against the needs of the group.

Still other medical services have a risk of serious iatrogenic injury to a small number of individuals. More expensive alternative services eliminate the risk, but it is impossible to know who is at risk in advance. An example is the use of contrast agents for radiographic tests. One kind of contrast agent is low-cost, but

a small number of patients have an allergic reaction to it that can cause death. It is not possible to know who they are in advance. An alternative kind of agent does not produce allergic reactions, but is substantially more expensive than the low-cost agent. The value judgment is whether it is worth the expense of using the high-cost agent for all patients to avoid risk to a small number of patients.\(^68\)

Since the extent of the benefits of providing medical care are often uncertain, physicians prefer to build a safety margin into their recommendations. When diagnosing a patient, physicians like to have as much information as possible, and therefore, they conduct diagnostic tests. When a patient has been hospitalized due to an illness, injury, or to receive a medical procedure, physicians like to have the patient in the hospital during the most difficult phases of recovery. Complications are likely to be noticed sooner and help is close by in the event of an emergency. Providing services increases the safety margin for the patient.

As safety margins are narrowed, it is likely that most of the patients in a health plan will not be harmed as a result, but the risk that one or more individual patients will be harmed increases. Reducing the margin of safety makes more money available for care needed by the group as a whole, but it places individual members of the group at risk. The value judgment that needs to be made is how much of a risk is acceptable, knowing that some individuals are going to be harmed as the degree of risk increases.

Ultimately, medical necessity can be thought of as a continuum, whereby services at one end of the continuum are clearly necessary for the diagnosis and treatment of an illness or injury, and services at the other end of the continuum are clearly unnecessary, but in between are services that have some degree of likelihood of benefiting a patient.\(^69\) As one moves along the continuum from clearly necessary to clearly unnecessary, the percentage of likelihood of a benefit from the provision of the health care involved decreases. The value judgment that must be

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made is how large the percentage of likelihood of a benefit should be for care to be provided.\textsuperscript{70} The closer that percentage is to 100\%, the more likely it is that some individuals will be harmed by the withholding of care that could have benefited them.

While value judgments have to be made to apply the concept of necessity in medical decision making, our society still does not have any express standards for doing so. For example, there is no commonly agreed upon percentage at which the likelihood of patient benefit makes providing medical care worthwhile.

Under the traditional medico-legal structure, the patient, in consultation with a physician, decided how high the percentage of benefit should be before receiving care. That enabled the process of making the value judgment and the result of the value judgment to be highly patient-centered. The lack of standards for use in making the value judgment was not perceived as a serious problem because each patient was able to make the value judgment about the patient's care.

Now that power is being taken away from patients and is being determined by health plan managers acting on behalf of the insured group. The societal interest is being incorporated into the value judgment. Health plans are proceeding along an undefined path in applying concepts of necessity to medical decision making. Each plan has substantial latitude for how it defines necessity, and different plans proceed in varying ways.

VII. TECHNIQUES USED BY HEALTH PLANS TO INJECT THE SOCIETAL INTEREST INTO NECESSITY DETERMINATIONS

Numerous techniques are used by health plans to eliminate unnecessary care. These are effective at injecting the societal interest into necessity determinations.

The techniques can be divided into two major categories. One category enables the health plan actually to make medical decisions for individual patients or to directly influence such medical decisions. These techniques can put the physician and patient at odds with the health plan, as the health plan may re-

\textsuperscript{70} Hirshfeld, supra note 20, at 1828-31 (discussing the difficulty of establishing a standard of care when the benefits derived vary from case to case).
fuse to pay for medical treatment that a physician recommends for the patient and the patient may want. The result of the application of these techniques can be a clear confrontation between the patient interest and the societal interest, where the physician represents and advocates the patient interest and the health plan represents and advocates the societal interest. The conflict is visible to the patient and to society as a whole.

Other techniques indirectly influence medical decision-making. They enlist the physician to adopt the societal interest in medical decisions. The physician is given incentives to practice in a way that minimizes the use of medical resources. These incentives align the interest of the physician with the interest of the health plan in guarding the societal interest. This can cause both the health plan and the physician to be at odds with the interests of the individual patient. It also minimizes open conflict between the patient interest and the societal interest, primarily because it makes the incorporation of the societal interest into medical decision making less visible to the patient.

Indirect techniques are generally believed to be more effective than direct techniques, because indirect techniques enlist the physician on the side of the societal interest. Therefore, use of indirect techniques is growing and they are expected to predominate in the near future. Examples of both types of techniques are described below.

A. Direct Influences Over Medical Decision Making

Techniques that directly involve health plans in medical decision making include prospective and concurrent utilization review, case management, and the required use of practice guidelines.

Utilization review requires patients and physicians to obtain authorization from the health plan prior to the provision of medical services. If authorization is not obtained, the services will not be covered. These techniques are generally used for expensive services such as hospitalization. They give the health plan an opportunity to review and override the recommendation of the physician if the health plan disagrees with its necessity. Application

of these techniques is very visible to the patient. The physician can remain patient-centered and advocate for the patient before the health plan.

Case management involves the assignment of an agent of the health plan to direct the provision of care to health plan beneficiaries with serious illnesses. The manager may direct that certain providers be used who apply an agreed upon course of treatment. Like the utilization review techniques, case management directly involves the health plan in decision making for individual patients, and is visible to the patient.

Required use of practice guidelines involves mandating that physicians follow certain guidelines promulgated by the plan as a condition of participation in the health plan. Failure to follow the guidelines can cause the physician to be terminated from participation. This technique does not directly involve the plan in medical decision making for individual patients, and it is less visible to the patient, but it does restrict the ability of the physician to be patient-centered. The physician also has an incentive to comply with the mandate — comply or face termination from the plan — and becomes more closely aligned with the societal interest.

B. Indirect Influences on Medical Decision Making

Indirect influences on medical decision making include the use of physician profiling to monitor physician performance and the use of financial incentives. Some of these techniques enable the health plan to compel the physician to adopt the societal interest, others give the physician a strong incentive to adopt the societal interest.

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72. Peter R. Kongstvedt, Changing Provider Behavior in Managed Care Plans in The Managed Health Care Handbook 91, 91 (Peter R. Kongstvedt ed., 2d ed. 1993); Vogel, supra note 66, at 52-53 (1993) (asserting that utilization management has been proven to increase the quality of care and cut costs).

73. Memorandum from Dr. E. Freidherm, Chairman of the Board, Illinois State Medical Society and C. Jonathan Shattuck, Senior Vice President of Health Care Affairs, Blue Cross/Blue Shield of Illinois to Illinois Physicians (Feb. 24, 1994) (discussing practice guideline implementation by Blue Cross/Blue Shield). See also Jim Montague, Illinois Blue Cross and Blue Shield Medical Director Arnold Widen, HOSP. & HEALTH NETWORKS, Feb. 20, 1993, at 50.
Physician profiling involves keeping data about the treatment decisions of an individual physician, and comparing that data with the profiles of other physicians or with practice guidelines.\textsuperscript{74} Physicians who recommend more medical services than their peers, or who appear to be practicing outside the scope of practice guidelines, are informed of this and are asked to change their practice patterns to become more closely aligned with the societal interest. Physicians who do not change their patterns after being given an opportunity to do so may be terminated from the panel. Sometimes plans terminate physicians who recommend more services than others without giving them an opportunity to modify their practice patterns.\textsuperscript{75}

The profiling technique does not involve the health plan in medical decisions for individual patients, and it is not visible to the patient. However, this technique influences how physicians practice, and it restricts the ability of the physician to be patient-centered. It is particularly effective in eliciting physician cooperation in markets where there is an oversupply of physicians, as physicians in such markets fear that they will not be able to practice medicine if they are terminated from the panels of health plans. Application of the profiling technique, together with the threat of termination in markets with a physician surplus, strongly aligns the physician with the societal interest.

Financial incentives include fee withhold arrangements, capitation, and others. Health plans using fee withhold arrangements set goals for participating physicians for the use of resources. A portion of the physician’s fee for each patient encounter is withheld, ranging from fifteen percent to thirty percent, and is paid to the physician if the goal for resource usage is met. If the goal is exceeded, then the amount withheld is kept by the plan. The intensity of the incentive to withhold care experienced by the physician depends on a number of factors that vary from arrangement to arrangement, such as the number of patients involved, the number of physicians subject to the withhold arrangement,


\textsuperscript{75} American Med. Ass’n, Deselection Predilection, Medical Staff and Physician Organization Legal Advisor, Mar. 1994, at 1 (discussing the increasing practice of deselection of physicians from plans without notice or disclosed criteria).
the time period over which the resource usage goal is set, and the percentage size of the withhold.\textsuperscript{76}

Financial withholds are generally not visible to the patient, and do not bring the patient directly into conflict with the plan. However, because the intensity of the incentive to withhold is often low in these arrangements, they may not strongly align the physician with the societal interest. As a result, withholds are usually combined with utilization review, profiling, and/or the threat of termination. Combining these techniques can influence the physician to be strongly aligned with the societal interest.

Capitation involves assigning patients to a physician and paying the physician a flat amount of money for each patient for a set period of time. The result is a pool of funds that is received by the physician. Payments are usually made to the physician on a per member, per month basis. If the patients assigned to the physician use less money than is in the pool, then the physician profits for that period of time. If the patients use more resources than the money in the pool, then the physician loses money.\textsuperscript{77}

Capitation is a powerful means of aligning the physician with the societal interest. The financial interests of the physician then coincide with the health plan, because the physician loses potential profit every time the physician provides services for the assigned patients.\textsuperscript{78} There is significant variation in capitation

\textsuperscript{76} See, e.g., Arnold Milstein et al., In Pursuit of Value: American Utilization Management at the Fifteen-Year Mark, in \textit{Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions} 371, 374 (1991) (finding that physician behavior was not modified by a 10\% withhold applicable only to a small number of patients); María K. Gordon & Randall P. Herman, \textit{Appropriate Reimbursement Methodologies for Managed Care Systems}, in \textit{Making Managed Healthcare Work: A Practical Guide to Strategies and Solutions} 331, 337-39 (1991) (suggesting that if physicians do not expect a withhold to be returned to them, they may view the withhold as a discount on fee-for-service and increase the volume of services they provide to patients in order to increase their total reimbursement); Alan L. Hickman et al., \textit{How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations}?, 321 \textit{New Eng. J. Med.} 86, 90 (1989) (asserting that the higher the proportion of HMO patients in a physician's practice, the greater the likelihood of his knowledge of HMO practices); Stephen H. Moore et al., \textit{Does the Primary-Care Gatekeeper Control the Costs of Health Care? Lessons from the SAFECO Experience}, 309 \textit{New Eng. J. Med.} 1400 (1983) (suggesting that small financial incentives do not change physicians' behavior); Letter from Mark J. Horoschak, Assistant Director, Federal Trade Commission to Paul W. McVay, President, ACMG, Inc. (July 5, 1994) (on file with the American Medical Association).


\textsuperscript{78} \textit{Id.} at 8 (describing the risks of lost profits resulting from capitated payments).
which can vary the intensity of this technique. For example, a physician may contract to accept capitation for a limited set of services. It may benefit the physician to refer patients to other providers as much as possible in order to avoid the expense of caring for the patients involved.

Alternatively, the physician may accept capitation for more services than the physician can provide, and may subcontract with other providers to provide the additional services. The physician profits more if the physician does not have to refer the patient to these other providers. This kind of arrangement, sometimes called "global capitation," gives the physician a powerful incentive to minimize the amount of care that the physician provides to patients and to minimize referrals to other providers. Global capitation strongly aligns the interests of the physician with the societal interest. The nature of the alignment is not visible to the patient.

Different kinds of health plans are characterized by the kinds of techniques that they use to eliminate unnecessary care. The traditional indemnity health plan does not use any of these techniques and relies entirely on physician judgment to determine what is necessary. Managed indemnity plans generally apply utilization review, and may also apply case management procedures or mandated practice guidelines. The preferred provider organization (PPO) generally applies the aforementioned techniques and also restricts the size of its panel — physicians who do not incorporate the societal interest in their medical decisions are likely to be terminated from the panels. Health maintenance organizations use all of the aforementioned techniques and financial incentives. Some limit themselves to fee withhold arrangements, others use capitation.

Use of techniques to eliminate unnecessary care also affects the choice of providers that is available to patients. Under traditional indemnity plans and managed indemnity plans, patients generally have an unlimited choice of providers. PPOs also allow unlimited choice, but the patient has a financial incentive to use

80. See generally CONGRESSIONAL BUDGET OFFICE, EFFECTS OF MANAGED CARE: AN UPDATE 1 (1994) (describing procedures used by different health care organizations to cut costs and reduce unnecessary health care).
the providers that are on a panel selected by the PPO. The patient is reimbursed a larger percentage of the cost of care when using a PPO provider than when using a non-PPO provider. When the care provided is expensive, the use of a non-PPO provider may be prohibitively expensive for most patients.

Health maintenance organizations (HMOs) restrict the choice of providers available to those on its provider panel. In addition, most HMOs assign patients to a primary care physician known as the “gatekeeper,” and patients must see the gatekeeper for all health care problems. The patient may not initiate a visit to a specialist without seeing the gatekeeper; all visits to specialists must be authorized by the gatekeeper. Further, the choice of primary care physicians and specialists available to patients varies according to the type of HMO. Some HMOs contract with associations of independent physicians known as independent practice associations (IPAs) to deliver care, and these associations often have very large panels of physicians. Other HMOs contract with a single multispecialty group practice to provide care, and still others employ the physicians that provide the bulk of care to the HMO patients.

The purpose of restricting patient choice is two-fold. As discussed above, limiting the number of physicians induces them to identify more with the societal interest being promoted by the health plan. Restricting patient choice to those physicians assures that the health plan will not have to pay for health care rendered by providers who do not identify with the societal interest.

VIII. NECESSITY DETERMINATIONS UNDER THE MARKET MODEL

Necessity determinations are not made in a vacuum. They can be made in the context of government-administered health benefits programs, as has been done under the Medicare program, or they can be made in the context of the market. During recent years, our society has favored use of the market model as opposed to the government model. That means health plans make necessity determinations in the context of competition with each other for the patronage of beneficiaries.

Competition is based on a variety of factors, including premium level, extent of coverage for the premium, and how wide a choice of providers is available under a health plan. Health plans vary widely in how they balance these factors. Generally, health plans that offer the widest choice of providers with the least restrictions on medical decisions by those providers are the most expensive. Those with the greatest restrictions on choice of providers and those which exert the greatest control over medical decisions by the providers have the lowest premiums. Therefore, the patient faces a trade-off. The patient can pay more for a health plan with a wide range of providers that are patient-centered, or the patient can pay less and get a health plan that restricts the choice of providers available to those who cooperate with the health plan's efforts to inject the societal interest into medical decision making.

During recent years, increasing costs have made premium levels a very important factor in patient selection of health plans. A larger number of patients have become willing to accept restrictions on their choice of providers in order to obtain lower premium levels. Health plans that restrict the choice of provider and offer lower premiums have grown rapidly at the expense of more expensive health plans that offer a wider choice. In 1980 there were only a small number of persons enrolled in PPOs and 9.7 million persons enrolled in HMOs. As of 1995, over sixty million Americans were enrolled in PPOs and fifty-five million in HMOs.

The increase in Americans enrolled in plans with restricted panels of providers has sparked greater competition among physicians and other providers. Providers fear that they will not be

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82. For an estimate of the extent to which certain kinds of Health Maintenance Organizations that restrict choice can lower costs, see Verdon S. Staines, Potential Impact of Managed Care on National Health Spending, HEALTH AFF., Supp. 1993, at 248. See also Maureen Cameron, Indemnity Plans Costs Rise While Managed Care Prices Moderate, BUS. & HEALTH, Apr. 1993, at 22 (comparing indemnity and managed care plan costs, and describing managed care actions and utilization); Norma Harris, Managed Care is Right Course Employers Say, BUS. & HEALTH, July 1992, at 32 (reporting poll indicating employers' belief that managed care can control costs and citing employers' views on how to cut costs).

83. For a description of the features of different kinds of health plans that purchasers face in deciding upon a health plan, see Jonathan P. Weiner & Gregory de Lissovoy, Raising a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans, 18 J. HEALTH POL. POL'Y & L. 75, 86-90 (1993).

84. AMCRA Foundation, 1994-95 Managed Care Overview 9, 27 (1995); Amy Bernstein et al., 1994 HMO Performance Report Group Health Ass'n of Am. 1 (1994); Marion Merrill Dow, Inc. Managed Care Digest/PPO Edition 3 (1993).
able to acquire enough patients to be viable if they do not become part of PPO and HMO panels. Therefore, they have become willing to compete with respect to two factors of great importance to health plans. First, they have become willing to discount their fees and charges and to accept fee withhold arrangements and capitation in order to attract health plans. Second, and more important, they have become willing to incorporate the societal interest in their medical decisions in order to gain access to health plan panels.85

As competition among health plans intensifies in a market, they look for ways to lower costs more in order to gain an advantage over their competitors. To do this, they push providers to lower fees, charges, capitation rates,86 or other forms of payment and to find ways to eliminate the provision of more services by broadening the definition of unnecessary care. In markets with a physician surplus, the physicians find themselves under intense economic pressure to comply with these demands.87

Under ideal market conditions, health plans and physicians would have standards of necessity that could be used as reference points for how they reduce costs. These standards would place a floor below which physicians could not go in refashioning what constitutes necessary care. Health plans and providers would then have to focus exclusively on the efficiency with which care was delivered. However, as discussed earlier, such standards will not be available in the near future. As a result, different health plans and different providers have different thresholds for what constitutes unnecessary care. In other words, some health plans require a higher percentage likelihood that a medical service will benefit patients before it will be covered.

Clark C. Havighurst has argued that patients should be able to contract for the threshold of necessity for which they are willing to pay. Contracting for different levels of necessity means contracting for different levels of risk, because as concepts of necessity become more restrictive, the level of risk to individual patients rises. Havighurst has argued that patients could review the medical policies of health plans and compare those policies

86. Frank Cerne, Cash Kings, Hosp. & HEALTH NETWORKS, Apr. 5, 1991, at 51 (discussing the controversy surrounding the growing economic power of HMOs and their methods of lowering costs to gain an advantage over their competitors.)
87. Federico, supra, note 69.
against premium levels in making their purchasing decisions. Instead of there being a generally understood societal standard for necessity that is the minimum amount of risk that any patient could take, each patient could decide upon the level of risk that the patient was willing to accept.\textsuperscript{88}

The Havighurst alternative sounds radical, and also appears to contravene concepts of equality. Patients with less money could be forced to accept low-priced health plans that carried a high level of risk, while wealthier patients would be able to afford more expensive health plans with lower levels of risk. However, this alternative is in fact the one that is prevailing today. Patients unwilling or unable to pay for more expensive health plans purchase HMOs or PPOs. The physicians on the panels of HMOs and PPOs have incorporated the societal interest in conserving health care to a higher degree than those who see patients under managed indemnity or traditional indemnity plans. And as discussed earlier, there are variations even within PPOs and HMOs.

However, the Havighurst alternative is being implemented without the benefit of the flow of information that Havighurst envisioned in his suggestion. Patients do not receive a set of medical policies that they can compare in purchasing health plans, and they do not receive a set of outcomes data that compares the performance of plans. The information that they receive is the price of the plan, the restrictions placed on the choice of physicians that may be seen, and the identities of the physicians who may be selected.\textsuperscript{89} Patients may receive information about utilization review procedures that places obligations on them, such as the need to obtain authorization for hospitalization, but they generally do not receive information about the pressures of incentives that physicians are working under to incorporate the societal interest in medical decisions.

It is debatable whether patients understand the differences in necessity thresholds among health plans. Certainly some patients understand that, but it appears that the bulk of the patients are not even aware of the physician’s cooperation with the societal

\textsuperscript{88} Clark C. Havighurst, \textit{Altering the Applicable Standard of Care}, 49 Law \& Con-temp. Probs. 265, 274-75 (1986) (arguing that patients should have room to choose the physician standards they feel are most appropriate at an early point in their insurance transaction).

\textsuperscript{89} William Sherman, \textit{The ‘Cookbooks’: Docs Use Recipe for Cut-Rate Care}, N.Y. Post, Sept. 20, 1995, at 4.
interest, and are not aware of the techniques used to engender this cooperation or of how some techniques elicit a greater amount of cooperation than others. That means patients do not know what they are purchasing when they select a health plan.

IX. THE POTENTIAL DANGER TO PATIENTS

Health plans have been successful in eliminating substantial amounts of care. The largest amount of care eliminated has been reduced use of hospitals.90 Patients are not admitted to hospitals as frequently as in prior years and if admitted, they do not stay in as long. Reduced admissions result from the substitution of alternative treatments for procedures formerly performed in the hospital and from decisions not to treat. Savings also result from the increased use of primary care physicians who are generally less expensive than specialists.

Further, it appears that substantial amounts of care can still be eliminated through the application of techniques to reduce the provision of unnecessary services in numerous markets where these techniques are not common. Most of the savings have been achieved in markets where PPOs and HMOs have achieved large market shares, and the highest degree of savings have come from markets where HMOs have achieved high market shares and where capitation arrangements with physicians have become prevalent. If the savings achieved in markets where HMOs and capitation are prevalent are extrapolated to the rest of the United States, where HMOs and capitation arrangements are less prevalent, then it is clear that additional medical services can be eliminated.91

The savings achieved by the application of techniques to eliminate unnecessary care have been achieved without any apparent large scale degradation of the quality of patient outcomes. In fact, most studies that compare the outcomes of medical care provided by health plans that limit care to the outcomes resulting from traditional fee-for-service plans have concluded that the outcomes of plans that limit care are no different than or better

than care provided through fee-for-service plans. From these results, one might conclude that there is an optimal amount of health care for any given patient, and that traditional health plans may have resulted in the provision of too much care to the detriment of patients.

However, these studies are not consistent with a substantial number of anecdotal reports about patient harm caused by the withholding of medical care by health plans. During 1995, the Los Angeles Times, the New York Post, and Newsweek magazine have featured exposés on adverse patient incidents caused by withholding care; a major television network had a series of reports that featured patient care problems attributable to health plans; and there have been many other media reports about these incidents.

There are several reasons why the studies differ from the anecdotal reports. One reason is that many of the adverse incidents reported in the media did not in fact result in an adverse patient outcome. These are incidents where a PPO or HMO refused to provide the care recommended by a physician or desired by the patient. Subsequently one of two courses of events occurred. One is that the patient's symptoms worsened making it obvious care was necessary, the care was then authorized by the plan, and the patient recovered satisfactorily. No harm occurred to the patient, but the patient had a frustrating and frightening experience.

The other scenario is that the patient obtained the desired care outside of the health plan. A good example of this is the experience of the Christy family whose daughter was diagnosed with Wilm's tumor. That disease is curable with an operation, but

92. For a summary of the results of these studies, see David Orentlicher, Health Care Reform and the Patient-Physician Relationship, 5 HEALTH MATRIX 141, 161-66 (1995). But see JOHN E. WARE ET AL., Differences in 4-year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee for Service Systems, 276 JAMA 1039 (1996), (finding that elderly and poor chronically ill patients have worse physical health outcomes in HMOs than in fee-for-service systems).
94. Sherman, supra note 89.
96. CBS Evening News With Dan Rather: Eye on America (CBS television broadcast, July 24-26, 1995) (discussing various problems encountered by HMO consumers).
the operation is technically very difficult. The HMO involved insisted that it be performed by a general surgeon who did not have any experience with the operation. The Christy family wanted a pediatric surgeon with experience. The family hired the pediatric surgeon and the girl recovered.97 The HMO was subsequently penalized by the California Department of Corporations for withholding necessary care.98 Again, the family had a frustrating and frightening experience, but no harm came to the patient.

These kinds of incidents, because the patient was not harmed, would not show up in studies of patient outcomes. However, there are also incidents where the patient clearly was harmed. Given the incentives to conserve care, it seems inevitable that mistakes will occur and that care will be withheld when it should not be. It may be that these incidents are not numerous enough to affect the results of aggregate outcomes. However, like malpractice incidents under conventional fee-for-service medicine, they may generate substantial public attention when they do occur.

Another reason is that the studies might not be representative of health plans as a whole. Different health plans use different criteria to determine necessity, they have different pressures on and incentives for physicians to withhold care, and they use different physicians. Therefore, studies which are limited to comparing a small number of health plans may miss a substantial amount of adverse care resulting from the application of techniques to eliminate unnecessary care.

The most likely explanation for the difference in the studies and the anecdotal reports is probably a combination of the above reasons. Patients and the public are disturbed by the withholding of care that did not result in harm, but was a “near miss” or demonstrated a willingness to take risks with patient well-being that seemed unacceptable (such as the Christy incident described above). Patients and the public believe that it is inevitable that such near misses or willingness to take risks with patient care

will eventually result in some incidents where patients are in fact harmed. Some incidents of adverse care do occur, and there are HMOs or PPOs where the managers and physicians are too aggressive in withholding care.

Although studies of HMOs have not shown adverse outcomes in the aggregate, the existence of the anecdotal reports of adverse incidents due to the withholding of care is of concern. The reason is that, for the most part, HMOs and PPOs have not yet been put under severe economic pressure. If anecdotal reports of adverse incidents abound now, then the amount of those incidents is likely to increase when HMOs and PPOs are put under severe economic pressure and press providers for increasingly restrictive interpretations of what constitutes necessary care.

HMOs and PPOs have not been put under severe pressure because they have had a substantial cost advantage over traditional fee-for-service medicine due to their ability to eliminate unnecessary care. HMOs and PPOs have been able to grow at a rapid rate by taking market share from indemnity plans, and they have been able to generate substantial profits. In most markets, they have not been forced to engage in intense competition with each other.\textsuperscript{99} When they have to compete more directly with each other for market share, and increases in market share for one HMO or PPO come at the expense of other HMOs or PPOs, profits will decline and some HMOs and PPOs will be forced from the market. At that point they will be under severe economic pressure to find ways to gain cost advantages over each other, and will continue to press for ways to eliminate more unnecessary care.

However, it will become increasingly difficult for HMOs and PPOs to find ways to reduce costs. Many health care economists believe that the savings achieved by HMOs and PPOs are not sustainable on a long-term basis. At some point they will have succeeded in eliminating virtually all of the unnecessary care from the system. However, expenses will continue to in-

\textsuperscript{99} During the period 1992-1994, the growth rate in HMO premiums per member declined from 10.6\% to 5.6\%, and it is projected that there will be an absolute decline in per member premiums of -1.5\% during 1995. See Bernstein et al., supra note 84, at 9. See also U.S. Congress, Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 2-4, 22 (indicating that the recent overall rate of increase is low, and that HMO competition is not necessarily intense).
crease due to advances in medical technology.\textsuperscript{100} Purchasers of health plans will continue to be heavily influenced by premium levels, as they will want to find ways to reduce the rate of increase of their health care expenditures. This will cause HMOs and PPOs severe economic pressure.

Similarly, providers will come under serious economic pressure. There is already evidence of a physician surplus and excess hospital capacity in many markets in the United States.\textsuperscript{101} Health care economists predict that the surplus and excess capacity will become much larger than it is today. That will force providers into intense competition with each other in order to have enough patient volume to remain viable in the market. As that occurs, providers will be vulnerable to pressures from health plans to eliminate more unnecessary care, and will be tempted to employ increasingly strict definitions of what constitutes necessary care and to withhold care that may be needed by patients.

Two factors may prevent severe economic pressures on health plans and providers from withholding so much care that patients are harmed. One is that additional progress in saving health care resources may be yielded in prevention and efficiencies in delivering health care. Prevention techniques might include efforts to encourage patients to avoid poor diets and other behavior that puts health at risk, screening populations to identify risk factors and then assisting patients with risk factors to minimize the likelihood of disease, or managing patients with chronic illnesses to minimize the adverse effects.\textsuperscript{102} Very few health plans make heavy use of these techniques, yet they may result in additional savings by preventing the need for expensive medical services.

However, the extent to which savings may be achieved by prevention techniques is still theoretical. It is not known whether they will be significant. Further, like the elimination of unnecessary care, it is likely that the extent of savings that can be achieved with these techniques has limits, and only postpones the

\textsuperscript{100} Schwartz, supra note 46; Rettig, supra note 46; Garber, supra note 46.


\textsuperscript{102} See David Lawrence, \textit{The Market is Already Doing It}, WALL ST. J., Mar. 16, 1994, at A18 (extolling the financial successes and quality of care provided by the managed-care market as positive reform).
time that health plans exhaust their ability to gain cost advantages over other health plans.

The other factor is buyer resistance. Once purchasers start to have adverse experiences with a health plan, they are likely to abandon it and turn to health plans that offer higher quality. Purchasers will not turn to plans with lower prices if they fear that the quality of those plans is so poor that they might be harmed. Therefore, if levels of quality start to degrade, the market is likely to correct itself as purchasers realize that the tradeoff in price is not worth the risk of adverse events.

However, there is a problem with relying on the ability of the market to correct levels of quality that are unacceptably low. There is likely to be a time lag during the period when quality degrades and purchasers become aware of the degradation and force health plans to correct the problem. This time period could be lengthened because of the lack of information available to purchasers about the policies and performance of health plans. The lack of information will increase the amount of time it takes for visible evidence of a degradation in quality to build up. During that period, many patients could be harmed.

The kind of dynamics described above are normal for many markets, and the swings in price and quality that occur are considered to be acceptable. However, because of the importance of health care to life and the enjoyment of life, these dynamics may not be acceptable for health care.

X. LACK OF LEGAL RESTRAINTS ON HEALTH PLANS: EVOLUTION OF THE LEGAL SYSTEM TO FACILITATE THE SOCIETAL INTEREST

As has been demonstrated above, legal and moral accountability historically rested with physicians as the primary providers of care. This responsibility led to certain developments in the legal system, including malpractice and tort liability, the corporate bar on the practice of medicine, and the establishment of a hospital medical staff structure, all directed at the supremacy of the patient interest. As the market and alternative health care delivery models have developed, the legal system has modified this structure to facilitate the ability of health plans to assert the societal interest in medical decisions. In particular, the liability of health plans for harm to patients resulting from the withholding of medical care is limited. It exists; there are theories that pa-
tients can pursue; but they are not nearly as well-established as the malpractice liability of physicians. These theories are difficult to use because the theories themselves are subject to challenge when lawsuits are brought by patients. Patients must first survive a battle over whether the theory applies and can be used against a health plan before they can begin to prove the facts establishing the elements of the theory.

However, the legal system has not facilitated the ability of physicians to incorporate the societal interest. Although the medical decisions of patients are controlled by or heavily influenced by health plans, physicians remain ultimately liable for the medical decisions made in the care of patients, and they are required to place the interests of the patient above all other considerations. There has been no real change in that aspect of malpractice law. Therefore, the law has facilitated a scenario where health plans can use economic leverage to pressure physicians into incorporating the societal interest into medical decisions without clear liability, and where physicians are responsible for resisting this pressure when withholding care would lead to pa-

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Tient harm. This division of liability does not adequately protect patients. The physician does not have the economic leverage or the legal rights necessary to adequately withstand the economic leverage of health plans. Given this legal environment, it is inevitable that some patients will be harmed.

The following sections explain the current structure of the law on these issues.

XI. ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) governs self-insured health plans in which the employer pays for health care directly, rather than purchasing insurance coverage for its employees. Over half of all employees in the United States receive their health coverage through self-insured plans and over two-thirds of all employers self-insure. ERISA preempts state tort law; practically, this has meant that there is controversy over whether health plans and employers can be held liable for patient injury caused by the withholding of necessary care.104

Corcoran v. United Healthcare, Inc.105 illustrates this dilemma. The plaintiff had a high-risk pregnancy (her second), during which her physician decided hospitalization prior to delivery was required so that mother and fetus could be continuously monitored. Preauthorization of hospitalization was required of United Healthcare, which in this instance was acting as the utilization reviewer for the plan administrator under a self-insured plan. United Healthcare determined that hospitalization for Mrs. Corcoran was not called for, but authorized home care for ten hours a day instead. At a point when a nurse was not present, Mrs. Corcoran’s fetus went into distress and died. Plaintiff filed a wrongful death action against United Healthcare and the plan administrator, alleging that the unborn child died as a result of their negligence. The court granted summary judgment for the defendant because ERISA contains an express clause preempting all state laws as they relate to employee benefit plans. Because


105. 965 F.2d 1321 (5th Cir. 1992).
the injury arose as a result of a "benefits" determination, the plaintiffs had no remedy.\textsuperscript{106} ERISA, however, does not preempt a "generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan."\textsuperscript{107} If the state law is viewed as affecting an employee benefit plan in "too tenuous, remote, or peripheral a manner"\textsuperscript{108} it will not be preempted as it relates to the plan. Accordingly, two circuit courts have recently found that suits based on theories of vicarious liability, ostensible agency, and direct negligence by HMOs could be heard in state courts.\textsuperscript{109} In \textit{Dukes v. U.S. Healthcare, Inc.}, the court drew a distinction between a claim about the \textit{quality} of a benefit received and the receipt of the benefit itself.\textsuperscript{110} Finally, the Supreme Court recently found in \textit{New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.},\textsuperscript{111} that ERISA did not preempt a New York hospital surcharge tax, even when those taxes affected self-insured benefit plans.\textsuperscript{112} This decision seems to indicate that the broader the scope of state regulation, the less likely it is that the state action will be preempted by ERISA, on the grounds that such action is not specifically designed to reach ERISA plans.

The conclusion of all this is that health plan liability for medical decisions is uncertain. Given the vast number of health plans that fall under the jurisdiction of ERISA, this controversy leaves vast numbers of patients without a clear remedy against the health plan.

### XII. LACK OF CLEAR TORT LIABILITY OF HEALTH PLANS FOR MEDICAL DECISION MAKING

Not all health plans are protected from tort liability by ERISA, although when plans are found liable, such liability has

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106. \textit{See also} Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298 (8th Cir. 1993) (determining that state law claims arising from administration of medical plans are preempted as claims that "relate" to ERISA).
110. \textit{Dukes}, 57 F.3d at 357.
112. \textit{Id.}
been very narrowly drawn. One leading case held a health plan accountable for an action that directly resulted in an adverse influence on an individual treatment decision, *Wilson v. Blue Cross*. However, in another leading case, where patient injury resulted from a plan’s denial of treatment, but where the physician did not exhaust the plan’s appeal process, the health plan was absolved of liability. In this way, health plan accountability and liability have been limited. These cases demonstrate the controversy over the extent of health plan liability. These two cases are considered to be leading cases because, other than these opinions, there are very few reported decisions about the liability of health plans for medical decisions. The reasons may be that the liability of the physician is clear, the liability of the health plan is uncertain, and therefore it is easier to pursue the physician in the event of patient harm.

Other legal theories could be employed to find health plans liable for their adverse influence on medical decision making. Under the theory of respondeat superior, an employer is responsible for its employee’s actions when the employee is controlled by the employer. However, this theory is applicable only if physicians are employees. Only 4.6% of all HMOs used the staff model as of 1993, and many of those HMOs have primary care physicians only as employees and contract with independent physicians for specialty care.

Breach of contract or breach of warranty theories are another option. Under such theories, the health plan would be held accountable for explicit or implicit promises made in application materials, plan summaries, or advertising. Claims could also be made for misrepresentation, false advertising, or breach of warranty. However, these are still novel theories of liability for medical decisions and are not reliable remedies for patients who have

113. 271 Cal. Rptr. 876 (Cal. Ct. App. 1990). In *Wilson*, a patient was hospitalized for severe depression, drug dependency, and anorexia. The admitting physician recommended a treatment plan that included four weeks of hospitalization. Blue Cross, however, denied coverage for more than ten days; accordingly, after ten days, the patient was discharged from the hospital and committed suicide. The family sued Blue Cross. Blue Cross claimed its action was a determination of benefits and not a medical treatment decision, but the court rejected this argument, finding the plan accountable when its payment decision substantially contributes to the patient’s injury. *Id.*


been harmed. Recent cases have focused on the new and different functions being performed by health plans. The administrative role played by the HMO guarantees that all medical costs would be covered, or claims that physicians are competent are theories that have all succeeded in recent years. Finally, cases have emerged raising the standard of care in situations where health plans have made representations about physicians’ credentials, some of which have been successful.

A final potential avenue for liability is the tort of bad faith insurance settlements. This tort is meant to cover situations where the insurer has unreasonably withheld payment for a covered liability. It arises out of a duty of good faith and fair dealing owed by the insurer to the insured. This duty does not rise to the level of a fiduciary duty, but one commentator has observed that it seems to approach that level in states which recognize the tort. This tort has been used to sue health plans that have refused to pay for health care services incurred by a beneficiary. However, this tort requires a higher standard of proof of wrongdoing than does the malpractice remedy for physicians. It is not

117. Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1234 (Pa. Super. 1988) (stating that “because the role of health care providers has changed in recent years, the ... rationale for applying the theory of ostensible agency ... is certainly applicable to HMOs”)

118. Health Am. v. Menton, 551 So. 2d 235 (Ala. 1989) (enforcing an HMO’s promise to cover all medical costs).

119. Health Am., 551 So. 2d at 238.

120. Boyd, 547 A.2d at 1231.

121. Shelmach v. Physicians’ Multispecialty Group, No. 53906 (Mo. Ct. App. June 13, 1989) (holding that clinic is liable to beneficiary as a result of clinic’s contractual promise to HMO that it would provide “good quality” care); Depenbrok v. Kaiser Found. Health Plan, Inc., 144 Cal. Rptr. 724 (Cal. Ct. App. 1978) (holding that breach of contract may occur where surgeon promised a particular result and patient relied on that promise); Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392 (Cal. Ct. App. 1979) (holding that HMO advertising “high standards” of care was not liable and advertising was “generalized puffery” that the plan physicians would exercise good judgment).


123. See, e.g., Berry v. United of Omaha, 719 F.2d 1127 (11th Cir. 1983) (holding that an action of bad faith nonpayment by a health plan can be maintained); Hughes v. Blue Cross, 245 Cal. Rptr. 273 (Cal. Ct. App. 1988) (affirming damages against insurer who breached covenant of good faith and fair dealing when investigating insured’s claim); Aetna Life Ins. Co. v. Lavoie, 470 So. 2d 1060 (Ala. 1984), vacated and remanded, 106 S. Ct. 1580 (1986) (addressing claim against a health insurer for bad faith refusal to pay a claim); National Sav. Life Ins. Co. v. Dutton, 419 So. 2d 1357 (Ala. 1982) (addressing consumer’s claim for bad faith settlement).
enough to show that it was error for an insurer to deny coverage for services which turned out to be necessary. There must be a showing of greater culpability, such as actual bad faith, reckless disregard for rights of the beneficiary, or malice. This higher standard of proof allows the insurer to defend by showing that the coverage was denied due to an error or a good faith misunderstanding.\textsuperscript{124} In addition, this tort is not consistently available in all states — only about half of the states recognize it for first party insurers.\textsuperscript{125}

A. Sovereign Immunity

Medicare is administered by the Health Care Financing Administration (HCFA), which contracts with “carriers” and “intermediaries” (usually insurance companies or Blue Cross/Blue Shield entities) to process and pay claims for health care provided to an estimated 36.8 million Medicare beneficiaries.\textsuperscript{126} Carriers and intermediaries are hired to retrospectively evaluate the necessity of care provided to beneficiaries, and Peer Review Organizations (PROs) are hired to retrospectively review claims to evaluate quality of care and identify substandard providers.\textsuperscript{127} As a federal agency, HCFA is protected from liability claims by the doctrine of sovereign immunity and can be sued to the extent permitted by the Constitution, specific federal legislation, and federal judicial decisions. For example, the Federal Tort Claims Act\textsuperscript{128} permits damage suits against federal agencies for negligence and other torts, but under specifically prescribed circumstances,\textsuperscript{129} and prohibits recovery for punitive damages.\textsuperscript{130}

\textsuperscript{124} See generally Harnett & Lesnick, supra note 1, § 14.04[2](a)-(c) (discussing denial of valid recovery claims by insurers such as in bad faith or a malicious manner).
\textsuperscript{125} Id. § 14.04[4] (indicating that many states do not recognize tort of bad faith dealing under first party insurance contracts consistently).
\textsuperscript{126} 42 U.S.C. § 1395u(a) (1994); STAFF OF HOUSE COMM. ON WAYS AND MEANS, 103D CONGRESS, 2D SESSION, STAFF OVERVIEW OF ENTITLEMENT PROGRAMS 124 (Comm. Print 1994).
\textsuperscript{127} 42 U.S.C. § 1320c (1994); 1995 MEDICARE & MEDICAID GUIDE (CCH) ¶ 13,460-13,540 (describing the retrospective claims review procedures used by Medicare).
\textsuperscript{129} 28 U.S.C. § 2680 (1994), which states that the United States may not be sued for: Any claim based upon an act or omission of an employee of the Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation be valid, or based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government, whether or not the discretion involved be abused.
B. Demise of the Bar on Corporate Practice

While the majority of states retain a bar on the corporate practice of medicine,\(^{131}\) corporate interests have managed to either find a way around, through, or ignored the intent behind the corporate bar.

For example, California has extensive precedent relating to the corporate practice of medicine,\(^{132}\) yet California is also one of the most highly developed managed-care markets in the country, where many physicians appear to be employees of health plans. How can this be? The answer lies in the development of the foundation model, a structure by which physicians may be employed by integrated delivery systems without violating the corporate bar on the practice of medicine.

The foundation model is named after an organizational structure in which a nonprofit foundation purchases the assets of individual physicians or groups and then enters into long-term service contracts with the physicians. The nonprofit foundation is able to raise capital unavailable to the physicians through the issuance of bonds, which can be used not only to fund the purchase of physician practices, but to provide information systems and the sophisticated infrastructure necessary to remain competitive today. However, in the first foundation to clear IRS scrutiny, only two of the ten board members could represent physicians, thus guaranteeing the organization would not be controlled by providers.\(^{133}\)

Often the partner in the nonprofit foundation is a for-profit managed care or insurance company. This skirts the corporate bar on the practice of medicine, as no for-profit corporation in

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131. Hansen, supra note 27.
133. Harris Meyer, Who's Afraid of Vertical Integration? Foundation Model for Medical Groups Passes IRS Test, A.M. MED. NEWS, Mar. 15, 1993, at 3, 50 (describing the IRS ruling on the tax-exempt status of Friendly Hills Healthcare Foundation). In that case, Friendly Hills Healthcare Network, a multispecialty for-profit physician group, sold its assets to a nonprofit foundation partly controlled by Loma Linda University Medical Center and contracted with the foundation to provide medical services.
California may lawfully employ or contract with physicians. According to an argument that, through use of a corporate screen, the physicians are being employed by a for-profit corporation — a violation of the corporate bar on the practice of medicine. Nevertheless, this model has proliferated throughout California in the last few years.

A different approach has been taken in Colorado. In that state, corporations are prohibited from practicing medicine; however, the General Assembly has authorized the establishment of “provider networks” involving joint ventures between physicians and lay entities. Three conditions must be met. First, a written agreement between the lay entity and the physicians must specify that the lay entity will not “affect the exercise of the licensed or certified professional’s independent judgment in the practice of the profession.” Second, the physician’s “independent judgment in the practice of [medicine] is in fact unaffected by the relationship.” Third, the physician is not required to take any action the physician believes is not in the patient’s best interest. However, it is unclear whether these principles are universally carried out in practice.

Not every jurisdiction has abandoned the corporate bar. Recently, an Illinois court invalidated an employment contract containing a noncompete clause between a surgeon and a hospital on the grounds that the corporate bar should be strictly enforced. Under Illinois law, only contracts permitted by law may be enforced; accordingly, since by law the hospital could not employ the physician, the contract was unenforceable. The judge, however, explicitly noted that the case did not involve the employment of a physician who practiced a hospital-based specialty, such as anesthesiology, pathology, radiology, or emergency medicine, leaving the door open for exceptions to the bar.

134. See supra note 132.
137. Id.
138. Id.
139. Id.
141. See id. at 8.
C. Lack of Medical Staff Model in Health Plans

Federal Medicare law and most state statutes relating to hospital licensure require the hospital medical staff to be organized, providing a structure for practitioner activity within a hospital. The Joint Commission on Accreditation of Healthcare Organizations, often acting as the deemed accrediting entity for purposes of state and federal law, requires hospitals to have a medical staff structure. The medical staff is the entity that defines the responsibilities of practitioners within the hospital and defines procedures, providing accountability. Hospital administration is separated from the provision of patient care. Laws and accreditation standards requiring a hospital medical staff do so to ensure a framework for physician input into the medical policy development of the institution. The medical staff bylaws have extensive rules regarding credentialing, peer review, and grievance procedures designed to ensure due process for providers and quality care for patients.

No such equivalent exists for other licensed entities — including health plans such as HMOs — yet entities other than hospitals are delivering or controlling a major portion of health care services rendered in the United States. The lack of a requirement for HMOs to establish a medical staff results from the market developing rapidly beyond and around legal strictures. It is time for statutory changes to handle this development.

XII. PROPOSED CHANGES TO THE LEGAL STRUCTURE

Changes need to be made to the legal structure to recognize the realities of health plan control over medical decisions. The current structure does not recognize the economic leverage that health plans have over physicians, and the difficulty that physicians will have in resisting pressures to withhold care in highly competitive markets. Changes should focus on restoring a better balance between health plans, physicians, and patients in medical decisions. It should include providing information to patients on health plan accountability, and on enabling physicians to be advocates for the patient interest.

A. Patient Information

Information for patients is more important than ever. Given the controls and economic incentives that health plans place on
physicians, the patient may be uncertain as to whether the patient is receiving all relevant information about treatment options for an illness or injury. The health plan and the physician, when under the control or influence of the health plan, have an incentive to steer the patient to the lowest cost option. It would be ideal if there was an extensive outcomes collection and reporting system that enabled patients to compare the cost and quality performance of health plans and providers. However, this does not exist now and the expense of such a system precludes its creation in the foreseeable future. In the absence of such a system, health plans should be required to disclose information to patients about their own outcomes and the techniques that they use to eliminate unnecessary care. This information should be drafted in easily understood language so that patients can decide whether they are comfortable with the combination of price and risk used by the health plan.

B. Health Plan Accountability

Health plans, including ERISA plans, should be held accountable for patient injury suffered from the withholding of medical care. This accountability should exist regardless of whether the health plan uses direct or indirect techniques to eliminate unnecessary care. This will give health plans an incentive to take care in evaluating the need for care when using techniques that directly involve them in medical decisions, and to oversee the quality of care provided when they use indirect techniques. Accountability can be created by providing a clear tort remedy for patients who feel that they have been harmed by the withholding of care.

One suggestion for such a remedy is enterprise liability.\textsuperscript{142} Under this proposal, health plans would be liable for malpractice committed by any of the health care providers delivering care on its behalf, and the physician would no longer have liability. This proposal is too extreme. First, it sweeps more broadly than is necessary, and would make the health plan liable for malpractice that is not attributable to the medical policies and conduct of the health plan. It would leave physicians without any personal sense

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of liability, and would require the health plan to exert even greater controls over physicians than they do today in order to control their malpractice exposure. This need for control could reduce the flexibility of health plans and physicians to structure their relationships in innovative ways.

Perhaps a better way to enhance health plan liability is to modify the tort of bad faith insurance settlements and make it applicable in all states. Given the role that health plans in fact have in making and influencing medical decisions, it is time to enhance the duty of good faith and fair dealing owed by the health plan to the beneficiary into a fiduciary duty. This enhanced duty would not require the health plan to abandon any effort to include the societal interest in medical decision making. However, it would require the plan to be certain that the patient is well-informed about the policies of the plan, that the physician has the freedom to inform the patient about all of the patient’s treatment options, and that the plan must exercise care in making medical decisions or in influencing the medical decisions of physicians.

C. Enabling Physicians to be Advocates for the Patient Interest

Most health plans do not have vehicles to involve their participating physicians to have input into their medical policies or other policies that affect how the physicians practice. Health plans generally have a medical director or even a panel of physicians with whom they consult, but they do not obtain broad-based input. Hospitals have a medical staff structure that has served the industry very well. It has provided a means for the physicians on the medical staff to participate in the development of hospital policy. There should be a similar means for physicians participating in a health plan to be involved in health plan policies. This does not have to be identical to a hospital medical staff structure, but it should provide vehicles for physicians to meet and to elect representatives to interact with health plan management.

Vehicles for input into health plans by participating physicians will not be of any benefit to patients unless the physicians feel free to advocate their beliefs about what constitutes good patient care. They should not have to fear being terminated from a health plan if they advocate policies that health plan management does not want. Therefore, there should be procedures for physi-
cians to use if they believe that they have been terminated from a panel because of their advocacy efforts. This procedure could have two dimensions. It would entitle the physician to an appeal to health plan management, and it would allow a tort remedy. This procedure would result in litigation, but measures could be taken to minimize frivolous cases.