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The Role of the States in Combating Managed Care Fraud and Abuse

by Joan H. Krause*

INTRODUCTION

The recent growth of managed care cost containment strategies has attracted a great deal of attention to the issues of quality of, and access to, health care services. Many concerns have focused on the potential effects of an increasingly cost-conscious health care system on the traditional physician-patient relationship, patient treatment choices, and broader issues of patient rights. These concerns have in turn fueled a so-called “backlash” against managed care, resulting in a growing number of laws and initiatives designed to prohibit what are perceived as particularly egregious activities undertaken by managed care organizations.¹

Although the quest for adequate patient protections is likely to continue, the focus of governmental investigations into managed care has begun to shift. Recognizing that a significant portion of the United States population now receives its health care through managed care organizations (and that a significant portion of health care reimbursement now flows to such entities), the federal and state governments have begun to investigate whether these organizations are in fact delivering what is being paid for — and whether the failure to do so constitutes health care fraud. At the federal level, for example, the Department of Health and Human Services Office of the Inspector General’s (“OIG’s”) 1999 Work Plan includes several initiatives designed to assess both the activities of and the reimbursement paid to managed care organizations under the Medicare and Medicaid programs.² Similarly, officials in many states have announced a

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1. See, e.g., Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF., July/Aug. 1998, at 82, 83. See also Louise G. Trubek, *Informing, Claiming, Contracting: Enforcement in the Managed Care Era*, 8 ANNALS HEALTH L. 133 (1999).

2. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, WORK PLAN: FISCAL YEAR 1999: HEALTH CARE FINANCING ADMINISTRA-

centralized, multi-level attack on managed care fraud in both the public and private sectors.³

This Article will focus on the weapons wielded by state regulators in the fight against managed care fraud. Though recent discussions of health care fraud have concentrated on *federal* efforts, this Article will argue that it is the *states*, using a variety of legal theories, that have the most flexibility to address fraudulent managed care practices. This flexibility, in turn, allows state regulators to craft penalties and structure settlements that are tailored to the specific misconduct at issue. These precisely targeted anti-fraud efforts, in contrast to some of the broader federal provisions, may allow state regulators to resolve problems more efficiently, with fewer interruptions in patient access to care — thus benefitting the patient population the laws were designed to protect.

I. FRAUD IN MANAGED CARE

For most of this century, health care in the United States was provided on a fee-for-service basis. Under this system, physicians charged for medical care on a per-service basis, such as the amount of time spent with the patient or the procedures performed. Until the Great Depression, patients generally paid these charges directly out of their own pockets, and physician charges, by necessity, were limited by the amount of money patients could afford to pay.⁴ In response to problems faced during the Depression by physicians and hospitals with an increasingly cash-strapped patient base, the concept of health “insurance” was developed. Initially, such insurance was offered on an “indemnity” basis: the physician’s bill was paid by the patient, who later was reimbursed by the insurer for a pre-set portion of the expenses. Over time, insurance was also offered on a “service” basis, under which the physician received

TION PROJECTS 22-27, (visited Feb. 21, 1998) <<http://www.dhhs.gov/progorg/oig/wrkpln/1999/99hcfawp.pdf>>.

3. See, e.g., *New York: New Bureau for Health Care Issues Set Up By Attorney General's Office*, BNA'S HEALTH L. REP., May 8, 1997, at 19 (describing new bureau created by Attorney General Dennis C. Vacco, whose duties would include investigation of certain HMO practices).

4. See Gary T. Schwartz, *A National Health Care Program: What its Effect Would Be On American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1358-59 (1994); MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 3 (1993).

payment directly from the insurer under a predetermined fee schedule.⁵

Clearly, the fee-for-service system created an economic conflict of interest for the physician, since “[t]he more services the doctor provided, the greater was his income.”⁶ Physicians thus had a financial incentive to *overtreat* their patients in an attempt to boost their own incomes, most commonly by ordering services that the patient did not actually need. Unfortunately, the growth of health insurance only exacerbated this temptation. Once payment for the bulk of treatment costs was supplied by a “deep pocket” insurance company, both physicians and patients were insulated from their previous budgetary limits, and patients’ financial constraints no longer operated as a check on physician charges.⁷ Eventually, virtually unlimited third-party reimbursement was accompanied by the rapid development and diffusion of highly advanced (and highly expensive) medical technologies, as well as a rapidly aging patient population — leading to a rapid increase in health care expenditures.⁸ While health care made up only five percent of the Gross National Product in 1950, it reached twelve percent in the early 1990s, and is predicted to grow to fifteen percent by the year 2000.⁹

In response to the escalating cost of health care, the largest health care payers — primarily businesses and the federal and state governments — increasingly have turned to mechanisms designed to contain health care costs. The primary cost containment strategy has been to replace providers’ traditional incentives to *maximize* the volume of services provided with incentives designed to do the *opposite* — generally by putting physicians at “financial risk” for the costs of services they provide or initiate.¹⁰ The use of such incentives commonly is referred to as “managed care,” and the entities adopting such

5. See Alexander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 712 (1986).

6. See Rodwin, *supra* note 4, at 2.

7. See *id.* at 14.

8. See, e.g., E. Haavi Morreim, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE’S NEW ECONOMICS 9-13 (1995).

9. See E. Haavi Morreim, *Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care*, 12 J. LEG. MED. 275, 280-81 (1991).

10. See E. Haavi Morreim, *Diverse and Perverse Incentives of Managed Care: Bringing Patients Into Alignment*, 1 WIDENER L. SYMP. J. 89-90 (1996); Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 429-30 (1997).

constraints are known as “managed care organizations” (“MCOs”).¹¹ The primary method by which MCOs shift financial risk to physicians is through “capitation,” whereby the MCO pays a single fee to the physician for providing complete care to an enrollee for a set period of time. The physician receives the same amount of money for each enrollee regardless of how many services are actually provided; because payment for additional services comes directly out of the physician’s pocket, capitation removes the physician’s incentive to order unnecessary services.¹²

Conceptually, managed care organizations both *provide* services to patients through contracted health care providers, and *administer* the provision of such services. Because of the sheer number of individuals and entities involved, and the variety of financial relationships that exist among them, both MCOs and their contracted providers have opportunities to engage in a wide variety of improper activities related to the delivery of health care.¹³ For example, MCOs may defraud their contracted providers by delaying payment or refusing to pay for previously approved services, and may defraud employers or government

11. In its most restrictive form, “managed care” can refer solely to health maintenance organizations (“HMOs”), which offer a wide range of health care services at a fixed price in return for limiting enrollees to a defined network of health care providers and employing strict utilization guidelines and referral restrictions. More broadly, however, “managed care” may be used to refer to *any* type of health insurance plan that utilizes *any* type of cost containment mechanism, such as requiring approval before patients are hospitalized for elective surgery. Thus, many so-called “managed care” strategies have been adopted by traditional insurers as well. See Schwartz, *supra* note 4, at 1362 (noting many fee-for-service plans are now subject to cost containment mechanisms, such as utilization review).

12. See, e.g., Morreim, “Diverse and Perverse Incentives,” *supra* note 10, at 91; David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158-59 (1996). Many MCOs also have adopted “bonus” or “withhold” systems, in which pools of funds are set aside to cover the costs of certain types of ancillary services; any funds remaining in the pool at the end of the year are distributed to the physicians. See *id.* at 159-60.

13. See, e.g., Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?* 31 GA. L. REV. 373, 385-93 (1997); Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 491 (1994) (questioning whether managed care cost savings “are eliminating waste or merely eliminating access to needed services”); Alan Bloom & Charles B. Oppenheimer, *Fraud in Managed Care: Old Wine in New Bottles*, 18 WHITTIER L. REV. 13 (1996). It is important to recognize that fraud may be perpetrated both by the MCO (e.g., when fraudulent charges are submitted to payers) and on the MCO (e.g., when contracted providers inflate their charges to the MCO). See, e.g., Gabriel Imperato & Jennifer Steward, *Perspectives: Managed Care Plans Are Victims, Perpetrators of Fraud & Abuse*, MANAGED CARE WK., Mar. 3, 1997, at *1.

payers by submitting false or fraudulent data to obtain payment.¹⁴

Moreover, to the extent that many MCOs do not operate solely under capitation, but continue to reimburse for certain types of services on a fee-for-service basis, all of the traditional incentives for overutilization — and thus for overtreatment, kickbacks, and self-referral practices — continue to flourish.¹⁵ On the other hand, while capitation clearly minimizes the overutilization of services, it may also create incentives to do the reverse: to *underutilize* services, thereby reducing the cost of care provided to patients. MCOs can achieve this result by explicitly denying coverage for expensive services, a tactic that may lead to protracted court battles with unhappy enrollees. But MCOs also may adopt more subtle approaches, such as imposing long delays before appointments can be scheduled or locating physician offices in inconvenient locations — making it difficult for patients to access the services to which they are entitled.¹⁶

Similarly, MCOs have an incentive to enroll the healthiest (and thus least costly) patients. Clearly, MCOs could accomplish this overtly, by declining to enroll sick patients or pressuring patients who become severely ill to disenroll from the organization. Again, however, MCOs may achieve a similar result more subtly by directing their marketing activities toward healthier individuals, such as by distributing brochures at health clubs, or holding informational sessions in locations that are not handicapped accessible.¹⁷ Other reported marketing improprieties have included overly aggressive recruitment tactics (particularly involving the Medicaid population), misrepresentations regarding the scope of services covered or the patient's cost-sharing portion, and enrolling fictitious patients in the MCO. In perhaps the most egregious cases, MCOs have been accused of enrolling *actual* patients *without their knowledge*.¹⁸

As this brief listing indicates, the opportunities for improper activities in the managed care context are myriad. Depending on the applicable regulatory structure, these activities may be actionable at the state level under a variety of legal theories,

14. See Davies & Jost, *supra* note 13, at 391-93.

15. See *id.* at 391.

16. See *id.* at 385-87.

17. See, e.g., Patricia Neuman et al., *Marketing HMOs to Medicare Beneficiaries: Do Medicare HMOs Target Healthy Seniors?*, HEALTH AFFAIRS, July/Aug. 1997, at 132, 135-36.

18. See Davies & Jost, *supra* note 13, at 387-91.

including: (1) traditional anti-fraud laws; (2) violation of applicable insurance laws and regulations; and (3) laws designed to protect consumers from unfair trade practices.

II. STATE RESPONSES TO MANAGED CARE FRAUD: THREE MODELS

A. *Traditional "Fraud and Abuse" Protections*

Both the federal and state governments have enacted a variety of criminal, civil and administrative provisions to prohibit health care fraud, predominantly in the fee-for-service context. At the federal level, the most important anti-fraud laws include the Civil and Criminal False Claims Acts, the Medicare and Medicaid Anti-Kickback Statute, and broad administrative civil monetary penalty and exclusion authorities.¹⁹ States have enacted a similarly broad range of anti-fraud legislation, often modeled on comparable federal provisions, targeting false claims, fee splitting and kickbacks in connection with both public programs and privately funded health care.²⁰ Under these provisions, violators may be subject to significant criminal fines and civil penalties, imprisonment, ineligibility for participation in certain government-sponsored programs, and professional discipline (including suspension or revocation of a professional license).²¹

To the extent that an MCO continues to make payments on a fee-for-service basis, such as by "carving out" certain types of services or paying specialists pursuant to a fee schedule rather than as part of the capitated rate, these anti-fraud laws should

19. See 31 U.S.C. § 3729 (1998) (civil false claims); 18 U.S.C. § 287 (1998) (criminal false claims); 42 U.S.C. § 1320a-7b (1998) (Medicare and Medicaid fraud and anti-kickback laws); 42 U.S.C. § 1320a-7a (civil monetary penalties); 42 U.S.C. § 1320a-7 (1998) (exclusion).

20. See, e.g., R.I. GEN. LAWS §§ 5-48.1-1, 5-48.1-3 (West 1998) (all-payor anti-kickback prohibition); MICH. COMP. LAWS ANN. §§ 400.604 (Medicaid false claims), 752.1004 (health care false claims) (West 1998); MINN. STAT. ANN. § 147.091(1)(p) (West 1998) (fee splitting constitutes grounds for disciplinary action against physician); ALA. CODE § 22-1-11(b) (1998) (Medicaid anti-kickback prohibition); Georgia Medicaid Fraud Forfeiture Act, GA. CODE ANN. § 49-4-146.1-3 (1998).

21. A recent New Jersey law combines several of these approaches, explicitly listing violation of the health care claims fraud statute as one of the grounds for revocation of a health care practitioner's license. See 1997 N.J. SESS. LAW SERV. ch. 353 (West). Some officials also have sought to extend the authority of the state Medicaid Fraud Control Units to investigate fraud in other sectors of federal and private health care programs. See, e.g., S. 2040, 105TH CONG. (1998); *Medicaid: Massachusetts Attorney General Seeks Waiver to Expand Medicaid Fraud Control Unit Jurisdiction*, 3 BNA'S HEALTH L. REP., Sept. 1, 1994, at 35.

apply to managed care in the same way they apply to traditional health care.²² With regard to other types of MCO activities, however, the application of these laws is less clear. For example, under capitation, a primary care physician receives a pre-set fee to provide care to an enrollee for a particular period of time; unlike under traditional insurance, no claims for specific services need be submitted in order to receive payment. While “encounter data” may be requested from the physician, it is used primarily for statistical rather than for reimbursement purposes. Thus, if the physician fails to provide required services or misstates the nature of services provided, it may be difficult to identify any “claim” that has been submitted for payment, as may be required for the purposes of false claims or false statements liability.²³ Clearly, traditional anti-fraud provisions may not adequately protect against all forms of managed care fraud.

While commentators have called for revision of existing laws to explicitly define common managed care activities as actionable fraud and abuse, little progress appears to have been made at the state level.²⁴ At present, only the expanding use of mandatory managed care for the Medicaid population has generated sufficient concern to warrant the enactment of new criminal laws. For example, a recent New Mexico law criminalizes a variety of improper activities involving Medicaid managed care, including furnishing treatment that is “substantially inadequate” with intent that a “claim” (defined broadly as *any communication* identifying a treatment, item, or service as reimbursable) be relied upon to expend public money.²⁵ But to the extent that traditional anti-fraud laws have not been amended (or interpreted through case law) to explicitly prohibit similar activities, they will remain of limited use in addressing non-traditional forms of fraud and abuse in managed care.

22. See Davies & Jost, *supra* note 13, at 390-92.

23. See *id.* at 396-97 (describing problems with current criminal sanctions). Despite these problems, federal prosecutors have made clear their intention to address underutilization through application of the False Claims Act. See, e.g., Mary DuBois Krohn, Comment, *The False Claims Act and Managed Care: Blowing the Whistle on Underutilization*, 28 CUMB. L. REV. 443, 456-72 (1998); *Fraud: Underutilization in Managed Care New Target of Joint Fraud Efforts*, 4 BNA'S HEALTH L. REP., Dec. 7, 1995, at 47 (discussing formation of Department of Justice Managed Care and Fraud Working Group).

24. See, e.g., Davies & Jost, *supra* note 13, at 411-12 (recommending that current laws be amended to explicitly state that submission of false encounter data constitutes a false statement).

25. 1997 N.M. LAWS ch. 98, § 1 (adding N.M. STAT. ANN. §§ 30-44-2(B), 30-44-7A(2)(b) (Michie 1998)).

B. Regulation of the Insurance Industry

Rather than relying on traditional “fraud and abuse” laws, many states have made efforts to address MCO activities under the insurance regulatory structure. As both insurers and providers of health care, MCOs are regulated by state laws requiring licensure both for health care *entities* (e.g., HMOs), and for undertaking certain types of common managed care *activities* (e.g., utilization review).²⁶ In most states, HMOs must comply with requirements generally applicable to all licensed health insurers, as well as with traditional HMO-centered provisions (including recent legislation specifically targeting perceived abuses within the managed care industry). Rather than criminal or other traditional types of fraud prosecutions, MCOs increasingly face investigations and administrative proceedings for failure to comply with these licensure requirements — an approach that may offer advantages for state officials.

For example, MCOs are subject to a host of administrative requirements regarding the business of insurance, including laws regulating the content and sale of insurance policy forms.²⁷ An increasingly common requirement is that insurers create internal programs designed to identify fraudulent practices. In California, for example, insurance carriers have been required by regulation for several years to establish “Special Investigative Units” to detect and investigate suspected fraudulent claims, train claims handlers to identify possible fraudulent claims, and facilitate reporting of fraudulent claims to state regulators.²⁸ Similar requirements now exist in almost half of the states, and regulators have begun to enforce these laws against non-compliant insurers and MCOs alike.²⁹

26. See, e.g., TEX. INS. CODE ANN. ch. 20A (HMO Act), art. 21.58A (utilization review) (West 1998).

27. See, e.g., *Plan Regulation: Colorado Regulators Fine Kaiser For Various Policy-Form Violations* (hereinafter “Kaiser”), 4 BNA’S MANAGED CARE REP., Sept. 16, 1998, at 912, 913 (describing fines imposed on Kaiser and several of its competitors under recently enacted health insurance reform laws).

28. See CAL. CODE REGS. tit. 10, § 2698.40 (1998). Recent legislation imposed similar anti-fraud requirements on HMOs. See CAL. HEALTH & SAFETY CODE § 1348 (West 1998) (requiring each health care service plan to establish an anti-fraud plan, refer suspected fraud cases to a law enforcement agency, and submit an annual report to the Insurance Commissioner).

29. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 11, § 86.6 (1998) (requiring insurers to develop fraud prevention plans); *State Takes Action Against Insurers That Do Not Have Anti-Fraud Programs*, 2 BNA’S HEALTH CARE FRAUD REP., July 1, 1998, at 488; Kirk J. Nahra, *MCOs Need to Adopt New Mindset to Pursue Anti-Fraud Activity*,

MCOs are also required to comply with state provisions regulating the payment of insurance claims. These laws and regulations often include "prompt payment" requirements, which mandate that "clean" claims (*i.e.*, complete claims without any defects) be paid within a certain time period after receipt.³⁰ Recently, several MCOs in New York were accused of violating these requirements, and ultimately entered into negotiations with state regulators to resolve the allegations.³¹ Similarly, Maryland regulators recently prevented an HMO from recouping overpayments to doctors in violation of a 1997 law that limited such "retroactive denials" to six-months after payment.³²

Moreover, the recent "backlash" against managed care has fueled a variety of legislative and enforcement initiatives designed to prohibit what are perceived as particularly egregious MCO activities.³³ Among the more popular initiatives are laws prohibiting MCOs from using financial incentives that induce physicians to limit "medically necessary" care,³⁴ imposing contractual "gag clauses" that restrict physician communications with patients,³⁵ and denying payment for emergency care fur-

2 BNA'S HEALTH CARE FRAUD REP., June 17, 1998, at 456, 457 (describing efforts in New York and New Jersey).

30. See, e.g., N.Y. INS. LAW § 3224-a (McKinney 1998) (requiring insurers to pay claims within 45 days of receipt); N.J. ADMIN. CODE tit. 8, § 8:38-16.1 (1998) (requiring HMOs to pay clean claims within 60 calendar days of receipt).

31. See, e.g., *Claims Administration: New York Attorney General Seeks Talks On Aetna U.S. Healthcare Payment Delays*, 4 BNA'S MANAGED CARE REP., Aug. 12, 1998, at 814 (describing attorney general's negotiations with Aetna, as well as a previous settlement with Oxford Health Plans, Inc. involving similar allegations).

32. See MD. CODE ANN., INS. § 15-1008 (1998) (retroactive denial of reimbursement); *MAMSI Ordered to Comply Again with Maryland Claims Payment Law*, 2 BNA'S HEALTH CARE FRAUD REP., Aug. 12, 1998, at 605.

33. See, e.g., Blendon et al., *supra* note 1, at 82; *States Setting Detailed Quality Standards Rather Than "Legislating By Body Part,"* 7 BNA'S HEALTH L. REP., July 2, 1998, at 1059 (noting that more than half of all states considered bills in the first half of 1998 to regulate MCO quality of care).

34. See D. Ward Pimley, *States Tell Health Plans That Incentives May Not Limit Medically Necessary Care*, 4 BNA'S MANAGED CARE REP., Oct. 14, 1998, at 1030-31 (at least 21 states have addressed this issue). However, there is little guidance regarding exactly which types of incentives will fall within these prohibitions. See, e.g., *Insurance Commissioner Abandons Plan For HMO Financial Incentive Guidelines*, 2 BNA'S HEALTH CARE FRAUD REP., Nov. 18, 1998, at 882 (describing failed effort to formulate guidance regarding TEX. INS. CODE ANN. § 20A.14(l) (West 1998)).

35. See, e.g., GA. CODE ANN. § 33-20A-7 (1998) ("No health care provider may be penalized for discussing medically necessary or appropriate care with or on behalf of his or her patient."); MINN. STAT. ANN. § 62J.71(1)(1) (West 1998) (prohibiting "any agreement or directive that prohibits a health care provider from communicating with an enrollee with respect to the enrollee's health status, health care, or treatment options"). A number of statutes also prohibit health plans from penalizing providers

nished in out-of-network hospitals,³⁶ as well as laws mandating coverage of specific benefits or the services of specific types of health care professionals.³⁷ Thus, in addition to long-standing licensure requirements, MCOs must now comply with an increasing number of new managed care-specific provisions.

The ability to pursue MCO activities as a violation of relevant insurance requirements, rather than as criminal or civil "fraud," offers some advantages to state regulators.³⁸ In contrast to potential imprisonment, exclusion and the extensive fines and penalties that can be imposed under traditional fraud and abuse laws, violations of state insurance provisions traditionally have been addressed through lesser fines, cease and desist orders, and injunctive relief. More serious penalties, including license revocation and suspension, usually are imposed only for repeated violations or otherwise egregious practices.³⁹

In addition, the detailed nature of insurance requirements may make it easier to identify the steps that must be taken by

who advocate on behalf of their patients. See, e.g., PA. STAT. ANN. tit. 40, § 991.2113(c)(1).

36. See, e.g., Vickie Yates Brown & Barbara Reid Hartung, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 40-41 (1998); CAL. HEALTH & SAFETY CODE § 1371.4(c) (West 1998) (requiring payment for emergency services unless enrollee "reasonably should have known" that it was not an emergency); *State's Suit Against Kaiser Alleges Emergency Care Claims Denied, Delayed*, 2 BNA'S HEALTH CARE FRAUD REP., July 29, 1998, at 561 (describing Texas v. Kaiser Found. Health Plans, No. 9807419 (Tex. Dist. Ct., filed July 13, 1998)).

37. See Brown & Hartung, *supra* note 36, at 33-35 (describing state mandated benefits laws), 36-40 (describing "any willing provider" laws that force MCOs to contract with any provider willing to accept the MCO's terms).

38. For a description of recent state "anti-fraud" efforts centering on MCO failures to comply with relevant regulatory provisions, see Kristen Hallam & Chris Rauber, *Fraud Probes Target HMOs: States Attack Plans for False Marketing, Care Denials*, MOD. HEALTHCARE, Sept. 14, 1998, at 22 (describing MCO fraud probes in California, New York, and South Carolina, alleging that HMOs have used misleading marketing materials, improperly denied enrollees access to mental health professionals, improperly delayed claims payment, and engaged in improper enrollment and disenrollment activities).

39. For example, the Texas Insurance Code provides for revocation of an insurer's license for violations of (or failure to comply with) the relevant laws, rules or regulations. In lieu of revocation, the Commissioner may: (1) suspend a license for not more than one year; (2) enter a cease and desist order; (3) impose an administrative penalty (generally not to exceed \$25,000); or (4) require the violator to make restitution. See TEX. INS. CODE ANN. art. 1.10(7), 1.10A (cease and desist orders), 1.10E (monetary penalties) (West 1998). See also N.J. STAT. ANN. §§ 26:2S-16, 26:2S-24 (West 1998) (imposing civil penalties, license suspension or revocation, cease and desist orders, and/or injunctive relief against licensed insurer or MCO that violates anti-gag clause law).

the MCO to bring its activities into compliance.⁴⁰ Where violative activities can be identified and corrected, and past practices can be remedied through restitution and the imposition of reasonable fines, interruption in the MCO's provision of services should be minimal. Moreover, the ability to look to detailed insurance requirements also makes it possible to craft settlements carefully targeted to eliminating the problematic behavior, rather than addressing improper conduct solely with the "blunt-edged sword" of large financial penalties or exclusion from government programs.⁴¹

C. Consumer Protection

In addition to potentially violating state fraud and insurance laws, improper MCO activities also may be construed as a breach of the terms of the enrollment agreement (at least as those terms were understood by the enrollee). By consistently using a misleading enrollment agreement, or marketing policies in an inappropriate manner, the MCO clearly may violate the insurance provisions described above. To the extent that the MCO's actions are misleading or improper only with respect to an *individual* enrollee, that enrollee theoretically may have a viable cause of action against the MCO under a variety of legal theories, including breach of contract⁴² and the torts of misrepresentation, common law fraud, and bad faith breach of contract.⁴³ As Professor Joanne Stern has noted:

40. See, e.g., *Kaiser*, *supra* note 27, at 912 (identifying specific deficiencies in Kaiser's policies, such as inadequate disclosure of prostate screening availability and overly restrictive definitions of certain terms).

41. For example, even prior to enactment of the New York prompt payment legislation, Oxford Health Plans settled allegations of claims delays by instituting a timely payment schedule and agreeing to pay providers interest on delayed claims. See *Oxford Agrees to Pay Providers Interest on Delayed Claims, Ending Investigation* (hereinafter "Oxford"), 3 BNA's MANAGED CARE REP., Aug. 6, 1997, at 753, 754.

42. See, e.g., *McClellan v. Health Maint. Org.*, 604 A.2d 1053, 1061-62 (Pa. Super. 1992) (plaintiffs' allegations that MCO breached the subscriber contract, based on the MCO's express representations regarding the competency of its physicians and access to specialists, were sufficient to withstand a demurrer).

43. See, e.g., *McEvoy v. Group Health Coop.*, 570 N.W.2d 397 (Wis. 1997) (holding that the common law tort of bad faith applies to HMOs when they make decisions regarding the coverage of out-of-network benefits). However, it may be difficult for plaintiffs to succeed on these claims. See, e.g., *Humana Hospital-Bayside v. Lightle*, 407 S.E.2d 637 (S.C. 1991) (plaintiff unsuccessfully alleged negligence, fraud, bad faith and estoppel against HMO for failure to pay claim for emergency services where HMO was not notified of hospitalization within time period required by the subscriber contract); Kathy L. Cerminara, *The Class Action Suit as a Method of Patient Empowerment in the Managed Care Setting*, 24 AM. J. L. & MED. 7, 28-29 (1998)

[C]ertain insurance cases have pointed to the consumer's misplaced reliance on company slogans and advertisements promising security ("a piece of the rock"), partiality and concern ("we're on your side"), and peace of mind ("you're in good hands"). When the "good hands" drop you arbitrarily or you discover that "your side" consistently is not their side, this may lead to a tort action based on breach of the good faith covenant, as well as on fraud and misrepresentation.⁴⁴

However, plaintiffs often face significant legal obstacles in challenging their MCOs.

In particular, where the patient is enrolled in the MCO through an employee benefit plan, many of these causes of action may be preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").⁴⁵ As one means of promoting safety and uniformity in the administration of plans nationwide, ERISA preempts state laws that "relate to any employee benefit plan," with the exception of laws that regulate insurance, banking, or securities.⁴⁶ Although primarily designed to protect employees and their dependents, this broad "preemption clause" has also been used as an affirmative defense by HMOs, who successfully have argued that tort and contract suits by patients covered by employer-sponsored health benefit plans are preempted because such suits "relate to" the administration of the health plan.⁴⁷

Rather than relying on common law theories of tort and contract, patients and state regulators have begun to look to an-

(noting heavy burden of proof that plaintiffs must meet in order to prove common law fraud claims).

44. Joanne B. Stern, *Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?*, 85 W. VA. L. REV. 911, 925 (1983).

45. See 29 U.S.C. § 1001 *et seq.* (1998).

46. See *id.* § 1144(a), (b)(2)(A).

47. See, e.g., *Toledo v. Kaiser Permanente Med. Group*, 987 F. Supp. 1174 (N.D. Cal. 1997) (plaintiffs' allegations of breach of contract, breach of implied covenant of good faith, fraud, and infliction of emotional distress were preempted under ERISA); *Ryan v. Fallon Community Health Plan, Inc.*, 921 F. Supp. 34, 37-38 (D. Mass. 1996) (common law breach of contract claims are preempted by ERISA); *McClellan*, 604 A.2d at 1062 (although record was not sufficient to resolve the question, court noted that if the defendant "is a valid ERISA employee benefit plan, it would appear that the contract claims are preempted"); *McManus v. Travelers Health Network*, 742 F. Supp. 377, 379-80 (W.D. Tex. 1990) (common law claims of breach of duty of good faith and fair dealing are preempted under ERISA). *But see* *HealthAmerica v. Menton*, 551 So. 2d 235 (Ala. 1989) (ERISA does not preempt common law action for fraud in the inducement because allegation that plaintiff relied on defendant's misrepresentations in dropping his previous insurance and electing defendant's coverage does not "relate to" an employee benefit plan).

other source for protection: state consumer protection laws, which generally prohibit “unfair methods of competition” and “unfair or deceptive trade practices.”⁴⁸ Unlike more recent provisions enacted specifically to protect patients from specific managed care activities, these laws protect patients as “consumers” in their “business” dealings with MCOs. The use of traditional consumer protection statutes provides a number of advantages for plaintiffs. From an advocacy perspective, MCO enrollees’ ability to use these laws situates their disputes squarely within the rich tradition of consumer protection actions, and may help to rally patients and legislators to fight for the rights of health care patients.⁴⁹ From a practical perspective, these statutes are useful because they often permit private actions by competitors or consumers who have been injured by the unfair practice, in addition to permitting actions by the state attorney general.⁵⁰ Moreover, the penalties available under these laws are extremely broad, including discontinuance of the improper practice, injunctive relief, restitution, civil penalties payable to the state, and dissolution of a business entity or loss of the right to do business in the state (for repeated violations). Additionally, double or treble damages, as well as costs and attorney fees, are often available for private plaintiffs who can prove certain wilful violations.⁵¹

Yet the road to consumer protection for patients has not been a smooth one. Most consumer protection statutes apply only to

48. These laws are often based on the Federal Trade Commission Act or model consumer protection statutes, such as the Unfair Trade Practices and Consumer Protection Law, the Uniform Consumer Sales Practices Act, and the Uniform Deceptive Trade Practices Act. See Lee Ann Bundren, *State Consumer Fraud Legislation Applied to the Health Care Industry: Are Health Care Professionals Being “Consumed”?*, 16 J. LEG. MED. 133, 134-36 (1995) (describing various models of consumer protection); MICHAEL M. GREENFIELD, *CONSUMER LAW: A GUIDE FOR THOSE WHO REPRESENT SELLERS, LENDERS, AND CONSUMERS* 159-63 (1995).

49. See generally Cerminara, *supra* note 43, at 18-19 (describing relatively powerless status of patients in managed care, and the heightened need for consumerism). However, not all patient rights advocates agree that consumerism is an acceptable model. As Professor George Annas has argued, “We can call people who buy health insurance consumers and people who join health plans members, but we must recognize that sick people who seek medical care are patients with rights that should be protected.” George J. Annas, *A National Bill of Patients’ Rights*, 338 NEW ENGL. J. MED. 695, 697 (1998).

50. See, e.g., MASS. GEN. LAWS ANN. ch. 93A, §§ 4, 9, 11 (West 1998). By contrast, traditional fraud and abuse statutes and insurance regulations usually do not allow private rights of action for damages (outside of the False Claims Act *qui tam* context). See Bundren, *supra* note 48, at 164.

51. See, e.g., MASS. GEN. LAWS ANN. ch. 93A, §§ 4-5, 8-9, 11 (West 1998); Bundren, *supra* note 48, at 164-65.

“goods or services” in “trade or commerce,” and not to “professional services.” The traditional theory behind such exclusions is that professions such as medicine are regulated by other means, most notably the professional licensure and disciplinary structure.⁵² Moreover, in an attempt to limit the reach of these laws to activities that were not otherwise actionable under common law tort and contract theories, legislators and courts often restricted these laws to situations where the activities at issue affected the public interest, and resulted (or had the potential to result) in public injury.⁵³

As the practice of medicine has increasingly grown to resemble that of a traditional business, however, legislative and judicial recognition of both the professional exclusion and the public injury requirement have waned. For example, in 1990, the Illinois legislature amended the Consumer Fraud and Deceptive Business Practices Act to abolish the public injury requirement; a federal district court later relied on this amendment in holding that the “business aspects” of medicine were *not* exempted from the law.⁵⁴ Similarly, the Minnesota Court of Appeals has recognized that patients may have a private right of action against physicians under the state’s Consumer Fraud Act, provided they can prove the existence of the requisite financial injury.⁵⁵ And even where the actual practice of medicine by a *physician* remains exempted, courts have applied consumer protection statutes to health care business *entities*, including HMOs. In *Johnston v. Anchor Organization for Health Maintenance*, for example, the Illinois Appellate Court held that an HMO’s misrepresentations regarding the payment of a patient’s bills (including a refusal to cover previously approved care, concealment of eventual payment of the bill, and misrepresentations that the patient still owed money) were actionable under

52. See, e.g., Bundren, *supra* note 48, at 141; OHIO REV. CODE ANN. § 1345.01 (Anderson 1998) (excluding dealings between physicians and patients from the definition of “consumer transactions” covered by the Consumer Sales Practices Act).

53. See, e.g. Bundren, *supra* note 48, at 138-41.

54. See *Gadson v. Newman*, 807 F. Supp. 1412, 1415-18 (C.D. Ill. 1992). The current version of the statute requires “[p]roof of a public injury, a pattern, or an effect on consumers and the public interest” in actions against vehicle dealers, but is silent regarding actions against others. See 815 ILL. COMP. STAT. 505/10a(a) (West 1998).

55. See *D.A.B. v. Brown*, 570 N.W.2d 168, 172-73 (Minn. Ct. App. 1997) (dismissing Consumer Fraud Act claims by patients against physician previously convicted of accepting kickbacks in connection with the prescription of a particular drug, on the grounds that plaintiffs failed to allege the requisite injury).

the Illinois Consumer Fraud and Deceptive Business Practices Act.⁵⁶

In fact, the potential conflicts of interest inherent in many managed care financial arrangements, combined with patients' relative lack of power, would appear to warrant increased application of consumer protection statutes to MCOs.⁵⁷ For patients, however, the biggest obstacle to successful suits may continue to be the federal law of ERISA. Federal courts have held that consumer protection statutes are preempted as applied to MCO enrollees who receive health benefits from their employers because the claims usually "relate to" employee benefit plans, and the statutes cannot be "saved" as laws primarily regulating the business of insurance. In *Anderson v. Humana*, for example, the Seventh Circuit rejected a challenge under the Illinois Consumer Fraud and Deceptive Business Practices Act by an ERISA plan participant who alleged that her HMO's incentive structure perpetrated a fraud on consumers.⁵⁸ Finding that the particular health plan information sought by the plaintiff would require a revision of various plan documents, the court held that the claim clearly "related to" the employee benefit plan. Applying the traditional definition of the "business of insurance," the court soundly rejected any argument that the consumer protection statute was "saved" as a law regulating the business of insurance:

Anderson invokes not a law regulating the methods of pooling risks or the prices to be charged. Instead she contends that Humana deceived consumers about the costs and benefits of the choices open to them under ERISA plans. . . Anderson relies on an all-purpose truth-in-business statute, applicable primarily to used car salesmen and the promotional literature for vacuum cleaners. It does not apply to insurance at all—not directly, anyway.⁵⁹

Because the plaintiff failed to argue that the HMO's actions violated ERISA itself, the court upheld dismissal of the complaint.⁶⁰

56. See *Johnson*, 621 N.E.2d 137 (Ill. Ct. App. 1993).

57. See, e.g., Bundren, *supra* note 48, at 153-60 (arguing that HMOs are appropriate targets for consumer protection actions).

58. See *Anderson*, 24 F.3d 889 (7th Cir. 1994).

59. *Id.* at 892.

60. See also *Ryan*, 921 F. Supp. at 38 (Massachusetts consumer protection statute "clearly is not a state statute which regulates insurance"); *McManus*, 742 F. Supp. at 382 (Texas Deceptive Trade Practices Act does not fall within ERISA's savings clause). The Federal Employees Health Benefits Act also has been held to preempt

In contrast, in *Napoletano v. CIGNA Healthcare*, the Supreme Court of Connecticut allowed a group of physicians who had been removed from a managed care health network, as well as their patients, to sue under the Connecticut Unfair Trade Practices and Unfair Insurance Practices Acts.⁶¹ The court explained that the plaintiffs' allegations in the case did not "relate to" the employee benefit plan:

Rather than affecting or prescribing the establishment, administration, regulation or maintenance of an employee benefit plan, the plaintiffs' claims merely turn on requiring CIGNA to enforce the benefit plan that it has already established and is maintaining. . . . Neither class of plaintiffs is requesting that CIGNA change the method by which it determines which physicians will be providers under its plan—in other words, the plaintiffs are not claiming that CIGNA should change its list of criteria. Instead, the plaintiffs are merely asking that CIGNA disclose its criteria and, subsequently, adhere to them.⁶²

Because it found the claims did not "relate to" an employee benefit plan, the court did not address the issue of whether the consumer protection laws would fall within the savings clause.⁶³ Thus, whether an action based on violation of state consumer protection laws will be subject to ERISA preemption is likely to depend on the substance of the underlying dispute. Despite the potential pitfalls associated with the consumer protection pri-

consumer protection claims against HMOs by federal employees who receive medical benefits through the government's employee benefits program. *See, e.g.,* *Negron v. Patel*, 6 F. Supp. 2d 366 (E.D. Pa. 1998). In many of the ERISA cases, the plaintiffs have sought to rely on the consumer protection statute only after arguing unsuccessfully for a private right of action under the relevant *insurance* regulations — which presumably *would* fall within the savings clause. *See, e.g.,* *Anderson*, 24 F.3d at 892 (no private right of action under insurance regulations tracking the Consumer Fraud Act); *Ryan*, 921 F. Supp. at 38 (rejecting private right of action under insurance code).

61. *See Napoletano*, 680 A.2d 127 (Conn. 1996), *cert. denied*, 117 S. Ct. 1106 (1997).

62. *Id.* at 143. *Cf. Moran v. Rush Prudential HMO, Inc.*, No. 98 C 0422, 1998 WL 325204 (N.D. Ill. June 9, 1998) (remanding to state court plaintiff's suit for specific performance by HMO under state law requiring HMOs to provide independent physician review of medical necessity, on the grounds that it was not an ERISA claim).

63. However, a federal district court had held two years earlier that a plaintiff's claims under the same laws that her insurer improperly released her husband from a treatment center, leading to his subsequent suicide, were preempted because they were "based on the contention that defendant improperly administered her husband's claim." *See Bailey-Gates v. Aetna Life Ins. Co.*, 890 F. Supp. 73, 77 (D. Conn. 1994). The court went on to note that "it is well established in this district that ERISA's savings clause does not except the [consumer protection] claims from preemption." *Id.* at 79.

vate right of action, it may remain a viable cause of action under certain circumstances.

Moreover, consumer protection statutes offer a great deal of flexibility to state attorneys general, who have crafted innovative settlements with health care entities. For example, even before the enactment of the New York health insurer prompt payment requirements, Attorney General Dennis Vacco invoked the general consumer protection laws to investigate payment delays by Oxford Health Plans, an investigation that resulted in Oxford's agreement to pay interest on delayed claims and to establish a schedule of timely payments.⁶⁴ Regardless of whether these allegations would have prevailed in court, these settlements demonstrate the significant power and flexibility of consumer protection laws as applied to the health industry by state regulators, and sound a cautionary note for future MCO practices.

III. THE ROLES OF THE STATE AND FEDERAL GOVERNMENTS

Clearly, the states have a great deal of flexibility to address improper activities by MCOs. Activities may be pursued as violations of relevant insurance requirements, either general or MCO-specific, which are likely to result in fines and agreements to cease the improper behavior. Activities also may be addressed through consumer protection actions, brought by the attorney general or by individual MCO subscribers, resulting in damages, fines, injunctive relief and restitution. In more egregious cases, when there is concrete evidence of an intent to defraud patients or payers, violators may be pursued through traditional anti-fraud laws, potentially resulting in heavy fines or penalties (including criminal liability). State regulators may combine or choose among these options in tailoring settlements

64. See *Oxford*, *supra* note 41, at 753. Similarly, in the mid-1990s, there were several agreements between drug manufacturers and a consortium of state attorneys general that resulted in payment of substantial fines under state consumer protection laws. In one of these cases, the manufacturer had instituted a program (without patient knowledge) under which it offered to compensate pharmacists for "educating" patients whom they convinced to switch to the manufacturers' newer products — allegedly failing to provide for appropriate disclosure to consumers. See, e.g., *In re Upjohn Co.*, No. C7-94-7856, Order Approving Assurance of Discontinuance (Ramsey Cty. Dist. Ct., Aug. 1, 1994) (settlement with Attorneys General in Minnesota, Arizona, Iowa, Missouri, New York, North Carolina, Texas and Wisconsin) (copy on file with author).

or enforcement actions that target the specific activities involved.

In contrast, the federal government appears to have fewer options to address MCO activities. Unlike the states, the federal government does not license health care professionals or entities; it merely determines which state-licensed individuals and entities will be permitted to receive payment for treating patients under the various federal health care programs.⁶⁵ Accordingly, federal settlements tend to consist of repayment of improperly received funds, payment of sizeable civil penalties or criminal fines, the imposition of onerous procedures designed to assure future compliance with program rules and, in the most egregious cases, imprisonment or exclusion from participation in all government-funded health plans.⁶⁶ The opportunities to tailor a settlement to the specific allegations at issue, except perhaps by varying the amount of the penalty or the specific conditions of the corporate integrity agreement, are limited.

This dual approach to MCO regulation may have a number of unintended effects, particularly with respect to the characterization of government investigations. While improper activities in the state context may be characterized as a mere "failure to comply" with relevant insurance requirements, those undertaken in the context of federal health care programs are invariably investigated, publicized, and denounced as outright "fraud." As an example, consider two articles that appeared in the trade press during the summer of 1998 regarding MCO failures to pay claims in a timely manner. One article, appearing under the heading "Claims Administration," described the New York Attorney General's desire to hear Aetna U.S. Healthcare's "side of the story" and to negotiate a resolution regarding allegations of delayed payment.⁶⁷ Yet on the *very next page*, an article under

65. See, e.g., 42 U.S.C. §§ 1395 (providing that "[n]othing in [the Medicare law] shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided"), 1395w-25(a) (requiring that all Medicare+Choice organizations be licensed under state law as risk-bearing entities eligible to offer health insurance or health benefits coverage, with the exception of certain provider-sponsored organizations) (1998).

66. Settlements often result in the imposition of mandatory "corporate integrity agreements" to assure future legal compliance. See, e.g., U.S. *ex rel.* Wagner v. Allied Clin. Labs., No. C-1-94-092 (S.D. Ohio, Mar. 20, 1995), reprinted in MEDICARE & MEDICAID GUIDE (CCH) ¶ 43,142.

67. See *Claims Administration: New York Attorney General Seeks Talks on Aetna U.S. Healthcare Payment Delays*, 4 BNA'S MANAGED CARE REP., Aug. 12, 1998, at 814.

the heading “Fraud and Abuse” related comments made by an Assistant U.S. Attorney and an F.B.I. supervisor, both of whom indicated that the federal government would aggressively pursue the same activity — MCO payment delays — under civil and criminal *anti-fraud* laws.⁶⁸

While the differences in characterization may be understandable, this example certainly illustrates the confusing and somewhat contradictory approaches taken at the federal and state levels. It also raises the somewhat disturbing possibility that whether or not an MCO is engaged in “fraud” depends not on *what the MCO is doing*, but on *who is investigating*. More importantly, it raises the question of which approach better serves MCO patients. Clearly, low quality MCOs, or those that engage in truly fraudulent activities, should lose their ability to provide services to patients — a result that can be achieved under either the state or federal approaches. But what of the MCO that engages in less abusive practices, violating applicable requirements without the risk of patient harm or threat of loss to government programs? Patients of these entities would appear to be better served by a regulatory settlement requiring the MCO to return improperly paid funds, pay a reasonable fine, and cease the offensive activities, instead of requiring the organization to pay an enormous penalty under the False Claims Act and threatening the MCO with the possibility of criminal liability and/or exclusion. Thus, the flexibility available to state officials would appear to better serve the interests of the patient population the laws are designed to protect.

The federal government has begun to recognize the importance of so-called “intermediate sanctions” providing for less draconian remedies than termination of the MCO’s ability to serve Medicare and Medicaid patients. Since 1994, the OIG has had the authority to suspend enrollment or payment and to impose moderate civil penalties on HMOs that engage in a variety of improper activities, such as failing to provide medically necessary items and services, improperly disenrolling or refusing to enroll beneficiaries, misrepresenting or falsifying information, or failing to comply with prompt payment requirements.⁶⁹ As one author has noted, these intermediate sanctions were neces-

68. See *Fraud and Abuse: MCOs Face Potential Criminal Actions for Claims Payment Delays, Denials*, 4 BNA’S MANAGED CARE REP., Aug. 12, 1998, at 815.

69. See 42 U.S.C. §§ 1395mm(I)(6)(A), 1396b(m)(5)(A) (1998); 42 C.F.R. § 417.500(a) (1997).

sary because the Health Care Financing Administration (“HCFA”) previously had been “reluctant to impose th[e] ultimate sanction [of termination] because this could result in less access to care for Medicare and Medicaid beneficiaries.”⁷⁰ These authorities have been augmented by additional (and controversial) requirements imposed on MCOs by the new Medicare+Choice regulations, including requirements that the MCO establish a compliance program, submit marketing materials for approval, certify the accuracy of all encounter data, and adopt specific types of grievance procedures.⁷¹

The ultimate effect of these new federal regulations is unclear. To the extent that they impose new requirements on MCOs similar to those imposed under the traditional state insurance licensure process, they should allow the federal government more flexibility in crafting settlements to better target specific improper MCO activities. However, to the extent that the new regulations merely duplicate (or preempt)⁷² existing state insurance requirements, they are likely to confuse the process even more, and subject both MCOs and their patients to an even more fragmented anti-fraud universe.

CONCLUSION

As this Article has argued, the states currently have a great deal more flexibility than the federal government to pursue improper MCO activities under a variety of theories, ranging from insurance regulation to traditional anti-fraud laws. This, in turn, allows the states to craft targeted settlements to address potential problems without interrupting patient access to care. There are some indications that the federal government is attempting to broaden its authority over more “regulatory” MCO violations, potentially offering greater flexibility at the federal level as well. However, the federal government still lags behind the states in this respect. Yet regardless of whether the authority is wielded by the federal government or by a state, the object of

70. See W. Bradley Tully, *New Intermediate Sanctions are Bad News for Managed Care*, 9 HEALTHSPAN 15 (1994).

71. See 63 Fed. Reg. 34,968 (1998) (interim final rule with comment period). See also 63 Fed. Reg. 52,022 (1998) (similar requirements contained in the proposed rule allowing states greater flexibility to require Medicaid recipients to enroll in MCOs). The breadth of the Medicare+Choice regulations has been controversial, however, and it remains to be seen whether many of these requirements will be implemented.

72. See 42 U.S.C. § 1395w-26(b)(3) (1998) (Medicare+Choice standards supersede inconsistent state laws or regulations).

MCO anti-fraud efforts should be the same: to achieve an appropriate resolution of the problem without imposing costs so great that they jeopardize the MCO's ability to provide quality services to its patients. Or, in the immortal words of Gilbert and Sullivan, the goal should be "to let the punishment fit the crime."⁷³

73. W.S. Gilbert, "*The Mikado, or The Town of Titipu*," in *THE BEST KNOWN WORKS OF W.S. GILBERT* 143-44 (1932).