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PHYSICIAN TERMINATIONS IN MANAGED CARE: WHY ARE THEY OCCURRING? HOW DO WE ENSURE THEY ARE JUST?

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I. INTRODUCTION

THIS ARTICLE DISCUSSES THE PROBLEMS faced by the physician and patient (also referred to in this Article as the “enrollee”) when a physician is terminated from a managed care plan. The Article also explains why physicians should be terminated only for reasons which constitute justifiable cause, and examines the laws developed in California to discourage unjust terminations.

II. NEGATIVE EFFECTS OF PHYSICIAN TERMINATION

Physicians currently are being terminated from managed care plans for various reasons, many of which are discussed herein. Managed care plans have coined the term “de-selection” to describe the process of terminating physicians from managed care plans. This term is a euphemism. Termination of the physician from a managed care plan often causes serious hardship for the physician’s patients who are, in most cases, unable to continue to see their physician. This can be devastating for patients, especially those with long-term illnesses who are accustomed to confiding in and trusting one physician. Long-term physician-patient relationships should not be interrupted unless good cause exists. Meaningful patient choice of a physician and a continuous physician-patient relationship is essential for enrollee satisfaction with a managed care plan. Moreover, termination from a plan often has a severe financial impact on the physician. Physicians

* Legal Counsel, California Medical Association. The author thanks Astrid G. Meghrigian, Esquire, for her assistance with the antitrust analysis contained in this Article.

could lose fifty percent (or more) of their patient bases when they are terminated from a plan.

III. THE PLAN SHOULD BE REQUIRED TO GIVE THE REASON FOR TERMINATION

Because of these extreme negative effects on both the patient and the physician, plans should be required, either by contract or pursuant to law, to give physicians the reason for their termination. Unfortunately, however, most physician participation contracts state that the physician may be terminated without cause, that is, for any reason or no reason, upon a prior written notice. A California law requires health maintenance organizations (HMOs) and other health plans licensed under California's Knox-Keene Act to give physicians the reason for termination whenever: i) the termination is for quality reasons; or, ii) the termination occurs during, as opposed to at the expiration of, the contract year.¹

Providing a reason for termination is important as it gives the physician terminated for quality reasons the option to pursue hearing rights afforded under state and/or federal law.² Providing the reason for termination also ensures that physicians have an opportunity to inform the plan of any mistake regarding the reason given. Moreover, if the reason for the termination involves patient relations, such as bedside manner or waiting times for appointments, disclosure of such information will enable physicians to improve their patient relation skills.

IV. POTENTIALLY APPROPRIATE REASONS FOR PHYSICIAN TERMINATION

The following discussion describes several reasons that may constitute good cause for physician termination where the termination is conducted appropriately.

1. CAL. HEALTH & SAFETY CODE § 1373.65 (West Supp. 1996). In California, the law governing HMOs (and some Blue Shield plans) is called the "Knox-Keene Act." Plans governed by the law are called Knox-Keene plans, most of which are HMOs. *Id.* § 1340.

2. See *infra* IV.A.1.

A. Termination For Quality Reasons

As a general matter, if a physician is terminated because his or her care or competence remains substandard after educational intervention and an opportunity to improve skills, the physician's termination is best for all parties involved. Patients should not be subject to incompetent physicians, and incompetent physicians should not be permitted to practice. Termination for quality reasons triggers the filing of a report with the state licensing board and the National Practitioners Data Bank. This ensures that the physician's license to practice is affected appropriately by the reason for termination.

1. Hearing Rights

A physician may be terminated purportedly for quality reasons, however, in order to mask the true reason for termination. The termination may be political or it may be for anticompetitive reasons.³ Therefore, when a physician is terminated purportedly for quality reasons, state law should require that a hearing be afforded the physician.⁴ A hearing is necessary to determine

3. See, e.g., *Miller v. Indiana Hosp.*, 843 F.2d 139, 144-45 (3rd Cir. 1988) (finding sufficient evidence to preclude summary judgment on the question of whether termination was for anticompetitive or quality reasons). See also *Patrick v. Burget*, 486 U.S. 94 (1988). In *Burget*, an Oregon surgeon declined an invitation to join a clinic, and instead became a competitor. The peer review committee, comprised in part of the competing physicians, recommended termination from the hospital medical staff on the grounds that the physician's care was substandard.

4. See, e.g., CAL. BUS. & PROF. CODE §§ 809.1-809.9 (West 1990 & Supp. 1996). Under the Code, the entities must afford the physician, as well as other practitioners, a hearing if the physician is terminated for medical quality reasons. A hearing must be afforded even if the physician's contract says that a termination is final and the physician has no hearing rights:

(A) A medical or professional staff of any health care facility or clinic . . . or of a facility certified to participate in the federal Medicare program as an ambulatory surgical center.

(B) A health care service plan registered under [the Knox-Keene Act]

(C) Any medical, psychological, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(D) A committee organized by any entity [e.g., an IPA] consisting of or employing more than 25 licentiates of the same class which functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

Id. § 805(a)(1)(A)-(D). The code also specifies many protections for the accused physician to ensure that due process is afforded. *Id.* §§ 809.1-809.9.

whether a true quality issue exists, whether termination, which is an egregious remedy, is warranted, or whether physician education would remedy the problem.

If a hearing is not required under state law, or if the physician is contracting with a plan outside of the physician's state, the plan may provide for a hearing when the physician is terminated for quality of care reasons in compliance with the federal Health Care Quality Improvement Act (HCQIA).⁵ The HCQIA does not mandate that plans comply with its notice and hearing provisions; rather, it provides immunity protections for those that do. The HCQIA generally immunizes from liability peer review action under state and most federal laws (including the antitrust laws) if the action is taken:

- a. in the reasonable belief that the action taken promotes quality health care;
- b. after a reasonable effort to obtain the facts;
- c. in the reasonable belief that the action is warranted by the facts known; and,
- d. after the physician involved receives adequate notice and a fair hearing.⁶

With respect to the fourth element of the immunity—the notice and hearing requirements—the Act establishes a “safe harbor” to guarantee that the notice and hearing will be found to be “fair” if certain stated procedures are followed.

B. Termination as a Result of Poor Utilization Profile After Educational Intervention

Managed care organizations increasingly are developing utilization profiles of physicians. Such profiles, or report cards as they are sometimes called, are used to tell physicians whether their utilization of services is appropriate, that is, whether they could provide lesser care or less expensive care while (hopefully) maintaining quality. These profiles may be used for everything from purely educational exercises, to calculating payment, to making termination decisions. Regardless of the use to which the profile will be put, utilization cannot be analyzed in a vacuum. In order for utilization reports to be accurate, to enable a physi-

5. 42 U.S.C. §§ 11101-11152 (1994) (providing standards for professional review actions and the reporting of such information to promote review activity).

6. *Id.* § 11112 (listing the general standards for professional review actions).

cian to educate herself, and, to provide a fair basis for termination decisions, the report should take into account at least the following points.

1. The Severity of Illness

Adjustments need to be made for the differences in severity of illness of the physician's patients, especially in the case of physicians who see relatively fewer patients and for whom catastrophic cases will have a greater chance of producing a negative utilization report. Severity of illness is a term used to describe the relative health of the physician's patient population. Physicians who see sicker patients should not receive a bad profile or report card when their high utilization is due primarily to that fact. Rather, such profiles should take into account the relative health of the physician's patients. Catastrophic cases should be eliminated from the physician's utilization analysis in determining the cost-effectiveness of the physician on a usual, day-to-day basis.

A recent study appearing in the *Journal of the American Medical Association* concludes that "nonwhite physicians are more likely to care for minority, medically indigent and sicker patients."⁷

With respect to physician profiling, the author states, Physician profiling requires adjustment for severity of illness to distinguish poor patient outcomes attributable to more severe illness from poor patient outcome attributable to poor-quality medical care. Because nonwhite physicians care for sicker patients, they are particularly dependent on accurate adjustment for severity of illness. Failure to adjust adequately could deny nonwhite physicians just reimbursement or erroneously attribute poor patient outcomes to poor care.⁸

Plans would do well to be aware of this study, adjust their statistics properly, and take care not to penalize minority and other physicians for treating a sicker population.

7. Ernest Moy & Barbara A. Bartman, *Physician Race and Care of Minority and Medically Indigent Patients*, 273 JAMA 1515, 1517 (1995).

8. *Id.* at 1518.

2. Physician Specialty and Diagnostic Mix: Patient Demographics

Specialists and primary care physicians (PCPs) should be evaluated separately. Generally, a patient who is referred to a specialist has a more advanced or complicated condition, and consequently, care is more costly. This problem is particularly acute for subspecialists. Likewise, adjustments should be made for each physician's diagnostic mix. This allows one to compare, for example, gynecologists who do not deliver babies with those who provide the full range of obstetrical and gynecological services.

The plan likewise should account for the demographic mix of patients. If a physician with an older patient mix is compared with a physician who has a younger patient mix, the former will appear less cost-effective if adjustments are not made for the demographic mix.

3. Profiling Systems and Procedures

Plans should use sophisticated software capable of making necessary adjustments to data and taking into account the points mentioned above. Moreover, regular assessments should be made of the quality of care provided by the physicians being profiled. Plans should use educational intervention before termination is considered, to teach physicians to use services which are of equal or better quality. These may include efforts to improve physician awareness of the costs and clinical indications of tests, procedures, and treatments, and to provide feedback to the physicians regarding their expenditures for patient care and the clinical appropriateness of their practices. Educational intervention often is effective in reducing the utilization of services. A physician participation contract never should be terminated for high utilization unless such utilization was inappropriate, the physician has been informed of the problem, and has been given sufficient time to correct the behavior.

4. Termination For Business Reasons

Managed care plans (like all businesses) should be permitted to terminate physicians for *legitimate* business reasons, for example, because the plan has too many physicians in a particular specialty or because a plan is appropriately "downsizing." How-

ever, business reasons should not be used as a ruse for inappropriate termination. For example, some plans hire large numbers of physicians before the open enrollment period⁹ so that their physician lists look expansive and contain many of the employees' preferred physicians. After open enrollment, some plans terminate many of the recently hired physicians, purportedly for business reasons. The doctors, however, were hired only to make the plan roster look comprehensive. This type of fraudulent activity should be prohibited and, indeed, is prohibited under some states' HMO laws.¹⁰ Too, plans should not be allowed to "downsize" their panels to the extent that there is not adequate, geographically accessible access to physicians.

V. INAPPROPRIATE REASONS FOR PHYSICIAN TERMINATION

Managed care plans terminate physicians for other reasons which are inappropriate and should not be tolerated under the law.

A. Retaliation By Managed Care Plans

Most managed care contracts state that the plan may terminate the physician "without cause"; that is, for any reason or no reason at all. Plans have terminated physicians under this no cause termination provision because a physician protested a utilization review (U.R.) decision that the physician felt was adverse to patient care.¹¹ Termination also has occurred where physicians have otherwise communicated with the plan regarding U.R. procedures that could adversely affect the quality of care. In one case, a patient needed a magnetic resonance imaging (MRI) scan, but it was denied by the U.R. committee. The physician was adamant that the MRI was medically necessary. He vociferously appealed to the committee to authorize the MRI. The committee again refused to authorize the scan. The physician repeatedly ap-

9. "Open enrollment" is the window period during which employees may change from one health care plan to another.

10. CAL. HEALTH & SAFETY CODE § 1360(a)(1) (West 1990) (providing that "[a] written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an enrollee . . . or potential enrollee . . .").

11. "Utilization review" is the term applied to a plan's oversight of a practitioner's services to determine whether the services are too costly and/or unnecessary.

pealed the U.R. committee's decision, and the MRI scan finally was approved. The physician, however, was terminated from the plan two weeks later.¹²

Another case involved a physician who requested a meeting with a plan's U.R. committee to discuss the plan's second-opinion program, an aspect of a U.R. program that requires patients to seek second opinions when costly treatment is prescribed by a physician. This physician felt that the program sometimes required his patients to travel great distances in order to obtain the second opinion, and that in many cases, such travel resulted in great hardship to the already ill patient. The U.R. committee listened to the physician's criticism of the program, then terminated the physician from the plan.¹³

Because of cases such as these, the California Medical Association sponsored legislation in California to address these problems. The law became effective in 1994. Under this law, plans (and other entities) are prohibited from terminating or otherwise retaliating against a physician for appealing denials of care or communicating with the plan in order to improve patient care.¹⁴ The law states that it is the public policy of the State of California that a physician be encouraged to advocate for medically appropriate health care for his or her patients. "To advocate for medically appropriate health care" under the statute means to appeal a payor's decision to deny payment for a service pursuant to the plan's grievance or appeal procedure, or to protest a decision or policy that the physician reasonably believes impairs the physician's ability to provide medically appropriate care to his or her patients.¹⁵ Moreover, the law provides that a decision to terminate an employment or other contractual relationship, or otherwise to penalize a physician for advocating for medically appropriate health care, violates the public policy of California.¹⁶ The new law, however, does not prohibit a payor from making a determination not to pay for a particular medical treatment or ser-

12. These facts were reported by the physician in requesting assistance from the medical association.

13. These two examples, among others, prompted the California Medical Association's sponsorship of corrective legislation.

14. CAL. BUS. & PROF. CODE § 2056 (West Supp. 1996) (stating that the law applies to medical groups, individual practice association (IPAs), preferred provider organization (PPOs), foundations, hospital medical staffs and governing bodies, and payers).

15. *Id.* § 2056(b).

16. *Id.* § 2056(c).

vice, nor does it prohibit a managed care plan or hospital medical staff from conducting necessary peer or utilization review.¹⁷

It is important that managed care plans be prohibited from terminating physicians who appeal decisions which adversely affect patient care, because both the physician and the plan may be held liable when a patient suffers harm as a result of a bad U.R. decision.¹⁸ The *Wickline* and *Wilson* cases require physicians to protest or appeal adverse U.R. decisions on behalf of their patients. This is done by exhausting the plan's appeal procedures, or, if none exist, by communicating with the plan to persuade the plan to change its decision.

B. Lack of Board Certification

Many employers require that their contracting HMOs be accredited by the National Committee for Quality Assurance (NCQA). NCQA Standards require that plans consider board certification¹⁹ as part of the credentialing and recertification standards.²⁰ Moreover, NCQA devises report cards for each HMO using what is known as the Healthplan Employer Data Information Set (HEDIS). One element of the HEDIS criteria is the percentage of board-certified physicians in the plan. Plans with higher percentages are seen (however accurately) as being of higher quality. Therefore, managed care plans now are excluding and terminating nonboard-certified physicians. No studies, however, have demonstrated that board-certified physicians provide higher quality care than nonboard-certified physicians.

The lack of board certification *standing alone* should not be a reason for exclusion from a plan. In a 1994 Report,²¹ the U.S. General Accounting Office stated that: "One measure of quality used by many health plans and included in report cards is the

17. *Id.* § 2056(d).

18. See *Wickline v. State*, 239 Cal. Rptr. 810 (Ct. App. 1986) (holding that a third party payor may be held liable for medically inappropriate decisions). See also *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 883 (Ct. App. 1990) (finding sufficient evidence to raise triable issue of fact as to whether U.R. decision to terminate benefits contributed to patient's death).

19. Physicians who complete an extensive residency program and pass an intensive exam in a particular specialty area are said to be "board certified" in that specialty.

20. See NATIONAL COMMITTEE FOR QUALITY ASSURANCE, REVIEWER GUIDELINES: STANDARDS FOR ACCREDITATION, CR 5.4, CR 10.2.4 (1995).

21. U.S. GEN. ACCT. OFFICE, HEALTH CARE REFORM: "REPORT CARDS" ARE USEFUL BUT SIGNIFICANT ISSUES NEED TO BE ADDRESSED, GAO/HEHS-94-219 (1994) (asserting that some measures of purported quality used by many health plans are misleading).

number of board-certified physicians on staff. Presumably, the more board-certified physicians a plan has on its staff, the better the health care will be. *But research has not shown conclusively that board-certified physicians furnish better care.*"²² The report, in discussing the validity of quality measures, went on to say: "*No one has proven that the patients of board-certified physicians have better results than other patients. In fact, in five of seven studies reviewed by the Office of Technology Assessment (OTA), physician board certification showed no effect on performance.*"²³ Moreover, the report questioned the relevancy of board certification as a predictor of clinical ability. "Additionally, the certification process may be invalid—written and oral tests used to evaluate physician performance may not measure success in clinical practice."²⁴

Because it does not appear that termination or exclusion for lack of board certification enhances the quality of patient care, patients, physicians, and their lawyers may wish to work toward eliminating the NCQA standards and the HEDIS criteria that imply that board certification should be required.

C. Failure of the Physician to Join Other Plan Products

Some physicians are terminated because they do not want to participate in, or have terminated relationships with, other plan products. For example, a physician may be terminated from a plan's PPO product because the physician will not join, or has terminated a contract with, a plan's HMO product. Such terminations are not for good cause, but are an effort by plans to maintain market power in the unwanted product. Terminations for such reasons may be a violation of federal and state laws.

D. State Law Violation

A plan's retaliation against physicians for terminating other plan contracts may violate the Knox-Keene Act (a California HMO law) which requires that all physician contracts be fair and reasonable.²⁵ An implicit term in the contractual arrangement between the physician and the plan is that if a physician terminates

22. *Id.* at 5 (emphasis added).

23. *Id.* at 39 (emphasis added).

24. *Id.*

25. CAL. HEALTH & SAFETY CODE § 1367(h) (West 1990 & Supp. 1996).

her contract with one product, the plan will terminate the physician's contract with another product. Certainly, this anticompetitive term is not fair and reasonable, particularly given the additional problems discussed below.

E. Illegal Tying Arrangement

Both federal and state laws generally outlaw any combination or agreement which restrains trade or competition.²⁶ One form of an unlawful agreement is a tying arrangement, which the Supreme Court described as the seller's exploitation of its control over one product to force the buyer into the purchase of another product "that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms. When such 'forcing' is present, competition on the merits in the market for the tied product is restrained and the Sherman Act is violated."²⁷ Tying arrangements have no procompetitive purpose, and, accordingly, are not tolerated by the courts. Courts have recognized that:

[T]ying agreements serve hardly any purpose beyond the suppression of competition (citation omitted). They deny competitors free access to the market for the tied product, not because the party imposing the tying requirements has a better product or a lower price but because of his power or leverage in another market For these reasons "tying agreements fare harshly under the laws forbidding restraints of trade."²⁸

A plan's termination of a physician from one product because the physician rejects a different plan product presents a classic mirror image of the typical tying arrangement. By conditioning the ability of physicians to participate in one product on participation in another, plans are, in effect, coercing sellers of health care services, that is, physicians, to participate in the tied product. The net result is that plans are "insulate[d] . . . from

26. 15 U.S.C. § 1 (1994). See also CAL. BUS. & PROF. CODE §§ 16720, 16722, 16726 (West 1990).

27. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 12 (1984). The alleged tying arrangement in *Jefferson Parish* was an exclusive contract between a hospital and a group of anesthesiologists requiring all anesthesiology services at the hospital to be performed by the group. If a patient wanted to use the hospital and needed anesthesia services, the patient had to use the group for those services. The court held there was no illegal tying because there was no showing that the hospital had the power to force patients to use the tied product (the anesthesia group) because it had no forcing power (leverage) in the tying product (hospital services). *Id.* at 28-29.

28. *Northern Pac. Ry. v. United States*, 356 U.S. 1, 6 (1958).

the competitive stresses of the open market.”²⁹ Physicians are not choosing to participate in certain products because it is a better product, but rather because they must do so in order to participate in the desired product. This is precisely the type of activity that the antitrust laws are designed to prevent. “[T]he use of power over one product to attain power over another, or otherwise to distort freedom of trade and competition in the second product,” is prohibited.³⁰

F. Violations of the Anti-Kickback Statute

By requiring physicians to participate in an undesired product in order to participate in a desired program, a plan is, in effect, requiring physicians to pay for patient referrals: participation in the unwanted product is “payment for” being permitted to participate in the desired product and for receiving the referral of patients through the desired product. This may be unlawful because federal and some state laws prohibit paying or receiving compensation for referral of patients. Federal Medicare and Medicaid law prohibits “fee-splitting.” Federal law provides in pertinent part:

(1) Whoever 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 —

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under subchapter XVIII of this chapter [Medicare] or a State health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.³¹

29. *Times-Picayune Pub. Co. v. United States*, 345 U.S. 594, 605 (1953).

30. *Jefferson Parish*, 466 U.S. at 13 n.19 (quoting *Fortner Enterprises v. United States Steel Corp.*, 394 U.S. 495, 512-14 (1969) (White, J., dissenting)).

31. 42 U.S.C. § 1320a-7b(b)(1) (1994). *See also* *United States v. Bay State Ambulance & Hosp. Rental Serv., Inc.*, 847 F.2d 20 (1st Cir. 1989) (affirming conviction of defendants for arranging illegal referrals); *United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985), *cert. denied*, 474 U.S. 988 (1985) (finding a violation of the Medicare statute when even just one

By engaging in such activity, plans are “knowingly,” albeit, “indirectly,” soliciting a rebate (physician participation in an undesirable plan) in return for referring patients to the physician through the desired product. The prohibitions established by section 1320a-7b(b) apply to both the Medicare and Medicaid programs.

G. California Business & Professions Code Section 650

The offense defined in California Business & Professions Code section 650 contains five elements:

- (1) An offer, delivery, receipt, or acceptance
- (2) by physicians or other licensed health care providers, of
- (3) “consideration” (anything of value) to or from any person,
- (4) as compensation or inducement
- (5) for the referral of patients.³²

At least one California appellate court has reviewed the practice of compensating for referrals and found that it violated Business & Professions Code section 650.³³ The court said it would look through any subtle effort to circumvent section 650 by disguising the referral scheme involved.³⁴ A plan’s tying participation in one plan to participation in another is one such subtle effort. Third-party payors have strong financial incentives to shift patients into their HMO lines, and the potential for abuse is real. By offering physicians an HMO contract as a condition of referring patients under the PPO contract, plans are, in fact, engaging in the very activity that the anti-fee splitting laws were designed to address.

H. Unfair Business Practice

Similarly, the termination of one contract due to a physician’s failure to contract with another product is likely to be prohibited as an unfair business practice under state law. The California Business & Professions Code provides: “[a]s used in this chapter, unfair competition shall mean and include any unlawful,

purpose of the payment made to a physician was to induce future referrals); *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989) (reiterating the *Greber* “one purpose” test).

32. CAL. BUS. & PROF. CODE § 650 (West 1990 & Supp. 1996).

33. *Mason v. Hosta*, 199 Cal. Rptr. 859 (Ct. App. 1984) (affirming summary judgment of dismissal based on contract illegality).

34. *Id.*, at 863.

unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with section 17500) of Part 3 of Division 7 of the Business & Professions Code.”³⁵

Not only is such plan activity unlawful, for the reasons set forth above, but it is also unfair. The determination of whether a practice is unfair “involves an examination of [the practice’s] impact on its alleged victim, balanced against the reasons, justifications and motives of the alleged wrongdoer.”³⁶ Accordingly, a court must “weigh the utility of the defendant’s conduct against the gravity of the harm to the alleged victim”³⁷ Further, practices may be “unfair” even if they fit no pattern previously condemned by statute or case law.³⁸

A plan’s effort to terminate physicians from a desired plan because they choose not to participate in another plan product is unfair in every sense of the term. There are multiple victims harmed by such schemes. Physicians lose access to the vehicle by which they provide medical care to their patients; patients lose access to the physician of their choice, thereby disrupting the physician-patient relationship and the continuous provision of medical care. In contrast to the harm suffered by the victims, there is absolutely no beneficial or otherwise procompetitive motive behind such conduct. Indeed, it appears to be undertaken purely for the sake of self-interest and retaliation against individuals upon whom many plan enrollees have come to rely and trust.

35. CAL. BUS. & PROF. CODE § 17200 (West 1987 & Supp. 1996).

36. *Motors, Inc. v. Times Mirror Co.*, 162 Cal. Rptr. 543, 546 (Ct. App. 1980).

37. *Id.*

38. *See Allied Grape Growers v. Bronco Wine Co.*, 249 Cal. Rptr. 872, 883 (Ct. App. 1988).

VI. NOTICE TO PATIENTS

Whatever the reason for physician termination, patients should be notified in advance when their physician will be terminated from the plan. Such notice should give patients plenty of opportunity to take the following actions: i) to find a new plan physician; ii) to protest the physician's termination when the patient disagrees with the decision; and, iii) to find out what other plans the physician has contracted with so that the patient may endeavor to join one of those plans. The last condition is discussed below.

Under California law, when an HMO terminates a contract with a medical group or IPA, the plan must notify enrollees of that medical group or IPA of the termination.³⁹ When a plan terminates a contract with an individual physician within a medical group or IPA, the plan may request that the group or IPA notify the enrollees who are patients of that physician of the termination.⁴⁰

A. Patients Should Have The Opportunity to Stay with the Terminated Physician

Physicians should have a role in notifying patients of termination. A letter may be sent jointly by the plan and the physician advising patients that they have the right to choose one of the other plan physicians, or transfer to one of the other (listed) plans with whom the terminated physician contracts. This gives both sides equal opportunity to retain the patient as a consumer and is most beneficial to the patient.

B. Plan Efforts to Thwart Patient Choice of Physician

Managed care plans design various contractual provisions to prohibit terminated physicians from continuing to see plan patients through the physician's other plan affiliations. Plans may designate patient lists as "confidential trade secrets" to attempt to prohibit physicians from utilizing those lists to contact patients and inform them that the physician has been terminated. Some contracts require the physician to transfer medical records or copies thereof to the plan upon termination.

39. CAL. HEALTH & SAFETY CODE § 1373.65(a).

40. *Id.* § 1373.65(b).

Many managed care contracts with physicians contain a covenant-not-to-compete with the plan, effective both during the contract period and after termination. Covenants-not-to-compete *after* contract termination are enforceable in most states, but are *unenforceable* in others, under certain circumstances. For example, in California, they are unenforceable against physicians who do not have an ownership interest in the contracting entity.⁴¹

Despite plan efforts to keep patients within the plan, current law strongly suggests that a physician leaving a plan has the right to inform patients of the move and give patients the opportunity to choose whether to remain with the plan or to go with the physician. In *Jones v. Fakehany*,⁴² the court concluded that an ex-employee physician's patients had the right to continue to be treated by that physician if they so desired, and, therefore, the ex-employee was entitled to notify patients of the new location. In so ruling, the court stated that "[s]ince the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable."⁴³ It further stated that the physician-patient relationship "may not properly be regarded as the subject of 'ownership' " and that patients' access to the care of their physician of choice is not to be circumvented by the " 'property rights' of any competing physician."⁴⁴ Although the *Jones* case related to an employer group and employee physician, its reasoning would apply to the plan-physician relationship as well.

Moreover, in a Florida case, *Humana Medical Plan, Inc. v. Jacobson*,⁴⁵ the court held that subscribers are *not* the property of the HMO. The court held invalid a clause in an HMO contract that required a physician to pay liquidated damages for seeing HMO patients at another HMO after the contract terminated.

Managed care contracts also may contain an anti-solicitation clause, prohibiting physicians from soliciting patients to join them at another plan or practice. Case law in California suggests that anti-solicitation agreements may prohibit physicians from

41. CAL. BUS. & PROF. CODE §§ 16600-16601 (West 1987). See also *Bosley Medical Group v. Abramson*, 207 Cal. Rptr. 477 (Ct. App. 1984) (concluding that any agreement not to compete is void under § 16600).

42. 67 Cal. Rptr. 810 (Ct. App. 1968).

43. *Id.* at 815 (quoting the Opinions and Reports of the Judicial Council of the American Medical Association).

44. *Id.*

45. 614 So. 2d 520, 522 (Fla. Dist. Ct. App. 1992).

going beyond an appropriate professional announcement and affirmatively soliciting the patient's business, that is, "[t]o ask for with earnestness, to make petition for, to endeavor to obtain, to awake or excite to action, or to invite" such business.⁴⁶ It is unlikely that courts that follow the reasoning in *Jones* will prohibit announcements informing patients that they may continue to see the terminated physician and may authorize the transfer of medical records to that physician for the reasons described therein. The line between a lawful "announcement" and an unlawful "solicitation," however, is not clear.

VII. APPEAL OF TERMINATION DECISION

Some managed care contracts prohibit physicians from appealing contract terminations. Such provisions generally are unfair because the termination may be based on information which is inaccurate, mistaken, or requires physician explanation. For example, as discussed above, a minority physician's contract may be terminated because of a bad U.R. profile, when that physician's more infirm patient population is not considered. Moreover, as discussed above, if the contract is terminated for quality reasons, the physician may be entitled to a hearing under some state and federal laws.

A. The *Delta Dental* and *Ambrosino* Cases

A California case, *Delta Dental Plan v. Banasky*,⁴⁷ suggests that physicians terminated by managed care plans are entitled to a fair hearing under certain circumstances. The case did not involve a termination, but, rather, an issue about payment levels. The Delta Dental Plan is a dental HMO in California. The plan's review committee determined that certain dentists's usual, customary, and reasonable (UCR) fees were lower than the dentists had represented. This determination resulted in lower plan payments to the dentists. (Plan payments were based on a discount based on the UCR.) The court ruled, consistent with the California common law right to fair procedure, that the plan was required to give the dentists a fair procedure in response to their

46. *American Credit Indem. Co. v. Sacks*, 262 Cal. Rptr. 92, 99 (Ct. App. 1989) (quoting *Aetna Bldg. Maintenance Co. v. West*, 246 P.2d 11, 15 (1952)).

47. 33 Cal. Rptr. 2d 381 (Ct. App. 1994).

challenge to the decision regarding lower payments.⁴⁸ The dentists were entitled to fair procedure because the plan's reduction of the dentists's fees affected their "important economic interests."⁴⁹ The case specifically recognizes termination from a plan as another circumstance requiring fair procedure. The court stated: "California courts have long recognized a common law right to fair procedure protecting individuals from arbitrary exclusion or expulsion from private organizations which control *important economic interests*"⁵⁰

The court further stated: "Delta controls an important economic interest as the largest dental health plan in California, covering over 8,000,000 individuals. Therefore, *continued membership on Delta's panel of participating dentists* and Delta's modification of a participating dentist's list of usual, customary, and reasonable fees implicates the right to fair procedure."⁵¹

Similarly, a large HMO, PPO, or IPA that terminates a physician may control an important economic interest for that physician, depending upon, *inter alia*, the number of patients that the physician has with the plan and the plan's market share in the physician's practice area. Therefore, a termination from the plan's panel may implicate the right to fair procedure in California. While the language quoted above regarding termination was *dicta*, plan termination is generally more detrimental than a change in payment, and the courts should extend fair hearing rights in cases that affect "important economic interests."

The Case of *Ambrosino v. Metropolitan Life Insurance Company*,⁵² provides further support for the argument that plans must provide fair hearings. In that case, a podiatrist was terminated from a plan because of *prior* drug use. The podiatrist argued that his membership in the defendant's network was subject to the right to a fair procedure (hearing) to protect providers from arbitrary expulsion. The court agreed, citing the *Delta Dental* case, above:

The common law right to fair procedures has recently been held to extend to health care providers' membership in provider networks such as that operated by Defendant, because

48. *Id.* at 385.

49. *Id.*

50. *Id.* (quoting *Applebaum v. Board of Dir.*, 163 Cal. Rptr. 831 (Ct. App. 1980)).

51. *Id.* (emphasis added).

52. 899 F. Supp. 438 (N.D. Cal. 1995).

such managed care providers [sic] control substantial economic interests. [Citing, *Delta Dental Plan v. Banasky*, 27 Cal. App. 4th 1598 (1994)]. In the instant case, it is undisputed that Defendant controls substantial economic interests affecting Plaintiff, since prior to Plaintiff's termination approximately fifteen percent of Plaintiff's patients were insured by Defendant.⁵³

Accordingly, the court ruled that the plaintiff had a right to a fair procedure, including the right not to be expelled for reasons which are arbitrary, capricious and/or contrary to public policy. The court stated that based upon the public policy of encouraging drug rehabilitation and prohibiting discrimination for past dependency, a termination of a contract solely because of a person's status as a formerly chemical dependent person would be arbitrary and capricious, and thus deprived plaintiff of his legal right to a fair procedure.

VIII. CONCLUSION

As managed care proliferates, it is clear that for many physicians, being a member of a certain plan has a huge economic impact on the physician's ability to practice. The *Delta Dental & Ambrosino* cases are likely the beginning of many court decisions that will recognize that termination from a managed care contract interferes with the physician-patient relationship and often puts physicians in economic straits. Thus, courts should not permit plans to terminate physicians without cause.

53. *Id.* Citing *Ascherman v. San Francisco Med. Soc'y*, 114 Cal. Rptr. 681 (Ct. App. 1974) (holding that an estimated loss of business of 10% for first four years and another 10% thereafter is sufficient economic deprivation to trigger application of doctrine of fair procedures). However, *Ascherman* precedes later cases which state that there is no need to show any percentage of business affected for hospital and medical society termination; the termination in itself shows the loss of an important economic interest.

