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The Princess and the Pea: The Assurance of Voluntary Compliance Between the Texas Attorney General and Aetna's Texas HMOs and Its Impact on Financial Risk Shifting by Managed Care

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**THE PRINCESS AND THE PEA: THE ASSURANCE OF
VOLUNTARY COMPLIANCE BETWEEN THE TEXAS
ATTORNEY GENERAL AND AETNA'S TEXAS
HMOS AND ITS IMPACT ON FINANCIAL
RISK SHIFTING BY MANAGED CARE**

BRANT S. MITTLER* AND ANDRÉ HAMPTON**

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[M]anaged care [is] a vast shell game in which the pea is risk and the players are the shell Each shell from time to time doffs his hat and kicks the pea into somebody else's pocket.¹

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¹ Diane Beulke, *On the Outside Looking In: Morrow on the Future of Health Care*, MINNEAPOLIS/ST. PAUL CITY BUS., June 27, 1988, at 10 (quoting George Morrow, former CEO of Physicians Health Plan HMO).

[R]egulators and employers, those who are charged with protecting consumers and policy-holders, are too often the last to know that the hurricane just blew through the house. They need to have better (and more timely) information about the true financial conditions of the HMOs, PPOs, and networks they regulate or purchase Right now there are more managed care organizations on the verge of collapse than at any time in the past decade.²

We asked our doctors to act like insurance companies; that didn't work well.³

INTRODUCTION

A central feature of managed care has been the shifting of the financial risk of insuring against health expenditures away from managed care organizations (“MCOs”), and onto other parties in the health-financing system—employers, providers of health care, and patients.⁴ Governmental tolerance for this risk shifting has subsidized the participation of MCOs in the health-financing system in the United States⁵ by allowing MCOs to export the costs of doing

² Barry Scheur, *Compliance: It's Bigger Than You Think*, 1 *MANAGED CARE INSIDER* 1 (Sept. 1999) (divulging that in the 1980s, his management group staffed the National Association of Managed Care Regulators and authored “The HMO Regulatory Primer,” which became the “regulatory bible”), available at [http://www.scheur.com/scheur.nsf/smg/ newsletterVol1D1.htm](http://www.scheur.com/scheur.nsf/smg/newsletterVol1D1.htm).

³ Leigh Page, *Capitation at the Crossroads: The Trend Back to Fee for Service*, 44 *AM. MED. NEWS* 21 (Mar. 5, 2001) (quoting Stanley Borg, D.O., vice president of Health Services, Anthem Blue Cross and Blue Shield in Colorado), available at http://www.ama-assn.org/sci-pubs/amnews/pick_01/bisa0305.htm.

⁴ André Hampton, *Markets, Myths, and a Man on the Moon: Aiding and Abetting America's Flight From Health Insurance*, 52 *RUTGERS L. REV.* 987, 1008-09 (2000) [hereinafter Hampton, *Markets*] (describing the mechanism by which insurers have managed to avoid insurance risk by passing risk onto employers through self-funded health-benefit plans and to providers through risk-sharing mechanisms); see also André Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogma New Tricks*, 66 *U. CIN. L. REV.* 489, 493 (1998) [hereinafter Hampton, *Corporate Practice*] (noting that “health care financing increasingly involves arrangements that shift some of the financial risk of health care expenditures from insurance companies and other payers of health care services to physicians and other providers”); *id.* at 517 (“[I]nsurance companies have required patients to assume larger portions of the first dollar [of] care by imposing higher deductibles and co-insurance requirements.”).

⁵ See Hampton, *Markets*, *supra* note 4, at 987-93. The article argues that governmental policies, which allow the health insurance industry to enter into arrangements in which other parties bear the risk for health care expenditures, allow the health insurance industry to export the cost of conducting its business. The author describes this process as the exploitation of a negative externality. A negative externality is an activity that generates costs that the actor does not need to take into account when deciding to engage in the activity. The classic example is pollution associated with the manufacture of a good. If the

business to others.⁶ This subsidization has helped to perpetuate the myth that the private-sector provision of health insurance remains a viable health-financing policy for the United States.⁷ To the extent that governmental policy seeks to curtail MCOs from shifting financial risk to others in the health care system, private-sector insurers will find it harder to justify participation in health care financing.⁸

This Article examines the Texas Attorney General's effort to curtail risk shifting by MCOs operating in the State of Texas. The Texas Attorney General has addressed a primary technique used by managed care to shift financial risk to providers of health care services. MCOs accomplish financial risk shifting either through direct contracts with individual physicians or by contracts with intermediary physician groups.⁹ These intermediary physician

manufacturer does not need to account for the harm caused by the pollution, this cost will not be reflected in the manufacturer's decisions to produce the good, or in the price charged for the good. Requiring actors to account fully for the costs associated with their activities increases the costs associated with that activity. Conversely, not requiring them to internalize those costs provides them with an implicit subsidy. The article takes the position that the insurance industry has been the beneficiary of an implicit subsidy because of governmental policies that have not required the industry to bear the costs of operating health insurance programs. This current Article places the activities of the Texas Attorney General in the context of a government policy, which attempts to require the health insurance industry to internalize costs.

⁶ *Id.* at 991 (demonstrating the private insurance industry's success in passing on risks to other entities in the health care system by describing the rise of self-funded benefit programs, under which employers agree to assume a portion of their employees' health care risk, and of risk sharing arrangements, under which health care providers agree to assume a portion of their patients health care risks).

⁷ *Id.* at 992 ("The managed care industry has created the temporary illusion that we can have access to adequate and affordable health coverage through operation of the insurance model in the free market."). This illusion was aided and abetted by the implicit subsidy described in note 5, *supra*.

⁸ *Id.* at 1038 ("To the extent that we collectively seek to curtail their exploitation of externalities in the health system, insurers and employers engage in or threaten a flight from health insurance which threatens to leave even fewer people protected by health coverage.").

⁹ See Hampton, *Corporate Practice*, *supra* note 4, at 511. Under the group method, the organized group of physicians usually accepts a capitation arrangement, whereby the group accepts capitation payments from the payer and takes responsibility for compensating the individual physicians from those payments. This is the "primary technique" referred to in the text. *Id.*; see also Allison Overbay & Mark Hall, *Insurance Regulation of Providers That Bear Risk*, 22 AM. J.L. & MED. 361, 361 (1996) (discussing health care providers, most notably physician-hospital organizations, that agree to bear the risk for medical expenses by accepting partial or total capitation payments for a portion of patients); Ericka L. Rutenberg, *Managed Care and the Business of Insurance: When is a Provider Group Considered to be at Risk?*, 1 DEPAUL J. HEALTH CARE L. 267, 280-81 (1996) (describing a typical MCO as a "system . . . composed of physicians and secondary health care service providers organized to manage costs directly affecting the delivery of health care services," and an MCO's achievement of shifting risk by arranging for payment systems that require a

groups are referred to as “downstream” entities.¹⁰ Downstream entities are commonly provider-sponsored organizations, such as Independent Practice Associations (“IPAs”),¹¹ Preferred Provider Organizations (“PPOs”),¹² Management Services Organizations (“MSOs”),¹³ and Physician Hospital Organizations (“PHOs”),¹⁴ and they ultimately contract with the individual

flat fee per member).

¹⁰ See Douglas J. Witten, *Regulation of “Downstream” and Direct Risk Contracting by Health Care Providers: The Quest for Consumer Protection and a Level Playing Field*, 23 AM. J.L. & MED. 449, 454-55 (1997) (discussing “no risk,” “full risk,” and “partial risk” contracts in which managed care organizations commonly deal); see also RISK-BEARING-ENTITIES WORKING GROUP OF THE STATE AND FED. HEALTH INS. LEGIS. POLICY (B) TASK FORCE, NAT’L ASS’N OF INS. COMM’RS, DRAFT NAIC WHITE PAPER ON RISK-BEARING ENTITIES (Dec. 1996), reprinted in 6 HEALTH L. REP. (BNA) 73, 85 (Jan. 9, 1997) [hereinafter NAIC DRAFT WHITE PAPER] (describing “downstream” risk arrangements as agreements between insurance providers and “subcontractor provider entities,” such as organizations or individuals, that call for the latter to assume part of the former’s risk); *infra* note 210 (referring to House Bill 2828 (“HB 2828”) in Texas where these entities are statutorily defined as delegated entities and delegated networks); Marsha R. Gold et al., *Provider Organizations at Risk: A Profile of Major Risk-Bearing Intermediaries, 1999*, 20 HEALTH AFF. 175, 175 (Mar.-Apr. 2001) (describing these entities as “intermediaries”).

¹¹ An IPA is defined as

the simplest form of physician organization. It is an organization composed of individual practitioners who partially integrate their practices through sharing risk in managed care contracting. An IPA contracts with payers to arrange for the provision of medical services and with individual physicians to provide services under those payer contracts arranged by the IPA. Because the IPA is nominally capitalized, it is attractive to physicians who have no prior experience with managed care or practicing as a group.

SHERYL DACSO & CLIFFORD DACSO, *THE MANAGED CARE ANSWER BOOK*, Q 6:21–Q 6:25 (4th ed. 2000).

¹² A PPO is an entity through which employer benefit plans and insurance carriers purchase health care services through a loosely aggregated group of providers who agree to negotiated, discounted fee-for-service rates in return for prompt payment. Most PPOs use utilization-management techniques to control costs and quality and are attractive to consumers because of enhanced choice of providers. PPOs are not governed by federal statutes but are regulated by many states. *Id.* at Q 3:17–Q 3:20.

¹³ An MSO is defined as

a business that provides management services to physicians and physician groups. The MSO can be hospital affiliated, physician owned, jointly owned, or investor owned MSOs develop out of the perceived need for separating the business and management functions for the medical practice The MSO often functions as an administrator of managed care contracts on behalf of its managed entities, in addition to the more common MSO services, such as furnishing facilities, staff, and support services.

Id. at Q 6:28–Q 6:29.

¹⁴ A PHO is defined as

a form of joint venture managed care contracting organization . . . that can offer to HMOs and managed care contractors both inpatient hospital and professional health care services on a risk basis. A PHO is similar to an HMO for contracting purposes,

physicians who provide health care. It is the relationship between the downstream entity and the individual physicians that ultimately affects patient care, the doctor-patient relationship, and the quality of care.¹⁵ However, because state regulations and statutes often focused on the managed care plan (typically, the HMO), there had been little attention focused on the downstream entities and how those entities subcontracted with individual physicians.¹⁶ Now, largely because of spectacular IPA bankruptcies in California,¹⁷ New Jersey¹⁸ and, to a lesser degree, in Texas,¹⁹ the regulatory community throughout the United States has made the regulation of downstream entities its number one priority.²⁰ Some prescient regulators have

but it represents a slightly broader group of providers.

Id. Q 6:34–Q 6:37.

¹⁵ See Marc Ballon, *State Demands Financial Data of Physician Groups*, L.A. TIMES, Mar. 31, 2001, at C1 (describing California's attempt to protect consumers from being left without medical care by heightening regulation of intermediary physician organizations), available at <http://www.latimes.com>; see also *infra* notes 90-112 and accompanying text (describing Texas lawsuits alleging patient damages resulting from financial incentives imposed on physicians).

¹⁶ See Linda R. Brewster et al., *Insolvency and Challenges of Regulating Providers That Bear Risk*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE ISSUE BRIEF NO. 26 (Feb. 2000) (discussing states' and Congress's lack of regulatory scrutiny of provider groups and contracting intermediaries in risk delegation arrangements), available at <http://www.hschange.org/CONTENT/56/>; see also *infra* notes 113-15 and accompanying text (describing a regulatory approach to downstream entities).

¹⁷ *Id.* at 4 (describing the disruptive effects on California's health care system after two national provider groups declared bankruptcy).

¹⁸ *Id.* at 2 (describing the financial collapse of a major HMO, leaving 190,000 New Jersey residents without health care and \$120 million in unpaid insurance claims to doctors and hospitals).

¹⁹ See Mary Sit-DuVall, *Swallowing a Bitter Pill; Group That Ran Physicians' Practices Got Overwhelmed, Leaving Doctors Holding Bag*, HOUSTON CHRON., Nov. 4, 2000, (describing the financial collapse of the North American Management Organization in Houston with resultant problems for the patients and doctors of the nineteen IPAs it managed), available at 2000 WL 24523592.

²⁰ See generally Minutes of Managed Care Organization Working Group, Dallas, Tex., Sept. 11, 2000 (on file with author); see also *Downstream Contracting and Delegation Summit, Proceedings of the National Association of Managed Care Regulators*, Nov. 13-15, 2000 (obtainable from Sheri Hiroms, Palomar Financial, L.C., Austin, Tex., slihiroms@palomar-lc.com (proceedings on file with author)); Minutes of Managed Care Organization Working Group, Boston, Mass., Dec. 3, 2000 (on file with author); Minutes of Managed Care Organization Working Group conference call, the National Association of Insurance Commissioners (NAIC), Feb. 28, 2001 (on file with author); see also NAT'L ASS'N OF MANAGED CARE REGULATORS, *Executive Summary*, DOWNSTREAM RISK & DELEGATION 4 (June 1, 2001) [hereinafter NAMCR] (describing appropriate regulatory attention to MCO risk-sharing arrangements as "one of the most complex and serious challenges faced by regulators at this time"), available at http://www.namcr.org/_members/memresources.asp.

learned that the financial failures of downstream entities are more than just a matter of who pays the bills. These failures are intimately related to continuity of care and other consumer-quality issues.²¹

It was in this context that then-Texas Attorney General Dan Morales filed suit against six HMOs in December 1998.²² The Office of the Attorney General ("OAG") charged that the HMOs were illegally using financial incentives to induce physicians to deny patients medically necessary care.²³ In April 2000, the OAG announced it had reached a settlement with Aetna, the nation's largest HMO. The settlement agreement, called an Assurance of Voluntary Compliance ("AVC"),²⁴ set out in comprehensive detail how Aetna would conduct its HMO business in Texas. The most striking aspect of the AVC was its provisions attempting to make Aetna responsible for the financial relationship between downstream entities and individual providers.²⁵ This was a bold move because the authority for achieving this through the regulatory powers given to the Texas Department of Insurance ("TDI") was questionable.²⁶ The AVC was initially termed a "landmark" document that

²¹ See Ballon, *supra* note 15 (quoting Daniel Zingale, the Director of the California Department of Managed Health Care, who noted that physician-group failures in California disrupted care and caused confusion among 2.5 million patients, and who justified the reason for increased attention to the financial health of physician groups by stating that "[o]ur goal is to protect consumers, who get hurt when medical groups fail"); see also Tipton Blish, *Medical Group Failure Results in New Policies*, L.A. TIMES, Mar. 15, 2001 (quoting Zingale on California's new financial-reporting rule for medical groups that engage in downstream contracts). Zingale said: "The bigger picture is that this experience underscores that financial instability in managed health care directly affects patient quality of care. It's another example of the financial negotiations being drawn out at the expense of patients."

²² See Plaintiff's Original Petition and Application for Injunctive Relief, *State v. Aetna U.S. Health Care, Inc.*, No. 98-13972 (Tex. Dist. Ct. 1998) [hereinafter Plaintiff's Petition, *Aetna*]; see also Travis E. Poling & Laura Tolley, *HMOs Seeking Talks on Contracts*, SAN ANTONIO EXPRESS NEWS, Dec. 18, 1998, at 1D (describing the Texas Attorney General's filing of charges against six HMOs for engineering illegal coverage arrangements with physicians).

²³ Plaintiff's Petition, *Aetna*, *supra* note 22, at 1.3.

²⁴ Assurance of Voluntary Compliance, *State v. Aetna U.S. Health Care, Inc.*, No. 98-13972 (Tex. Dist. Ct. Apr. 11, 2000) [hereinafter AVC, *Aetna*]; see Press Release, Office of the Attorney General, State of Texas, Cornyn Announces Landmark Agreement with Aetna U.S. Healthcare (Apr. 11, 2000) (announcing the settlement), available at http://www.oag.state.tx.us/newspubs/99_00press_rel.htm; see also Press Release, Aetna Inc., Aetna U.S. Healthcare and the Texas Attorney General Announce Agreement on Guidelines for Texas HMOs (Apr. 11, 2000) (Aetna's press release on the settlement), available at http://www.aetna.com/news/2000/prtpr_20000411.htm.

²⁵ See *infra* notes 165-206 and accompanying text (describing the AVC's handling of financial risk).

²⁶ See *infra* notes 129-54 and accompanying text (describing the regulatory power of TDI that existed at the time the lawsuit was filed).

would affect the way managed care is practiced far beyond the borders of the state of Texas.²⁷ As a result of the AVC, Aetna changed the way it contracted with physicians and rolled out an image of a “kinder and gentler” HMO.²⁸ However, to the extent that the AVC succeeds in establishing a model for the country, it will represent an additional hindrance to financial risk shifting by HMOs. HMOs have already begun to react to this prospect by introducing new health care plans which move risk to the patients instead.²⁹

This Article examines the AVC as an attempt to regulate financial risk shifting by MCOs. This Article will demonstrate that the AVC represents an attempt to regulate managed care practices that have long been resistant to effective regulation. The AVC is an approach to policymaking that undermines managed care’s ability to insulate itself from financial risk. Furthermore, the AVC attempts to make the process of risk shifting more transparent. If the process is more transparent, the true costs associated with the provision of health insurance will be borne by the MCOs.

Part I of this Article examines the widespread practice of downstream contracting at the national level. Notwithstanding these problems, recognition that downstream contracting requires governmental regulation has been slow to develop and has been hindered by disagreements over just what type of risk shifting should be regulated by states as the “business of insurance.”

Part II of this Article examines the statutory and regulatory bases for overseeing downstream risk in Texas at the time the OAG filed suit against six HMOs operating in Texas. The Texas statutes prohibit HMOs from using financial incentives to induce physicians to limit medically necessary services. However, the statute did not clearly give the TDI any regulatory authority to obtain the information that would be most relevant to enforcing that prohibition—that is, how the downstream entity compensates the individual providers. In light of this statutory void, it is apparent that the OAG may have achieved more through the AVC than would have been possible through the regulatory process.

Part III of this Article analyzes the AVC entered into by the OAG and the

²⁷ Paul Stordahl, *Health Plans Should Consider Proactive Response to Aetna’s Texas Settlement*, HEALTH PLAN ADVISOR (May 2000) (newsletter of the Towers-Perrin Consulting Company) (announcing that the AVC may represent “a foundation for the next generation of consumer-driven managed care,” and that, “the agreement may well mark the standard for acceptable market conduct by which other attorneys general will abide”); see also John Cornyn, *Aetna Settlement Protects Consumers*, DALLAS MORNING NEWS, May 5, 2000, at 37A. At the time the AVC was executed, John Cornyn was the Texas Attorney General.

²⁸ See Joseph B. Treaster, *Aetna’s Chief Financial Officer Will Leave*, N.Y. TIMES, Apr. 14, 2001, at B2 (quoting Kenneth S. Abramowitz, one of Wall Street’s foremost analysts of the managed care industry).

²⁹ See *infra* notes 240-44 and accompanying text (describing the rising phenomenon of “defined contribution” plans, pursuant to which employers provide employees with a lump-sum payment in lieu of health insurance coverage for non-catastrophic health expenses).

Aetna HMO concerning how Aetna would conduct its HMO business in Texas. This Part will evaluate the AVC's provisions on downstream financial risk in the context of the uncertain regulatory authority of the TDI to reach down to the level of the contract between the downstream entities and the individual providers with whom that entity contracted.

I. REGULATION OF FINANCIAL RISK SHIFTING

A. *Risk Shifting by Managed Care Organizations*

An important feature of managed care is the transfer of risk from insurers of health care to providers of care.³⁰ MCOs compensate physicians by a number of arrangements that relieve the MCO of the financial risk associated with health care expenditures. These include capitation, risk pools with fee withholds that can be for both upside and downside risk, global fees, and percent-of-premium arrangements.³¹ The key concept in all risk-transfer arrangements is that the transferor seeks to limit the risk that its obligations will exceed its collected payments by transferring that risk to others.³² The MCO may engage in risk shifting by directly contracting with individual providers.³³ However, in many situations, the MCO contracts with an intermediary physician organization, which in turn contracts with the individual physician.³⁴ In addition, these intermediary entities may further downstream risk to individual physicians, such as primary care and specialist physicians.³⁵ The effect of these arrangements is that there may be several

³⁰ See Hampton, *Corporate Practice*, *supra* note 4, at 505-06 (describing capitation arrangements, pursuant to which physicians are compensated according to the number of patients assigned to the physicians, as opposed to a fee schedule for services actually rendered, and fee withholding arrangements, pursuant to which a portion of a physician's fees are withheld and only paid to the physician to the extent that the physician's treatment decisions meet financial targets established by the managed care company); see also Hampton, *Markets*, *supra* note 4, at 1013-20 (describing in detail a variety of risk-sharing arrangements).

³¹ Hampton, *Markets*, *supra* note 4, at 1013-20 (naming and describing each of the listed risk-sharing arrangements).

³² See Hampton, *Corporate Practice*, *supra* note 4, at 505-06 (discussing risk sharing arrangements and their utility as cost-containment systems for payers of insurance moneys accomplished by forcing physicians and other spenders to bear certain costs, thereby providing incentive to keep costs low).

³³ See *id.* at 509 (describing individualized risk sharing in which a physician shares risks for the physician's own patients and not other patients, resulting in "direct financial consequence to the physician each time the physician referred a patient to a specialist or admitted a patient to a hospital").

³⁴ *Id.* at 511 (describing pooled risk-sharing arrangements with a group practice or an IPA in which a group of physicians' compensation is placed at risk based on the entire group's performance as opposed to any particular physician's performance).

³⁵ *Id.* at 511 n.130 (describing "three-tiered arrangements" pursuant to which "the HMO

layers of organization between the physician who renders the services and the HMO that was originally responsible for payments and which holds the necessary state licenses to operate a risk-bearing enterprise. This has served to obscure the reality that the HMO, which holds the state license, should ultimately be held responsible for the provision of care and payment to physicians.

B. *The Importance of Downstream Entities*

Intermediary entities are numerous, and they have accepted delegated responsibilities from the HMOs for payment of physicians and monitoring the quality of care provided to patients. The importance of these entities means that it is incumbent upon the government to regulate their operations in order to assure the quality of patient care and the viability of patient-care networks. Ignoring the significance of the intermediary organizations leads to poor quality and financial instability of patient-care networks.

A recently published 1999 survey examined "intermediate entities" (another name for the intermediary physician organizations an HMO contracts with that in turn contract with other health care providers).³⁶ The survey included twenty study markets in the United States.³⁷ Sixty-four of the intermediary entities contacted responded to the survey, representing only one-third of the contacted entities.³⁸ The sixty-four entities that responded accounted for ten million patients covered by HMOs.³⁹ Of these ten million patients, 2.7 million were covered under an arrangement in which the intermediary had accepted a global-risk contract with the HMO.⁴⁰ Approximately 6.3 million patients were covered by arrangements in which the intermediary had entered into a professional-risk contract with the HMO.⁴¹ The intermediaries' dominant sources of revenue were risk based, with about forty percent of those organizations receiving more than half of their revenues from risk-based sources.⁴² Fewer than five percent of entities reported that payments received from HMOs were "adequate."⁴³ These intermediaries also reported that they

contracts with some middle tier entity which in turn contracts with the individual physicians").

³⁶ Gold et al., *supra* note 10, at 175-76 (describing the authors' survey of "intermediate entities" that engage in "large at-risk contracts" with HMOs).

³⁷ *Id.* at 175 (article abstract).

³⁸ *Id.* at 177.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.* at 178 exhibit 2 (demonstrating that last fiscal year, thirty-nine percent of intermediate entities derived fifty to ninety-nine percent of their revenues from risk-based services).

⁴³ *Id.* at 181 ("Most commonly, respondents characterized payments as 'somewhat adequate' rather than 'not adequate.'").

entered into further downstream contracts: fifty-nine percent contracted with large physician groups, thirty-eight percent with an IPA, and twenty-seven percent with PHOs or Integrated Delivery Systems (“IDS”).⁴⁴

The survey demonstrated that about sixty percent of the intermediaries accepted responsibility for provider payments,⁴⁵ and in more than two-thirds of the cases, these intermediary organizations accepted delegated responsibility for quality assurance and encounter data development from the HMO.⁴⁶ Importantly, thirty-one percent were “greatly dissatisfied with the referring plan’s support and collaboration.”⁴⁷ Twenty percent were unhappy with the delegating HMO’s “delegation of sufficient authority to match risk.”⁴⁸ The authors concluded that “problems occur when risk is shared in the absence of equivalent authority and support,” and that “there may be some reduction in the amount of risk some entities bear.”⁴⁹ The authors noted that in some markets, there were questions as to whether some providers would ever become adept at insurance functions such as managing risk and utilization.⁵⁰ In fact, “many observers point to risk-bearing contracts as a key contributor to the failure of [IPAs]”⁵¹

Medical groups, individual physicians, and hospitals have all been unhappy with capitation.⁵² Most of this displeasure comes from the inability to judge accurately the risk of the insured population, resulting in financial losses—

⁴⁴ *Id.* at 180.

⁴⁵ *Id.* at 181 exhibit 4.

⁴⁶ *Id.* (showing that 71.0 percent of intermediate entities accepted the delegated global risk of the tasks of quality assurance and encounter data development).

⁴⁷ *Id.* (assigning a score of four or below as indicating “great dissatisfaction,” and finding that thirty-one percent were “greatly dissatisfied”).

⁴⁸ *Id.* at 182 (listing ratings of intermediate entities’ dissatisfaction with aspects of the HMO relationship).

⁴⁹ *Id.* at 182-83 (discussing implications of the survey results).

⁵⁰ *Id.* at 184 (acknowledging the questionable ability of provider organizations in less developed markets to effectively perform traditional insurance functions, and citing the failure to manage costs or economically forced withdrawal as examples of more fundamental problems).

⁵¹ See Cara S. Lesser & Paul B. Ginsburg, *Back to the Future?: New Cost and Access Challenges Emerge*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE ISSUE BRIEF NO. 35 (Feb. 2001) (discussing the fact that risk contracting has fallen into disrepute among most providers and the consequent steep decline of risk-shifting contracts entered into after 1999), available at <http://www.hschange.org/CONTENT/295>.

⁵² See David R. Olmos & Michael A. Hiltzik, *Doctors’ Authority, Pay Dwindle Under HMOs*, L.A. TIMES, Aug. 29, 1995, at A1 (detailing the material consequences, including unemployment and bankruptcy, for California doctors resulting from the ascendance of HMO-controlled health care); see also Page, *supra* note 3, at 17 (“Physicians are leaving capitation because they lost money on it, disliked its emphasis on cost containment and saw new opportunities in fee-for-service medicine.”).

some of which are catastrophic.⁵³ The consequent turmoil caused by failures of large medical groups and IPAs, all downstream contractors, has grabbed the attention of state insurance regulators, who have had to deal with the problems of displaced patients, unpaid doctors, unhappy HMOs, and legislators demanding answers.⁵⁴ Two important issues appear common to most discussions of downstream risk: (1) how to assure that providers get paid⁵⁵ and patients are held harmless;⁵⁶ and (2) how to assure that financial arrangements do not adversely affect the quality of patient care.⁵⁷

C. Downstream-Entity Insolvencies

Bankruptcies by downstream contractors help to underscore the importance of regulating the relationship between an HMO and its downstream

⁵³ See Michael D. Dalzell, *California Physicians Struggling—Problems Ahead for Other States?*, 8 *MANAGED CARE MAG.* (Oct. 1999) (“The California Medical Association says 115 of California’s 300 large groups and IPAs have gone bankrupt or closed in the last three years, and predicts that 34 more will do so by the end of this year.”), available at <http://www.managedcaremag.com/archives/9910/9910.calmodel.html>); see also Peter Wehrwein, *The March of Capitation: Reversed or Just Delayed?*, 6 *MANAGED CARE MAG.* (Nov. 1997) (noting that capitation plans, although popular, have not overhauled the health care system as dramatically as had been predicted), available at http://www.managedcaremag.com/archives/9711/9711.capitation_part1.shtml.

⁵⁴ See Leigh Page, *California Begins Asking Physician Groups About Finances*, *AM. MED. NEWS* 1 (Apr. 23, 2001) (reporting that new financial solvency standards for an estimated 350 to 500 provider groups that accept insurance risk went into effect on May 15, 2001, and that the new rules are “milder” than those being developed in Colorado and New York), available at http://www.ama-assn.org/sci-pubs/amnews/pick_01/bill0423.htm.

⁵⁵ Provider payment arrangements involve at least two issues: (1) solvency of the HMO and/or provider group, and (2) the so-called “double pay” issue. Solvency requirements are generally dealt with by state departments of insurance with no consistent standards throughout the states. The “double pay” issue involves whether or not an HMO, having paid a capitated fee to a downstream provider who then later goes bankrupt, is required by law to pay the subcontracted providers who have, in fact, delivered care to patients. Only three states have so-called “double pay” laws requiring the HMO to pay providers in the case of a downstream entity’s insolvency. Those states are Colorado, Maryland, and Nevada. See also NAMCR, *supra* note 20, § VII.D (stating the opinion of the regulators that “it should be clear that the MCO retains the ultimate financial responsibility where other mechanisms to avoid double payment fail”).

⁵⁶ “Hold harmless” refers to not billing an insured even after an HMO or downstream entity declares bankruptcy. See NAMCR, *supra* note 20, § VIII (advising that “[a]ll levels of contracts must contain ‘hold harmless’ wording to protect the members/insured’s [sic] from any balance billing for covered services, even after an entity declares bankruptcy or is liquidated”).

⁵⁷ See *id.* “The overriding concern of Federal and State regulators is the protection of MCO members and insured’s [sic]. They want members to receive timely, quality services for which premiums were paid. Regulators must decide what method of oversight they want to use to meet this responsibility.” *Id.*

contractors. There have been a number of large bankruptcies around the country. The problem of downstream-entity insolvency brought on by the transfer of risk from HMOs to medical groups first appeared in the mid-1990s in California, where almost 400 medical groups care for nearly twenty million HMO enrollees.⁵⁸ While only about ten percent of the medical groups took on global risk and were licensed by the State of California, the remaining unlicensed groups took on various degrees of risk, such as professional services and pharmacy, threatening their financial viability.⁵⁹ Between 1997 and 1999, 115 physician groups in California declared bankruptcy.⁶⁰ These insolvencies caused disruption and confusion for 2.5 million California HMO enrollees.⁶¹ The California Medical Association issued a report on September 2, 1999, predicting the “imminent collapse” of ninety percent of the physician groups in the state.⁶² A review in the *New England Journal of Medicine* concluded that California physician groups were engaged in a “Darwinian struggle for survival,” where success depended on “avoiding the high-cost patients who need us most.”⁶³

The wave of bankruptcies of provider risk-bearing groups that began in California hit Texas with the collapse of FPA Medical Management, a large national practice management company that took on global risk on behalf of almost 1.4 million health plan members and 7,900 physicians.⁶⁴ FPA filed for bankruptcy on July 19, 1998 with liabilities of \$345.5 million and assets of

⁵⁸ See Ballon, *supra* note 15 (describing the California Department of Managed Health Care’s decision to mandate periodical reports from 400 physician groups, and stating that these groups “provide care to most of the 20 million Californians enrolled in HMOs or managed-care plans”).

⁵⁹ See Brewster et al., *supra* note 16, at 5 (discussing the majority of the 300 or more provider groups in California who do not accept global risk and are therefore neither licensed nor regulated by the state, leading to “uncertain” financial conditions); see also Thomas Bodenheimer, *California’s Beleaguered Physician Groups—Will They Survive?*, 342 NEW ENG. J. MED. 1064 (Apr. 6, 2000) (describing the relationship between HMOs and physicians on the West Coast and the delegation of risk to physician groups, which has resulted in California IPAs “perform[ing] certain tasks that are not performed by most IPAs in other states”).

⁶⁰ See Dalzell, *supra* note 53.

⁶¹ See Ballon, *supra* note 15.

⁶² See Bodenheimer, *supra* note 59, at 1064 (discussing the highly publicized release of the California Medical Association’s report).

⁶³ *Id.* at 1068 (observing that, because a very small fraction of patients require a very large percentage of medical costs, refusing to enroll such patients “can mean financial survival or even success, whereas enrolling them can spell ruin,” and concluding that this puts California physicians in the perverse position of being fiscally rewarded for avoiding provision of care for patients who are most in need of it).

⁶⁴ Milt Freudenheim, *FPA Medical Files for Protection Under Bankruptcy Laws*, N.Y. TIMES, July 21, 1998, at D5 (discussing the implications of FPA’s bankruptcy).

\$46.3 million.⁶⁵ In California, where it operated under a limited HMO license, FPA owed physicians an estimated \$60 million.⁶⁶ At the time of the bankruptcy, FPA reportedly claimed that its contracts with its biggest customer, PacifiCare, covering 200,000 enrollees, “did not cover doctors’ costs.”⁶⁷ Wall Street analysts blamed FPA’s financial woes on “risky contracts with managed care companies.”⁶⁸

MedPartners, one of the nation’s largest physician management companies, suffered financial collapse beginning in 1998 after going into debt for over one billion dollars.⁶⁹ In March 1999, California regulators seized control of MedPartners’ California-provider network, which had 140 practice groups, twenty-three IPAs, 4,000 physicians, and 1.3 million HMO patients.⁷⁰ In late 1999, MedPartners owed California physicians \$50 million in unpaid claims.⁷¹

In New Jersey, in 1997, the state’s fourth largest HMO, HIP, in financial trouble, with the approval of state regulators offloaded risk to a provider-management company, PHP Healthcare Corporation.⁷² This subcontracting arrangement was not regulated by state law, but the state expected the HMO to be the ultimate guarantor of all contractual obligations.⁷³ A year later, both PHP and HIP collapsed with providers receiving thirty cents on the dollar for debts.⁷⁴

In Houston, North American Medical Management (“NAMM”), a physician-management company, for a decade took on global risk from HMOs on behalf of 1,800 physicians in nineteen IPAs, largely through capitation contracts.⁷⁵ On August 31, 2000, TDI placed NAMM’s operations under its supervision due to failure to pay providers.⁷⁶ One Houston IPA claimed it lost over one million dollars.⁷⁷

⁶⁵ *Id.*

⁶⁶ Brewster, *supra* note 16, at 4-5 (discussing concerns over the insolvencies of provider groups and legislation passed in response).

⁶⁷ Freudenheim, *supra* note 64.

⁶⁸ *Id.*

⁶⁹ Bodenheimer, *supra* note 59, at 1066 (discussing the financial troubles of California’s physician groups).

⁷⁰ *Id.* at 1066-67.

⁷¹ *Id.* at 1067.

⁷² Brewster, *supra* note 16, at 2 (discussing New Jersey’s response to the HIP-PHP agreement and HIP’s subsequent collapse).

⁷³ *Id.* at 2.

⁷⁴ *Id.* at 2-3.

⁷⁵ Renae Merle & Tanya S. Rutledge, *Physician-Groups Manager May Be on Verge of Dying*, WALL ST. J., Nov. 1, 2000, (discussing the probability of NAMM going out of business), available at 2000 WL-WSJ 26615203; Sit-DuVall, *supra* note 19 (discussing NAMM “on the brink of collapse”).

⁷⁶ IPA Management Associates, L.P., Official Order of the Commissioner of Insurance of the State of Texas, No. 00-1008, Aug. 31, 2000; Merle & Rutledge, *supra* note 75.

⁷⁷ Sit-DuVall, *supra* note 19 (reporting that NAMM was “the victim of computer

In January 2001, unpaid doctors and one HMO filed an involuntary chapter 7 bankruptcy petition against Heritage Southwest Medical Group, P.A., the largest IPA in Dallas, Texas, alleging millions of dollars in unpaid claims.⁷⁸ The IPA represented about 55,000 patients and 1,750 doctors in largely capitated contracts with health plans.⁷⁹ Heritage's problems were blamed on "[d]octors . . . assuming the risk normally borne by an insurer."⁸⁰

In San Antonio on July 18, 2001, Quantum Southwest Medical Associates ("QSMA") and Quantum Southwest Medical Management, Inc. ("QSMM") filed for bankruptcy protection.⁸¹ QSMA was a 5.01(a) Approved Non-profit Health Corporation ("ANHC") that delivered care to 45,000 PacifiCare HMO patients via full-risk capitation contracts that amounted to \$100 million in revenue in fiscal year 2000.⁸² At the time of the bankruptcy filings, QSMM had assets of \$9.3 million and liabilities of \$13.5 million, and QSMA had assets of \$15.4 million and liabilities of \$27.3 million.⁸³ In late 2002, the QSMM and QSMA bankruptcies were still not resolved, with the latest reorganization plan calling for PacifiCare to assume a type of "double-pay" role for the unsecured physician creditors by paying them an estimated thirty-five cents on each dollar of debt owed.⁸⁴

On July 24, 2001, another 5.01(a) entity, Medical Select Management, Inc. ("MSM"), filed for bankruptcy in Fort Worth, Texas.⁸⁵ MSM accepted full-risk contracts from PacifiCare and Aetna on behalf of 1,700 North Texas physicians.⁸⁶ In the year 2000, MSM collected \$155 million in capitated premiums from Aetna and PacifiCare for approximately 200,000 enrollees but, at the time of the bankruptcy filing, owed physicians over \$21 million.⁸⁷ In

problems, . . . and many doctors have been caught in the middle").

⁷⁸ See J. C. Conklin, *Providers File Petition to Force Doctors' Group Into Chapter 7*, DALLAS MORNING NEWS, Jan. 11, 2001, at 1D.

⁷⁹ *Id.*

⁸⁰ See J. C. Conklin, *Independent Doctors' Groups Shaken by Woes*, DALLAS MORNING NEWS, Mar. 4, 2001, at 1H.

⁸¹ Consolidated Debtors' Second Amended Disclosure Statement at 1, *In re Quantum S.W. Med. Mgmt., Inc.*, No. 01-53321-LMC (Bankr. W.D. Tex. July 18, 2001) [hereinafter *Disclosure Statement, Quantum*].

⁸² *Id.*

⁸³ W. Scott Bailey, *Medical Group's Bankruptcy Reveals Flaw in System, Observers Say*, SAN ANTONIO BUS. J., Aug. 3, 2001, at 1, 59.

⁸⁴ See *Disclosure Statement, Quantum*, *supra* note 81, at 6-7 (calling for PacifiCare to pay over \$4 million to a settlement trust, which would result in providers' recovering approximately thirty-five percent of their claims).

⁸⁵ Statement of José Montemayor, Texas Insurance Commissioner, *Physician/Provider News from the Texas Department of Insurance* (July 24, 2001) (on file with author).

⁸⁶ *Id.*; see also Trebor Banstetter, *Group Files for Chapter 11 Medical Select Has \$40 Million in Debts and \$17 Million in Assets, Documents Show*, FORT WORTH STAR-TELEGRAM, July 26, 2001, at B2.

⁸⁷ Trebor Banstetter, *Bankrupt Group Owes Doctors Millions*, FORT WORTH STAR-

late 2002, the MSM bankruptcy was not resolved, with over 200 physicians retaining counsel to sue PacifiCare directly for monies owed.⁸⁸ Referring to the collapse of Quantum and MSM, José Montemayor, the Texas Insurance Commissioner, said the full-risk model for contracting is “a particular model that is not working.”⁸⁹

D. *Lawsuits Over Financial Incentives*

The relationship between the financial incentives inherent in risk shifting and the impact on patient care has not been lost on the legal community. In Texas and elsewhere, a number of suits have been brought against HMOs and their downstream contractors alleging that the downstream contractor financial arrangement with an individual physician lead to a patient’s harm.

In *Zamora v. HealthTexas*, a San Antonio federal court case, two physicians and ten patient-plaintiffs sued HealthTexas, a hospital-owned clinic and medical-services organization, and four HMOs that had downstream contracts with HealthTexas.⁹⁰ The suit was brought under the ADA, claiming that financial incentives were used to discriminate against patients with disabilities.⁹¹ Dr. Zamora, a rheumatologist, claimed he had been wrongfully

TELEGRAM, Aug. 24, 2001, at B1.

⁸⁸ Telephone conversation with Robert Provan, lead counsel for several MSM providers seeking full payment from PacifiCare for debts owed (Sept. 4, 2002).

⁸⁹ See Bailey, *supra* note 83, at 59 (explaining that Montemayor looked forward to working under the new HB 2828, which came into effect on September 1, 2001, and observing that “[t]he new law means we won’t have to wait for the train wreck to happen and then pick up the luggage off the tracks”). But see Bob Carlson, *Health Plans’ Financial Instability Presents New Regulatory Challenges*, MANAGED CARE, Oct. 1999 (reporting that Montemayor acknowledged the regulatory challenge of “risk-assuming physician groups, but said that Texas health plans were ‘taking steps to protect themselves against insolvent providers,’” and that “[t]he plans, to their credit, have done a marvelous job of policing that”), available at <http://www.managedcaremag.com/archives/9910/9910.states.html>.

⁹⁰ See *Zamora v. HealthTexas Med. Group*, 34 F. Supp. 2d 433, 437-38 (W.D. Tex. 1998) (denying motion to dismiss in part, as plaintiff did not have to exhaust administrative remedies, had standing to seek an injunction under the Americans with Disabilities Act (the “ADA”), and stated claims under the ADA and Rehabilitation Act). For background on *Zamora*, see Donna J. Blevins, *The Lessons of Zamora: A Plaintiff’s Perspective on Suing HMOs*, Presentation to the Medical & Health Care Litigation Symposium (Mar. 2, 2001) (describing plaintiff’s strategy); Donald B. Wilcox, *Physicians and Managed Care—The Texas Experience 4*, Presentation to the Medical & Health Care Litigation Symposium (Mar. 2, 2001) (giving background on the case); Julie A. Jacob, *Texas Physician Says His HMO De-selection Violates ADA*, AM. MED. NEWS, Mar. 24, 1997, at 1 (discussing the theory of discrimination involved in the case).

⁹¹ Maro Robbins, *Discrimination Lawsuit Targets HMOs: Claim Says Profits Put Before Patients*, SAN ANTONIO EXPRESS NEWS, Nov. 5, 2000, at 1B (describing the merits of the suit shortly before the beginning of trial); see also Milo Geyelin, *A Disabled Attorney Puts Civil-Rights Spin on HMO Litigation*, WALL ST. J., Jan. 25, 2000, at 1A (discussing the use of the ADA to protect doctors of the disabled).

fired after advocating for his patients and had been berated at weekly utilization-review meetings.⁹² After a three-week trial, the parties reached a confidential settlement.⁹³ The Texas Medical Association (the “TMA”) later described the settlement as “an end [to] a multi-year successful effort to develop a new remedy for patients and physicians for discriminatory treatment by managed care entities, including clinics, which can act like ‘mini-insurance companies’ in rationing services.”⁹⁴

Zamora is significant because it underscores the importance of the downstream-entity’s relationship with the individual practitioner. HealthTexas clinic was a downstream provider that was an ANHC.⁹⁵ This provider was not required to be licensed as an insurance company or an HMO under Texas law, although it could accept global risk from a licensed HMO.⁹⁶ The court, in a pretrial hearing, bifurcated the trial and set the trial of the downstream entity first, to be followed by the trial of the HMOs only if the provider group was found culpable.⁹⁷ This established the primary importance of the downstream provider as the primary actor unable to place the blame on the HMO. Financial incentives acting upon the downstream entity and used by the downstream providers on their own providers were at the very heart of this case.

In *Ingram v. Harris Health Plan, Inc.*, three patient plaintiffs filed a class-action suit against Harris Health Plan, a licensed HMO, and other defendants, including MSM, an unlicensed downstream contractor.⁹⁸ The suit charged the

⁹² See Geyelin, *supra* note 91.

⁹³ See Wilcox, *supra* note 90, at 4; Blevins, *supra* note 90, at 2; Maro Robbins, *Medical Bias Suit Settled*, SAN ANTONIO EXPRESS NEWS, Nov. 23, 2000, at 1B (describing settlement efforts and the agreement).

⁹⁴ See Wilcox, *supra* note 90, at 4.

⁹⁵ See Texas Board of Medical Examiners, *Non-Profit 162.001(b) Non-profit Health Organizations*, at <http://www.tsbme.state.tx.us/institutions/nphorg.htm> (accessed June 11, 2003) (listing HealthTexas as a section 162.001(b) nonprofit health organization). Nonprofit health organizations are certified by the Board of Medical Examiners under Texas Occupations Code section 162.001. See TEX. OCC. CODE ANN. § 162.001 (Vernon 2002). This entity was previously called a “5.01(a)” organization because it was previously certified under section 5.01(a) of the Medical Practice Act, TEX. REV. CIV. STAT. ANN. art. 4495b (Vernon 1999).

⁹⁶ See *infra* note 129 and accompanying text (describing the regulation of downstream entities in Texas).

⁹⁷ See Maro Robbins, *Testimony Begins in HMO Bias Suit: Claim Costs Drove Quality of Care*, SAN ANTONIO EXPRESS NEWS, Nov. 8, 2000, at 1B (noting that the current trial focuses on the clinic, but a finding of discrimination will lead to a second trial against the managed care organization).

⁹⁸ See Order for Notice to Class Members of Pendency of Class Action, Conditional Class Certification and Hearing on Proposed Settlement, *Ingram v. Harris Health Plan, Inc.*, No. 598-CV-179 (E.D. Tex. Jan. 12, 2000) [hereinafter Order for Notice, *Ingram*] (notifying recipients of Harris Methodist Health Plan Insurance of the pendency of the class action suit

defendants with failing to disclose financial incentives and using those incentives as inducements to limit medically necessary care.⁹⁹ This case was ultimately settled on March 20, 2000 with some \$4.6 million set aside for a settlement fund for a class of approximately 203,000 members from which \$33,500 went to three individual plaintiffs and \$1.15 million for attorneys' fees for class counsel.¹⁰⁰

Another case indicates that an examination of the HMO's financial relationship with its downstream contractor may not suffice to root out significant financial incentives. In *Barley v. Pugh*, plaintiffs sued a Fort Worth cardiologist, his medical group, and the decedent's HMO for medical negligence, wrongful death, and commercial bribery.¹⁰¹ The plaintiffs alleged that the HMO's financial incentives, specifically a ten percent withhold, which could vary upward or downward at the discretion of the HMO, induced the cardiologist and his medical group to not do appropriate diagnostic studies and to not give the patient a timely reference for aortic valve-replacement surgery.¹⁰² On the day before trial, the HMO settled with the plaintiffs for a confidential amount.¹⁰³ The jury found for the plaintiffs, holding the doctor blameless, the decedent nurse fifty percent contributorily negligent, and the doctors' group responsible for the rest of the harm caused.¹⁰⁴

Interestingly, the HMO paid the doctors' group pursuant to a discounted fee-for-service schedule through contracts with the individual physician cardiologists.¹⁰⁵ The group itself paid its employee physicians a base salary plus bonus arrangement with the bonus being based on a Relative Value Unit

and the proposed settlement hearing); see also *Harris Methodist HMO Members Challenge Compensation Arrangements*, 7 HEALTH L. REP. (BNA) 840 (May 21, 1998) (describing the filing of the suit).

⁹⁹ Order for Notice, *Ingram*, *supra* note 98.

¹⁰⁰ See Final Judgment and Order of Dismissal at 15, *Ingram* (No. 598-CV-179) (describing and approving of the settlement agreement).

¹⁰¹ See *Cases of Interest Around the State: Charles Barley v. Billie R. Pugh, M.D.*, CA No. 236-177180-99 (236th Dist. Ct., Tarrant County, Tex., Feb. 8, 1999), 5 TEXAS BLUE SHEET, Feb. 19, 2001 [hereinafter BLUE SHEET] (describing the plaintiffs' claim and the results of the case).

¹⁰² See Plaintiff's Sixth Amended Original Petition at 5, *Barley v. Pugh*, CA No. 236-177180-99 (Tex. Dist. Ct. Feb. 26, 2001) (alleging that the percentage of physician's withheld fee could be "any amount determined by the HMO").

¹⁰³ See Trebor Banstetter, *Cigna Settles Wrongful Death Suit*, FORT WORTH STAR-TELEGRAM, Mar. 1, 2001, at A1.

¹⁰⁴ See BLUE SHEET, *supra* note 101.

¹⁰⁵ See Healthsource North Texas Preferred, Inc. Participating Physician Agreement with Billie R. Pugh, M.D. (introduced at trial as Plaintiff's Exhibit 45, dated Jan. 9, 1995), *Barley* (CA No. 236-177180-99). Exhibit B to this agreement provides for payment for physician's services pursuant to fee-for-service compensation subject to a maximum allowable fee as established by Healthsource.

("RVU") system.¹⁰⁶ The group's defense with regard to the role of managed care financial incentives was that the doctors were blind to the influence of managed care because they were compensated pursuant to a fee-for-service schedule, which meant that the more they did, the more they were paid.¹⁰⁷ However, Plaintiffs alleged that a close analysis of the RVU system indicated that cardiologists received no RVU points for doing chest x-rays and ECGs, two of the most important diagnostic tools doctors use, but did receive RVUs for attending group business meetings and meetings of a closely related physician-controlled 5.01(a) organization.¹⁰⁸

In *Correll v. NYLCare Health Plans, Inc.*, plaintiff brought a wrongful death claim against an HMO, numerous physicians, and, importantly, the Heritage Southwest Medical Group, an unlicensed downstream contractor.¹⁰⁹ The suit alleged that the decedent had died from complications of late-diagnosed inflammatory bowel disease after over forty physicians' visits over a several-month period without access to appropriate specialist management and diagnostic testing.¹¹⁰ The suit specifically charged the defendants with violations of the Texas Deceptive Trade Practices Act (the "DTPA") and the Texas HMO Act, particularly indicating the use of financial incentives to place "money over medicine."¹¹¹ This case was ultimately resolved confidentially without a trial.¹¹²

E. *National Approach to the Regulation of Downstream Entities*

The regulation of downstream entities such as IPAs is made difficult because, in many states, they do not have to be licensed.¹¹³ That stems from a consensus among insurance regulators that the assumption of downstream risk is subcontracting or service risk and not the business of insurance.¹¹⁴ As long

¹⁰⁶ See Spread Sheet of RVUs by Quarter 96-97 and Consultants in Cardiology Inter-office Memo (Plaintiff's Exhibit 66 dated Sept. 15, 1997), *Barley* (CA No. 236-177180-99) [hereinafter Spread Sheet, *Barley*].

¹⁰⁷ Telephone interview with Geno Borchardt, Lead Counsel for Plaintiff, *Barley* (2000).

¹⁰⁸ Spread Sheet, *supra* note 106 (indicating that zero RVUs were assigned for chest-x-rays and ECGs, while RVUs were assigned for Committee Memberships and NTSP Board Membership).

¹⁰⁹ See *Correll v. NYLCare Health Plans, Inc.*, No. 48-173889-98 (Tex. Dist. Ct. May 27, 1998).

¹¹⁰ See Plaintiffs' First Amended Petition at 8-14, *Correll* (No. 48-173889-98) (detailing decedent's ordeal with inflammatory bowel disease and systematic neglect by several doctors).

¹¹¹ *Id.* at 21-22.

¹¹² Telephone interview with Geno Borchardt, Lead Counsel for Plaintiff, *Correll* (n.d.).

¹¹³ See Witten, *supra* note 10, at 467-68 (describing various state approaches to requiring licenses for PHOs).

¹¹⁴ See Overbay & Hall, *supra* note 9, at 376-77 (explaining the differences for licensing purposes between provider groups and HMOs).

as the upstream contracting HMO is licensed, the downstream entity usually need not be licensed.¹¹⁵

States employ a variety of strategies to deal with the issue of regulating downstream risk.¹¹⁶ To understand the various state approaches, it is useful to consider several proposed analytical frameworks to structure this complex problem. One simple approach is “direct contracting” versus “downstream-risk arrangements.”¹¹⁷ When direct risk is involved, the presumption is that the entity should be directly regulated.¹¹⁸ When downstream risk is involved, the presumption is that the state will regulate the contracting HMO, which, in turn, is responsible for supervising the behaviors and financial solvency of the downstream subcontractor.¹¹⁹

The most influential treatise on the regulation of downstream risk has been the 1997 National Association of Insurance Commissioners’ (the “NAIC”) White Paper, *The Regulation of Health Risk-Bearing Entities*.¹²⁰ That paper defined “downstream risk arrangements” as “contractual agreements between licensed insurers, such as HMOs, and subcontracting provider entities (organizations or individuals) that involve the provider entity assuming part of the licensed entity’s risk.”¹²¹ The NAIC observed that there was widespread agreement that physician service organizations that accept downstream risk “should not be subject to licensure requirements that are as strict as those imposed on HMOs.”¹²² According to the NAIC’s view, entities that accept direct risk, however, should be licensed.¹²³ At the time the NAIC paper was published, states were divided as to whether the licensed entity should be held

¹¹⁵ See *infra* text accompanying note 122.

¹¹⁶ See NAT’L ASSOC. OF INS. COMM’RS, DOWNSTREAM RISK CHART: CALIFORNIA, COLORADO, NEW JERSEY, NEW YORK, AND MARYLAND (2001) (on file with author) (giving comparison charts from these states on subjects of (1) how downstream-risk entities are defined; (2) how downstream-risk entities are regulated; (3) “pay twice” provisions; (4) how financial information about downstream-risk entities is reported to the Department of Insurance; (5) how the Department of Insurance is able to audit the downstream-risk entity directly; (6) mechanisms of enforcement; and (7) provisions for addressing continuity of care); see also Witten, *supra* note 10, at 467-74.

¹¹⁷ NAIC DRAFT WHITE PAPER, *supra* note 10, at 81, 85 (comparing direct-contracting with downstream-risk arrangements). “Direct-contracting arrangements involve agreements between the risk-bearing entity and individuals, employers, or other unlicensed groups. These arrangements may involve full or partial risk assumption.” *Id.* at 81. “Downstream-risk arrangements are contracted agreements between licensed insurers, such as HMOs, and subcontracting provider entities (organizations or individuals) that involve the provider entity’s assuming part of the licensed entity’s risk.” *Id.* at 85.

¹¹⁸ *Id.* at 82.

¹¹⁹ *Id.* at 85.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* at 82.

responsible for the actions of the downstream entity, as they still are.¹²⁴

A new treatise, *Downstream Risk & Delegation*, presented by the National Association of Managed Care Regulators (“NAMCR”),¹²⁵ is likely to become quite influential on the issue of regulating downstream risk. The NAMCR believes that:

[T]he Managed Care Organization (MCO), as licensed entity, shall be ultimately responsible in all aspects *regardless* of how the delivery of, and payment for, care is subcontracted or shared or how many levels of subcontracting are involved. The only exception to this would be where the subcontractor was licensed by the State, thereby sharing some responsibility with the MCO Statutes and regulations should make this point very clear and uncontestable.¹²⁶

The NAMCR warns that even if subcontracting arrangements do not appear to transfer medical financial risk, regulators must be careful to look for excessive administrative fees that create a “*de facto* transfer of risk.”¹²⁷ In all cases, it recommends “swift, effective, and proactive corrective action” to ensure the protection of the insureds.¹²⁸

II. REGULATION OF DOWNSTREAM ENTITIES IN TEXAS

At the time the AVC was promulgated, the regulation of downstream entities in Texas mirrored the national approach to such regulation. Downstream entities that accepted risk from a licensed HMO were not required to obtain any license as an HMO or any other certification related to accepting such risk.¹²⁹ The TDI was only given the indirect power to regulate downstream entities through the licensed HMO with which they contracted and through the licenses that such entities held related to their claims processing

¹²⁴ *Id.* at 82-85.

¹²⁵ NAMCR, *DOWNSTREAM RISK & DELEGATION* (June 1, 2001).

¹²⁶ *Id.* at 46.

¹²⁷ *Id.* at 49.

¹²⁸ *Id.*

¹²⁹ Downstream entities that provide, for example, only physician services do not fall under the purview of the HMO Act. *See* TEX. INS. CODE ANN. § 20A.26(f) (West Supp. 2003) (defining physicians and providers who are “engaged in the delivery of health care services” as not falling under the HMO Act). This caveat generally applies to those provider entities, such as physician groups, that do not take on global risk. The Texas HMO Act also does not apply to one particular entity that can take on global risk from an HMO, namely, the Approved Nonprofit Health Corporation (“ANHC”) organized pursuant to section 162.001 of the Texas Occupations Code. The ANHC is not required to obtain a certificate of authority from the TDI if it accepts risk from an HMO. *See id.* § 21.52F. The ANHC has been the subject of much controversy in Texas because of the ability of these organizations to be owned by a hospital, thereby raising fears of an “end run” around the long-standing Texas ban on the corporate practice of medicine.

and utilization-review functions.¹³⁰ Although Texas law prohibited HMOs from using compensation arrangements that induced physicians to limit medically necessary services,¹³¹ the Texas regulatory structure did not clearly give the TDI the means by which to monitor this provision. Likewise, there was no way for the TDI to monitor the solvency of downstream entities in Texas.

At the time that the OAG entered into the AVC with Aetna, the TDI's regulation of downstream entities was governed by article 20A.18C of the Texas Insurance Code, effective during the fall of 1999.¹³² According to this article, an agreement between an HMO and its delegated networks had to be in writing, with a copy of the contract provided to the TDI.¹³³ The TDI, however, did not have to approve the contract before it became effective.¹³⁴ Some in the TDI felt that the department did not have the staff or the monetary support to review contracts between HMOs and their delegated networks before contracts were ratified.¹³⁵

Under the Texas regulatory scheme, the HMO essentially assumed the responsibility for monitoring how its delegated network lived up to the agreements with the HMO. This was provided by written information about monitoring, financial performance, compliance with statutory Third Party Administrator performance, and utilization-review performance, among others.¹³⁶ The delegated network was required to acknowledge that the HMO was obliged to maintain a delivery system, a quality-assurance system, a credentialing system, and all other systems to meet the statutory requirement of the Texas HMO Act.¹³⁷ The HMO was required to provide the delegated network with "detailed risk-pool data" and other data about "the percent of premium attributable to hospital or facility costs."¹³⁸ The HMO also had to

¹³⁰ *Id.* §§ 20A.18C, 21.07-6, 21.58A (Vernon 2000) (defining, respectively, the delegation of certain functions by HMOs, third-party administrators, and health care utilization review agents).

¹³¹ *Id.* § 20A.14(l) (prohibiting HMOs from utilizing "any financial inducement" that "acts directly or indirectly" to limit services).

¹³² *Id.* § 20A.18C (laying out the scope of the TDI's regulatory authority over HMOs that have delegated any functions to a downstream entity).

¹³³ *Id.* § 20A.18C(a) (requiring HMOs to file any written agreement with the TDI within thirty days of the agreement's execution).

¹³⁴ *Id.* (detailing the provisions and summaries required in a written agreement, while not expressly delegating any approval power to the TDI).

¹³⁵ Telephone interview with Barbara Halthaus, Staff Attorney, Director of Special Projects, Texas Department of Insurance (Mar. 28, 2001) (notes on file with author) (speaking for herself and noting that her comments are not the official position of the TDI).

¹³⁶ TEX. INS. CODE ANN. § 20A.18C(a) (Vernon 2000) (detailing the requirements for a written agreement between an HMO and its delegated networks).

¹³⁷ *Id.* § 20A.18C(a)(11)(A)(i) (listing one of the requirements for a written agreement between an HMO and a delegated network).

¹³⁸ *Id.* § 20A.18C(c).

take action, in writing, to correct any delegated network's poor performance as well as notify the TDI if a network failed to take timely action to correct deficiencies.¹³⁹ After receiving a request for intervention from an HMO, the TDI could conduct an audit¹⁴⁰ of the network or suspend the network's TPA or Utilization Review license.¹⁴¹ The TDI could then request that a delegated network take corrective actions to ensure compliance with the HMO Act.¹⁴² Individual physicians were exempted from regulation by article 20.18C, as were ANHCs, which were classified as physicians even though they took on global risk from HMOs.¹⁴³

The statutorily-required contract provisions applied only to the first layer of downstream risk.¹⁴⁴ Arrangements between the delegated network and other downstream entities and individual physicians were largely not covered by the statute. Specifically, it was not clear whether the TDI had authority to review the financial arrangements between delegated entities and downstream providers.¹⁴⁵ Thus, it was not clear whether the TDI could even review the

¹³⁹ *Id.* § 20A.18C(d) (requiring HMOs to act when "aware" that a delegated entity is "not operating in accordance with its written agreement" or if the entity's continuing operation is "hazardous to enrollees").

¹⁴⁰ *Id.* § 20A.18C(g) (granting the TDI the power to "examine the matters contained in the notice as well as any other matter relating to the financial solvency of the delegated entity").

¹⁴¹ *Id.* § 20A.18C(n) (giving the commissioner the authority to "suspend or revoke the license of any third party administrator or utilization review agent that fails to comply with [Article 20A.18C]").

¹⁴² *Id.* § 20A.18C(1) (listing the corrective actions that the TDI can request, including reassuming the functions of the delegated entity, temporarily or permanently ceasing assignments of new enrollees, and, in extreme cases, terminating the contract with the delegated entity).

¹⁴³ *See supra* note 129.

¹⁴⁴ Telephone interview with Barbara Halthaus, *supra* note 135.

¹⁴⁵ *See* TEX. INS. CODE ANN. § 20A.18C(a)(12) (Vernon 2000) (providing that the HMO must include in its contract with the delegated network a requirement that the delegated network would provide samples of its contracts with physicians). The HMO, however, "may not require that the delegated entity make available to the health maintenance organization contractual provisions relating to financial arrangements with the delegated entity's physicians and providers." *Id.* The effect of this would be that the HMO would not have access to the specific financial arrangements that could be inducing physicians to withhold medically necessary services. The statute provided that the TDI could "request financial and operational documents from the delegated network." The TDI, however, could request this information only *after* the HMO's request for the TDI's intervention. *Id.* § 20A.18C(g) (giving the TDI power to request information after a receipt of notice under subsection (d) of Article 20A.18C). The TDI had authority to directly obtain copies of contracts between an HMO and any physician with whom the HMO had a contract, but this does not appear to apply to contracts between a delegated entity and a physician. *See id.* § 20A.17 (examinations). This authority was subsequently explicitly granted by HB 2828 passed by the Texas Legislature on May 17, 2001. HB 2828 amended article 20A.18C(a)(6)

very financial incentives and arrangements that could lead physicians and other providers to withhold medically necessary care.

Most observers, including, most important, the TDI itself, felt that the regulations in place at the time the OAG entered into the AVC were weak.¹⁴⁶ The TDI felt that the statute limited possible action against network providers after an HMO complained about non-compliance to a reactive position.¹⁴⁷ It is important to note that in 2001, after the AVC had been implemented, the Texas Insurance Commissioner asked the Texas Legislature to hold HMOs one-hundred percent financially accountable for any downstream financial failures.¹⁴⁸ The Commissioner also requested authority to investigate potential downstream network problems, “without waiting to be notified by the HMO.”¹⁴⁹ Note that the Texas Insurance Code provided that an HMO was responsible for the viability of its network.¹⁵⁰ What seemed to be missing in the regulatory understanding was that, notwithstanding any statutorily permissible delegation of duties by an HMO, HMOs remained ultimately responsible for the acts and financial condition of their downstream entities.

An example of this uncertainty concerning an HMO’s ultimate responsibility was the enforcement of prompt payment of providers. The Texas Insurance Code required HMOs to make payment to providers within forty-five days.¹⁵¹ Prompt pay to physicians was an important political issue in

to provide that the contract between the HMO and the delegated entity must include a provision that requires the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to . . . the ability of the delegated entity to meet the entity’s responsibilities in connection with any function delegated to the entity by the health maintenance organization.

TEX. INS. CODE ANN. § 20A.18C(a)(6)(B) (West Supp. 2003).

¹⁴⁶ Letter from José Montemayor, Commissioner of Insurance, State of Texas, to Connie M. Barron, Associate Director, Legislative Affairs, Texas Medical Association (Feb. 27, 2001) (on file with author) [hereinafter Montemayor Letter]; see also Telephone interview with Barbara Halthaus, *supra* note 135 (commenting that the Insurance Code regulations in effect at the time of the AVC had “no teeth”).

¹⁴⁷ Telephone interview with Barbara Halthaus, *supra* note 135.

¹⁴⁸ See Montemayor Letter, *supra* note 146.

¹⁴⁹ *Id.*

¹⁵⁰ TEX. INS. CODE ANN. § 20A.05(a)(1)(A) (Vernon 2000) (holding out as a requirement for obtaining a certificate of authority that the HMO applicant demonstrate the willingness and potential ability to assure that “health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities, in a manner enhancing availability, accessibility, and continuity of services”). Failure to meet these requirements can result in suspension or revocation of the HMO’s license. *Id.* § 20A.20(a)(4). In addition, the Texas Insurance Code provided that any delegation agreement must include a provision stating that “the delegation agreement may not be construed to limit in any way the health maintenance organization’s authority or responsibility, including financial responsibility, to comply with all statutory and regulatory requirements.” *Id.* § 20A.18C(a)(4).

¹⁵¹ *Id.* § 20A.18B(c) (West 2000) (setting out how HMOs make total and portion

Texas and many other states at the time the AVC was promulgated.¹⁵² While a thorough discussion of prompt-pay issues is beyond the scope of this Article, it is important to note that the Texas Insurance Commissioner, in a letter to the TMA, identified slow payment by delegated networks to providers as a significant problem.¹⁵³ The Commissioner did not have any clear authority to control the process of claims paying by delegated networks and entities other than through their TPA license.¹⁵⁴

Thus, it appears that at both the national level and in Texas, the relationship between downstream entities and the ultimate providers of care was largely unregulated at the time that the OAG filed suit against the HMOs. This situation allowed HMOs to do business without due regard for the actions of downstream providers, possibly resulting in the withholding of medically necessary care. In addition, without a concept of the HMOs' ultimate responsibility for the financial condition of the downstream entities, the HMOs could operate without any regard for the financial solvency of those entities. This represented a major cost-shifting opportunity for HMOs, allowing them to continue to pose as meaningful participants in the system of health-care financing in the United States. The OAG's lawsuit and the AVC that resulted

payments to physicians and providers).

¹⁵² See Trebor Banstetter, *Doctors Up In Arms Over Tardy Fee; Hospital and Physicians Will Ask the State to Crack Down on Insurers Who Fail to Pay On Time*, FORT WORTH STAR-TELEGRAM, Feb. 18, 2001, at B1 (reporting that doctors in Texas are frustrated over the late payment of submitted insurance claims in spite of a state law requiring valid claims be paid within forty-five days); see also TEX. INS. CODE ANN. § 20A.18B (West 2000 & Supp. 2003) (defining payments from HMOs to physicians or providers as completed or "clean" claims); Proposed legislation, C.S.H.B. 1862 (Tex. April 2, 2001) (amending the current statute to establish a standardized clean-claim form for health care plan providers, setting forth provisions for the receipt of a claim by a health care provider, making it an unfair or deceptive act for an insurer to fail "to make a payment or otherwise act in good faith with respect to services for which coverage is reasonably clear under the health benefit plan," and detailing other deceptive practices regarding failure to pay bills promptly); D. Ted Lewers, *Keeping the Fires Lit on Issue of Prompt Payment*, 44 AM. MED. NEWS, Apr. 2, 2001, at 29; Illinois Dep't of Ins., *Illinois Insurance Facts Prompt Pay Law*, available at <http://www.ins.state.il.us/HealthInsurance/PromptPay.htm> (last modified Mar. 27, 2003) (noting that there are separate prompt-pay requirements for IPAs and PHOs). For IPAs and PHOs, the Illinois Prompt-Pay law grants specific authority to the Illinois Department of Insurance for enforcement of this law. The Department anticipates it will adopt the rules for the enforcement of the Prompt-Pay Law in relation to IPAs and PHOs.

¹⁵³ See Montemayor Letter, *supra* note 146.

¹⁵⁴ The current Texas Prompt-Pay Law does not contain language that is as specific as the interpretation by the Illinois Department of Insurance of that state's prompt-pay law. See Illinois Dep't of Ins., *supra* note 152. In Texas, the insurance code does not apply to a capitation payment made to a physician or provider but does apply to a "person with whom a health maintenance organization contracts to process claims or to obtain the services of physicians and providers to provide health care services to health care plan enrollees." TEX. INS. CODE ANN. § 28.18B (Vernon 2000).

from that lawsuit reflect a rising consciousness that HMOs should not be allowed to shift to others their cost of doing business. It is in this context that one must evaluate the AVC.

III. THE ASSURANCE OF VOLUNTARY COMPLIANCE AND ITS AFTERMATH

A. Introduction

In December 1998, then-Texas Attorney General Dan Morales filed suit against six HMOs for violations of the Texas Insurance Code,¹⁵⁵ the Texas Administrative Code,¹⁵⁶ and the Texas DTPA.¹⁵⁷ The suit accused the HMOs of illegally using financial incentives to induce physicians to limit medically necessary care to HMO members¹⁵⁸ and not disclosing to consumers these perverse financial incentives.¹⁵⁹ The OAG ultimately arrived at a settlement with only the Aetna defendants on April 11, 2000.¹⁶⁰ The settlement is reflected in a document known as the "Assurance of Voluntary Compliance."¹⁶¹ The AVC represents an attempt to control Aetna's use of downstream risk. In evaluating the AVC's attempt to regulate the HMO's ability to shift financial risk to downstream entities, it is important to keep in mind the regulatory structure in Texas at the time the AVC was negotiated. It is clear that Texas law prohibited financial inducements to limit necessary care; however, that same insurance law did not clearly give the TDI the regulatory authority to obtain the information that was necessary to enforce this law.

The OAG alleged that the HMOs had employed incentives like "shared risk funds," whereby costs for particular services, such as hospital admissions, were estimated by the HMO and then physicians were financially penalized if actual costs exceeded the HMO's projected costs.¹⁶² Other incentives were "bonus"

¹⁵⁵ See Plaintiff's Petition, *Aetna*, *supra* note 22 and sources cited therein; see also TEX. INS. CODE. ANN. § 20A.14(l) (West 2000) ("A health maintenance organization may not use any financial incentive or make any payment to a physician or provider that acts directly or indirectly as an inducement to limit medically necessary services . . .").

¹⁵⁶ 18 TEX. ADMIN. CODE §§ 21.103(d), 21.105(c) (West 2000).

¹⁵⁷ See TEX. BUS. & COM. CODE §§ 17.46(a), (b)(23) (West 2000) (stating that failing to disclose to HMO members the existence or possible effect of financial-incentive arrangements, as well as failing to disclose to members that physicians may suffer penalties if they candidly talk with their patients would fall under the section 17.46(a) prohibition of "false, misleading, or deceptive acts or practices in the conduct of any trade or commerce," where subsection (b)(23) defines "false, misleading, or deceptive" to include "filing suit upon written contractual obligations" with the physicians in question).

¹⁵⁸ Plaintiff's Petition, *Aetna*, *supra* note 22, at 1.2.

¹⁵⁹ *Id.* at 1.5.

¹⁶⁰ AVC, *Aetna*, *supra* note 24.

¹⁶¹ *Id.*

¹⁶² Plaintiff's Petition, *Aetna*, *supra* note 22, at 9.4, 9.5, 9.9.

arrangements which paid physicians more based on fewer services rendered to consumers.¹⁶³ The OAG characterized these incentives as attempts to “limit treatment to members in order to maximize profits.”¹⁶⁴ The AVC addressed these matters in a comprehensive fashion.

B. *The AVC's Approach to Downstream Risk Contracts*

Section II of the AVC is entitled, “Improving the Quality and Integrity of the Physician-Patient Relationship.”¹⁶⁵ In subsection A of Section II, “Capitation and Other Financial Incentive Arrangements,” Aetna agreed:

1. Not to use any financial incentives to penalize individual physicians and primary care provider groups for “exceeding certain budgets,”¹⁶⁶ or for “incurring expenses that are medically necessary.”¹⁶⁷
2. To use contracts that “will not be affected by the actual (as opposed to projected) costs of services incurred by Aetna or by the actual rate of utilization of services during that contract year . . .”¹⁶⁸ Thus, the AVC permitted payment arrangements based on projected utilization, such as capitation, but barred payment arrangements based on actual utilization, such as withholds or downside-risk sharing.¹⁶⁹
3. To only use financial incentive arrangements that are “actuarially sound” in all risk-transfer arrangements, including those between network providers and downstream entities.¹⁷⁰ The actuary used by Aetna must be certified,¹⁷¹ and the actuary’s certification of the arrangement must show that the arrangements are appropriate to cover all of the medically necessary services for which the provider was responsible.¹⁷²
4. Not to engage in risk transfer without assuring that there is stop-loss

¹⁶³ *Id.* at 9.6-9.7.

¹⁶⁴ *Id.* at 9.7.

¹⁶⁵ AVC, *Aetna*, *supra* note 24, § II.

¹⁶⁶ *Id.* § II.A.2(a).

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* § II.A.2(b).

¹⁶⁹ See *supra* notes 162-64 (discussing the financial arrangements with which the OAG took issue in *State v. Aetna*). A common theme in such arrangements was that the physicians would be rewarded if their actual costs were under projected costs, and they would be punished if actual costs exceeded projected costs.

¹⁷⁰ AVC, *Aetna*, *supra* note 24, § II.A.3.

¹⁷¹ *Id.* (deeming an actuary “certified” if the actuary is “knowledgeable regarding Physician and Health Care Provider compensation” and is a member of the American Academy of Actuaries or a fellow of the Society of Actuaries).

¹⁷² *Id.* (stating that an actuary must certify that a formula or method of calculating soundness of the arrangement is “based on reasonable assumptions, actuarially sufficient to compensate the Network Provider for the risk being assumed”).

insurance or reinsurance to prevent any network provider or downstream contractor from bearing “extraordinary costs.”¹⁷³

5. To allow individual physicians and small primary care physician groups to choose whether to be paid by capitation or a fee-for-service schedule, particularly for those with groups of fewer than one hundred enrollees.¹⁷⁴

The AVC also requires that all financial incentives be “clearly and unambiguously disclosed in contracts” with providers at all levels downstream.¹⁷⁵ Furthermore, the AVC requires that any financial incentives be disclosed to consumers in their member handbook.¹⁷⁶

Section II.B of the AVC deals with economic profiling of providers by the HMO.¹⁷⁷ The AVC prohibits HMOs from terminating or penalizing a provider for providing, or proposing to provide, medically necessary care by a variety of statistical and professional methodologies.¹⁷⁸ All profiling must be by objective peer review and directly related to quality.¹⁷⁹ The terms of section II.B fully apply to downstream providers.¹⁸⁰ Aetna also agreed not to discriminate against any enrollee because of a life-threatening or disabling condition¹⁸¹ and agreed to screen for “[c]linically [i]nappropriate [u]nderutilization of health care.”¹⁸² The AVC prohibits Aetna from unilaterally amending a capitation rate or fee schedule for individual physicians or small groups without written notice,¹⁸³ and it prevents Aetna from retroactively amending contracts for other providers, “except as specifically otherwise agreed to within the contract.”¹⁸⁴

To the extent that the above-referenced provisions concern Aetna’s direct

¹⁷³ *Id.* § II.A.4.

¹⁷⁴ *Id.* § II.A.5(a) (detailing how a “directly contracted Individual primary care physician or directly contracted Primary Care Physician Group” can opt for fee-for-service payment instead of capitation payment).

¹⁷⁵ *Id.* § II.A.8.

¹⁷⁶ *Id.* § II.A.9 (detailing, specifically, the language Aetna must use to make such disclosures).

¹⁷⁷ *Id.* § II.B.

¹⁷⁸ *Id.* § II.B.1 (defining statistical and professional methodologies as “(a) projected; (b) the statistical norm; (c) provided or proposed to be provided by peers; or (d) established as a goal”).

¹⁷⁹ *Id.* § II.B.2 (indicating that Aetna also agreed not to use economic profiling to discourage providers from providing medically necessary care to patients).

¹⁸⁰ *Id.* § II.B.5 (requiring that Aetna must contractually require all its downstream providers to implement sections II.B(1)-(4) of the AVC in their contracts with other downstream entities).

¹⁸¹ *Id.* § II.B.4.

¹⁸² *Id.* § II.B.8.

¹⁸³ *Id.* § II.C.9 (requiring ninety days written notice for a payment method change).

¹⁸⁴ *Id.* § II.C.10.

contracts with individual providers or provider groups, they are not remarkable. In the case of direct contracts between Aetna and any entity, there was adequate statutory basis under Texas Insurance Code article 20A.14(1)(1) for prohibiting arrangements that induce physicians to withhold medically necessary services.¹⁸⁵ In fact, the TDI had previously exercised similar authority in dealing with a licensed entity that the TDI believed to be entering into direct contracts with physicians, in violation of Texas Insurance Code article 20A.14(1).

On April 1, 1998, the TDI issued a report charging Harris Methodist HMO ("Harris"), a licensed HMO, with using financial incentives that penalized doctors for providing medically necessary care.¹⁸⁶ On August 18, 1998, Harris signed a consent order with the TDI including findings of fact that Harris had put primary care physicians ("PCPs") into risk pools for pharmacy benefits, hospital inpatient, and specialist referrals.¹⁸⁷ According to the findings of fact, Harris had ranked PCPs into five tiers based on medical expenses, and the PCPs' payments had been adjusted according to the deviation between the actual expenses and the budgeted expenses.¹⁸⁸ Amounts withheld from the risk pools were as high as fifty percent.¹⁸⁹ Pharmacy risk pools had a penalty of as much as thirty-five percent and a bonus potential of forty-nine percent.¹⁹⁰ Capitation rates were adjusted according to economic performance, with no-bonuses-upward adjustment for the lower three tiers.¹⁹¹ In the consent agreement with the TDI, Harris agreed to pay over \$2 million to the PCPs, which had been taken out of their pay due to pharmacy benefit overruns, and almost \$800,000 in bonuses that had been withheld.¹⁹² Harris also agreed to cease ranking physicians based on economic performance, to limit bonuses based on performance to no more than ten percent of base-rate compensation, and to base any such bonuses on appropriate quality measures.¹⁹³ Furthermore, Harris agreed that PCPs with fewer than 500 enrollees and medical groups with fewer than 1,000 enrollees could not receive bonuses based upon economic performance.¹⁹⁴ The TDI's regulatory action resulted in dramatic

¹⁸⁵ TEX. INS. CODE ANN. § 20A.14(1) (Vernon 1997) ("A health maintenance organization may not use any financial incentive or make any payment to a physician or provider that acts directly or indirectly as an inducement to limit medically necessary services.").

¹⁸⁶ See Harris Methodist Tex. Health Plan, Inc., Official Consent Order No. 98-0975 (Comm'r of Ins. of the State of Tex. Aug. 19, 1998) (on file with author).

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.*

¹⁹⁴ *Id.*

changes in Harris's use of financial incentives in physician contracts.¹⁹⁵

What the episode with Harris revealed was that, when dealing with direct contracts, the Texas Insurance Code provided the TDI with a sufficient basis for regulating financial risk shifting. However, in the AVC, the OAG attempted to reach beyond these first-tier contracts between a licensed HMO and its direct downstream contractor. The AVC also addresses the relationship between Aetna's unlicensed downstream entities and the individual providers with whom the downstream entities contract.¹⁹⁶ As stated before, the TDI's statutory authority to accomplish this was uncertain.¹⁹⁷

The OAG had more tools at its disposal than the TDI. In particular, the OAG filed its lawsuit on behalf of the consumers of the State of Texas.¹⁹⁸ Its statutory authority for consumer protection gave it more sweeping powers than those possessed by the TDI.¹⁹⁹ In addition, because the OAG filed a lawsuit, it could demand from the HMOs any evidence that was relevant to the lawsuit.²⁰⁰

¹⁹⁵ *Id.*

¹⁹⁶ AVC, *Aetna*, *supra* note 24, § II.A.6 (stating that "Aetna agrees that it will contractually require all Risk Bearing Network Providers to implement the conditions agreed to by Aetna in this [section] in the Risk Bearing Network Provider's Down stream Contracts with other Network Providers").

¹⁹⁷ *See supra* notes 144-47 and accompanying text.

¹⁹⁸ *See* Plaintiff's Petition, *Aetna*, *supra* note 22, at 1-2.

¹⁹⁹ The lawsuit alleged violations of the Texas DTPA. TEX. BUS. & COMM. CODE ANN. §§ 17.41-17.80 (Vernon 1997). By invoking this law, the OAG was acting in a capacity that was in addition to its capacity as the attorney for the TDI. The Texas DTPA provides that the Consumer Protection Division of the OAG has the power to file a cause of action to restrain deceptive trade practices and to seek civil monetary penalties for such practices if such a cause of action is in the public interest. TEX. BUS. & COMM. CODE ANN. §§ 17.47(a)-(d) (Vernon 1997) (granting the OAG power to bring an action against any person that "the consumer protection division has reason to believe . . . is engaging in, has engaged in, or is about to engage in any act or practice declared to be unlawful by this subchapter," and providing for various remedies and penalties, including damages and restitution). In the Complaint, the Attorney General alleged that the action was in the public interest. Plaintiff's Petition, *Aetna*, *supra* note 22, pt. IV. Even in the absence of a lawsuit, the Attorney General had the power to investigate violations of the Texas DTPA. TEX. BUS. & COMM. CODE ANN. § 17.60 (Vernon 1991) (granting the OAG the power to investigate potential violations by (1) requiring statements by the accused concerning the event in question, (2) examining witnesses under oath, and (3) examining merchandise deemed necessary and proper). The Attorney General could also issue Civil Investigative Demands for any documentary material relevant to the subject matter of such an investigation. *Id.* § 17.61. In addition, the AVC itself is a creature of the Texas DTPA. *See id.* § 17.58(a) (granting the Attorney General authority to accept assurance of voluntary compliance with respect to any act or practice which violates the Texas DTPA).

²⁰⁰ Under the Texas Rules of Civil Discovery, "[a] party may obtain discovery regarding any matter that is not privileged and is relevant to the subject matter of the pending action." TEX. R. CIV. DISC. 192.3(a), *cited in* Order in Misc. Docket 98-9196, Nov. 9, 1998, *reprinted in* 61 TEX. B.J. 1140, 1147-48 (Dec. 1998) [hereinafter Nov. 9 Order]. Note the

Thus, the OAG had the ability to demand the very financial information that the TDI wanted but was uncertain it could obtain.

The OAG used its additional power to negotiate provisions in the AVC clarifying that a licensed HMO bears the responsibility for the activities of its downstream contractors. Thus, the AVC makes Aetna responsible for ensuring that the financial prohibitions in the AVC are also included in its downstream contracts with other network providers.²⁰¹ Under the AVC, if a network provider does not implement these financial incentive provisions, then Aetna has the responsibility to report that information to the OAG.²⁰²

The AVC also makes clear that Aetna could not absolve itself from responsibility for maintaining a network in the event that one of its downstream contractors suffered a financial collapse. Section II.D of the AVC specifies that Aetna must assure continuity of care in case of the failure of a risk-bearing network provider by contracting directly with the downstream providers or reporting to the OAG those who refuse to do so.²⁰³ If a risk-bearing entity fails, Aetna can make payments directly to the downstream provider without being subject to any injunctive relief.²⁰⁴

Section V.6 of the AVC directs Aetna to identify to the OAG the network providers that refuse to contractually commit to any of the six specifically enumerated AVC provisions relating to the use of financial incentives.²⁰⁵

contrast to the scope of discovery in litigation versus the uncertainty surrounding the TDI's authority to obtain financial information under the Texas Insurance Code. *See supra* notes 144-47 and accompanying text. Such financial relationships may have been privileged as "trade secrets"; however, the privilege would be overcome if its allowance would conceal fraud or otherwise work an injustice. *See* TEX. R. EVID. 507. In this litigation, it was the very nature of the financial relationships that was the basis of the lawsuits. In addition, a judge may institute protective measures to protect trade secrets from unnecessary disclosure "as the interests of the holder of the privilege and of the parties and the furtherance of justice may require." *Id.*

²⁰¹ AVC, *Aetna*, *supra* note 24, § II.A.2(c) (stating that Aetna will "contractually require all Network Providers to implement the conditions agreed to by Aetna in [this section] in the Network Providers' Downstream Contracts with other Network Providers").

²⁰² *Id.* § II.A.2(d) ("[I]f a Network Provider refuses to contractually commit to implement the provisions of [this section] . . . then Aetna . . . shall report the identity of that Network Provider to the Attorney General.").

²⁰³ *Id.* § II.D.1 (stating that Aetna must include in all contracts a provision to maintain continuity of care to its members if the other contracting party is unable to do so).

²⁰⁴ *Id.* § II.D.2 (stating that Aetna's contracts must also require "Risk Bearing Network Provider[s] to agree not to seek . . . any injunctive relief prohibiting Aetna from making direct payments to the participating Network Providers" if and when the Risk Bearing Network provider cannot make a timely payment).

²⁰⁵ These are:

[(1)] [T]he prohibition against utilization based compensation as specified in Section II.A.2(b), (c) and (d) of this AVC; [(2)] the requirement for stop loss insurance or similar measures as specified in Section II.A.4 of this AVC; [(3)] the option to be paid per office visit as specified in Section II.A.5(a) of this AVC; [(4)] the prohibition

These are non-mandatory exceptions requiring a good-faith effort to comply, whereas all of the other AVC provisions relating to downstream entities are mandatory.²⁰⁶ Aetna also agreed to abstain from contracting with any network provider that refuses to implement the AVC²⁰⁷ and to “obtain certification” demonstrating that each network provider is in compliance with the AVC.²⁰⁸ For those providers not in compliance, Aetna agreed to take corrective action.²⁰⁹

The AVC was important for a number of reasons. It clarified the HMOs’ ultimate responsibility for the effects of their downstream contractors’ activities. It provided some detail on the prohibition against financial incentives that could induce physicians to withhold medically necessary services. Finally, it delivered the message that there was a new regulatory approach on the horizon, bringing to a close the implicit subsidy created by the past governmental tolerance of HMO risk-shifting activity.

The AVC appeared to set the stage for a new era of managed care regulation in Texas. Subsequent to the execution of the AVC, the Texas Legislature, the TDI, and the OAG took steps to emphasize a renewed focus on the ultimate responsibility of HMOs in Texas. In the spring of 2001, the Texas Legislature passed House Bill 2828, which gives the Texas Commissioner of Insurance more power to monitor the solvency and performance of downstream contractors.²¹⁰ Among other things, HB 2828 allows the Commissioner of

against compensating an Individual Physician through a Financial Incentive Arrangement for services provided by others as specified in Section II.A.6 of this AVC; [(5)] the requirement that Network Providers implement effective preventive care programs as specified in Section II.A.7 of this AVC; and [(6)] the requirement that services provided pursuant to a financial incentive agreement be clearly and unambiguously disclosed as specified in Section II.A.8 of this AVC.

Id. § V.6.

²⁰⁶ Telephone interview with Robert C. Robinson III, Assistant Attorney General, State of Texas (Apr. 30, 2001) (notes on file with author).

²⁰⁷ AVC, *Aetna*, *supra* note 24, § V.6 (“Aetna agrees that it will not contract with any Network Provider that refuses to contractually commit to implement any agreements that Aetna is required by this AVC to obtain from Network Providers.”).

²⁰⁸ *Id.* § V.7 (stating that Aetna must use its “best efforts” to make sure that Network Providers are in compliance with “Aetna’s standards, this AVC, and applicable law”).

²⁰⁹ *Id.* (“Aetna agrees to take corrective action, as necessary, to ensure that each Network Provider complies with Aetna’s standards, this AVC, and applicable law.”).

²¹⁰ See TEX. INS. CODE ANN. § 20A.18C(a)(6) (Vernon 2001), *as amended* by HB 2828 (requiring HMOs to include in their contracts with delegated entities a provision that requires the delegated entity to permit the Commissioner of Insurance to examine at any time any information the commissioner reasonably believes is relevant to the financial solvency of the delegated entity and the delegated entity’s ability to perform its responsibilities in connection with functions delegated by the HMO). As amended by HB 2828, section 20A.18C(g), gives the Commissioner of Insurance authority to examine matters related to the delegated entity’s financial solvency and ability to meet its obligations for delegated responsibilities. *Id.* § 20A.18C(g).

Insurance to:

[O]rder the health maintenance organization to take any action the Commissioner determines is necessary to ensure that the health maintenance organization is in compliance with [the HMO Act], including . . . reassuming the functions delegated to the delegated entity, including claims payments for services previously rendered to enrollees of the health maintenance organization.²¹¹

HB 2828 explicitly adopts reserve requirements for “delegated networks,” defined as downstream entities that “assume total financial risk for one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs.”²¹²

Since the execution of the AVC, the TDI has also entered into consent orders with HMOs pursuant to which the HMOs were financially liable for their delegated entities’ failure to pay certain claims owed to physicians and other providers.²¹³ In recent litigation filed against PacifiCare of Texas, Inc., in February 2002, the OAG has returned to the theme of ultimate financial responsibility for the licensed HMO.²¹⁴ The lawsuit seeks to hold the HMO financially responsible for the failure of its downstream entities to fulfill the requirements of Texas prompt-pay statutes.²¹⁵ In this lawsuit, the OAG asserts

²¹¹ *Id.* § 20A.18C(l)(1).

²¹² *Id.* §§ 20A.18D, 20A.02(ff) (requiring “delegated networks” to establish and maintain reserves adequate to cover the liabilities and risks assumed by the network). It should be noted that the term “delegated network” does not include a delegated entity that shares risk for a category of services with a health maintenance organization. *Id.* § 20A.02(ff). A “delegated entity” is any entity “other than a health maintenance organization . . . that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide medical or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the health maintenance organization any function regulated by [the Texas HMO] Act.” *Id.* § 20A.02(ee). The term “delegated entity” does not include “an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to [non-employee providers] is less than 20 percent of the total collected revenue of the group.” *Id.*

²¹³ See, e.g., Tex. Dep’t of Ins., *Aetna Consent Order Summary*, at <http://www.tdi.state.tx.us/consumer/nr11011b.html> (accessed Feb. 28, 2003) [hereinafter *Aetna Consent Order*]. In this consent order, Aetna was required to “use reasonable efforts to enforce contract obligations of certain of its delegates” to pay claims of physicians and other providers. *Id.* The delegates included several clinics, PPOs, and IPAs. In addition, upon the failure of the delegates to pay the required amounts within sixty days, Aetna itself was required to make payment. *Id.*

²¹⁴ See Plaintiff’s Complaint, *State v. PacifiCare of Tex., Inc.*, No. GV200718 (Tex. Dist. Ct. Feb. 11, 2002).

²¹⁵ *Id.* § X.C. According to the complaint:

PacifiCare paid its delegated networks a monthly capitation fee. The delegated networks were contractually obligated to use this capitation fee to pay physicians and

that the HMO is “statutorily prohibited from contractually relieving itself of regulatory responsibility for . . . delegated functions”²¹⁶ and may not contractually relieve itself of its responsibility to promptly pay claims in compliance with Texas statutes and regulations.²¹⁷

C. *Aetna’s Corporate Performance Since the AVC*

The AVC was a harbinger of a new regulatory approach to risk shifting by HMOs. The AVC emphasized the ultimate responsibility of the HMO for things that occurred downstream. This meant that this avenue of cost shifting would no longer be available to Aetna in the State of Texas. The handwriting was on the wall; Aetna would be required to bear the full cost of operating its networks, and that necessarily meant that profits would decline for HMOs. HMOs would need to find another avenue by which to achieve risk avoidance if they wanted to remain significant players in the health care financing system in the United States.

A national health care consulting firm urged its clients to view the AVC as “a clear and concrete reminder that it is time to start focusing on new ways to conduct their business if they are to remain competitive.”²¹⁸ In light of the AVC, Aetna began promoting a vision of a new corporate identity embodied in the slogan, “The new Aetna: turning promise into practice.”²¹⁹ At the same time, however, Aetna embarked on a course of risk-shedding by pulling out of certain markets. The actions that Aetna has taken subsequent to the AVC support the proposition that removing the implicit subsidy provided to HMOs

providers for covered services provided to PacifiCare members. However, as a result of PacifiCare’s failure to properly manage, monitor, and oversee its networks, physicians and providers who contracted with the delegated networks and cared for PacifiCare’s members were not paid by the delegated network.

Id. The complaint further asserts that:

PacifiCare’s failure to assure that its delegated networks complied with its contract and with regulatory requirements for prompt and proper payment to physicians and providers resulted in many millions of dollars of physicians’ and providers’ claims left unpaid when PacifiCare’s delegated networks became insolvent PacifiCare is responsible for its delegated network’s failure to comply with the prompt-pay laws

Id. § X.D.

²¹⁶ *Id.* § VIII (citing TEX. INS. CODE ANN. § 20A.18C(a)(4) (Vernon 1997)). Section 20A.18C(a)(4) of the Texas Insurance Code provides that the health maintenance organization’s written agreement with a delegate must include a provision “that the delegation agreement may not be construed to limit in any way the health maintenance organization’s authority or responsibility, including financial responsibility, to comply with all statutory and regulatory requirements.” TEX. INS. CODE ANN. § 20A.18C(a)(4) (Vernon 1997).

²¹⁷ Plaintiff’s Complaint § IX.B, *PacifiCare* (No. GV200718) (citing TEX. INS. CODE ANN. § 20A.18C(a)(4) (Vernon 1997)).

²¹⁸ Stordahl, *supra* note 27.

²¹⁹ Aetna, Advertisement, N.Y. TIMES, Oct. 4, 2001, at A19.

will cause them to withdraw from insurance markets.

On May 10, 2000, shortly after the announcement of the AVC, the then-Aetna Chairman and CEO, William H. Donaldson, announced a new vision for Aetna.²²⁰ He described a new business model based on a better partnership with participating physicians.²²¹ Acknowledging the Texas AVC, Donaldson warned that “[w]hile local-market issues make it difficult to apply the same approach nationally, we are moving quickly to make sensible and thoughtful improvements in other markets.”²²² On December 19, 2000, Aetna announced nationally that it was adopting a “more flexible physician contracting strategy.”²²³ The stated reason for this policy change was to “improv[e] physician relationships with the goal of improving health care quality.”²²⁴ Aetna noted ongoing discussions with the physicians in California, Connecticut, Georgia, New Jersey, and Virginia.²²⁵ With respect to the Texas AVC, Aetna said it was considering making some of those changes on a “market-by-market” basis.²²⁶

Press accounts raised concerns that eliminating financial incentives for doctors would affect an HMO’s ability to hold down costs.²²⁷ In fact, Aetna’s financial performance deteriorated throughout 2000 and 2001.²²⁸ After announcing that profits would not meet expectations, Aetna saw its stock fall

²²⁰ See Press Release, Aetna United States Healthcare, Aetna Chairman William H. Donaldson Speaks at Connecticut Medical Society Annual Meeting (May 10, 2000) (announcing new changes to improve relationships with physicians and access to care for patients), available at http://www.aetna.com/news/2000/prtpr_20000510B.htm (accessed Feb. 28, 2003); see also William H. Donaldson, Aetna CEO, Address to Connecticut State Medical Society (May 10, 2000) (sharing a vision of how to improve the relationship between Connecticut doctors and Aetna), available at http://www.aetna.com/news/2000/prtpr_20000510.htm (accessed Feb. 28, 2003) (notes on file with author).

²²¹ Press Release, *supra* note 220 (describing changes such as giving physicians the flexibility to opt out of Aetna’s all-products policy and allowing those physicians with fewer than 100 HMO members to be paid on a fee-for-service basis).

²²² Donaldson, *supra* note 220.

²²³ See Press Release, Aetna United States Healthcare, Aetna President CEO John W. Rowe, M.D., Announces National Implementation of More Flexible Physician Contracting Strategy (Dec. 19, 2000), available at http://www.aetna.com/news/2000/prtpr_20001219.htm.

²²⁴ *Id.*

²²⁵ *Id.* (listing on-going changes in Florida, California, New Jersey, Georgia, Texas, and Virginia).

²²⁶ *Id.*

²²⁷ See Diane Levick, *Can Aetna Heal Itself?*, HARTFORD COURANT, Apr. 22, 2001, at A1 (stating that the “kinder, gentler” Aetna has recently made concessions that may potentially hurt its bottom line), available at <http://www.ctnow.com>.

²²⁸ See Joseph B. Treaster, *Aetna Says First-Quarter Profit Will Fall Far Short of Expectations*, N.Y. TIMES, Apr. 11, 2001, at C1 (announcing that Aetna’s costs for 2000 and 2001 were much greater than originally projected).

more than seventeen percent in one day.²²⁹ A longtime Wall Street HMO analyst observed that Aetna “tried to become kinder and gentler so quickly that it has led to a dramatic increase in their costs.”²³⁰ Indeed, Aetna announced \$90 million in unanticipated medical costs in the first quarter of 2001.²³¹ Aetna suffered \$12.3 million in losses in Texas in both of its HMO units in the first three quarters of 2000.²³² Hospital costs in Houston were up thirty percent.²³³ This financial impact of the AVC and Aetna’s new business was entirely predictable. Financial risk shifting had granted HMOs a significant implicit subsidy during the heyday of managed care. The threatened removal of this subsidy affected the bottom line.

The reality that the implicit subsidy was no longer going to be a viable option triggered a predictable response. Aetna began to reduce its risk by pulling out of certain markets, including the more risky small business and Medicare markets. Aetna’s insured members dropped from twenty-one million in 1999 to 19.3 million by December 31, 2000.²³⁴ In 2001, Aetna eliminated one million enrollees in HMOs in which Aetna took financial risk for losses, terming these “unprofitable,” and continued in more profitable HMOs for self-insured employers where the employer, and not Aetna, bore the financial risk.²³⁵ By April 2002, Aetna had shed another four million enrollees and now had enrollment of fifteen million.²³⁶ By April 2002, Aetna had become profitable for the first quarter since December 2000.²³⁷ That profitability extended through the second quarter, and its CEO observed, “I’m a believer in cost sharing for consumers, to [giving them] some skin in the game, if you will.”²³⁸ Having shed the risk of unprofitable, high-risk patients and risk-

²²⁹ *Id.* (stating that “[s]hares in Aetna . . . dropped more than 17 percent yesterday after the company warned that its first-quarter earnings would be significantly lower than expected”).

²³⁰ See Treaster, *supra* note 28 (quoting Kenneth S. Abramowitz, a managing director at the Carlyle Group).

²³¹ *Id.* (“Aetna said it expected an additional \$90 million in medical expenses for the first quarter.”).

²³² John B. Harkey, *Some Texas HMOs Cut Losses*, 3 HARKEY REPORT—TEXAS MANAGED CARE 2 (Feb. 2001).

²³³ *Id.*

²³⁴ See Levick, *supra* note 227 (stating that Aetna dropped from twenty-one million members to 19.3 million members by December 31, 2000).

²³⁵ Milt Freudenheim, *Aetna to Close Some Unprofitable H.M.O. 's*, N.Y. TIMES, July 12, 2001, at C5 (“Aetna plans to shed up to one million members of unprofitable health plans this year.”).

²³⁶ Milt Freudenheim, *Aetna Health Care Unit Posts a Profit, Ending Its Drought*, N.Y. TIMES, Apr. 26, 2002, at C6 (stating that Aetna was the nation’s second-largest health insurer with fifteen million members).

²³⁷ *Id.*

²³⁸ *Aetna Posts Higher Profit, Raises Outlook*, REUTERS, Aug. 1, 2001, available at http://www.foxnews.com/printer_friendly_story/0,3566,59324,00.html.

bearing HMOs, Aetna was transferring risk to its remaining 14.4 million HMO enrollees and, in the process, becoming profitable.²³⁹ Due to this risk shedding, however, Aetna was no longer the country's largest HMO.²⁴⁰

CONCLUSION

Aetna's evolution subsequent to the AVC is not unlike the experience of other HMOs during the same period as they anticipated the end of the risk-shifting era. Around the country, HMOs began to withdraw from certain markets, increase premiums in other markets, and introduce new products in which the consumer is called upon to bear a greater responsibility for the risk. The rise of so-called "defined contribution" plans is reflective of the fact that the risk pea is being transferred to another player's pocket shell in the shell game. Because governmental policy threatens to shut off all other avenues of risk avoidance, under the new shell game, the consumer will be left bearing the risk.

It appears that after having effectively held down cost increases for a decade, managed care has begun to lose the ability to control such increases.²⁴¹ The close of the 1990s and the beginning of the new millennium have ushered in the return of double-digit increases in the cost of health coverage.²⁴² It seems that the price restraints that were in effect in the 1990s were merely illusory. What appeared to be controlling costs was, in reality, the result of an elaborate shell game. Managed care did not truly control the costs of health care; it merely moved those costs to another side of the ledger by entering into arrangements in which providers actually took on insurance risk. In effect, managed care exported the costs of operating an insurance program to another party in the health care system.

By imposing upon managed care the burden of the cost of insuring against health expenditures, new governmental policies threaten the viability of managed care. The AVC reflects one such effort. In addition, the continuing—and seemingly never-ending—congressional discussion about a federal patient protection act reflects a similar governmental approach to

²³⁹ Kim Dixon, *Aetna Sees Earnings to Doubling Estimates*, REUTERS BUS. REP., Oct. 9, 2002, at <http://www.insurance-portal.com/101002.htm#9>; see also *Now-profitable Aetna Axing 2,750 Jobs*, HOUSTON CHRON., Sept. 27, 2002, at 2C (reporting an Aetna spokesperson's acknowledgment that the company intentionally cut unprofitable plan members and planned further membership cuts to reach 13.7 million members by the end of 2002).

²⁴⁰ See Dixon, *supra* note 239.

²⁴¹ Reed Abelson, *Hard Decisions for Employers As Costs Soar in Health Care*, N.Y. TIMES, Apr. 18, 2002, at C1 (noting that employers were facing a third straight year of double-digit increases in health care costs and that double-digit increases were last common in the 1980s and early 1990s).

²⁴² *Id.* (stating that increases stem from rising hospital admissions, increasing labor costs, and dramatic increases in prescription drug prices).

prevent risk shifting.²⁴³ Such efforts have encouraged the managed care industry to find other mechanisms by which export their costs. Since it appears that the employers have reached the limits of the costs they are prepared to assume, the consumer is left as the next recipient of the health care risk.

This explains the latest wave of so-called “consumer-driven” health plans,²⁴⁴ such as defined-contribution plans.²⁴⁵ Under such plans, the employee is given a specific amount of money with which to purchase health care.²⁴⁶ Once this dollar amount is used up, the employee is responsible for the costs of his own health care, with the exception of catastrophic coverage.²⁴⁷ The theory behind the plans is that patients will deal directly with providers, and, because they are responsible for payment, they will be more prudent purchasers of health care.²⁴⁸ Theoretically, this will hold down the costs of health care. In effect, however, the consumer is actually being called upon to assume the role of insurer of the consumer’s own health care expenditures. The consumer is asked to take on the risk that the premium he collects—in the form of the

²⁴³ Amy Goldstein, *Patients’ Rights Talks Hit Impasse*, WASH. POST, Aug. 1, 2002, at A4 (describing Congress’s failure to reach agreement on patient protection legislation, which would provide consumers with a means to redress injuries caused by managed care treatment decisions), available at <http://www.washingtonpost.com/ac2/wp-dyn/A32020-2002Aug1.html>; see also Hampton, *Markets*, *supra* note 4, at 1023-24 (discussing the impact of removing the HMOs’ exemption from liability for improper medical necessity determination).

²⁴⁴ See John K. Iglehart, *Changing Health Insurance Trends*, 347 NEW ENG. J. MED. 956, 960 (2002) (noting that insurers and employers are increasingly using the term “consumer-driven health care” when referring to new coverage arrangements); see also Kathy M. Kristof, *New Health-Care Plans May Not Be a Panacea*, L.A. TIMES, Aug. 25, 2002 (stating that consumer-driven health plans are a growing trend in an effort to make consumers spend more prudently when seeking health care), available at <http://www.latimes.com/la-fi-perfin25aug25.story>.

²⁴⁵ See Iglehart, *supra* note 244, at 960-61 (stating that defined-contribution plans have only been developed recently and were traditionally used in the context of pension benefits for retirees); see also Eric W. Ford, *Economic Implications of Defined Contribution Health Plans*, 37 BUS. ECON. 38, 39-40 (Jan. 2002).

²⁴⁶ Iglehart, *supra* note 244 (“Under this approach, the employee would pay for any costs that exceeded the employer’s contribution, up to a maximal amount, beyond which insurance would cover the cost of a serious or catastrophic illness.”); Ford, *supra* note 245, at 39, 40-41 (discussing different types of defined-contribution plans).

²⁴⁷ See Iglehart, *supra* note 244, at 961; see also Kristof, *supra* note 244 (providing an example of an employee with a \$1,000 annual health-care account from employer and a \$2,500 deductible with the insurer, where, after the first \$1,000 is spent in medical expenses, the employee would be responsible for payment of the remaining \$1,500 of the \$2,500 deductible).

²⁴⁸ See Iglehart, *supra* note 244, at 961 (“The assumption is that people will be more prudent in purchasing health care services if they recognize that they are spending their own money.”).

defined contribution—will exceed the consumer's expenditures for health care. This is, of course, the essence of the business of insurance. Over the long term, it is unlikely that consumers will be able to manage risk, control costs, and ensure quality better than the managed care industry, employers, and health care providers that the consumers will be forced to replace.