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ARTICLES

STANDARDS OF CARE AND STANDARD FORM CONTRACTS: DISTINGUISHING PATIENT RIGHTS AND CONSUMER RIGHTS IN MANAGED CARE

*Wendy K. Mariner**

INTRODUCTION

There is hardly a legislature in the country that is not currently debating the issue of patient rights in managed care. Not surprisingly, legislators, as well as reporters covering the debate, have called upon George J. Annas, Edward R. Utey Professor of Health Law and Chair of the Health Law Department at Boston University, for information and advice. Professor Annas has earned the title of “father of patient rights” for his decades of research, writing, and advocacy on behalf of individuals who need health care and deserve justice.¹

Today, however, one might ask whether patient rights are compatible with managed care.² After all, much of the impetus for managed care

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1. Professor Annas literally wrote the book on patient rights: GEORGE J. ANNAS, *THE RIGHTS OF PATIENTS* (2d ed. 1989) [hereinafter *THE RIGHTS OF PATIENTS*]. Other books by George Annas dealing with patient rights issues include *SOME CHOICE: LAW, MEDICINE, AND THE MARKET* (1998) [hereinafter *SOME CHOICE*]; *STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS* (1993) [hereinafter *STANDARD OF CARE*]; and *JUDGING MEDICINE* (1988) [hereinafter *JUDGING MEDICINE*]. Professor Annas has also written extensively on the rights of research subjects, who may or may not also be patients. See, e.g., *THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION* (George J. Annas & Michael A. Grodon eds., 1992); GEORGE J. ANNAS ET AL., *THE SUBJECT'S DILEMMA* (1977).

2. The term “managed care” is used in its broadest sense to mean any health insurance plan that, in exchange for a fixed premium, finances and arranges for medical care for a group of individuals, with varying degrees of management of the medical care provided to those individuals or the mechanisms for delivering

was to counter the rising demand for, and cost of, medical care. Much of the managed care industry's success in lowering health insurance premium costs may be attributed to limiting patient choices and treatments, especially in regard to the length of hospital stays.³ Indeed, the managed care industry does not speak of the rights of "patients." Instead, it describes the rights *and responsibilities* of members or consumers.⁴

such care. The National Conference of State Legislatures has defined managed care as:

a term that describes health care systems that integrate the financing and delivery of appropriate health services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health services, explicit standards for selection of health care providers, formal programs for ongoing quality assurance and utilization review, and significant financial incentives for members to use providers and procedures associated with the plan.

KENNETH R. WING ET AL., *THE LAW AND AMERICAN HEALTH CARE* 83 (1998) (quoting The National Conference of State Legislatures). Insurance companies, hospital and medical service companies, and employers offer managed care plans in a wide variety of structures, from closed panel health maintenance organizations (HMOs), to preferred provider organizations (PPOs), to networks of insurers and groups of physicians and hospitals. For a reasonably comprehensive description of the types of managed care organizations, see HEALTH LAW CENTER, ASPEN PUBLICATIONS, *MANAGED CARE ORGANIZATIONS, AFFILIATED ENTITIES, AND INTEGRATED DELIVERY SYSTEMS, MANAGED CARE LAW MANUAL* 1-9 (1997). For descriptions of the recent growth and variety of managed care organizations, see generally Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, 16 *HEALTH AFF.* 134 (1997); Alice G. Gosfield, *The New Playing Field*, 41 *ST. LOUIS L.J.* 869 (1997).

3. See Wendy K. Mariner, *Business v. Medical Ethics: Conflicting Standards for Managed Care*, 23 *AM. J.L. MED. & ETHICS* 236 (1995). Managed care organizations have recently begun to raise premiums, prompting renewed fears that the cost reductions achieved to date were one time only savings, and that, given a growing elderly population and more advances in medical technology, higher premiums are necessary to cover new costs. See Ian Fisher, *H.M.O. Premiums Rising Sharply, Stoking Debate on Managed Care*, *N.Y. TIMES*, Jan. 11, 1998, at A23. A Health Care Financing Administration report predicts that national health expenditures will double to \$2.1 trillion in 2007. See Robert Pear, *Sharp Rise Predicted in Health-Care Spending in the Next Decade*, *N.Y. TIMES*, Sept. 15, 1998, at A21. For seminal accounts of the inevitability of such increases, see Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 *SCIENCE* 418 (1990); William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Provide Only Temporary Relief*, 257 *JAMA* 220 (1987).

4. See, e.g., NATIONAL COMM'N FOR QUALITY ASSURANCE, *STANDARDS FOR ACCREDITATION OF MANAGED CARE ORGANIZATIONS*, 49-53 (1996);

Professor Annas critiqued "managed care's attempt to transform the patient into a consumer" because it portends the potential loss of important rights for everyone.⁵ The change in language both reflects and encourages conceptualizing health care as a market commodity.⁶ While doctors and hospitals have patients, markets have consumers. Annas argues that if patients metamorphose into consumers, the law must continue to protect individuals as patients. Just as he developed a model bill of patient rights in 1975,⁷ Annas now proposes a national bill of patient rights for the new era in which managed care plays a prominent role.⁸

Annas has been the trailblazer in patient rights, mapping new ground in law with succinct and pungent writing that captures the essence of a

PRESIDENT'S ADVISORY COMM'N ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUS., CONSUMER RIGHTS AND RESPONSIBILITIES, REPORT TO THE PRESIDENT (Nov. 1997) [hereinafter, PRESIDENT'S ADVISORY COMM'N]; PRINCIPLES FOR CONSUMER PROTECTION (1997) (a joint statement of Kaiser Permanente, Group Health of Puget Sound, Health Insurance Plan (HIP), and Families USA). Health plan contracts typically refer to individual members as members or enrollees.

5. See George J. Annas, *A National Bill of Patient Rights*, 338 NEW ENG. J. MED. 695, 696 (1998) [hereinafter *A National Bill*].

6. This follows a general shift from medical terminology to market terminology, in which physicians, nurses, dentists, hospitals, home health agencies, other professionals and facilities are all called "providers" or, sometimes "vendors," and the proportion of premium revenues spent on patient care is the "medical loss ratio." Insurers have also called their insureds "covered lives," which does not include people without insurance. See SOME CHOICE, *supra* note 1, at 44-51 (arguing that the market metaphors used in health care have transformed not only the way people think about medicine, but also misrepresent reality); see also generally Edmund D. Pellegrino, *Words Can Hurt You: Some Reflections on the Metaphors of Managed Care*, 7 J. AM. BD. OF FAM. PRAC. 505 (1994) (noting how the use of certain terms changes the general perception of health care).

7. See GEORGE J. ANNAS, *THE RIGHTS OF HOSPITAL PATIENTS* (1975).

8. See *A National Bill*, *supra* note 5, at 697-99. Annas proposes that the following categories of patient rights be protected by national legislation applicable to all Americans, whether or not they are covered by health insurance or managed care: The right to treatment information; the right to privacy and dignity; the right to refuse treatment; the right to emergency care; and the right to an advocate. In addition, he proposes that consumers with health insurance should be entitled to information about the health plan and financial incentives for physicians to limit care, payment for emergency care, a reasonable choice of primary care physicians, reasonable access to specialists, timely access to an independent appeals mechanism for denial of benefits, and free communication with one's physician without health plan interference. See *id.*

patient's place in medicine. He has left little for the rest of us to do but fill in the details. This article follows in that tradition by developing the distinction between patient rights and consumer rights and examining what the contours of law that protects both might look like. The first section of this article describes the difference between rights ascribed to patients and consumers respectively, and the general nature of laws that have traditionally protected each. Patient rights focus on the relationship between patients, physicians or other "providers" regarding the type and quality of care provided. Consumer rights focus on purchasing decisions before forming a provider relationship or agreeing to a contract. The second section differentiates the health care delivery and insurance functions of managed care that affect patient rights and consumer rights, respectively, noting that some elements have mixed effects. These differences are developed in the third section, which argues that current efforts to regulate managed care conflate patients with consumers, and that the resulting reliance on consumer choice to protect patient rights is misplaced. Section four outlines the problems with conceptualizing managed care issues solely within the consumer model. The choice of a health plan is but one of many rights today's patients deem important. However, an increasing number of Americans retain little, if any, meaningful choice of health plans. Consumer rights are necessary to help people choose a health plan, but they are not sufficient to protect patients when they need medical care. Moreover, consumer choice encourages a perception that managed care plans can be understood as simple contracts between willing buyers and sellers, with the contract defining all the parties' rights and duties. This raises the question whether contracts should supersede tort obligations in providing patient care. Section five argues that managed care issues cannot always be resolved satisfactorily by applying traditional contract principles exclusive of tort principles. Finally, section six suggests viewing managed care plans as a hybrid incorporating elements of standard form insurance contracts, far removed from the idealized contract model, as well as elements of professional service agreements for personal medical care traditionally governed by tort standards. While some contract doctrines may serve to protect consumers in their financial dealings, the law should protect patients as well as consumers in the complex reality of managed care relationships. Thus, there is a need for extra-contractual tort standards to protect the rights of patients, whether or not they are members of a managed care plan.

I. DIFFERENCES BETWEEN CONSUMERS AND PATIENTS

A. Consumers

Consumers are buyers of goods and services. In the ideal competitive marketplace, buyers and sellers have equal bargaining power, so that their decisions to buy and sell are made freely, without coercion or undue advantage.⁹ Of course, the perfectly competitive market of economic theory has yet to exist. There are multiple imbalances between buyers and sellers, in both information and ability to make choices and purchases. In some circumstances, the law has intervened to help make the buyer's bargaining position more equal to that of the seller.¹⁰

Buyers may be disadvantaged in two ways. They may be unable, wittingly or unwittingly, to make a voluntary *choice*, or they may be unable to make a desired *purchase*. Constraints on choice include lack of information or incorrect information about products. Buyers may not be aware of material facts about a product that might dissuade them from buying it. Also, advertising influences some buyers' judgments in ways they may not recognize or desire. These informational constraints make it difficult for consumers to make informed choices about whether to buy a certain product. As to the second point, some consumers cannot buy what they would choose because they cannot afford it or it is not available where they are located. Others may have such an immediate need for a product that they must buy whatever is immediately at hand.

Consumer protection laws are intended to protect consumers' freedom to make voluntary *choices*, not purchases. The law does not concern itself with consumers' inability to pay for a desired product or service. The notion of consumer as buyer implies the ability to pay, but not the capacity to afford whatever one might choose given unlimited financial resources. One does not assume consumers as a class are equal in resources or ability to pay. Nevertheless, the law justified intervention to redress other imbalances in bargaining power.

The major tool of consumer protection laws is information disclosure.

9. See generally MARK A. HALL, *MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS* (1997); RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* (1997).

10. See generally Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1319 (1996) (providing a comprehensive analysis of consumer protection issues in managed care).

Where consumers are likely to lack information that is relevant to deciding whether to buy something, legislation requires sellers (or manufacturers) to disclose that information. For example, banks are required to inform borrowers of the effective annual percentage rate (APR) of interest charged on a loan.¹¹ Product liability law requires manufacturers and sellers to disclose product risks that would not be expected by the average prudent consumer.¹² The goal is to redress the imbalance in information between buyer and seller, thus moving toward the market ideal that consumers should have perfect information to make reasonably informed choices.¹³ Consumer protection laws also prohibit deceptive marketing and advertising practices.¹⁴

A second, less often used tool of consumer protection is product standards.¹⁵ The law rarely requires sellers to offer any particular product.

11. See, e.g., Consumer Credit Protection Act, 15 U.S.C. §§ 1601-1694 (1997 & Supp.); Real Estate Settlement Procedures Act, 15 U.S.C. §§ 2601-2617 (1994).

12. See RESTATEMENT (SECOND) OF TORTS § 402A cmts. j, k (1965); RESTATEMENT (THIRD) OF TORTS: PRODUCT LIABILITY § 2 cmt. i, § 10 (1998).

13. Disclosure of product information is not a panacea, however. Even assuming, contrary to much evidence, that relevant information can be collected and distributed in a useful form, consumers are often unable to understand it or act on it. See Marc A. Rodwin, *Physicians Conflicts of Interest: The Limitations of Disclosure*, 321 NEW ENG. J. MED. 1405, 1406 (1989); see also MARC A. RODWIN, *MEDICINE, MONEY & MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 216-17 (1993) (noting that laypeople are significantly less familiar with medical matters than with market and financial matters, so that obtaining and understanding medical information is especially difficult for patients); Susan Edgman-Levitan & Paul D. Cleary, *What Information Do Consumers Want and Need?*, HEALTH AFF., Winter, 1996, at 42, 44; John E. Ware, *What Information Do Consumers Want and How Do They Use It?*, 33 MED. CARE JS25 (J. Supp. 1995).

14. See *Morgan v. Cincinnati Ins. Co.*, 307 N.W.2d 53, 54 (Mich. 1981) ("Recognizing the disparity in the bargaining positions of the companies which write insurance and the consumers who buy the policies, both the statutory law and judicial decisions have aimed at making certain that the interests of every insured are protected.").

15. If managed care organizations considered their insurance policies or health plans to be "products," then arguably such products could carry an implied warranty of merchantability or fitness for use, which includes at least minimum standards of quality in the care actually provided. For an argument that managed care plans should be subject to an implied warranty of quality, see generally William S. Brewbaker III, *Medical Malpractice and Managed Care Organizations: The Implied Warranty of Quality*, 60 L. & CONTEMP. PROBS. 117 (1997).

However, both state and federal consumer protection legislation occasionally require that products meet certain safety standards. Both state and federal law prohibit provisions in banking, securities, residential lease, and consumer product sales contracts that are unfair or in violation of public policy. For example, banks are often prohibited from foreclosing on delinquent loans without giving the debtor an opportunity to pay the amount owed. Such statutory limitations typically apply to contracts of adhesion where individual consumers are seldom in positions of bargaining equality with sellers like banks and large corporations.¹⁶

Finally, consumer protection laws also serve the larger goal of promoting market efficiency. In this, they resemble antitrust laws, whose purpose is to foster free and competitive markets, where no seller is able to obtain monopoly power, to achieve the most desirable array of goods and services of the quality and at the lowest prices valued by the population.¹⁷

B. Patients

Everyone is, or will be, a patient, whether or not one has health insurance. The rights of patients developed outside the context of commercial markets, independently of health insurance, and without regard to the existence or source of payment for health care.¹⁸ Although patients historically purchased their health care, patients were not considered consumers until very recently. This is because the concept of "patient" denotes a *recipient* of health care services. Whether, or how, health care

16. For the seminal exposition of contracts of adhesion, see generally Friedrich Kessler, *Contracts of Adhesion—Some Thoughts about Freedom of Contract*, 43 COLUM. L. REV. 629 (1943).

17. The U.S. Supreme Court's often cited statement on the purpose of anti-trust laws appeared in *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 3 (1958). There, the Court stated:

The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions. But even if that premise were open to question, the policy unequivocally laid down by the Act is competition.

Id.

18. See *A National Bill*, *supra* note 5, at 697.

might be paid for is irrelevant to the status of patient. One becomes a patient when one is ill, injured or in need of medical care. Ordinarily, a patient is in a relationship with a physician, nurse or other health care professional. The law governing patient rights developed hand-in-hand with the medical profession's increasing capacity to cure disease.

Historically, patients never were in an "equal bargaining relationship" with their physicians. It was assumed that physicians have special knowledge and skills that patients do not possess.¹⁹ This is why patients seek the advice and care of physicians. This inherent imbalance in knowledge and skill is a defining characteristic of the physician-patient relationship. Moreover, patients are usually sick and not able to function at their own normal capacity. Thus, while consumers are in a position of equal bargaining power with sellers, patients are in a position of inequality with physicians and other health professionals.

Unlike consumer protection law, the law of patient rights does not seek to give patients and physicians equal medical knowledge. Instead, the law accepts the inequality in knowledge and skill and protects patients by imposing on physicians a fiduciary duty to use their skills only in the patient's best interest and to provide medical services that meet professionally accepted standards.²⁰ In contrast businesses do not have fiduciary obligations to their customers.²¹ They are in an arm's length relationship.²² In general, businesses are not legally bound to meet professional standards of care in their relationships with customers. Businesses may be liable for negligence, strict liability in the manufacture of their products, or misrepresentation. However, customer service does not include a legal duty to protect the customer's best interest or well being.²³

19. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 1-29 (1984).

20. See generally ROBERT BURT, *TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONSHIPS* (1979). Physicians and many other health professionals such as nurses, dentists or optometrists must be licensed under state law intended to set minimum (some would say minimal) requirements for specialized knowledge and skill. See GEORGE J. ANNAS ET AL., *AMERICAN HEALTH LAW* 668-74 (1990).

21. For-profit corporations have a (financial) fiduciary obligation to their investors. See Mariner, *supra* note 3, at 238.

22. See *A National Bill*, *supra* note 5, at 695.

23. For a thoughtful discussion of the nature of the fiduciary status of physicians, see generally Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided*

This is not to suggest that patients lack equal respect as persons under law. On the contrary, the doctrine of informed consent grants explicit recognition to patient autonomy and self-determination.²⁴ It is precisely because the patient is more knowledgeable than the physician about the patient's life and wishes, that courts have recognized the patient's common law right to decide what, if any, medical care he or she will receive.²⁵ The patient's right to decide what medical care to accept is somewhat analogous to a consumer's choice of what to buy. However, because medical care requires specialized knowledge that patients lack, courts have imposed on physicians the common law duty to provide patients with sufficient information to enable them to make decisions about what care to accept.²⁶ Thus, patient rights to make medical decisions require the correlative duty of physicians to provide information.²⁷

This contrasts with the consumer-seller relationship, in which there is no presumption of specialized knowledge and no general obligation to provide consumers with the information that consumers deem material to deciding to buy a product. Common law principles governing product liability require manufacturers and sellers to offer consumers warnings of risks that would not be expected by the ordinary consumer.²⁸ However, warnings about medical devices and drugs that are available to patients only through physicians by prescription need only be given to

Physician Loyalties and Obligations in a Changing Health Care System, 21 AM. J.L. & MED. 241 (1995).

24. See generally THE RIGHTS OF PATIENTS, *supra* note 1; JUDGING MEDICINE, *supra* note 1, at 27-35; RUTH FADEN & TOM BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986); PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP (1982).

25. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. App. 1972); *Cobbs v. Grant*, 502 P.2d 1 (1972).

26. See cases cited *supra* note 25.

27. See generally Drummond Rennie, *Informed Consent by "Well-Nigh Abject" Adults*, 32 NEW. ENG. J. MED. 971 (1980). To date, courts have recognized the duty to provide information only for physicians. If other health professionals are responsible for making medical recommendations to patients, then they may also be become bound by a similar duty.

28. See RESTATEMENT (SECOND) OF TORTS §§ 388-389; RESTATEMENT (THIRD) OF TORTS § 2 (1998).

physicians.²⁹ This is because their use requires specialized medical knowledge. The physician should act as a "learned intermediary" between the manufacturer and the patient by weighing the risks and benefits of a particular product and by determining whether to recommend it to a patient. Of course, the patient still has the right to reject the recommendation. But it is the physician, not the manufacturer or seller, that has the obligation to provide information to the patient.

Since the patient rights movement of the 1970s, patients have consistently received more protection than consumers. While consumers may have access to some of their credit information, patients are entitled to all the information in their medical records because the information belongs to them. Some patients' rights have no analogy in the marketplace. For example, the right to privacy during the course of medical treatment is based on the need for openness and trust in the physician patient relationship, and the fact that the patient often must expose his body to the physician.³⁰

Of special importance is the recognition of patients' rights to emergency care, beginning with court decisions in the 1960s³¹ and culminating in state and federal legislation requiring hospitals with emergency departments to provide care to patients with emergency medical conditions regardless of insurance coverage or the ability to pay.³² This is the

29. See Margaret Gilhooley, *Learned Intermediaries, Prescription Drugs, and Patient Information*, 30 ST. LOUIS U. L.J. 633, 699 (1986); Nancy K. Plant, *The Learned Intermediary Doctrine: Some New Medicine for an Old Ailment*, 81 IOWA L. REV. 1007, 1007 (1996).

30. See also *Roe v. Wade*, 410 U.S. 113, 153 (1973) (recognizing a different constitutional right to privacy, encompassing a woman's right to decide to terminate her pregnancy, but emphasizing that the decision was a medical decision to be made in the privacy of the physician-patient relationship). See generally PRIVACY PROTECTION STUDY COMM'N, PERSONAL PRIVACY IN AN INFORMATION SOCIETY (1977); George J. Annas, et al. *The Right of Privacy Protects the Doctor-Patient Relationship*, 263 NEW ENGL. J. MED. 858 (1991). See, e.g., *Estate of Berthiaume v. Pratt*, 365 A.2d 792, 797 (Me. 1976) (discussing privacy during treatment); *Horne v. Patton*, 287 So.2d 824 (Ala. 1974) (discussing confidentiality); *Hague v. Williams*, 181 A.2d 345, 349 (N.J. 1962) (discussing confidentiality).

31. See *Manlove v. Wilmington Gen. Hosp.*, 174 A.2d 135 (1961) (recognizing a state common law obligation for private hospitals offering emergency services to provide care in an emergency); Karen Rothenberg, *Who Cares? The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 33-50 (1989).

32. Texas was the first state to adopt such legislation. See TEX. HEALTH &

only right to medical care enjoyed by all Americans.³³ The right to emergency care is an entitlement unique in the common law and it is justified entirely by patient need. Not even housing or education assumes equal importance in the law.³⁴

Courts have recognized patient rights primarily to protect patients against the possibility of physicians' misuse of expertise. It is little wonder why courts are willing to protect patients where they would not protect consumers. In addition to the difference in circumstances, lack of protection in matters of health care can result in serious disability or death. Moreover, patients do not choose their own medical treatment in the same way that consumers choose to buy services. For the most part, providers must first determine what is appropriate for the patient, and the patient may only accept or refuse what is offered by providers.³⁵

Courts have consistently viewed physician responsibilities to patients as a matter of tort law governing standards of conduct to prevent personal harm.³⁶ The law imposes legal duties on physicians regardless of their consent.³⁷ In contrast, consumer rights are based primarily in con-

SAFETY CODE ANN. § 4438(a) (superceded by TEX. HEALTH & SAFETY CODE §§ 311.021-311.022 (West 1992)). The federal law applies to all hospitals with emergency departments that participate in Medicare or Medicaid, although the obligation to provide emergency care applies to all patients with an emergency medical condition or women in active labor. See *Emergency Medical Treatment and Active Labor Act*, 42 U.S.C. § 1395dd (1994).

33. States have an obligation to attend to the serious medical needs of prisoners and pretrial detainees incarcerated in correctional institutions under the U.S. Supreme Court's interpretation of the Eighth Amendment because they are unable to obtain medical care without the state's permission and assistance. See *Estelle v. Gamble*, 429 U.S. 97 (1976) (finding that the state's "deliberate indifference" to the serious medical needs of prisoners can violate the Eighth Amendment's prohibition against cruel and unusual treatment).

34. See, e.g., *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432 (1985).

35. See Adam Yarmolinsky, *Supporting the Patient*, 332 NEW ENG. J. MED. 602, 602 (1995) ("Patients may be the only consumers who have to seek permission from someone else in order to obtain services.").

36. Legislation has supplemented or modified some common law principles with respect to the confidentiality of medical records and the patient's right to gain access to, and copies of, such records. See *THE RIGHTS OF PATIENTS*, *supra* note 1, at 160-74.

37. Indeed, the obligation to provide information as required by the doctrine of informed consent was strenuously resisted by many in the medical profession for many years. See generally KATZ, *supra* note 19.

tract law, where the defining characteristic is the voluntary consent of both parties to the contract terms. Courts have not permitted physicians to contractually alter their fiduciary duties.³⁸

II. PATIENT RIGHTS AND CONSUMER RIGHTS IN MANAGED CARE

Table I of this paper offers a possible classification separating managed care issues into predominantly consumer concerns and predominantly patient concerns. For the purposes of this classification, consumer concerns are defined as issues that are relevant to decisions to purchase and/or join a managed care plan. Patient concerns are defined as issues that are primarily relevant to personal health care, independent of payment. There are, of course, issues that concern both consumers and patients. Included in a third category of mixed issues, shown in Table II, are those issues with the strongest claim to both concerns. This classification does not purport to be either exhaustive or immutable. It is intended primarily to demonstrate that there are important differences between protecting consumers and protecting patients.

A. Consumer Concerns

Consumer protection laws do not attempt to ensure that a manufacturer of consumer goods remains financially capable of staying in business. However, the states seek to ensure the fiscal solvency of insurance companies so that companies will be able to make promised payments to

38. There have been several proposals to allow providers and patients to contractually alter the standard of care in return for lower charges, either to reduce health care costs in general or to reduce the frequency or cost of malpractice claims. *See generally, e.g.,* Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. BAR FOUND. RES. J. 87 (1976); *see also* Clark C. Havighurst, *Private Reform of Tort Law Dogma: Market Opportunities and Legal Obstacles*, 49 LAW & CONTEMP. PROBS. 143 (1986). *See, e.g.,* Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 589 (1997) (proposing enterprise liability as an exclusive remedy for patients, with opportunities to reduce liability by voluntary contractual waivers). For arguments against contractual limitations on the standard of care, *see generally* P. S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS. 287 (1986); Sylvia A. Law, *Medical Malpractice: Can the Private Sector Find Relief?—Perspectives on the Reform Agenda*, 49 LAW & CONTEMP. PROBS. 305-20 (1986); RANDALL BJØVBERG, *MEDICAL MALPRACTICE: PROBLEMS & REFORMS* (1995).

claimants.³⁹ A managed care plan is, in part, an insurance policy. Thus, consumer issues in managed care include a managed care organization's financial solvency and investments. Furthermore, management capacities are relevant because managed care organizations promise to deliver not money payments but health care services to those insured. This requires sufficient expertise and organization to maintain relationships with and pay providers for the duration of the service period. In addition, the providers must be sufficient in number to provide the services promised to the consumer in the future. Indeed, this assurance is the basic product the consumer seeks. Because medical services are to be provided in the future, and not at the time of the signing of the contract, consumers are justifiably concerned with a managed care organization's ability to provide care at a later date. A reasonable consumer would not be likely to enter into a contract with an organization that offered no assurance of being able to fulfill its promises.

Many consumer concerns are information-related because consumers are presumed to base purchasing decisions on information about the products. As noted earlier, the law rarely concerns itself with the nature of products on the market. The managed care industry argues that government should not impose content requirements for managed care plans because organizations should be free to offer a variety of insurance products, and regulation would stifle innovation.⁴⁰ Instead, the emphasis is on facilitating consumer choice by offering information that describes various plan "products."⁴¹ Thus, consumer concerns include disclosure

39. See Henry T. Greely, *The Regulation of Private Insurance*, in HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION § 8.13.1 (Mark Hall ed., 1997).

40. Examples of testimony before legislative committees and white papers can be found at the web sites of trade associations, such as the American Association of Health Plans (AAHP) and the Health Insurance Association of America. Some non-profit health plans favor some types of government regulation. See generally Steve Zarkin, *A Health Plan's View of Government Regulation*, HEALTH AFF., Nov./Dec., 1997, at 33.

41. Alain C. Enthoven's early advocacy of prepaid group health plans argued that consumers would force plans to improve quality and reduce premiums prices by choosing and joining only the best plans. See generally ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980). Current proponents of leaving health insurance, including managed care, to a more or less unregulated market use the same or similar arguments. See, e.g., REGINA HERZLINGER, MARKET DRIVEN HEALTH CARE (1997); EPSTEIN, *supra* note 9; Alain C. Enthoven & Sara J. Singer, *Markets and*

of information about the benefits covered and excluded by a managed care plan, limitations on benefits, and procedures that must be followed to obtain care or coverage. Their concerns also include disclosure of information about physicians and other health professionals, such as licensure, specialty certification, years of experience, malpractice claims, location, and whether they are accepting patients. Consumers are also concerned with obtaining similar information about health care facilities. Disclosure requirements do not impose any specific substantive requirements on the care provided. However, they help consumers learn what kinds of care may be expected, where, from whom, and under what conditions.

B. Patient Concerns

The quality of care is a uniquely patient-oriented concern, independent of payment.⁴² Quality includes the competence of providers in diagnosing, preventing, and treating illness and injury. Concerns about the quality of care arise primarily when one becomes a patient and seeks diagnosis, prevention, or treatment. The law of professional negligence, of course, imposes on physicians and other providers a duty of care to patients, without regard to payment.⁴³ The duty arises out of the provider's special knowledge and skill in the treatment of human beings, and the exclusive authority to use that knowledge as conferred by state

Collective Action in Regulating Managed Care, HEALTH AFF., Nov./Dec. 1997, at 26.

42. This is not to suggest that measuring quality is a simple matter. See generally Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept./Oct. 1997, at 7 (1997); REPORT TO THE CHAIRMAN, COMMITTEE ON LABOR AND HUMAN RESOURCES, HEALTH CARE REFORM: "REPORT CARDS" ARE USEFUL BUT SIGNIFICANT ISSUES NEED TO BE ADDRESSED (1994); Symposium, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525 (1996); Arnold Epstein, *Performance Reports on Quality—Prototypes, Problems and Prospects*, 333 NEW ENG. J. MED. 57 (1995); Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J.L. & MED. 37 (1994); Jerome P. Kassirer, *The Quality of Care and the Quality of Measuring It*, 329 NEW ENG. J. MED. 1293 (1993).

43. Payment may serve as evidence that a physician-patient relationship exists in order to determine whether a physician owes a duty of care to the patient. Nonetheless, the law applies to the relationship, however created, not because of any payment made. See generally WING ET AL., *supra* note 2, at 606-12.

licensure. Physicians are directly and personally accountable to patients for injuries caused by their failure to conform to the professional standard of care.⁴⁴ Physicians cannot require patients to accept a lower standard of care or waive the right to sue for malpractice.⁴⁵

Other concerns traditionally associated with receiving medical care include privacy and confidentiality of personal medical information. Patients have come to expect their physicians to keep their personal information confidential and not to disclose it without the patient's approval. Courts justify a physician's obligations to keep patient confidences in order to encourage patients to tell their physicians anything that might facilitate diagnosing and treating medical conditions.⁴⁶

Arguably, a person ceases being a consumer and becomes a patient upon enrollment in a managed care plan. This is because the individual's relationship with the organization and its health care professionals is no longer that of buyer to seller. When the person begins to use the plan's services, he or she is a patient. Moreover, as a practical matter, since almost all managed care plans are in effect for a fixed term, typically one year, the consumer is not able to leave the plan, rescind the contract, or return the product until the end of the term. Thus, the person cannot act like a consumer again until the term expires and he or she can choose to remain in the plan or buy a different product.

C. Mixed Concerns

Several components of managed care are relevant to individuals both as consumers and as patients. Although the package of benefits covered by an insurance policy traditionally was considered part of the consumer contract, individuals are also concerned about the type of treatment they will receive as patients in the event of illness or injury. This is why the so-called bills of patient rights before many legislatures typically include a few specific benefits. The most widely accepted mandated benefit is coverage of emergency care when an individual reasonably be-

44. Even state laws governing incorporation generally prohibit physicians (and other professionals) from insulating themselves against personal liability for negligence in the performance of their professional services. *See generally*, THE RIGHTS OF PATIENTS, *supra* note 1.

45. *See* Emory Univ. v. Proubianski, 282 S.E.2d 903 (Ga. 1981); Tunkl v. Regents of Univ. of Cal., 383 P.2d 441 (Cal. 1963) (holding that release of liability for free medical care generally unenforceable as against public policy).

46. *See* cases cited *supra* note 30.

lieves that serious illness or death could result from an injury or acute medical condition.⁴⁷

Both patients and consumers also have interests in the providers who will take care of them in a managed care plan. Patients and consumers have concerns about access to qualified physicians and other health professionals who are capable of properly diagnosing and treating their medical conditions. Managed care plans that have a closed panel of physicians place contractual restraints on the patient's freedom to consult any licensed physician. The managed care industry often considers the number and specialty of physicians and hospitals in a plan's network as one component of the benefit package specified by the insurance contract.⁴⁸ The available pool of providers is also a critical element of the quality of care for patients. Thus, basic requirements such as professional or facility licensure, certification, and accreditation are relevant to both patient concerns about the quality of care they receive, and consumer concerns about the qualifications of the providers to whom they have access through a health plan.

Other factors influencing provider competence and the quality of care can be relevant to both patients and consumers. For example, consumers as well as patients have an interest in ensuring that decisions about their care will not be influenced by conflicts of interest. Thus, statutory prohibitions against referral arrangements, such as those barred by the Medicare Anti-Kickback Statute⁴⁹ and Stark Amendments,⁵⁰ serve both consumers and patients. The same is true of statutory prohibitions against gag clauses that bar physicians from telling their patients about how they are financially compensated by a managed care plan.⁵¹

47. See, e.g., discussion *supra* note 32.

48. It is undoubtedly for this reason that the National Association of Insurance Commissioners' Managed Care Plan Network Adequacy Model Act contains provisions on network adequacy which require that a health plan have arrangements with a sufficient number and types of providers to meet the anticipated medical needs of its entire membership. See NATIONAL ASS'N OF INSUR. COMM'RS, MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT, NAID MODEL LAWS, REGULATIONS AND GUIDELINES 74-1 - 74-13 (1996). The President's Advisory Commission recommended a similar requirement based on the NAIC language.

49. 42 U.S.C. § 1320a-7b(b) (1994).

50. 42 U.S.C. § 1395nn (1994).

51. Most statutory prohibitions against gag clauses ensure that physicians are free to tell patients about treatment options, including those not covered by the

Both patients and consumers also have legitimate interests in holding a managed care plan accountable for intentional or negligent errors. Ordinarily, consumer interests lie in enforcing fair contract provisions, including promised benefits, while patients are concerned about the quality of care they receive.⁵² In addition, both consumers and patients have an interest in non-discriminatory treatment and access to plan services. In all instances, consumers and patients expect the plan to be accountable for its promises and obligations. Thus, the plan's legal responsibility for its acts and omissions is of critical concern, as are the means to enforce that responsibility, the remedies, and the damages available. Although the substance of particular disputes may vary between consumers and patients, managed care plans often provide the same internal remedy, grievance or appeal procedures, for both groups. Thus, one must address the fairness of mechanisms to hold managed care plans accountable simultaneously for both patient and consumer concerns.

III. CONFLATING CONSUMERS WITH PATIENTS

The call for regulation of managed care stems from recognition that patients need protection against managed care abuses.⁵³ However, most

patient's health plan. They do not typically require disclosure of other types of information, such as physician compensation. The Massachusetts' statute does not require any disclosure by physicians. It merely prohibits health plans from refusing to contract with or pay physicians who tell patients about treatment options. See MASS. GEN. LAWS ch. 175, §§ 108, 110 (1998). Gag clauses that restrict individual patient care recommendations are most closely related to patient concerns. Federal legislation prohibiting gag clauses has not yet been enacted. See, e.g., The Patient Right to Know Act, S. 449, 105th Cong. §§ 1-4 (1997).

52. Quality concerns include not only the quality of care that is provided, but also a failure to provide care, as in missed diagnoses, misdiagnoses, and failures to provide treatment in accordance with the appropriate standard of care.

53. The word "abuses" is used to emphasize that the practices complained of are not inherent in managed care. For examples of such complaints, see generally GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* (1996); Thomas Bodenheimer, *The HMO Backlash—Righteous or Reactionary?*, 335 NEW ENG. J. MED. 1601 (1996); Jerome P. Kassirer, *Managing Managed Care's Tarnished Image*, 337 NEW ENG. J. MED. 338 (1997); David S. Hilzenrath, *Backlash Builds Over Managed Care; Frustrated Consumers Push for Tougher Laws*, WASH. POST, June 30, 1997, at A1. Many media reports about managed care emphasize problems or perceived abuses. See Paul M. Ellwood & George D. Lundberg, *Managed Care: A Work in Progress*, 276 JAMA

proposals for patient rights recently debated in Congress and state legislatures focus on protecting consumer concerns.⁵⁴ Such bills included provisions requiring managed care organizations to give their members information about health plan benefits and limitations, physicians in the network, treatment preauthorization rules, and grievance procedures.⁵⁵ This is consistent with the assumption that, like consumer protection laws, the legislation's goal is to permit consumers to make a knowledgeable choice of health plans, not to prescribe what the products should be.

Some legislation requires that health plans cover emergency care and other mandated benefits, such as requiring health plans to pay for a minimum post-delivery hospital stay for women and their newborns.⁵⁶ Some require health plans to permit standing referrals to specialists for certain medical conditions,⁵⁷ while still others prohibit "gag clauses" in

1083, 1084 (1996); *see generally* Karen Ignagni, *Covering a Breaking Revolution: The Media and Managed Care*, *HEALTH AFF.*, Jan./Feb. 1997, at 26 (1998).

54. In 1998, Congress failed to pass any of the bills introduced to regulate managed care or protect consumers. The House of Representatives passed the Republican leadership's bill in July 1998, The Patient Protection Act of 1998, H.R. 4250, sponsored by Rep. Newt Gingrich (D-Ga.) and others, which later died in the Senate along with the competing bills, such as The Patients' Bill of Rights Act of 1998, S. 1890, sponsored by Sen. Tom Daschle and others. *See* S. 1890, 105th Cong. (1998).

55. For analyses of earlier state legislation adopted by the states, *see* GERALDINE DALLEK ET AL., *1 CONSUMER PROTECTION IN STATE HMO LAWS, ANALYSIS AND RECOMMENDATIONS* (1995); PATRICIA BUTLER & K. POLZER, *PRIVATE-SECTOR HEALTH COVERAGE: VARIATIONS IN CONSUMER PROTECTIONS UNDER ERISA AND STATE LAW* (1996).

56. Maryland was the first state to adopt such a law, quickly followed by New Jersey, Massachusetts, and other states. *See* George Annas, *Women and Children First*, 333 *NEW ENG. J. MED.* 1647, 1648 (1995). However, the Employee Retirement Income Security Act (ERISA), precludes enforcement of such mandated benefits against self-funded ERISA plans. *See* *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). For overviews of the effect of ERISA on state legislation to regulate managed care, *see* Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 *NEW ENGL. J. MED.* 1986 (1996). Congress adopted the Mothers and Newborns Protection Act, 29 U.S.C. § 1185 (1997), which amended ERISA to imposed minimum standards on all plans offering childbirth benefits. *See id.*

57. *See* Fred J. Hellinger, *The Expanding Scope of State Legislation*, 276 *JAMA* 1065, 1066 (1996).

contracts with physicians.⁵⁸ So far, sixteen states require external review of some or all denials of benefits.⁵⁹ In addition, Medicare and Medicaid regulations limit the financial incentive arrangements that participating managed care organizations may use to compensate their physicians.⁶⁰ These specific statutes resemble consumer protection laws that impose individual product safety standards or bar particular practices in response to consumer complaints about specific dangers or deceptions. Laws requiring minimum post-delivery hospital stays, for example, were prompted by outrage from women who felt that they were being denied necessary medical care promised under their health plan.

There has been little pressure, however, for laws that would regulate corporate governance, for-profit or nonprofit status, overall health plan benefit structures, operating expenditures, "medical loss ratios," utilization review standards, or other larger issues. The result is legislation that tells consumers more about what health plan "products" are on the market, but does little to make the product "safe." Moreover, many state laws are not enforceable against managed care plans offered by employers and unions that are governed by the federal Employee Retirement Income Security Act (ERISA).⁶¹

Federal legislation could produce a true national bill of patient rights that Professor Annas proposes. This is because federal legislation could apply to all patients, regardless of their insurance status.⁶² By and large, however, federal efforts to regulate managed care mimic state law proposals and suffer from the same narrow focus on consumer concerns. Therefore, federal legislation preempting state law may result in patients having fewer rights than they have now. State managed care legislation

58. For a critical view of gag clauses, see generally Steffie Woolhandler & David U. Himmelstein, *Extreme Risk - The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706 (1995).

59. See U.S. GENERAL ACCOUNTING OFFICE, HMO COMPLAINTS AND APPEALS: MOST KEY PROCEDURES IN PLACE, BUT OTHERS VALUED BY CONSUMERS LARGELY ABSENT, GAO/HEHS-98-119 (May 1998). See generally George J. Annas, *Patients' Rights in Managed Care—Exit, Voice and Choice*, 337 NEW ENG. J. MED. 210 (1997).

60. See Requirements for Physician Incentive Plans, 42 C.F.R. § 417.479 (1997).

61. See generally Mariner, *supra* note 56, at 1986; Mary Ann Chirba-Martin & Troyen A. Brennan, *The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFF. 142 (1994).

62. See *A National Bill*, *supra* note 5, at 697.

at least has the virtue of leaving patient rights under state law undisturbed.

The legislative emphasis on consumer, as opposed to patient, rights can be illustrated by the recommendations of the President's Advisory Commission.⁶³ One would expect any bill of rights to include the right to informed consent. The Commission's surprisingly worded recommendation says that "consumers have the right and responsibility to fully participate in all decisions related to their health care."⁶⁴ What counts as participation is not clear. Although the commentary includes a good list of information subject to disclosure, it does not indicate whether its conception of this right includes the well-established right to refuse treatment for any reason.⁶⁵ Similarly, the Commission's statement of a right to confidentiality of health information is less protective than existing law.⁶⁶

The Advisory Commission also recommended that consumers should have "a right to a choice of health care providers sufficient to ensure

63. It is significant that the Commission did *not* recommend that the "rights" be enacted into law to ensure that they would be legally enforceable.

64. PRESIDENT'S ADVISORY COMM'N, *supra* note 4, at ch. 4. The Commentary notes that open communication promotes positive outcomes, compliance and consumer satisfaction. In particular, the justification of this right is the "asymmetry of information between consumer and health care provider." *Id.* This supports the physician's legal duty to provide information to patients. But that duty is premised on the individual patient's right to autonomy and self-determination, which the Commission fails to mention.

65. The information should include treatment options, their benefits, the risks, and the consequences, the use of advance directives, methods of physician compensation, and other financial interests that could influence treatment decisions. *See id.*

66. The Commission states that "the quality of the health care system also depends on the regular exchange of information between providers, employers, plans, public health authorities, researchers, and other users." *Id.*, at ch. 6. With such a wide exchange, it is hard to imagine who does not have access to one's confidential medical information. The Commission notes that individually identifiable information should not be disclosed without written consent except "in very limited circumstances where there is a clear legal basis for doing so." *Id.* These reasons include "medical or health care research for which an institutional review board has determined anonymous records will not suffice, investigation of health care fraud, and public health reporting." *Id.* This evidences either poor drafting or a misunderstanding of the law governing federally funded research with human subjects, which precludes the use of identifiable information for research without written consent.

access to appropriate high-quality health care.”⁶⁷ This does not mean that consumers are entitled to choose their health plan or their physicians. The Commission rejected any requirement that consumers be offered any particular choices.⁶⁸ As the commentary makes clear, it amounts to a duty on the part of managed care plans to contract with a minimum number of providers to provide covered benefits for plan members.⁶⁹ The Commission argued that this “right” is justified because it benefits the marketplace to have consumers choose among competing “products.” The Commission described consumer choice as the “hallmark of a healthy marketplace,” enhancing consumer satisfaction and confidence in their caregivers. This may be true, but it is thin justification for a legal right. If, in the future, consumer choice turned out to hinder a “healthy marketplace,” would that mean that the consumer’s right to choose should be revoked? There was no mention of the value of having the market provide products that consumers need. In essence, it was assumed that because the market is the best way to meet the needs of consumers, patient rights should be limited to those things that promote the efficient functioning of a market. This turns the role of patient rights on its head.

IV. PROBLEMS WITH THE CONSUMER MODEL

The debate over patient rights in managed care and the proposed protective legislation are based on an idealized consumer model. Proponents of a competitive health insurance market argue that consumer

67. *Id.* at ch. 2. The language tracks that of the National Association of Insurance Commissioners’ Model Act. This is certainly a necessary element of a plan, since no plan should be considered competent to offer services if it does not have the professional resources to provide care.

68. The Commission decided that it was “unacceptable” to recommend that people be given more choice because it would cost more and employers might reduce or drop coverage. *See id.* However, the percentage of employees covered by employer-provided plans steadily declined during the past decade while premium costs remained relatively stable. *See* U.S. GENERAL ACCOUNTING OFFICE, EMPLOYMENT-BASED HEALTH INSURANCE: COSTS INCREASE AND FAMILY COVERAGE DECREASES (Feb. 1997).

69. The Commission rejected any requirement that plans contract with all qualified providers or that plans allow members to see providers outside the plan’s network. Plans are permitted to have closed panels of providers as long as the pool itself is adequately large. *See* PRESIDENT’S ADVISORY COMM’N, *supra* note 4, at ch. 2.

choice will force managed care organizations to compete by improving quality and service, as well as lowering prices, to meet consumer demand.⁷⁰ Hence, the emphasis is on improving consumers' ability to choose among plans by providing accurate and unbiased information. But there are both empirical and conceptual problems with this approach. As a practical matter, consumers are not free to exercise the choices on which a competitive market depends. Furthermore, it is unlikely that they can, or will, make choices about their medical care that will solve the problems of quality or price. In addition, if contract law is the dominant legal paradigm for consumer rights, contract obligations that ignore important concerns of patient care may displace important patient rights now governed by tort law.

Characterizing members of managed care plans as consumers is both inaccurate and misleading. It assumes that individuals select and negotiate their own individual contracts with health plans and insurance companies. The emphasis is on the consumer's freedom to choose. But only a tiny proportion of managed care members buy their membership individually from a managed care organization. This portion includes people who are self-employed and employees of businesses that do not offer group health insurance.⁷¹ Most people obtain their health insurance through their employer or union's group health plan.⁷² The employer's

70. See generally HALL, *supra* note 9; EPSTEIN, *supra* note 9; ENTHOVEN, *supra* note 41.

71. About 150 million people are insured under group health insurance plans offered by private employers and trade unions. About ten million people are enrolled in managed care plans under individual policies. See EMPLOYEE BENEFIT RESEARCH INSTITUTE, EBRI DATABOOK ON EMPLOYEE BENEFITS (1995).

72. Because employers outnumber unions that offer health benefits, for simplicity, this article uses the term "employer" rather than employers, unions, and multiemployer groups. See Thomas Bodenheimer & Kip Sullivan, *How Large Employers Are Shaping the Health Care Marketplace*, 338 NEW ENG. J. MED. 1084, 1086 (1998). Nor do individuals that get their benefits from government programs like Medicare and Medicaid negotiate a health plan contract because a federal statute defines the benefits and regulations. Theoretically, beneficiaries could peruse the law to determine their specific entitlements, although few do and it is unclear how many, including attorneys, understand what the law covers. Both Medicare and Medicaid issued summaries for beneficiaries, which may or may not be more informative than the summaries issued by private plans. At the same time, there is no pretense that beneficiaries negotiate the terms of their coverage. Courts consistently find such programs to be voluntarily offered by government, which defines the benefits. See *Harris v. McRae*, 448 U.S. 297, 299 (1980). Beneficiaries

benefit manager or financial officer typically selects the health plans that the company offers to its employees. Some employers negotiate the terms of the insurance contract, but many simply choose among standard plans offered by the managed care organizations and insurers.⁷³ Employees must choose from one or more plans in final form on a take it or leave it basis.⁷⁴ The employee cannot renegotiate the terms of the plan. If the employee is displeased with the plan's offer, his only option is not to enroll. Of course, many employees do not even have that option because their employer only offers one plan.⁷⁵ Furthermore, some plans charge such high premiums that employees cannot afford them, so that choice is illusory.⁷⁶

Critics of employer-provided group insurance argue that most employers base their choice of plans almost exclusively on price, preferring

are not denied benefits on the theory that they have agreed to limitations.

73. Havighurst argues that employees are well served by having relatively sophisticated employers negotiate health insurance contracts on their behalf. See Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1767 n.27 (1992).

74. See Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 370 (1990). In fact, employees typically receive only a summary of benefits, not the plan itself.

75. About 48% of moderate and large employers reported offering only one plan in the 1995 KPMG Peat Marwick Health Benefits Survey. Thirty-five percent of moderate and large employers offered three or more plans. Small employers are less likely to offer a choice of plans, although many still offer indemnity insurance instead of managed care plans. See Lynn Etheredge et al., *What Is Driving Health System Change?*, HEALTH AFF., Winter 1996, at 93, 94. See also Atul A. Gawande et al., *Does Dissatisfaction With Health Plans Stem From Having No Choice?*, HEALTH AFF., Sept./Oct. 1998, at 184, 187 (noting that 42% of those insured through either their employer or spouse have no choice of health plans).

76. See generally Jon R. Gabel et al., *Small Employers and Their Health Benefits, 1988-1996: An Awkward Adolescence*, HEALTH AFF., Sept./Oct. 1997, at 103 (analyzing KPMG Peat Marwick survey on small employer utilization of health care plans); see also generally John R. Gabel et al., *When Employers Choose Health Plans, Do NCQA Accreditation and HEDIS Data Count?* (Sept. 1998) <http://www.cmwf.org/programs/health_care/gabel_ncqa_hedis_293.asp> (noting that only five percent of employers reported HEDIS data as "very important" in selecting an HMO for their employees; only one percent of employers provided any HEDIS data to their employees).

plans with low premiums, with little attention to quality.⁷⁷ The Health Plan and Employer Data and Information Set (HEDIS),⁷⁸ developed by large employers with the National Committee for Quality Assurance, is a welcome attempt to evaluate the quality of care provided by health plans. Unfortunately, the information's utility is limited. It relies primarily on counting the number of members who receive relatively simple procedures like mammograms and immunizations. Patients are more likely to want information about how plans treat diabetes, different forms of cancer, and other complicated conditions. However, it is difficult to measure quality in such cases because of the differences in standards of practice in different locations, and the fact that therapeutic standards are often a moving target. Thus, employers who want to assure their employees of good quality health care find it hard to obtain useful comparative information.

Thus, managed care contracts do not fit the idealized competitive market model of a voluntary negotiated agreement between two individuals of equal bargaining power for mutually beneficial trade; the contract is not necessarily voluntary, nor does the individual negotiate it. Indeed, in group health plans, the contract is not between individuals at all, but between companies. The individual has no bargaining power and little awareness of the bargaining process. The result is often "membership" in an off-the-shelf standard form plan about which the individual knows little more than the price and rudimentary information about benefits and exclusions. Under these circumstances, it is unlikely that consumer choice can, or will, play the role expected of it in managed care.

V. PROBLEMS WITH THE CONTRACT MODEL

Managed care brought together elements of health insurance and patient care that traditionally have been handled separately by the law. Most courts that have reviewed disputes between patients and managed care organizations have felt constrained to categorize the issues for decision as either wholly contract issues or wholly tort issues.⁷⁹ This has proved particularly problematic in cases involving benefit decisions that

77. See Mehlman, *supra* note 74, at 376.

78. For a full description of HEDIS, see *National Committee for Quality Assurance* (visited Dec. 2, 1998) <<http://www.ncqa.org>>.

79. See, e.g., *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992).

influence the nature of patient care, because benefit decisions are typically governed by contract, while patient care decisions are typically governed by tort law.

In *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*,⁸⁰ the Eighth Circuit faced the question of whether the choice of a particular hospital should be considered a decision about covered benefits under a health plan contract or a decision about the quality of care to be provided.⁸¹ In April 1989, Buddy Kuhl had a heart attack. All the physicians who examined him agreed that he should have surgery at Barnes Hospital in St. Louis because the hospitals in Kansas City did not have adequate equipment for the surgery.⁸² Kuhl's health plan, however, was located in Kansas City, and would not authorize the surgery to be performed at Barnes because Barnes hospital was not in its network of participating providers.⁸³ In July, the plan reversed its decision, but the Barnes surgical team was not available until September.⁸⁴ By then, Kuhl's heart deteriorated to the point where surgery was no longer possible, and his physicians recommended a heart transplant to save his life.⁸⁵ Pre-certification for a transplant at Barnes was also denied, and Kuhl died in December before his request for reconsideration was decided.⁸⁶ Kuhl's wife sued the plan for medical malpractice, claiming that the plan wrongfully delayed heart surgery.⁸⁷ The court of appeals found that there was no valid malpractice claim because the plan did not make

80. 999 F.2d 298 (8th Cir. 1993).

81. *See id.* at 302. The primary legal issue was whether Kuhl's wife's malpractice claim was preempted by ERISA, but resolution of that issue required determining whether the health plan made a medical decision, which would be judged according to negligence standards in state court, or merely denied a claim for benefits under an employee group contract, which would be governed by ERISA. *See id.* at 304.

82. *See id.* at 300. Kuhl's plan physicians found that Kuhl was at risk for sudden death from ventricular tachycardia and recommended bypass surgery together with electrophysiologically guided left ventricular aneurysm resection and subendocardial resection, all needed within a few weeks. *See id.* The health plan's participating cardiologists and cardiac surgeon agreed that their hospitals did not have the necessary equipment and that no physician in Kansas City had as much experience or success with this type of surgery as the Barnes physicians. *See id.*

83. *See id.*

84. *See id.*

85. *See id.*

86. *See id.*

87. *See Kuhl*, 999 F.2d at 300.

a medical decision. Instead, it characterized the suit as a claim for denial of benefits or improperly processing a claim for benefits defined by the group health plan.⁸⁸

The court's decision is unsatisfying because it fails to recognize the medical treatment choices imbedded in the plan's actions. Both the patient's medical condition and the recommended surgery were concededly covered as part of the plan's benefits. Thus, the plan did not deny the benefit itself. The plan's objection was not to the surgery, but who performed it and where. A responsible plan would undoubtedly consider the quality of care in selecting a hospital to provide surgery for its members. Thus, the plan's choice of hospital entails a representation that it will provide good care for a patient. At the very least, the plan's decision has elements of medical judgment for a covered benefit. Like the Lincoln National Health Plan, many health plans limit the providers who care for their patients in order to control both the cost and quality of care. Decisions about *how* to provide care may share some procedures with decisions about *whether* a condition or treatment is a covered benefit, but they are also decisions about the quality of care. Medical decisions are often so entangled with benefit decisions that any distinction between the two appears artificial.

The mixed nature of many managed care decisions blurs the boundary between medical and benefit decisions that courts use to classify legal claims. By and large, benefit decisions have been judged according to contract law, while tort law governed medical decisions. But just as it is difficult to distinguish benefit decisions from medical decisions in managed care, it is often impossible to neatly separate contractual issues from tort issues in managed care disputes. An insurer's obligation to decide claims in good faith, for example, is an extra-contractual duty enforceable by a tort cause of action on the part of an insured. These duties, however, are limited to the insurer's actions in deciding whether a claim qualifies as a covered benefit.

Managed care goes further. It has imported into its contracts service

88. See *id.* at 303. The effect of that decision was to dismiss any state law claim for malpractice. Kuhl's family could bring a claim for nonpayment of benefits under ERISA. However, even if successful, the remedy would be limited to the cost of the benefit itself and exclude any damages for personal injury. For a discussion of the effect of ERISA on negligence claims against managed care plans, see generally Wendy K. Mariner, *Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field*, 86 AM. J. PUB. HEALTH 863 (1996).

obligations and standards of professional conduct ordinarily governed by tort law. Managed care plans sometimes offer services directly to their members, such as advice and assistance in selecting particular physicians, hospitals, and treatment. They may encourage members to use the plan's preventive care services and exercise club activities. In addition, they select and monitor physicians, hospitals, and other service providers that their members use.⁸⁹ They may also specify a drug formula to be used by providers. The methods used to pay providers may create incentives to recommend particular treatments and not others.⁹⁰ Paradoxically, then, contractual provisions affect the type and quality of care provided to patients, and tort standards govern the services provided as insurance benefits. It is becoming impossible to characterize components of managed care as wholly contractual or wholly tort, which makes it quite difficult to determine which body of law governs.

If all managed care decisions are benefit decisions governed by contract, then it is impossible to hold the health plan accountable for its influence on the quality of care provided to the patient. For example, suppose that a managed care plan covers services provided only by physicians that it has selected to be in its network. For several years, a patient with a recurrent cough is seen by a network physician who negligently fails to diagnose lung cancer until the patient is terminally ill. Under the benefit/quality-of-care distinction, the plan satisfied its obligations to the patient to provide covered benefits by paying for visits to its participating physician. Although the patient's estate may have a cause of action for negligence against the physician, it will have no case against the health care plan even though the patient's choice of physician was influenced by the fact that the plan selects and pays for that physician's services. The patient might have made the effort to see another physician outside the network, but that option would have appeared unnecessary because treatment was a covered benefit. The pa-

89. See generally John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173 (1996); Mark A. Kadzielski et al., *Credentialing for Managed Care Providers: Risks and Opportunities*, 18 WHITTIER L. REV. 87 (1996).

90. For a description of the types of incentive compensation methods in use, see generally Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678 (1995). For a summary of concerns about the effect of financial incentives on physician behavior, see generally Barry R. Furrow, *Incentivizing Medical Practice: What (If Anything) Happens to Professionalism*, 1 WIDENER. L. SYMP. J. 1 (1996).

tient's right to obtain medical care that meets acceptable medical standards was affected by the plan's selection of a limited network of physicians to provide covered benefits. A plan has a responsibility to ensure that its physicians are competent and provide acceptable medical care for covered medical conditions.⁹¹ This is a tort obligation, but it arises out of the plan's contractual obligations to the patient.

Several commentators argue that individuals should be free to agree to a lower standard of care in return for paying a lower premium or fee. This, in effect, waives their right to bring a negligence suit for substandard care.⁹² Arguments against permitting such contracts include the patient's relative lack of bargaining power and the difficulty of appreciating what a lower or different standard of care might mean. But such proposals raise the broader question of whether contract provisions should supersede any and all patient rights grounded in tort.

For example, suppose that a patient refuses a recommended amputation to stop a gangrenous infection, and therefore requires a lengthy hospitalization.⁹³ Could the patient's health plan refuse to cover the hospitalization on the ground that it is not medically necessary and therefore not a covered benefit? The patient might have avoided hospitalization had he agreed to amputation, and the plan would have avoided the resulting expense. But the insurance contract should not override the patient's right to refuse treatment. If the plan properly upholds the patient's refusal, can it still deny coverage of the hospitalization? What if the contract provides it will pay only for treatment that it has pre-authorized as medically appropriate, and that other forms of treatment will not be covered? As long as the treatment options are medically acceptable, patients who exercise their right to refuse treatment should not be penalized by forfeiting their benefit coverage.

There are many examples of the ways that tort-based patient rights and contract-based health plan rights can interact and conflict in managed care. Patient rights to confidentiality of their medical information

91. If a plan acts with reasonable diligence and the physician is indeed competent, but makes a negligent error, the plan would have no liability to the patient, unless the physician were the plan's employee or agent. See generally Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419 (1997). For the early development of corporate liability in managed care, see generally John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191 (1989).

92. See discussion *supra* note 38.

93. See *Lane v. Candura*, 376 N.E.2d 1232, 1233 (Mass. App. Ct. 1978).

are often affected by insurance contracts. Employers may obtain patient records to monitor health plan costs for their employees.⁹⁴ But disclosure of personal medical information violates a patient's right to confidentiality. Contract provisions requiring patient consent to disclosure effectively vitiate this right.

For many years, courts insisted that buyers have an obligation to read the terms of their contracts and are bound by them whether they read them or not.⁹⁵ During the 1960s and 1970s, many courts and commentators found that classical contract law theory failed to capture the reality of agreements or their performance, and, as a result, the courts fashioned more flexible standards for interpreting contractual obligations.⁹⁶ Many courts have claimed to interpret provisions in light of the parties' expectations.⁹⁷ Others allowed the parties' deeds or oral representations to modify contractual obligations on the ground that the actions spoke louder than written words.⁹⁸ However, there has been little judicial challenge to the premise that the goal is to interpret the contract itself, not to require the contract to conform to any broader goals of social policy. Moreover, the past decade reveals evidence that courts may be returning to a more classical approach to deciding contract cases.⁹⁹ This

94. *See Doe v. Southeastern Penn. Trans. Auth.*, 72 F.3d 1133 (3rd Cir. 1995).

95. Meyerson criticizes such decisions on the ground that "[c]ourts should not presume something they know is untrue." Michael I. Meyerson, *The Reunification of Contract Law: The Objective Theory of Consumer Form Contracts*, 47 U. MIAMI L. REV. 1263, 1326 n.40 (1993). As to the resulting law, he notes, "[i]f it is both unreasonable and undesirable to have consumers read these [standard] terms, courts should not fashion legal rules in a futile attempt to force consumers to read these terms or to punish those who do not." *Id.* at 1270.

96. Not coincidentally, many of the first consumer protection laws were adopted during the same period. *See Rodwin, supra* note 10, at 1333.

97. Professor Keeton may have been the first to suggest that one of the unifying principles underlying seemingly inconsistent court decisions was that the reasonable expectations of the parties to an insurance contract would be enforced even where the policy language dictated a different result. *See Robert E. Keeton, Insurance Law at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970).

98. Such exceptions to the parole evidence rule, however, have been somewhat limited in application.

99. *See Ralph James Mooney, The New Conceptualism in Contract Law*, 74 OR. L. REV. 1131, 1189 (1995) (arguing that courts have resurrected much of classical contract law's abstract and formal rules, emphasizing "freedom of contract" and marketplace economics, and that such rules have tended to favor large eco-

includes perpetuating the untenable assumption that people know and understand all the terms and conditions of a written agreement, and therefore, have agreed to them and should be bound by them.

Several scholars used classical contract theory to argue that patients should be bound by exclusions and limitations in their health insurance contracts.¹⁰⁰ The argument is usually part of a strategy to reduce health care costs by reducing the demand for health care covered by insurance. It is assumed that when patients get sick, they often want medical care that is not covered by their health insurance contract and that courts often grant coverage in spite of contract exclusions.¹⁰¹ The remedy is better enforcement of contractual limitations. This is sometimes justified as upholding the individual patient's "freedom" to choose a cheaper health

nominically powerful entities, including banks, employers, and insurance companies). For earlier predictions of the same trend, see E. Allan Farnsworth, *Developments in Contract Law During the 1980's: The Top Ten*, 41 CASE W. RES. L. REV. 203, 216 (1990); Kerry L. Macintosh, *Gilmore Spoke Too Soon: Contract Rise from the Ashes of the Bad Faith Tort*, 27 LOY. L.A. L. REV. 483, 534 (1994). A similar retrenchment can be seen in tort law. See Theodore Eisenberg & James A. Henderson, *Inside the Quiet Revolution in Products Liability*, 39 UCLA L. REV. 731, 788 (1992).

100. See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1647 (1992); Havighurst, *supra* note 73, at 1764.

101. The degree to which courts actually favor insured plaintiffs in benefit disputes is a matter of some controversy. Although both insured individuals and insurers can point to specific horror stories, the court decisions do not demonstrate any uniform bias. Hall studied 203 published decisions on medical necessity issued from 1960 to 1994 and found patients won in thirty-nine percent of federal appeals and 62% of state appeals. The results varied based on the type of insurance, with plaintiffs winning 54% of all private insurance cases, 70% of public benefit program court decisions, and 31% of government employee health insurance cases. Insurer discretion to interpret the contract produced marked differences, with plaintiffs winning 80% of cases in which the insurer did not reserve the discretion to interpret the contract, and 37 % of cases in which the insurer did reserve discretion. See Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055, 1064 (1996); see also Willy E. Rice, *Judicial Bias, The Insurance Industry and Consumer Protection: An Empirical Analysis of State Supreme Courts' Bad-Faith, Breach-of-Contract, Breach-of-Covenant-of-Good-Faith and Excess-Judgment Decisions*, 41 CATH. U. L. REV. 325, 377 (1992) (finding different results in courts in different parts of the country).

plan with fewer benefits.¹⁰² Insurers would then be justified in refusing care that is not covered because the limitations were freely and rationally agreed to by both parties to the contract.

This argument carries an eerie echo of *Lochner v. State of New York*¹⁰³ in which "freedom of contract" was used to justify enforcing contracts of adhesion against employees.¹⁰⁴ Long ago, Professor Freidrich Kessler warned of the dangers of such freedom:

Society, when granting freedom of contract, does not guarantee that all members of the community will be able to make use of it to the same extent. On the contrary, the law, by protecting the unequal distribution of property, does nothing to prevent freedom of contract from becoming a one-sided privilege. Society, by proclaiming freedom of contract, guarantees that it will not interfere with the exercise of power by contract. Freedom of contract enables enterprisers to legislate by contract and, what is even more important, to legislate in a substantially authoritarian manner without using the appearance of authoritarian forms. Standard contracts in particular could thus become effective instruments in the hands of powerful industrial and commercial overlords enabling them to impose a new feudal order of their own making upon a vast host of vassals.¹⁰⁵

Fears of such overreaching may motivate public backlash against managed care. Even if such fears have no foundation, they undergird strong resistance to blind enforcement of contracts. Where courts declined to enforce contract limitations, they sometimes resorted to unpersuasive textual interpretations, finding ambiguity where there was none, or questionable applications of consumer expectation theories to avoid serious harm or expense to patients. Such interpretations only highlight the lack of fit between contract doctrines and managed care problems. Too often, patient concerns have little to do with how to interpret the contract. Rather, they arise from contract provisions of which patients were not aware and, when discovered, find unfair. Consumer protection

102. Havighurst has argued that health plans "should therefore be alert for opportunities to assist consumers in economizing by surrendering legal rights that systematically induce or excuse excessive spending by physicians." Havighurst, *supra* note 13, at 1794.

103. 198 U.S. 45, 64 (1905) (holding that the limitation of employment in bakeries to 60 hours a week and 10 hours a day is an arbitrary interference with the freedom of contract guaranteed by the U.S. Constitution).

104. *See id.*

105. Kessler, *supra* note 16, at 640.

laws provided some counterweight to the theory of freedom of contract's potential for private authoritarianism. However, legislation designed to remedy contract issues alone did not address the concerns of patients in managed care. Future law governing managed care, therefore, cannot be limited exclusively to contract.

At the same time, patients cannot expect managed care plans to provide whatever a patient might want, without regard to quality, effectiveness, or cost. Unlimited health care is not a realistic option. Patients may expect more care than can or should reasonably be provided in some circumstances.¹⁰⁶ After years of public debate over health care costs, the public may be beginning to appreciate the cost of unlimited care. Nevertheless, individuals are likely to perceive a virtually unlimited need for care when they or their loved ones are sick.¹⁰⁷ Even if they decide to forgo some kinds of care, they may rightly expect to have the choice. This means that they are likely to expect that their insurance covers the care that their physician recommends and they accept. When people are sick, they act like patients, not consumers, and they may not be willing to hear that a health plan contract excludes the care.¹⁰⁸

Although patient rights do not include rights to unlimited care, they simply do not address financial or resource issues. Tort law deals with standards of care, not the cost of care. Tort law recognized patient rights

106. Annas cautions that patients cannot be condemned for expecting and demanding more and better medical care. For decades, physicians and hospitals fostered the notion that their services were necessary and valuable, and the more technologically advanced, and expensive, the better. Traditional indemnity insurance did little to counter such impressions until relatively recently. In many respects, the health care system reaped what it sowed. At the same time, patients do not always demand more care. A recurrent theme in the patient rights arena was the resistance some patients and their families meet when they refused care. See *STANDARD OF CARE*, *supra* note 1, at 215.

107. No one disputes the American romance with medical care, or the tendency to demand whatever is possible to treat an illness, especially a potentially fatal illness. There is a wealth of literature debating the causes of, and possible solutions to, increasing demand for medical care. For a comprehensive discussion, see DANIEL CALLAHAN, *WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS* (1990). For an social and psychological analysis of Americans' focus on health, see ARTHUR J. BARSKY, *WORRIED SICK: OUR TROUBLED QUEST FOR WELLNESS* (1988).

108. Annas noted that "there is no possibility of containing costs (and thus making quality medical care available to all Americans) unless we can come to grips with our mortality." *STANDARD OF CARE*, *supra* note 1, at 214-15.

to make decisions about their own care and Americans cherish this right as part of their autonomy. Annas correctly points out that to argue against individual self-determination is to argue against the most fundamental value of the American political system.¹⁰⁹ Arguments based in contract alone are not likely to be persuasive.

This suggests that, by itself, neither contract nor tort offers a sufficient or satisfactory basis for defining the array of legal rights and obligations arising out of managed care plans. Moreover, the interaction of tort and contract issues in managed care argues against picking one or the other to control a mixed issue. Managed care creates both contract and tort relationships with consumers who become patients. Contracts are a useful way to regulate financial transactions. Tort law is better suited to defining rights and obligations in personal and professional relationships. Yet, the line dividing contract and tort in managed care is as permeable as the line dividing decisions about benefits and the quality of care. Standards for judging managed care must account for its insurance and financial performance as well as its provision of services. This will require a new synthesis of the law applicable to managed care decisions.

VI. TOWARD A HYBRID STANDARD FOR MANAGED CARE

If the law is to provide a more realistic and credible basis for judging managed care, it must begin by recognizing that managed care contracts have elements of both standard form insurance contracts, and contracts for personal and professional services. Each of these has somewhat different implications for interpreting managed care obligations than the idealized contract often held up as the model.

Although public debate over managed care often refers to the importance of the contract, there is surprisingly little discussion of the fact that the contract is a standard form contract.¹¹⁰ Group health insurance plans are necessarily standard form contracts because the contract must be the same for all employees in the group.¹¹¹ Among the advantages of

109. *See id.*

110. *See, e.g.,* *McPhee v. American Motorists Ins. Co.*, 205 N.W.2d 152, 155 (Wis. 1973) ("Contracts of insurance rest upon and are controlled by the same principles of law that are applicable to other contracts.")

111. *See* W. David Slawson, *Standard Form Contracts and Democratic Control of Lawmaking Power*, 84 HARV. L. REV. 529, 531 (1971) (noting that standard form contracts have become an integral part of our mass-production soci-

standard form contracts is the efficiency of administering consistent terms and procedures.¹¹² Yet this useful consistency means that there is little point for consumers to read a standard form contract. Indeed, companies do not expect consumers to read all the provisions in a standard form contract and probably do not want them to do so.¹¹³

Insurance contracts are a special category of standard form contracts.¹¹⁴ Instead of delivering a commodity, like a car or a loan, when the contract is made, the seller delivers a promise to pay if and when a designated contingency materializes.¹¹⁵ An insurance contract or policy creates a relationship between insurer and insured, instead of ending a transaction between buyer and seller. In managed care relationships, the insurer promises not merely to make payments in the event of future illness, but to arrange for medical care throughout the contract period. Indeed, care is provided to the insured, while payment is made to physicians and other caretakers. Moreover, the care typically includes periodic examinations and preventive services that the insured is expected to use. Unlike indemnity insurance, managed care companies assume that almost all their members will, and should, regularly take

ety).

112. Advantages include promoting efficiency by allowing companies to complete numerous small transactions quickly and administer them uniformly. It would be impossibly expensive and time consuming to expect every customer to negotiate every detail of a bank loan, lease, or insurance policy. See RESTATEMENT (SECOND) OF CONTRACTS § 211 cmt. b (1981), notes that “[o]ne of the purposes of standardization is to eliminate bargaining over details of individual transactions, and that purpose would not be served if a substantial number of customers retained counsel and reviewed the standard terms.” *Id.* In addition, standard provisions can acquire reliable consistency of meaning by repeated use, or by judicial interpretation. See also Kessler, *supra* note 16, at 631 (“The standard clauses in insurance policies are the most striking illustrations of successful attempts on the part of business enterprises to select and control risks assumed under a contract.”).

113. See Meyerson, *supra* note 95, at 1270; see also Keeton, *supra* note 97, at 968 (noting that “insurers know that ordinarily policyholders will not in fact read their policies.”);

114. For a general discussion of the formation of insurance contracts, see BERTRAM HARNETT & IRVING I. LESNICK, *THE LAW OF LIFE AND HEALTH INSURANCE* (1995).

115. This promise of future payment for which a consumer has already paid justifies regulating the financial solvency of insurance companies. There is no comparable regulation to ensure that car manufacturers, for example, stay in business.

advantage of certain services, like periodic check-ups and immunizations. Thus, the managed care contract creates an ongoing relationship for the provision of professional services.

Managed care plans create relationships, but individuals rarely select the seller/insurer or negotiate the contract terms. Even if individuals can choose among different health plans, there is little variation in standard terms offered by different companies, so that choices may be even more limited than they appear. Most important, individuals never see the insurance contract before they agree to it and pay the first premium.¹¹⁶ Indeed, employees in group health plans may only receive a plan summary and never see the governing contract itself.¹¹⁷ The failure to receive a copy of the contract makes it difficult to claim that the insured willingly agreed to each and every term and condition.¹¹⁸

For these reasons, courts have ordinarily treated insurance policies, at least those covering individuals, as contracts of adhesion.¹¹⁹ The one-

116. See Keeton, *supra* note 97, at 968. The practice of withholding delivery until after the insured is committed is common — for all types of insurance, including homeowners, automobile, life and health insurance. In fact, few individuals consider it remarkable. See Deborah Stone, *Promises and Public Trust: Rethinking Insurance Law Through Stories*, 72 TEX. L. REV. 1435, 1438 (1994). In addition, insurers typically structure the process of entering into an insurance contract in such a way that the individual must make the initial “offer” by submitting an application for insurance, which the insurer “accepts” to form the contract. See MALCOM CLARKE, *POLICIES AND PERCEPTIONS OF INSURANCE*, 68. (1997).

117. In some cases, the governing contract may not even be reduced to writing beyond a certificate of coverages. See, e.g., *Wells v. Prudential Ins. Co. of Am.*, 13 F. Supp. 2d 1326 (M.D. Fla. 1998).

118. Standard form contracts have often posed problems for contract law because they deviate from the hypothetical one-on-one contract between a willing buyer and a willing seller that served as the foundational premise for an enforceable contract. The assumption that the buyer agreed to all the terms and conditions of a standard form contract is often, if not always, unfounded. See, e.g., Meyerson, *supra* note 95, at 1265, 1269-70. If the justification for enforcing contract terms against a buyer is his or her acceptance of those terms, the absence of acceptance should render the contract void.

119. See Keeton, *supra* note 97, at 967. Jones, Farnsworth and Young note that the term “contrat d’adhesion” was coined by Saleilles. The term was imported from France by American scholars who studied abroad, and was first used in the United States to describe an insurance policy by Edwin Patterson. See Edwin W. Patterson, *The Delivery of a Life-Insurance Policy*, 33 HARV. L. REV. 198, 111 (1919). Saleilles described the contrat d’adhesion as a contract “in which one predominant unilateral will dictates its law to an undetermined multitude rather

sided nature of a contract of adhesion has encouraged application of doctrines like *contra proferentum*,¹²⁰ and the good faith requirement, which holds insurers liable for bad faith denials of claims.¹²¹ The one-sided nature of contracts of adhesion also provides the justification for state legislation regulating the form, and occasionally, the content of insurance policies, including requirements for specific “mandated bene-

than to an individual” RAYMOND SALEILLES, DE LA DECLARATION DE VOLONTE 229 (1901); HARRY W. JONES ET AL., CONTRACTS: CASES AND MATERIALS 151 n.b (1965). Earlier, Kessler described standard form contracts as contracts of adhesion:

Standard contracts are typically used by enterprises with strong bargaining power. The weaker party, in need of the goods or services, is frequently not in a position to shop around for better terms, either because the author of the standard contract has a monopoly (natural or artificial) or because all competitor use the same clauses. His contractual intention is but a subjection more or less voluntary to terms dictated by the stronger party, terms whose consequences are often understood only in a vague way, if at all. Thus, standardized contracts are frequently contracts of adhesion; they are *a prendre ou a laisser*. Not infrequently the weaker party to a prospective contract even agrees in advance not to retract his offer while the offeree reserves for himself the power to accept or refuse; or he submits to terms or change of terms which will be communicated to him later.

Kessler, *supra* note 16, at 632. This remains a remarkably accurate portrayal of standard form contracts, with particular application to group health insurance contracts.

120. Literally, “[a]gainst the party who proffers or puts forward a thing.” As a rule, the doctrine requires that “a contract be construed against a person preparing terms thereof.” BLACK’S LAW DICTIONARY 327 (6th ed. 1990). In insurance cases, ambiguous contract language may be construed against the insurer, who writes the contract, and in favor of coverage. See generally Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996).

121. See HARNETT & LESNICK, *supra* note 114, at 1401. Such doctrines are sometimes applied in an apparent attempt to remedy an injustice arising out of circumstances in which traditional contract assumptions do not hold without abandoning traditional contract principles. As several scholars note, the result is often tortured or unconvincing. See, e.g., E. Haavi Morreim, *Benefit Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and An Emerging Problem for Employer-Sponsored Organizations*, 65 TENN. L. REV. 511, 516 (1998); Mark A. Hall & Gerard F. Anderson, *Health Insurers’ Assessment of Medical Necessity*, 149 U. PA. L. REV. 1637, 1650-51 (1992). For example, in an effort to limit their intrusion on the parties’ freedom to contract to merely “interpreting” the contract — as opposed to imposing extracontractual duties — some courts found ambiguity where the provisions were reasonably clear but the “bargain” was unfair. See Abraham, *supra* note 120, at 531-32 (1996); Kessler, *supra* note 16, at 633.

fits" in health insurance policies.

At a minimum, managed care contracts should be recognized as standard form insurance contracts of adhesion that are neither bargained for, nor read by, the insured. But this characterization only captures part of managed care. The benefits financed by insurance are professional services, so that managed care contracts can also be understood as agreements to provide professional services financed by insurance. This characterization has several implications. Patients cannot be assumed to read or understand any contract provision unless it was specifically drawn to their attention by the insurer and explained to them. This has the virtue, as well as the vice, of respecting reality. It means, however, that there must be extracontractual standards for determining what the contract requires. Although courts have not been willing or able to develop such standards, a recent case illustrates why such standards are necessary.

In *Engalla v. Permanente Group, Inc.*,¹²² the Supreme Court of California found that a binding arbitration clause could not be enforced automatically against a member of a Kaiser Permanente Health Plan because of the plan's fraud in inducing acceptance of the arbitration clause.¹²³ Wilfredo Engalla submitted a claim of malpractice against Kaiser for failure to diagnose lung cancer.¹²⁴ Engalla's health plan required arbitration of the claim and Engalla and his family initiated arbitration proceedings in May 1991.¹²⁵ Kaiser, however, delayed the proceedings until after Engalla died in October.¹²⁶ Finally, the Engallas sued Kaiser in state court in February 1992, claiming fraud in the inducement of the agreement to arbitrate.¹²⁷ Kaiser then sought to compel arbitration and limit potential damages to a lesser amount as a result of Engalla's death.¹²⁸ The California Supreme Court found ample evidence to support a claim that Kaiser misrepresented its arbitration process as

122. 938 P.2d 903 (Cal. 1997).

123. *See id.* at 916. Plaintiffs also claimed that the defendant's dilatory actions in pursuing the arbitration constituted a waiver of its right to enforce arbitration. Because the trial court made no findings on this claim, the Supreme Court remanded to permit the trial court to do so. *See id.* at 922.

124. *See id.* at 909.

125. *See id.*

126. *See id.* at 910-12.

127. *See id.* at 914.

128. *See id.*

one that functioned efficiently.¹²⁹ The court said, “[T]here is evidence that Kaiser established a self-administered arbitration system in which delay for its own benefit and convenience was an inherent part, despite express and implied contractual representations to the contrary.”¹³⁰

To establish fraud in the inducement, however, the Engallas had to show that this misrepresentation was a material factor in concluding the agreement.¹³¹ It was Engalla’s employer, of course, that contracted with Kaiser. Engalla received documents stating only that plan members’ claims must be submitted to arbitration “if the [health plan] agreement so provides.”¹³² It is unlikely that, when he enrolled, Engalla was aware of any arbitration agreement. The court, however, found that an efficient arbitration system was likely to be material to his employer.¹³³ The employer was bound to act as the employees’ agent in negotiating group health insurance, and therefore had a fiduciary duty to act in the employees’ interests.¹³⁴ Thus, the employer may have sought an efficient arbitration process to further its employees’ interests.¹³⁵

129. The opinion included a lengthy summary of the facts “[b]ecause the nature of this case cannot be appreciated without a detailed understanding of its factual context” *Id.* at 908. Unlike many health plans, Kaiser administered its own arbitration cases, using outside legal counsel to control the selection of arbitrators and the timing of events. *See id.* A survey of Kaiser arbitrations between 1984 and 1986 showed that, on average, a neutral arbitrator was appointed to begin the process 674 days, almost two years, after a patient’s demand for arbitration. *See id.* at 913. The health plan agreements required the appointment within sixty days, but only one percent of cases met that target. *See id.* The average time to a hearing was 863 days, almost two and a half years. *See id.* Moreover, there was ample evidence that Kaiser was well aware of these delays. *See id.*; *see also* Michael A. Hiltzik & David Olmos, “Kaiser Justice”: System’s Fairness is Questioned, L.A. TIMES, Aug. 30, 1995, at A1 (suggesting that the company’s frequent use of arbitration makes it difficult for arbitrators who decide cases against Kaiser to get jobs).

130. *Engalla*, 938 P.2d at 918.

131. *See id.* at 919.

132. *Id.* at 908 (quoting Engalla’s enrollment form).

133. Engalla’s employer conceded that it did not really care whether there was an arbitration clause in its health plan, although it sort of looked with favor on a good arbitration process. *See id.* at 920.

134. *See id.* at 919 (citing *Madden v. Kaiser Foundation Hosp.*, 552 P.2d 1178, 1181-82 (Cal. 1976); *Fischer v. Machado*, 50 Cal. App. 4th 1069, 1072 (Cal. Ct. App. 1996)).

135. The Court did not completely depart from its prior holding that arbitration agreements between an HMO and its members are not inherently one-sided

The California Supreme Court found that there was sufficient evidence that Kaiser misrepresented its one-sided arbitration system and denied Kaiser's petition to compel arbitration.¹³⁶ This avoided directly confronting the problem of whether to enforce agreements included in contracts accepted by employers on behalf of their employees when employees have no knowledge of the agreement. The court simply assumed that employers act in their employees' interests in negotiating such agreements. In a footnote, however, the court noted that if an employer does not act in its employees' interest, "then an employee bound by an arbitration agreement of which he was scarcely aware could well raise a claim that such agreement was unconscionable."¹³⁷

In reality, almost all members of managed care plans are "scarcely aware" of provisions like arbitration clauses. Managed care contracts contain too many procedural details and cannot be expected to specify the benefits offered in sufficient detail to enable an individual to predict what kind of treatment might be covered in the future. Thus, both managed care organizations and individuals would benefit from extracontractual standards for determining what provisions should be enforced and how to interpret enforceable provisions that individuals are not expected to read or that cannot specify their precise coverage in sufficient detail to permit reliable predictions.

The need for a reasonable, objective standard against which to measure benefit coverage is particularly acute in health insurance cases. It is not always clear what the contract covers.¹³⁸ The description of benefits

in favor of the HMO. See *Madden*, 552 P.2d at 1186. Recent California decisions strongly favored arbitration for its potential for speed, efficiency and, possibly, keeping cases out of court. See, e.g., *id.* Like many states, California law mirrors much of the Federal Arbitration Act. See *Arbuthnot, McCarthy, Kearney & Walsh, Inc. v. 100 Oak Street*, 673 P.2d 251, 256-58 (Cal. 1983).

136. This may be a departure from recent California decisions in contract cases, which have used a formalistic approach to enforce the literal terms of a contract, with little or no allowance for representations or conduct that contradicts the writing. See *Engalla*, 938 P.2d at 919.

137. *Id.* at 919 n.11. Although the court attempted to distinguish between arbitration as it should be and Kaiser's misuse of arbitration in *Engalla's* case, in practice, it may be difficult to find the ideal arbitration that the court system seems to expect.

138. Contracts are drafted in legal language which, even if clear to lawyers and judges, can be misunderstood by laypeople. State laws requiring insurance contracts to be written in "plain English" may be difficult to interpret, since plain English may sacrifice the use of words whose meaning is settled in law, thereby

are typically and necessarily in general language, such as inpatient hospital care, physicians' services, and laboratory services. Furthermore, benefits are often limited to services that are "medically necessary" or "appropriate."¹³⁹ Unlike most insurance that pays monetary benefits in the event of a defined loss, the benefits covered by managed care are intended to be limited to particular medical services. Yet, it would be too difficult to specify each and every service in advance in the contract itself. This means that many benefits are necessarily open to speculation or at least different expectations on the part of the insurer and the insured. Finally, when the individual needs the services, both parties to the contract may have little incentive to abide by their earlier agreement. The insurer has little financial incentive to pay benefits that deplete its revenues, while patients have little incentive to forego care for which their premiums have already "paid."

Resort to traditional conceptions of consumer expectations or even reasonable consumer expectations applicable in indemnity insurance cases is unsatisfactory. The insured's expectations are often influenced by advertising or summary descriptions of a health plan's benefits. Insurance sales pitches often promise "security" rather than a specific list of dollar payments for particular losses.¹⁴⁰ Insurers may characterize the policy as promising security, freedom from fear, peace of mind, trust, and, in the case of health insurance, the finest quality of care.¹⁴¹ Such

throwing doubt on the coverage intended. See CLARKE, *supra* note 116, at 121-24.

139. See generally Wendy K. Mariner, *Patients' Rights after Health Care Reform: Who Decides What Is Medically Necessary?*, 84 AM J. PUB. HEALTH 1515 (1994) (discussing the difficulty of determining what is medically necessary).

140. See Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1426 (1994). Baker argues that these marketing promises should be used to resolve disputes over coverage and that damages for breach of contract should include an award for the emotional distress caused by the insurer's failure to pay a claim that its advertising appeared to promise. See *id.* at 1426-28; see also Robert H. Jerry II, *Remedying Insurers' Bad Faith Contract Performance: A Reassessment*, 18 CONN. L. REV. 271 (1986) (arguing that actions against insurance companies for bad faith failure to pay claims could be replaced by expanding the scope of damages available in ordinary breach of contract actions).

141. See *McCorkle v. Great Atlantic Ins. Co.*, 637 P.2d 583, 588 (Okla. 1981) ("[O]ne of the primary reasons a consumer purchases any type of insurance (and the insurance industry knows this) is the peace of mind and security that it provides in the event of loss.").

images are reassuring and probably just what a consumer seeks.¹⁴² However, when the insured makes a claim or seeks health care, peace of mind is never a covered benefit. Coverage is limited to specific conditions described in the contract.

A contract solution would be to use advertising as evidence of additional promises which modify the written contract. However, as Deborah Stone suggests, a mere reinterpretation of the contract itself, even supplemented by advertising, cannot resolve the tension inherent in the relationship between insurer and insured.¹⁴³ The shock sometimes experienced by the insured is only partly attributable to reassuring advertising and a failure to read the fine print. Insurers and patients typically bring quite different expectations to the relationship.¹⁴⁴ Insurers are in the business of spreading financial risk by carefully calculating the nature of the risk insured, the probability of its occurrence, and its likely cost. Even a minimally profitable business requires insurers to think in highly specific terms; specific risks are covered for specific losses in specific circumstances. In contrast, outside of business, individuals do not necessarily think about insuring specific risks. Instead, they expect care when a feared risk materializes. Also, the risk of illness or injury is different in kind than the risk of financial loss covered by property insurance. Thus, while managed care organizations may think like insurers when it comes time to pay benefits, insureds who are sick are likely to think like patients. Although insurers and economists may expect or wish people to behave like rational economic beings, such beings may not exist in a health insurance pool, if they exist at all.¹⁴⁵

The different assumptions that insurers and patients bring to any dispute argue against using either tort or contract law as the sole basis for

142. See CLARKE, *supra* note 116, at 33. Malcolm Clarke notes that "the insured seeks insurance, in part at least, to find some degree of peace of mind concerning the risk insured. Insurers are aware of this and, to sell their insurance, have projected a certain image of themselves and of their products." *Id.* Television and print advertising of managed care plans often display images of happy, healthy individuals romping in meadows and celebrating with their families. Even given the brief number of seconds or space allotted for such advertising, there is no indication that the product being sold is a series of payments or services for defined circumstances.

143. See generally Stone, *supra* note 116.

144. See generally Leslie P. Francis, *Consumer Expectations and Access to Health Care*, 140 U. PA. L. REV. 1881 (1992) (discussing consumer expectations).

145. See CLARKE, *supra* note 116, at 6 (footnote omitted).

determining benefit coverage. The consumer expectations standard that is often applied in cases involving standard form contracts for consumer products is difficult to apply to managed care disputes. It is likely to be impossible to discover what an individual consumer actually expected when he or she first joined a managed care plan. Given the inevitable generic language used to describe medical care and the impossibility of predicting in advance what future care an individual might need, even a reasonable consumer expectations standard appears inadequate. Moreover, when consumers become patients, their expectations are likely to change and expand. The subjective expectations of patients who now know what they need and want may be unreasonable.

One alternative to this dilemma would be to adopt a standard package of benefits that would be publicly understood. However, the United States has yet to agree on, much less adopt, such a package. Indeed, after the failure of health care reform proposals in 1994, managed care promised to provide a variety of consumer products with benefits tailored to meet the needs of different groups. Thus, it currently appears that a uniform benefit package for all individuals is neither feasible nor universally desired.

Another alternative would be to develop a common understanding of what different types of benefits are encompassed in the coverage. There is considerably more precedent for this approach. Most industrialized countries have in place a system of national health insurance that covers a wide array of benefits defined by statute.¹⁴⁶ But those definitions are no more, and typically less, specific than the benefit definitions included in American health insurance policies. Generic terms like physician services and inpatient hospital services are used for the same reason they are used by industry: itemization would be too lengthy and risk omitting important services. Instead, many countries rely on developing a consistent interpretation of what the benefits mean.

The same approach could be used to interpret benefit language in managed care contracts. In order to incorporate financial limits on benefits, it may be necessary to restrict benefit coverage to the types of medical care that could reasonably be provided within resource constraints. But this should not mean that any and all contractual limits are

146. See generally, e.g., CHRISTOPHER NEWDICK, WHO SHOULD WE TREAT? LAW, PATIENTS AND RESOURCES IN THE N.H.S. (1995); Gerard F. Anderson, *In Search of Value: An International Comparison of Cost, Access and Outcomes*, HEALTH AFF., Nov./Dec. 1997, at 163.

acceptable. Rather, the benefits should also comply with relevant tort standards governing the quality of acceptable medical care and administration. Thus, the health plan's obligations should be those that reasonable managed care organizations, and reasonable patients, with equal bargaining power and good information, would expect as fair and reasonable for the stated price. This amounts to a revitalized doctrine of informed reasonableness. It contains an element of tort in imposing extra-contractual standards on both the managed care organization and the health plan contract itself. In addition, it contains an element of contract in allowing contracts to specify financial limitations. It differs from current notions of consumer expectations in removing the focus of reasonableness from the individual consumer and his or her individual experiences. Instead, it focuses on the reasonableness of the resulting plan, as well as the behavior of the managed care organization, by using the admittedly artificial concept of what would be expected by a well-informed group of health plan members.¹⁴⁷

Other proposals to adapt legal doctrines for managed care may be equally suitable or compatible.¹⁴⁸ The important point is that it is no longer tenable to insist that the resolution of managed care disputes be governed by narrow legal doctrines that fail to account for managed care's hybrid roots. Forcing inherently mixed issues into a single doctrinal straightjacket produces poor results or tortured reasoning without offering the solace of either consistency or justice. There is an urgent need for extra-contractual standards by which to establish and judge both the content and operation of managed care plans. Standards governing patient issues described above, including the nature of treatment provided as part of covered benefits, should be solidly grounded in tort. Consumer issues that are predominantly financial, such as co-payments, treatment costs, and notification procedures, may draw upon contract

147. There may be a hint here of Gilmore's prediction that contract and tort could merge, at least for the purpose of applying standards for managed care. See generally GRANT GILMORE, *THE DEATH OF CONTRACT* (1974).

148. See generally Mehlman, *supra* note 74 (fiduciary contracting); Meyerson, *supra* note 95 (extracontractual standards for standard form contracts); Jerry, *supra* note 140 (expanded damages for breach of contract in lieu of claim for bad faith denial of insurance benefits); Brewbaker, *supra* note 15 (implied warranty of quality). It would differ from Hall's theory of economic informed consent, however, because it does not assume that patients must consent to all decisions made under the auspices of managed care plan simply because they are informed of the benefits and exclusions covered by the plan. See HALL, *supra* note 9, at 211.

law.

The use of such standards for interpreting benefits and other plan obligations should avoid the major problems associated with relying on unrealistic, subjective, individual perceptions. Individuals should not be surprised by arcane insurance industry practices of which they have no knowledge. Informed and objectively reasonable expectations should take account of patient needs, but they cannot encompass an unlimited demand for inappropriate, incompetent, or purely experimental care. This approach also has the advantage of accommodating changes in medical technology without requiring rewriting a contract. Currently, since treatment options can change during the period of insurance, an insurer may change the particular services for which it is willing to pay, thereby effectively changing the benefit package without an individual's knowledge. If benefits are not interpreted according to a reasonable standard of what reasonable parties should expect as medical care, then, in theory, this type of change might require an amendment to the contract. Obviously, no such amendments are offered to insureds for their approval due to impracticality. But it offers further support for applying an extra-contractual standard to determine the type of medical care that should be covered.

A revitalized reasonableness standard may help to overcome a fear among some patients that limitations are being applied unfairly in individual cases. If everyone can expect that benefits are being interpreted according to the same standard, it may encourage more trust in the system. In contrast, a focus on consumer choice may exacerbate the fear of unfair or arbitrary denials of care.¹⁴⁹ Where one health plan denies Smith care that Jones receives under a different health plan for the same medical condition, Smith may feel that his health plan is acting arbitrarily or unfairly. Unless there is an explicit and obvious difference in the two

149. It is difficult to expect patients to sacrifice what they perceive as necessary care unless they are satisfied that their "sacrifice" is justified or at least shared generally. This is particularly problematic when patients in one health plan are denied services that are covered in another plan. The proliferation of competing health plans with different coverages and exclusions weighs against the development of any sense of common "sacrifice" for the general good. See Wendy K. Mariner, *Rationing Health Care and the Need for Credible Scarcity: Why Americans Can't Say No*, 85 AM. J. PUB. HEALTH 1439, 1442 (1995). See generally Normal Daniels, *Why Saying No to Patients in the United States Is So Hard—Cost Containment, Justice, and Provider Autonomy*, 314 NEW ENG. J. MED. 1380 (1986).

plans' coverage and price, it is likely to be difficult to justify such differences in care. For example, if one plan explicitly covers organ transplants and the other, cheaper plan does not, and the exclusion is made clear to Smith before he joins, then the different treatment would be both fair and more acceptable.

Application of a revitalized standard of reasonable expectations might change the result in some cases. For example, in the *Kuhl* case, it would probably hold the health plan responsible for providing competent heart surgery facilities for a patient in Kuhl's condition. This is because it is reasonable to believe that both a responsible health plan and reasonable health plan members would expect that covered benefits included competent life-saving care for a heart condition that was susceptible to effective treatment. If no hospital in the health plan network were capable of providing the necessary heart surgery competently, then the health plan should be held accountable for failing to secure a capable hospital and surgical team, and later for failing to authorize surgery at a capable facility. In its defense, the health plan should be able to demonstrate that its network hospitals were competent to perform the surgery. Then the dispute would focus properly on the adequacy of the plan's resources for providing care, rather than being summarily disposed of on the pretext that the plan had no influence on the care selected. In addition, the standard would permit a health plan to exclude coverage of heart transplants, for example, if the exclusion were properly drawn to the attention of all plan members before they joined the plan.

Although a reasonable expectation standard should permit an analysis of the merits of disputes, it would not necessarily change the result in other cases. For example, in the often-cited case of *Corcoran v. United Healthcare, Inc.*,¹⁵⁰ a health plan's utilization review company rejected the physician's recommendation that Florence Corcoran be hospitalized to monitor her high risk pregnancy.¹⁵¹ Instead, it authorized ten hours per day of home nursing care. The fetus suffered distress and died when no nurse was on duty. The Fifth Circuit Court of Appeals noted that the plan's actions involved medical decisions as well as a benefit determination, but felt constrained to put those actions into one category, bene-

150. 965 F.2d 1321 (5th Cir. 1992).

151. See *id.* at 1322. This case was also decided on the health plan's claim that the plaintiff's cause of action was preempted by ERISA because the plan's action merely denied a benefit and did not amount to a medical decision. See *id.* at 1329.

fit determinations.¹⁵² Consequently, ERISA preempted the Corcoran's state law negligence claim for the death of their baby *in utero*.¹⁵³ Again, the health plan did not deny that pregnancy care was a covered benefit. The dispute centered on what type of care should have been provided as part of that benefit. There was some evidence that the fetus was at risk and needed monitoring. The prior year, the same physician had hospitalized Mrs. Corcoran during an earlier pregnancy and performed a successful Caesarian section when the fetus went into distress. This time, the utilization review company decided that ten hours of nursing care was medically sufficient. What would a responsible plan and its members reasonably expect? It is likely that some form of round-the-clock monitoring would be necessary if the pregnant woman could not detect fetal distress without professional help. In-patient hospitalization, however, may not have been necessary. Twenty-four hour home nursing may have been sufficient, unless a nurse would not be able to respond immediately to the expected risk at home. Under a reasonable expectations standard, a court should be able to consider not only whether United acted negligently in choosing limited home nursing as it would do in a negligence action, but also whether the covered benefits should include round-the-clock monitoring in such high risk pregnancies.

Another case in which the reasonable expectation standard would not guarantee a plaintiff victory in all benefit disputes is the widely publicized case of Helene Fox, whose estate obtained an \$89.1 million verdict against Health Net for denying coverage of autologous bone marrow transplantation (ABMT) to treat her metastatic breast cancer.¹⁵⁴ The case has been cited as an example of a health plan allowing profit to override necessary medical care. There is reason to believe that there should be no coverage for the experimental treatment at issue because a responsible plan and its members would not reasonably expect such a benefit. If experimental therapies are not excluded, it becomes difficult to define any limits on benefits. The plan's prior approval of ABMT for two other patients raises a different, but equally important issue: whether Health

152. See *id.* at 1331.

153. See *id.*

154. See *Fox v. Health Net of California*, No. 219692 (Cal. App. Dep't Super. Ct. Dec. 28, 1993); Christine Woolsey, *Jury Hits HMO for Coverage Denial*, *BUS. INS.*, Jan. 3, 1994. The California legislature responded by making ABMT a mandated benefit of most health plans in California. See *CAL. WELF. & INST. CODE*, § 14133.8 (Deering 1994).

Net's decision was a responsible analysis of ABMT's investigational status, existing data on its effectiveness for advanced breast cancer, and the condition of each patient, or whether Health Net acted arbitrarily or selectively in providing coverage for different patients in its plan. A reasonable expectations analysis might find it reasonable to exclude coverage of ABMT in Ms. Fox's case. However, it would probably also find it unreasonable to apply different standards to different patients in similar circumstances. Furthermore, it would likely be unreasonable to delay a decision on coverage until it was too late for Ms. Fox to obtain other treatment outside the plan.

Although the purpose of using a new reasonableness standard to determine the nature of covered benefits is to avoid the problems arising from standard form contract language with which patients are not familiar, it need not preclude special health plans with special provisions. However, if such provisions are not generally expected under the reasonableness standard, then it would be unfair to enforce them unless they were expressly and knowingly agreed to by the individual. Given the personal service nature of the managed care relationship, the managed care organization should have an obligation to disclose and explain all terms in the contract that it wishes to enforce. This should be an ongoing obligation in which the organization must announce and explain all changes in such terms sufficiently in advance of any attempt to enforce them. No change in enforcement should take effect in the middle of the contract year without the agreement of the member. Therefore, managed care organizations should have a corporate duty to obtain the informed consent of each member to material issues in the contract and to material changes in benefits, exclusions, providers, and procedures.

Reasonable expectations can also apply to the distribution of benefits and burdens among members of a managed care plan. Insurers already have an obligation to use their premium revenues for the benefit of the health plan population. However, a reasonable expectation of a fair distribution of benefits goes beyond an insurer's duty to use good faith in determining and paying claims.¹⁵⁵ It should include a duty to ensure that

155. Today, health plan members may not feel a strong kinship with other people solely by virtue of being members of the same plan. In the past, mutual insurance groups and cooperatives had a closer sense of community and mutual assistance. See Emily Freedman, *Capitation, Integration, and Managed Care: Lessons from Early Experience*, 275 JAMA 957, 958 (1996). However, even individuals randomly associated in a modern health plan can appreciate the need to distribute benefits fairly among members of the group.

the organization's assets are used prudently for patient care and not diverted to unnecessary administrative expenses, such as uninformative advertising, or excessive compensation. The duty to use an organization's assets for the benefit of patients is effectively a fiduciary obligation that sounds in tort rather than contract. A managed care organization's obligations therefore should include fiduciary duties to each individual patient, as well as to the entire population of its members. Such fiduciary duties should ensure that the benefit package covers appropriate care and that care is provided properly to each individual on a non-discriminatory basis. Finally, managed care organizations must be accountable to individuals for their acts and omissions. This means ensuring that individuals have meaningful recourse for enforcing plan obligations, both contractual and extra-contractual, and obtaining compensation for injury resulting from negligence.

Extra-contractual standards are most appropriate for judicial elaboration. Better judicial standards are necessary because legislation cannot eliminate disputes between individuals and their health plans. However, ERISA is likely to preclude enforcement of extra-contractual standards developed in state common law against ERISA health plans. Such standards may affect, and therefore "relate to," the benefit contract by requiring specific disclosures, benefits, or principles by which one may measure the benefits or performance.¹⁵⁶ Moreover, although state law

156. See, e.g., *Rice v. Panchal*, 65 F.3d 637, 645 (7th Cir. 1995) ("[W]here state law has the effect of creating a qualitative standard (e.g., 'bad faith,' 'improper') by which the performance of the contract is evaluated, then that state law is completely preempted."). Section 514(a) of the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461, preempts any state law, including common law, that "relates to" an employee benefit plan governed by ERISA. Originally ERISA was enacted to protect employees from losing their pensions as a result of mismanagement or inadequate funding. ERISA established uniform national standards for pension funding and vesting, imposed standards for fiduciary responsibility, requirements to report plan information to the Labor Department, and disclosure of a summary plan for information to participants. ERISA preemption applies to virtually all employee benefit plans, including group health insurance plans, voluntarily offered by employers and unions. There are some exceptions, such as churches and the federal government. However, ERISA does not contain any substantive standards for health insurance, or other non-pension plan benefits, such as covered benefits, provider arrangements, utilization review procedures, or grievance mechanisms. The U.S. Supreme Court interpreted the preemption clause expansively to foreclose the application of a wide range of state laws that affected, sometimes negligibly, ERISA plans until its 1995

holds all managed care organizations legally accountable in theory, ERISA preemption provisions shield ERISA plans from liability for their own negligence.¹⁵⁷ While it may be possible to craft a few standards that meet the narrow exceptions to ERISA preemption in this

decision in *N.Y. State Conference of BlueCross & BlueShield Plans v. Traveler's Ins. Co.*, 514 U.S. 645 (1995). Even after the *Traveler's* decision, courts frequently found that ERISA preempts much state legislation regulating managed care. See Mariner, *supra* note 56, at 1989.

157. Following the Supreme Court's lead, courts generally found that negligence or malpractice claims based on state law could not be brought against ERISA health plans. See *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993); *Kuhl v. Lincoln Nat. Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (9th Cir. 1992). Patients were sometimes able to bring a claim against the plan for denial of benefits under ERISA section 502(a). See, e.g., *Velez v. Prudential Health Care Plan of N.Y., Inc.*, 943 F. Supp. 332 (S.D.N.Y. 1996). Yet, the statute limits recovery to the cost of the benefit — the price of the treatment denied — and precluded compensatory damages for personal injury, such as medical expenses, lost wages, emotional suffering, and other losses. Beginning with the Third Circuit's decision in *Dukes v. US Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), several courts of appeals found that ERISA does not preempt malpractice claims against an ERISA plan that are based on the plan's vicarious liability for a physician's negligence in providing treatment if the physician was the plan's employee, agent, or ostensible agent. The Third Circuit distinguished between complaints about the quality of care received — medical decisions — and complaints that the plan wrongfully denied covered benefits or negligently administered plan benefits — benefit decisions. Several courts of appeals have followed the *Dukes* reasoning, allowing vicarious liability claims to proceed as ordinary malpractice actions under state law on the theory that the claim is not preempted because it does not relate to plan benefits or administration. See *Jas v. Prudential*, 88 F.3d 1482 (6th Cir. 1996); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995). At the same time, most courts continue to find that state law claims based on corporate liability — that a plan negligently denied benefits entirely, delayed authorizing benefits, limited coverage to plan providers, or failed to ensure the competence of its physicians — are preempted because they relate to the health plan's benefit determinations. See *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003 (9th Cir. 1998); *Turner v. Fallon Comm. Health Plan*, 127 F.3d 196 (1st Cir. 1997), *cert. denied*, — U.S. —, 118 S.Ct. 1512 (1998); *Jas*, 88 F.3d at 1482; *Cannon v. Group Health Serv. of Okla., Inc.*, 77 F.3d 1270 (10th Cir. 1996). See generally *Furrow*, *supra* note 90; *Mariner*, *supra* note 88 (collecting cases and arguing that the distinction between vicarious liability and corporate liability claims is increasingly untenable for purposes of ERISA preemption).

arena, such efforts may only invite more controversy and litigation.¹⁵⁸ Thus, legislation will be necessary to permit the development of extra-contractual standards. Once again, Annas is right. Protecting patients will require national legislation. Even protecting patients in private, voluntary employee benefit plans will require national legislation.

CONCLUSION

There is a danger that enthusiasm for consumer rights in managed care may unwittingly sweep aside important patient rights that remain necessary for all patients, whether or not they are members of managed care plans. Proponents of a competitive market in health insurance argue that consumer choice will force managed care organizations to compete by improving quality and service, as well as lowering prices, to meet consumer demand. But employer-provided health plans restrict consumer choice, and the use of standard form insurance contracts all but eliminates any remaining role for individual choice. It is unlikely that cost control can be achieved by enforcing contract exclusions against insured patients, especially if the justification for enforcement is freedom of contract.

The interpretation and regulation of health insurance contracts as ordinary standard form insurance policies may have been acceptable when health insurance contracts provided indemnity benefits alone. Managed care, however, also recommends, organizes, and often determines what services may be obtained from which providers. The dual nature of managed care, therefore, demands attention to both tort and contract elements. Although legal principles governing standard form insurance policies may apply to the consumer elements in managed care, they cannot adequately define or enforce legal rights and obligations for patient care.

The undesirability, not to mention the difficulty, of drafting legislation specifying standards of care and other matters of personal medical services, argues against exclusive reliance on legislation, or even regulation, as a definitive solution to interpreting and enforcing managed care arrangements. Although federal legislation may be required to de-

158. *See, e.g.,* *Corporate Health Ins., Inc. v. Texas Dep't. of Ins.*, Civil Action No. H-97-2072, 1998 U.S. Dist. LEXIS 14831 (S.D. Tex. Sept. 18, 1998). For a more nuanced discussion of what relates to ERISA plans for purposes of ERISA preemption, see *American Drug Stores, Inc. v. Harvard Pilgrim Health Care*, 973 F. Supp. 60 (D. Mass. 1997).

velop non-legislative responses, it cannot, and need not, specify the details of managed care relationships. There will inevitably be a need for general principles that courts can use to assess new issues. Developing principles to regulate and enforce managed care obligations will require a hybrid approach that recognizes the reality of managed care's mixed functions. This approach should apply contract, tort, and mixed standards to resolve disputes. Tort standards can and should apply to many issues of managed care performance, specifically including the provision of personal medical services. At the same time, some issues traditionally associated with tort obligations may require contractual enforcement mechanisms. Courts should treat managed care contracts as a special type of standard form contract that combines elements of insurance and obligations to provide the services of qualified professionals, subject to extra-contractual standards based on a revitalized concept of reasonable expectations. The policy goal should be to foster contracts that cover whatever responsible managed care organizations and patients with equal bargaining power and good information would consider fair at a stated price.

Patient rights are not only compatible with managed care, they are necessary to make it work. This approach will not directly protect the rights of patients who have no health insurance. However, this approach recognizes that all patients have rights that cannot be overridden by contract. Unlike some consumer protection legislation, the approach does not threaten to eliminate the rights of patients. After all, being a patient does not depend on having health insurance, and the rights of patients should not depend on health insurance contracts.

TABLE I – CONSUMER V. PATIENT

<u>CONSUMER</u>	<u>PATIENT</u>
<i>Product Availability</i>	<i>Access to Care</i>
Range of "products" (indemnity, service benefit, HMO, PPO, IPA, POS, etc.) Source of "product" (employer group health plan; individual policy/membership) Comparative information No false advertising No misleading marketing practices	Personal income/resources Private insurance Eligibility for government benefits (Medicare, Medicaid, VA, CHAMPUS, SCHIPS, etc.) Government employer health plan Free care for uninsured and indi- gent (free care pools, Hill- Burton, etc.) Price
<i>Financial Solvency & Management</i>	<i>Confidence in Availability of Services</i>
Adequate capital reserves Prudent investment standards Contingency plan/insurance for Bankruptcy or financial crisis Managerial expertise Timely, responsive administration Reasonable administrative expen- ditures	Patient membership on governing board
<i>Provider Pool Adequacy</i>	<i>Provider Pool Quality</i>
Adequate number of providers (based on membership need) Back up system when providers not available (e.g., out of net work providers) Accessible locations Full disclosure of available pro- vider information	Providers qualified by professional competence Patient choice of qualified pro- vider No provider conflicts of interest No barriers to care (e.g., language; discrimination on personal traits unrelated to provider compe- tence; unreasonable delays; unreasonable distances) Continuity of care

TABLE I (CONTINUED)

<u>CONSUMER</u>	<u>PATIENT</u>
<i>Benefit Package</i>	<i>Patient Care</i>
<p>Full disclosure of all covered benefits, exclusions and limitations</p> <p>Full disclosure of process of determining benefits and exclusions</p> <p>Use of credible/independent technology assessment data</p>	<p>Access to medically necessary services (including emergency care)</p> <p>Access to independent medical opinion on need for and appropriateness of recommended care or lack of treatment</p> <p>Access to independent patient advocate or ombudsperson to assist in benefit determinations</p> <p>Right to treatment only with informed consent (including right to refuse treatment)</p> <p>Prohibition against denying other Treatment or benefits for patient's refusal of a treatment</p> <p>Right to designate health care proxy (surrogate) with binding decision making power</p>
<i>Quality of Care</i>	<i>Quality of Care</i>
<p>Full disclosure of all covered benefits:</p> <p>Full disclosure of process of determining benefits and exclusions</p> <p>Use of credible/independent technology assessment data</p>	<p>Provider accountability (liability) to patient for negligence</p> <p>Confidentiality of all personal medical information and records</p> <p>No disclosure of confidential information beyond that authorized by patient or necessary to immediate care</p> <p>Respect for privacy and dignity in treatment setting</p>

TABLE I (CONTINUED)

<u>CONSUMER</u>	<u>PATIENT</u>
<i>Pricing</i>	<i>Pricing</i>
Full disclosure of prices Comparative price information Community rating No discriminatory annual or life-time caps on benefits No discriminatory deductibles or Copayments Government approval of premiums	Affordable prices Availability of free care for indigent
<i>Enforcement Mechanisms</i>	<i>Enforcement Mechanisms</i>
Fair and efficient grievance procedures for resolving complaints about benefits, exclusions, treatment, discrimination, etc. Full disclosure of grievance procedures and results Full disclosure of financial information to government regulatory authority	Access to independent patient advocate or ombudsperson Access to judicial review

TABLE II – MIXED PATIENT AND CONSUMER

<i>Provider Pool</i>
<p>Adequate number of providers available and accessible</p> <p>Adequate types of providers to meet medical needs (physicians and other health professionals, labs, hospitals, clinics, home care, etc.)</p> <p>Licensure and certification of health care professionals</p> <p>Licensure and accreditation of insurers and health care Facilities</p> <p>Prohibition against financial incentives to providers to withhold appropriate care or to provide inappropriate care</p> <p>Prohibition against self-referral arrangements or other conflicts of interest</p>
<i>Enforcement Mechanisms</i>
<p>Direct plan accountability (liability) for corporate negligence in determining benefits, selecting and monitoring providers, influencing medical treatment, advertising and marketing, and administering the plan</p> <p>Indirect plan accountability (liability) for negligence of all employees, agents, and (except when in contravention of corporate directives) contract-providers</p> <p>Independent external review of quality of patient care</p> <p>Government review and approval of:</p> <ul style="list-style-type: none"> Financial information Premiums Reasonableness of non-patient care expenditures Health plan terms and conditions Marketing materials Contracts with providers Quality assurance procedures Grievance procedures (for coverage decisions, treatment, discrimination, etc.)

