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CAPITATION: THE LEGAL IMPLICATIONS OF USING CAPITATION TO AFFECT PHYSICIAN DECISION-MAKING PROCESSES

Andrew Ruskin

I. INTRODUCTION

Although it is at best a mixed blessing, capitation has taken firm root in America's health care reimbursement system. Capitation refers to the prospective payment of a fixed sum per period for each patient under the care of a selected provider, regardless of the actual costs incurred by the provider in treating the patient.¹ As one of the primary tools used by managed care organizations ("MCOs") to bring about health care cost containment, capitation symbolizes the way that managed care has attempted to revolutionize the health care industry.² Because of its perceived success in lowering costs, MCOs are using capitation with increasing frequency.³ The increased prevalence of this payment mecha-

1. MARK V. PAULY ET AL., PAYING PHYSICIANS: OPTIONS FOR CONTROLLING COST, VOLUME, AND INTENSITY OF SERVICES 101 (1992).

2. See William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 476 (1991) (stating that cost containment measures form the heart of managed care).

Some evidence shows that capitation can be successful at lowering medical costs. Accounting for self-selection by using a randomized, controlled trial, one study of the use of services in different insurance plans found that the capitated population health expenditures were 28% less than fee for service plans. PAULY ET AL., *supra* note 1, at 111. Although this study prevented study bias arising from healthier patients' self-selection of managed care plans, many studies touting cost reduction in MCOs can be misleading because of their failure to consider this factor. Reed Neil Olsen, *The Impact of Health Maintenance Organizations on Health and Health Care Costs*, 25 APPLIED ECON. 1451, 1451-52 (1993).

There also is some debate as to whether capitation and other risk sharing devices lower medical costs by sacrificing quality of care. At this point, there is no clear evidence as to their effects on quality. Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations, 57 Fed. Reg. 59,024, 59,031 (1992). Even if some proof existed that risk sharing improved the health of enrollees, it would need to be tempered with an understanding of the enrollment of healthier patients in MCOs as a result of self-selection. Olsen, *supra*, at 1451.

3. Present estimates suggest that approximately six percent of all health care plan

nism should trigger legal scrutiny to determine its affect on the relationships of patients, MCOs, and physicians. Legislators then could use any resulting insights to better implement health care policies, while courts might better determine the party responsible for adverse medical outcomes that occur in a capitated setting.

This Article examines some of the ways that capitation impacts the decision-making processes of physicians, along with some of their potential legal ramifications. It first applies financial risk theory analysis to capitation to show how the various components of risk, inherent in capitation payments to physicians, can be determined. Next, it reviews various legal developments that suggest an insufficiency of compensation for risk could create legal liability for the MCO. To help lawmakers properly address the problem of insufficient compensation, this Article provides a framework for examining the minimum capitation rate necessary to compensate the physician for the components of risk confronting him. Following this analysis, the Article examines the mechanism by which capitation can directly control a physician's mode of practice. This examination considers the legal theories for finding an MCO liable when a physician under the direct control of the MCO acts inappropriately. It also offers a method of analysis for determining if capitation leads to control over a physician in a particular case. Finally, this Article suggests that other payment mechanisms could serve many of the same purposes for which capitation presently is used, while posing less of an intrusion into the physician's decision-making processes.

II. FINANCIAL RISK ARISING FROM CAPITATION

Through capitation, managed care organizations share financial risk with providers. Whereas traditional forms of health care financing do not rely on risk sharing methods, MCOs believe that their reimbursement

enrollees are covered under a fully capitated plan. Julie Johnsson & Mike Mitka, *Show-down at Capitation Corral: Control of System Hangs in Balance*, AM. MED. NEWS, Aug. 15, 1994, at 1, 1. Among HMOs, it is estimated that about 54% of all plans rely on capitation of their physicians to keep costs down. *Id.* Some experts predict that by the year 2005, about 50% of the entire population of the United States will be covered by a capitated plan. *Id.* at 24. This figure already describes certain heavily capitated markets, such as Southern California which has a capitation rate around 50% of its population, and Boston which has around 35% of its population in plans using capitation. Jeannie Mandelker, *The Unprecedented Shift to Managed Care is Resulting in Lower Health Costs, as the Private Sector Uses its Economic Clout to Transform Health Care Delivery in Ways Congress Can Never Hope to Match*, BUS. & HEALTH, THE STATE OF HEALTH CARE IN AMERICA, Jan. 1995, at 8, 9.

strategy gives physicians an incentive to make more cost conscious decisions in treating their patients.⁴ Until recently, all health care providers were paid under a fee-for-service system, receiving reimbursement for all the procedures they provided, at a price that the providers controlled.⁵ This system created an incentive to overtreat patients by delivering unnecessary services.⁶ Because MCOs place financial risk on providers, by paying them a fixed amount regardless of the labor and supplies involved in patient care,⁷ they replace the incentive to overtreat with an incentive to provide less care.⁸ Although less care sometimes results in sounder, more cost-effective care,⁹ overly severe financial incentives may lead the physician to provide insufficient, substandard treatment in some instances.¹⁰ As it always has been public policy to protect patients, courts and legislatures need to determine whether an MCO retains legal consequences for the effects its capitation rates have on a provider's treatment.

A. *Financial Model of Risk*

Financial analysts long have understood the importance of risk in determining the proper return on an investment. Risk theory revolves around the principle that a certain dollar is worth more than an uncertain

4. MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 135 (1993).

5. *Id.* at 2. Although in a fee-for-service system physicians can set their own prices, some indemnity insurers set their own limits on reimbursements to avoid losing all control over their expenditures. The limit is based on a combination of the usual, customary, and reasonable ("UCR") rates for a service. HENRY BERMAN, M.D. & LOUISA ROSE, *CHOOSING THE RIGHT HEALTH CARE PLAN* 23 (1990).

6. BERMAN & ROSE, *supra* note 5, at 112.

7. MCOs also use other techniques besides capitation for placing risk on providers, such as withholdings and bonuses. See *infra* notes 99-103 and accompanying text (discussing the need to look at financial incentives upon providers created by MCOs in their entirety).

8. RODWIN, *supra* note 4, at 153.

9. For example, capitated physicians have an incentive to find more cost-effective means of achieving improved treatment results. Jerome R. Gardner & Roxy Maroney, *Positioning for Capitation by Redesigning Internal Processes*, *HEALTHCARE FIN. MGMT.*, 40, 42 (July 1995). They also have an incentive to engage in more preventive treatment, which is less expensive than treating patients after they get sick. Leigh Page, *Can Plans Manage the Preventive Care Diabetics Need?*, *AM. MED. NEWS*, Mar. 20, 1995, at 4, 4. Thus if properly implemented, cost containment can lead to a healthier population with fewer health care expenditures.

10. See RODWIN, *supra* note 4, at 145 (noting the many lawsuits and anecdotal incidents suggesting that strong financial incentives have led to the withholding of services to the patient's detriment).

dollar.¹¹ Accordingly, financial analysis entails the quantification of the risk of receiving a profit on one's investment with a determination of the corresponding level of return required to compensate for the risk involved.¹² When examining a stock, investors look at the stock at several different levels: first, they examine the stock itself to determine how much risk it presents; second, they determine what effect the stock will have on their portfolio; and third, they decide how to combine their portfolio of stocks with a risk free investment, such as a government bond, to further create a risk and return level with which they are comfortable.¹³ Each level presents different analytical issues and needs to be examined separately.

Investors begin their risk analysis of a stock investment by looking at the stock itself. A stock's risk level is determined by examining the historic variability associated with the stock price.¹⁴ Investors first calculate a weighted average of all the stock's returns based on a series of price observations made over a period of time.¹⁵ The sample of returns must be large enough to make a bell curve distribution upon which a formal statistical analysis can be based.¹⁶ Investors then calculate the stock's variance around its average by subtracting the mean return from each individual return, squaring each amount, and adding up the squares.¹⁷ This figure is called the stock's variance, and the square root of the variance is the stock's standard deviation.¹⁸ As the standard deviation increases, investors will require greater returns on their investment to compensate them for the greater degree of risk.¹⁹ Hence, the price of a stock decreases as its risk increases until the expected return on the stock reaches

11. RICHARD A. BREALEY & STEWART C. MYERS, *PRINCIPLES OF CORPORATE FINANCE* 13 (4th ed. 1991).

12. *Id.* at 129 (referring to the required level of return as the opportunity cost of capital).

13. *Id.* at 131-61.

14. *Id.* at 135.

15. *Id.* at 134 (explaining this technique by using a coin tossing game as a model). For example, suppose that a sample generated the following five returns: 10%, 12%, 12%, 13%, and 14%. The weighted average would be 12.2%, i.e.: $(10 + 12 + 12 + 13 + 14)/5$.

16. PAUL G. HOEL & RAYMOND J. JESSEN, *BASIC STATISTICS FOR BUSINESS AND ECONOMICS* 157 (2d ed. 1977).

17. BREALEY & MYERS, *supra* note 11, at 134. Based on the figures from the previous example, this total would be 8.8%, i.e.: $(12.2 - 10)^2 + (12.2 - 12)^2 + (12.2 - 12)^2 + (13 - 12.2)^2 + (14 - 12.2)^2$.

18. *Id.* The standard deviation here would be 2.97, i.e.: $\sqrt{8.8}$

19. *See id.* at 131, 135 (demonstrating through tables that different classes of financial instruments exhibit different rates of return that are correlated with their standard deviations).

a level appropriate for its risk.²⁰ Through this analytical tool, investors tie the stock's price with its expected magnitude of variation.

Even if a stock is particularly risky, investors can remove some of the risk by owning simultaneously several stocks. In this way, investors can diversify the risk through a stock portfolio, which allows them to narrow the range of variability in their returns.²¹ However, there is no attenuation of the level of return in diversification, and thus portfolio owners receive a higher return at a certain level of risk than they can get from any individual stock.²² The effectiveness of diversification depends upon both the number of stocks in a portfolio and the covariance of the stocks to each other.²³ When an efficient portfolio is created, the risk level of its entirety of stocks in the portfolio becomes the market risk level, as opposed to the unique risk of any individual stock.²⁴ Thus, even a risky stock can be a smart investment for a risk-averse investor who is more concerned about its effect on the portfolio as a whole.

Although stocks always pose some risk, even in portfolio, investors can combine stocks with risk-free investments to obtain an ideal level of risk and return. Investors can reduce the risk to which they are exposed, below the market risk level, by combining a stock portfolio with government bonds.²⁵ Hence, rather than working only at the individual stock level, rational investors analyze a stock's risk in conjunction with its effect on their portfolios, and consider their ability to further diversify away the portfolio risk with risk-free investments.

B. *Application of the Financial Model of Risk to Capitation*

As capitation results in providers' assumption of risk of profit and loss, it is appropriate to study capitation rates under the same rubric as financial risk analysis. Although physicians traditionally have not engaged in a risk analysis as formal as investors in the stock market, risk sharing works on the principle that physicians are making intuitive judgments in this area.²⁶ Thus, when a risk analysis shows that a capitation rate leads to a

20. See *id.* at 13 (showing that the monetary value of an investment is inversely proportional to its rate of return).

21. *Id.* at 137.

22. *Id.* at 158 (demonstrating this phenomenon on a graph).

23. *Id.* at 142.

24. *Id.* at 137. Market risk refers to the risk inherent in global factors affecting the market. Investors can only diversify the unique risk associated with an individual stock in their portfolios. *Id.*

25. *Id.* at 159-61.

26. See RODWIN, *supra* note 4, at 156 (expressing incredulity at the view of many pro-

risk-adjusted income per patient below the physician's cost per patient, it creates a dangerous propensity for physicians to protect themselves from financial loss by reducing their level of care below their normal practices.²⁷ This reduction might indicate a provider fell below the legal standard of care, and may result in an adverse medical outcome.

To protect against these outcomes, MCOs, physicians, and legal analysts must examine the risk factor of different capitation systems. Each one can be regarded as a different security with its own risk level.²⁸ The risk level of the plans can be compared to each other by looking at their standard deviations.²⁹ Once the risk level presented to a provider is determined, the risk examiner then determines if there are mechanisms in place that diversify the physician's risk. This examination of diversifica-

ponents of risk sharing techniques that this mechanism only creates positive incentives without creating negative ones).

27. Because of the nature of health care delivery in a managed care environment, this hypothesis might be impossible to prove empirically. For instance, MCOs often use a combination of financial incentives, which would make it impossible to determine the effect of any one in isolation. *Id.* at 147. See also *infra* notes 99-103 and accompanying text (discussing the need to look at financial incentives in the aggregate before determining if a capitation rate is impermissibly low). Further, it is impossible to second guess which services a physician would have performed but for the financial incentives. RODWIN, *supra* note 4, at 146. However, there is data that shows capitation reduces physicians' health care expenditures. *Supra* note 2. Economic theory would embellish upon this figure by stating that stronger incentives are more likely than weaker incentives to reduce services to a dangerous level. RODWIN, *supra* note 4, at 147. See also *Managed Care . . . A View From the Inside*, 30 MED. MARKETING & MEDIA, May 1995, at 26, 38-40 (quoting one radiologist as saying that cost becomes more important than safety in choosing contrast materials for radiologists facing bankruptcy). Thus there is at least sound reasoning with at least some anecdotal support for this hypothesis.

Because physicians consider a whole range of factors in providing treatment, it might be insufficient to say that financial loss alone creates dangerous incentives to undertreat. For example, physicians are not likely to have perfect information regarding the degree of risk to which they are exposed. Because a large subset of physicians, like the overall population, are risk averse, they likely would overestimate their level of risk. This suggests that a risk-adjusted breakeven capitation rate is still dangerously low. However, this consideration finds its counteracting effect in physicians' calculations of expected malpractice premium increases resulting from adverse outcomes as well as calculations of lost income due to a loss of patients after acquiring a bad reputation within a community. Cf. BERMAN & ROSE, *supra* note 5, at 120 (discussing disincentives for Health Maintenance Organizations ("HMOs") to undertreat). Because of the opposite effects of these factors, perhaps the break-even point is the best estimate of the threshold beyond which incentives become dangerous.

28. Richard E. Schroeder et al., *Pricing Medical Services in the Managed Care Environment*, TOPICS HEALTH CARE FIN., Winter 1992, at 58, 58.

29. See Susanna E. Krentz, *Risk Versus Uncertainty in Managed Care Contracting*, HEALTHCARE FIN. MGMT., Oct. 1994, at 22, 22 (suggesting that providers reduce their standard deviations to increase the predictability of their costs).

tion should include an analysis of any risk free income, which further allows the provider to adjust his risk level to accommodate personal preferences. When this risk-adjusted income actually shows a loss, lawmakers might decide that this rate is too great an incentive to cut back on services. Accordingly, lawmakers may pass legislation preventing MCOs from refusing coverage, and holding the MCO liable for the physician's adverse outcomes.

At the most fundamental level, the physician and MCO need to understand the variance facing the physician by the portion of the organization's patient population for whom the physician will assume financial responsibility. Before a physician can assume that there will be any regular pattern to his patient costs, he must have a sizable number of patients for whom he receives capitation each month.³⁰ Once a physician attains a critical number of patients, his costs for treating them will follow a normal distribution from which he can derive an average cost per enrollee as well as a standard deviation.

Various factors affect the standard deviation of the costs of treating a given enrollee population. The demographics of a population can influence greatly the range of costs of care that a physician confronts in assuming responsibility for a population.³¹ Hence, the physician and MCO need to determine the respective percentages of the different demographic groups within the physician's enrollee population.³² Whereas a homogenous population would mean low financial risk, a polarized group that falls mostly into the extremes of high and low utilizers would mean high financial risk and a greater potential incentive to undertreat in the absence of adequate compensation for the risk factor.³³ Another source

30. DAVID W. LEE, PH.D., *CAPITATION: THE PHYSICIAN'S GUIDE* 29 (1995). The number of enrollees needed varies with the level of care provided. Accordingly, some experts believe that a primary care physician only needs about 200 enrollees to eliminate sample size risk, while a specialist will need a much larger number. Greg Borzo, *Breaking the Capitation Bronco*, *AM. MED. NEWS*, Apr. 18, 1994, at 19, 20.

31. See PAULY ET AL., *supra* note 1, at 107 (noting that some physicians attract a high cost group of patients).

32. Borzo, *supra* note 30, at 20. Age and sex seem to be the most important factors here, but disease trends and socioeconomic factors also play a role in determining the likely range of costs confronting a physician. *Id.*

33. Cf. PAULY ET AL., *supra* note 1, at 107 (discussing the potential for physicians to respond to a group of high cost patients by lowering their quality of care). Pauly et al. also assert that inadequate compensation for a sicker patient group might lead physicians to refuse accepting high risk patients as part of their patient pool, which would lead to their reduced access to health care services. *Id.* at 108. Thus they suggest that capitation should be readjusted periodically to compensate for the severity level of a doctor's patients. *Id.*

of variation in a physician's costs is the cost range of services for which he financially is at risk.³⁴ Thus, a primary care physician who is required to pay for hospital and specialists' services out of his capitation rate is more likely to be at a high financial risk, endangering the standard of patient care, than a physician who only had to pay for his own services from his capitation.³⁵ By studying the factors that affect the shape of the bell curve of health care costs of enrollees, lawmakers can better understand whether the risk premium within the physician's capitation rate is a sufficient prophylactic against underutilization.

Although one can derive the proper risk premium for an individual physician's capitation rate from the nature of his expected variance, a further adjustment is necessary for a physician practicing in a group setting. In a group practice, the risk posed by overutilization of any one physician's patient population is reduced through diversification. Within any given period of high patient utilization for one physician, the group practice in the aggregate will likely experience a more steady rate of utilization.³⁶ Hence, diversification alleviates both the danger of financial loss and, consequently, the danger of harsh financial incentives to under-treat.³⁷ Impacting greatly on risk when even a small group of doctors join together,³⁸ the diversification factor affects the risk level inherent in

34. *Id.* at 106. Specialists intrinsically face greater variation of costs than primary care physicians because they provide more costly services to a sicker patient group. Paul R. DeMuro, F.H.F.M.A., C.M.P.A., C.P.A., M.B.A., J.D., *Paying Specialists and Subspecialists on a Capitated Basis*, HEALTHCARE FIN. MGMT., July 1995, at 32, 34. Accordingly, MCOs must be careful in accounting for risk when capitating specialists.

35. RODWIN, *supra* note 4, at 142. Although the elevated risk associated with increasing the number of services for which the physician is responsible also leads to a greater danger to the patient, removing the financial risk for noncapitated specialists' services altogether gives primary care physicians an incentive to substitute specialist services for their noncapitated own. PAULY ET AL., *supra* note 1, at 106. If a plan chooses to hold a primary care physician responsible for specialist services, the primary care physician can either reimburse specialists using a fee-for-service system or a capitation system. If he reimburses them with fee-for-service payments, he loses control over the patient's health care expenditures, which increases his risk. DeMuro, *supra* note 34, at 33. Yet, as stated (*supra* note 34), capitation of specialists places an inordinate amount of risk on these providers. Because of all the dangers inherent in shifting the risk for other providers' services to the primary care physician, MCOs should use relatively weak financial incentives to control the potential for overutilization of these services.

36. See RODWIN, *supra* note 4, at 141 (stating that physicians in a large group practice bear less risk than physicians in a small one).

37. Cf. PAULY ET AL., *supra* note 1, at 103 (noting that physicians in a small risk pool more likely are to be aware of each other's resource utilization, which leads them to be more attentive to controlling each other's costs).

38. Cf. BREALEY & MYERS, *supra* note 11, at 137 (explaining that the bulk of the effect on risk stemming from diversification comes from the first few stocks and diminishes

agreements between MCOs and almost all group practices.³⁹ Because diversification can reduce the nature of the risk associated with a physician's income, courts and legislatures should give the MCOs greater latitude in determining the capitation rate for physicians in a group practice.

In addition to countervailing forces of variation and diversification, the physician's ability to further reduce risk through the receipt of risk free health care financing also is a relevant factor in determining an appropriate risk premium. Fee-for-service coverage allows physicians to charge standard rates for the services they choose to provide, and accordingly there is virtually no risk attached to providing services in such an environment.⁴⁰ If a physician practicing within a capitated environment also provides care to a substantial number of patients with fee-for-service type financing, the risk incurred from the capitated reimbursements would create less risk of loss overall.⁴¹ Hence the physician practicing under these circumstances would be less likely to lower his provision of services

almost entirely after about 20 stocks). Although covariance is also an important factor in determining the effectiveness of diversification in stock portfolios, it is less relevant in evaluating diversification in a group practice. The covariance of stocks is greater than zero when they are affected similarly by certain market conditions. *See id.* at 140 (explaining that stocks tend to move together and thus have a positive covariance). Unlike this synchronous responsiveness to global factors, sickness rarely is caused by a pervasive environmental stimulus. Thus the covariance of different doctors practicing in a group setting likely is around zero in most cases. Because the covariance does not likely change from one group practice setting to another, it becomes irrelevant in comparing the risk levels of different work environments.

39. *See supra* notes 21-24 and accompanying text. Owners of diversified portfolios experience no decrease in return from the decrease in the effect of the risk of an individual stock when included in their portfolios. However, while stock transactions generally are impersonal exchanges between stockholders and corporations conducted through the stock market, in which the stockholder has no allegiance to the corporation, doctors and MCOs usually operate under agreements formalized by contract. As part of this commitment to work together, the MCO might insist upon receiving some of the benefit achieved through diversifying risk in a group practice setting in the form of lower capitation rates. *See, e.g., PAULY ET AL., supra* note 1, at 113 (remarking that multi-specialty groups can lower their costs in preparation for capitation both through group risk sharing and through economies of scale). In contrast to the relationship between stockholders and corporations where the stockholders alone benefit from diversification, agreements between MCOs and physicians will likely result in a sharing of the benefits of diversification.

40. *See supra* note 5 and accompanying text (discussing fee-for-service medicine).

41. *See, e.g.,* Lauren M. Walker, *Turn Capitation into a Moneymaker*, *MED. ECON.*, Mar. 13, 1995, at 58, 71 (noting that financial distress did not set in for one group practice in Ohio until an HMO's capitated system accounted for about 35% of the physicians' income). Part of the reason that a fee for service practice can alleviate the effects of capitation is the ability to shift costs to fee-for-service insurers. Because of this tendency, markets with high HMO penetration sometimes also present higher than ordinary costs for

to an inappropriate level to counteract the financial risk factor.⁴² The effect of risk free income can cause a significant impact on physician incentives. Thus, any legal analysis of the appropriate risk premium for a physician with a given cost variance must include the degree to which the effects of risk free income have combined with any group practice diversification effect to reduce the physician's risk.

III. POTENTIAL LEGAL LIABILITY ARISING FROM IMPROPER RISK

A. Statutory Measures and Administrative Refinements

Risk incentives are likely to interfere with a physician's judgment when they become too onerous. Congress, therefore, has taken limited steps to control their severity. Although Congress initially sanctioned risk sharing within Health Maintenance Organizations ("HMOs"),⁴³ it has placed some limits on risk sharing by Medicare HMOs.⁴⁴ The law prohibits an HMO from providing incentives to physicians to reduce the amount of care they provide to specific patients.⁴⁵ Further, if the HMO places physicians at substantial financial risk, it also must provide some sort of stop-loss protection to prevent financial loss after a threshold point.⁴⁶ HMOs that shift substantial financial risk onto their providers also must provide documentation to their enrollees to show that the enrollees have proper access to medical services.⁴⁷ All risk-sharing mechanisms must be reported to the Health Care Financing Administration ("HCFA"), which has the authority to impose monetary penalties on HMOs that fail to comply with this law.⁴⁸ Although this statute is far from a complete prohibition of inappropriate risk shifting, it shows legislative intent to prevent the harms that result from these mechanisms.

As Congress entrusted enforcement of this statute to HCFA, the agency has enacted guidelines explaining its method of implementation.

non-HMO insurers. See Olsen, *supra* note 2, at 1451 (finding, however, that HMO competition can also force non-HMO insurers to lower their costs to retain market share).

42. Cf. PAULY ET AL., *supra* note 1, at 103 (asserting that physicians likely will not change their fee-for-service practice styles to accommodate the needs of a small HMO patient panel).

43. 42 U.S.C. § 300e(c)(2)(D) (1994).

44. *Id.* § 1395mm(i)(8).

45. *Id.* § 1395mm(i)(8)(B)(i).

46. *Id.* § 1395mm(i)(8)(B)(ii)(I). The statute suggests basing this threshold point on the number of physicians in the risk pool as well as the number of patients in the physician's patient panel. *Id.*

47. *Id.* § 1395mm(i)(8)(B)(ii)(II).

48. *Id.* § 1395mm(i)(8)(B)(iii).

In these guidelines,⁴⁹ HCFA defines substantial financial risk as the potential for loss of twenty-five percent or more of the provider's income due to physician referral costs.⁵⁰ With capitated plans that do not involve other compensation arrangements like withholdings and bonuses, the HMO must specify the maximum amount and the minimum amount of the capitation at risk.⁵¹ If the difference is over twenty-five percent of the total capitation amount, then the HMO will be considered to have placed its providers at substantial financial risk.⁵² Once an HMO has been determined to have imposed a substantial amount of risk upon providers, it will have to provide stop-loss coverage.⁵³ If the stop-loss protection is for the physician's patient population in the aggregate, the MCO must cover ninety percent of all expenses exceeding the twenty-five percent threshold.⁵⁴ For per-patient stop-loss protection, the per-patient cost threshold beyond which the MCO must provide coverage increases in proportion to increases in the patient panel size.⁵⁵ If an HMO fails to comply with these guidelines,⁵⁶ it could face a maximum penalty of \$25,000 for each violation of the regulations.⁵⁷ Although these guidelines are limited in

49. The guidelines originally were proposed in: Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations [hereinafter *Physician Incentive Plans*], 57 Fed. Reg. 59,024 (1992). In March, 1996, they officially became regulations, and they now are codified at 42 C.F.R. §§ 417, 434, and 1003 (1996).

50. 42 C.F.R. § 417.479(e). HCFA chose 25% as its cutoff because, historically, physicians voluntarily have cut their prices as much as 20 - 25% for some patients. *Physician Incentive Plans*, 57 Fed. Reg. at 59,028.

51. 42 C.F.R. § 417.479(f)(5)(i).

52. *Id.* If an HMO failed to provide this information, the default would be that it was placing its providers at substantial financial risk. *Id.* § 417.479(f)(5)(ii).

53. See *infra* notes 54 & 55 and accompanying text.

54. *Id.* § 417.479(g)(2)(i).

55. *Id.* § 417.479(g)(2)(ii). Note that this concern for patient panel size accords with accepted models of risk. See *supra* text accompanying notes 26-30, 43-51. HCFA considered including various other factors into its analysis of risk, but it ultimately decided against their inclusion until there is more empirical research into the effects of financial risk on physician behavior. *Physician Incentive Plans*, 61 Fed. Reg. 13,430, 13,434 (1996). Yet this decision to wait for further evidence of the impact of incentives is problematic because of the large number of intervening variables that might make it impossible to determine exactly how incentives work. See *supra* note 27 (describing why incentive mechanisms are difficult to study). Because it might not be possible to isolate the effects of different types of risk sharing through empirical research, HCFA should rely more on a theoretical approach to regulation of compensation plans, such as the one described in this Article.

56. In addition to following Congress' directions to set up guidelines for determining substantial financial risk, HCFA also has established standards for the implementation of both the mandated customer surveys and the mandated disclosure to HCFA. 42 C.F.R. § 417.479(g)(1),(h).

57. *Id.* § 1003.103(f)(1).

terms of the kinds of incentives they condemn, they manifest an administrative intention to ascertain the precise nature of risk sharing mechanisms so that they can be properly regulated.

Recognizing that federal statutory guidelines still are inadequate, state regulatory agencies are also attempting to propose rules that could be adopted by legislatures. The National Association of Insurance Commissioners ("NAIC") is creating an analytical framework under which it establishes capital requirements for groups assuming full risk for their patient populations.⁵⁸ These standards will force groups to determine realistically their level of risk, which in turn will determine their required level of capital reserves.⁵⁹ Once physicians know their risk levels, they can use these figures to negotiate reasonable capitation levels in addition to determining the amount of capital reserves they require to protect them from risk. As these measures likely will be adopted by state legislatures, the present lack of constraints in MCO risk sharing strategies accordingly will end in those jurisdictions.

B. Common Law Developments

Although the common law has yet to find MCO liability for capitation that did not properly consider risk, there are several cases that laid the foundation for such a finding. Some cases focused on imperfections within the design of cost containment mechanisms as a causative agent of an adverse medical outcome.⁶⁰ Other cases examined financial incentives to determine if they were a *per se* violation of public policy.⁶¹ Although the cases in this area resulted in divergent holdings, they established some precedent for finding liability for shifting an inordinate amount of risk upon a physician through capitation.

In *Wickline v. State*,⁶² the Court of Appeals for the Second District wrote a landmark decision that created the potential for finding liability of an MCO for the adverse medical outcomes of its enrollees. In this case, the plaintiff claimed that Medi-Cal, California's Medicaid HMO system, developed a faulty utilization review mechanism that led to her be-

58. Memorandum from Stephanie Lewis to State and Federal Legislative Policy (B) Task Force: Issues Relating to Risk-Bearing Entities in the Health Insurance Market 24 (Mar. 15, 1996) (Memorandum prepared by the NAIC) (on file with author).

59. *Id.*

60. See *infra* discussion of the *Wickline* and *Wilson* decisions and accompanying notes.

61. See *infra* discussion of the *Bush* decision and accompanying notes.

62. 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

ing discharged prematurely from the hospital.⁶³ As a result of this discharge, she alleged that her condition worsened, and she eventually needed to have her leg amputated.⁶⁴ Although the court found that neither her treating physician nor Medi-Cal fell below the standard of care,⁶⁵ it stated in dictum that a MCO could be found liable for imperfections in its design or implementation of cost containment mechanisms.⁶⁶ Because MCO reimbursement policies are similar to utilization review in their central role among cost containment strategies, the *Wickline* court created precedent for examining an MCO's rates of capitation.

The same court later clarified the meaning of the statements made in its *Wickline* decision in *Wilson v. Blue Cross of Southern California*.⁶⁷ In *Wilson*, the court denied the defendant insurer's motion for summary judgment where the plaintiff sued it for the suicide of an enrollee who was released from a psychiatric ward, despite the treating physician's opinion that a discharge would be premature.⁶⁸ After distinguishing *Wickline*,⁶⁹ the court stated that an insurer would be held liable for adverse medical outcomes whenever its cost containment policies were found to be a substantial factor in the harm caused by the substandard care.⁷⁰ If other courts follow this holding, they would find liability for any MCO whose inadequate capitation was a substantial factor in creating harm to a patient.

Although there are no reported cases involving allegations that improper financial incentives have led to a patient's injury, there are several cases that have questioned whether financial incentives should be toler-

63. *Id.* at 811. As proof of the prematurity of the discharge, the plaintiff brought the court's attention to the fact that Medi-Cal only granted her a four-day extension beyond her original discharge date despite her treating physician's recommendation of eight days. *Id.* at 813-14.

64. *Id.* at 811.

65. *Id.* at 819.

66. *Wickline*, 239 Cal. Rptr. at 819. However, it also stated that the physician bears primary responsibility for the care of the patient. *Id.* Though the court held both parties responsible for the care received, it failed to give any guidance as to where the distinction could be drawn between the physician's and the MCO's duties in this opinion.

67. 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).

68. *Id.* at 877-78.

69. *Id.* at 879. The court noted: the *Wickline* physician's conduct did not fall below the standard of care; the funding process was made according to the state's administrative code rather than by contract; and the Medi-Cal system was not one that intruded into a physician's medical judgment. *Id.*

70. *Id.* at 883 (relying on RESTATEMENT (SECOND) OF TORTS § 431).

ated at all. *Bush v. Dake*⁷¹ is one such case that examined this question. In *Bush*, the plaintiff alleged that her doctor's negligence in failing to take a Pap smear test delayed her detection of cervical cancer.⁷² The plaintiff claimed the HMO was liable because it provided financial incentives to the physician, including capitation, which allegedly led to her lack of treatment.⁷³ Pleading tortious interference with the patient-physician relationship as one of her causes of action, the plaintiff claimed that the whole system providing financial incentives violated public policy.⁷⁴ The HMO countered by claiming it had mandatory quality assurance programs in place to balance any incentive to undertreat.⁷⁵ Further, it asserted, the physician's awareness of the potential of a malpractice claim deterred him from underutilization.⁷⁶ Thus, any incentive was weak at best. The court stated, however, there was a material question of fact for a jury to decide.⁷⁷ Because this case was unreported and eventually settled out of court,⁷⁸ its holding has little precedential value for other courts confronting financial incentives. However, it reveals a willingness of at least one court to examine the effects of risk sharing.

Though the *Bush* court was open to the possibility that physician incentives could lead to MCO liability, most courts examining this issue decline to rule similarly for a multitude of different reasons. In *Pulvers v. Kaiser Foundation Health Plan*,⁷⁹ the court refused to find HMO liability for financial incentives, noting that the HMO Act of 1973 required its implementation.⁸⁰ Likewise, in *McClellan v. Health Maintenance Organization of Pennsylvania*,⁸¹ the court stated that any decision to forbid risk sharing was one of social policy, and thus should be made by the legislative branch.⁸² The notion that financial incentives influence physician judgment received its most skeptical treatment in *Madsen v. Park Nicollet*

71. No. 86-25767 NM-2, slip op. (Mich. Cir. Ct. - Saginaw Cty. Apr. 27, 1989) (summarized in Chittenden, *supra* note 2, at 481).

72. RODWIN, *supra* note 4, at 170.

73. Chittenden, *supra* note 2, at 481.

74. *Id.*

75. *Id.* at 482.

76. *Id.*

77. *Id.*

78. RODWIN, *supra* note 4, at 170-71.

79. 160 Cal. Rptr. 392 (Cal. Ct. App. 1979).

80. *Id.* at 394 (referring to 42 U.S.C. § 300e (1973)).

81. 604 A.2d 1053 (Pa. Super. Ct. 1992), *app. denied*, 616 A.2d 985 (Pa. 1992).

82. *Id.* at 1056 n.6.

Medical Center.⁸³ In that case, the court affirmed a ruling that barred testimony regarding the physician's incentives because of its irrelevance and potential for prejudice.⁸⁴

From these cases it appears that the bulk of the judiciary is unwilling to consider financial incentives as causative agents of adverse medical outcomes. Yet, although the plaintiffs in all of these cases questioned the effects of financial incentives, they did not attempt to establish that the risk sharing system in question was imperfect in its design, or implementation, in accordance with the framework of the *Wickline* and *Wilson* decisions. Rather, they alleged that financial incentives *per se* should result in liability. Courts might be less resistant to an argument suggesting liability due to imperfections in the design of the financial incentives. Hence, some courts might allow a jury to consider whether capitation that did not properly account for risk led to an adverse medical outcome.

Even when courts are willing to examine the adequacy of capitation rates, the plaintiff's claim might be preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").⁸⁵ For ERISA preemption to apply, the lawsuit must revolve around an ERISA regulated plan. This type of plan is defined broadly as "any plan . . . which was . . . established or maintained by an employer . . . for the purpose of providing . . . medical . . . care or benefits."⁸⁶ The scope of the preemption of claims against ERISA plans extends to any cause of action that "relates to" the employee benefit plan,⁸⁷ a phrase that the Supreme Court has interpreted expansively.⁸⁸ Hence, lower courts are reluctant to apply state remedies to cases where negligent implementation of cost containment has led to the infliction of physical harm upon enrollees.⁸⁹ When ERISA preempts a state claim, a plaintiff can only seek limited remedies, such as equitable remedies or those based on breach of fiduciary duty.⁹⁰ Because of the

83. 419 N.W.2d 511 (Minn. Ct. App. 1988), *rev'd on other grounds*, 431 N.W.2d 855 (Minn. 1988).

84. *Id.* at 515.

85. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1994)).

86. *Id.* § 1002.

87. *Id.* § 1144(a).

88. In *Shaw v. Delta Airlines*, 463 U.S. 85 (1983), the Court said that a law relates to an employee benefit plan if "it has connection with or reference to such a plan." *Id.* at 97.

89. *See, e.g., Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733 (C.D. Cal. 1989) (holding that the defendant insurers alleged negligent delay in the denial of coverage for a liver transplant, which supposedly caused the plaintiff's death, was a cause of action preempted by ERISA).

90. Chittenden, *supra* note 2, at 491 (interpreting 29 U.S.C. § 1132(a)). Although the

broad coverage of this statute, victims of an MCO's inadequate capitation rate might find that ERISA severely limits their chances of recovering damages.

IV. ASSESSING THE DEGREE OF RISK INCURRED THROUGH CAPITATION

As legislative and judicial bodies have in some instances demonstrated concern over risk sharing, they must develop a set of principles for judging whether any individual financing mechanism is inadequate. When questioning capitation rates, lawmakers can use a financial risk analysis approach to understand the determinants of risk. The logic of financial risk analysis provides some insight into the intuitive calculations of a rational physician.⁹¹ Therefore, the various influences on risk, elucidated by a financial risk analysis, should be examined in the context of an individual physician's practice. If this application of risk principles leads to the conclusion that a capitation rate is creating a loss for a physician, the MCO should be found to have created too great an incentive for substandard treatment. Legislatures should make such payment rates illegal, and courts should find that the *Wilson* substantial factor test of causation has been satisfied under these circumstances. In this way, lawmakers can align the law more appropriately with market realities.

Although presently the law does not regulate physician capitation rates, actuaries could calculate a minimum capitation rate that properly would account for the physician's risk factor by evaluating all the elements of the physician's costs and variance of costs. Such a formula could include: 1) the average cost of treating an enrollee;⁹² 2) the standard

claims under ERISA are severely limited, plaintiff attorneys are devising new ways to accord their complaints with ERISA requirements. For instance, in one case recently filed in New York, the plaintiff has claimed that Aetna's use of capitation places their own economic self-interest above the welfare of the patient in violation of the MCOs fiduciary duty to the patient. *Capitation: Aetna Sued Over Shift to Capitation Payments*, HEALTH CARE DAILY (BNA), Dec. 20, 1995, available in LEXIS, Nexis Library, BNA file (describing *Maltz v. Aetna Health Plans of N.Y., Inc.* (E.D.N.Y., filed Dec. 19, 1995)). Yet in an oral ruling, the court denied the plaintiff's request for a preliminary injunction. *Provider Compensation: Chronically Ill Patients Lose Bid to Keep Physicians Under Capitation*, HEALTH CARE DAILY (BNA), June 4, 1996, available in LEXIS, Nexis Library, BNA file. Significantly, Aetna re-evaluated its compensation package after a wave of complaints from its patients and doctors, and now it has limited physician risk through higher capitation rates and improved stop-loss coverage. Stephen Findlay, *Can Capitation Save the World?*, BUS. & HEALTH, June 1996, at 44, 50.

91. *Supra* note 27 and accompanying text.

92. *Cf.* Bruce J. Ryan & Scott B. Clay, *Funding Cash Reserves with Capitation Pay-*

deviation of these costs;⁹³ 3) the utilization rate of the enrollee population;⁹⁴ 4) the number of covered lives;⁹⁵ 5) the required profit margin;⁹⁶ 6) the expected incurred, but not reported, expenses ("IBNR");⁹⁷ and, 7) the required degree of certainty that the capitation rate will result in a positive net cash flow.⁹⁸ If a physician is working in a group practice, the

ments, HEALTHCARE FIN. MGMT., May 1995, at 22, 22 (using average patient cost as part of a statistical formula that informs a hospital under capitation if it has sufficient cash reserves to withstand random fluctuations in enrollee utilization). This cost estimate should also include indirect costs, such as replacement costs and working capital costs. Mark E. Toso & Anne Farmer, *Using Cost Accounting Data to Develop Capitation Rates*, TOPICS IN HEALTH CARE FIN., Fall 1994, at 1, 6-7.

93. Cf. Ryan & Clay, *supra* note 92, at 22 (including this figure in the formula). See also *supra* notes 29-35 and accompanying text (defining the sources of a high standard deviation of costs for a physician).

94. Cf. Ryan & Clay, *supra* note 92, at 22 (deriving this figure for its formula from demographic information). This figure also is influenced by the MCO's policies regarding "phantom" patients. Phantom patients are those who remain unassigned until they come in to see a physician. Gregory N. Herrle & William M. Pollock, *Multispecialty Medical Groups: Adapting to Capitation*, J. HEALTH CARE FIN., Spring 1995, at 37, 42. The physicians working in a plan with a significant number of phantom patients likely experience higher costs because they have fewer patients for whom they are receiving capitation without incurring costs in the performance of services.

95. Cf. Ryan & Clay, *supra* note 92, at 22 (remarking that this figure can change over the course of a contract).

96. Toso & Farmer, *supra* note 92, at 7.

97. Cf. Ryan & Clay, *supra* note 92, at 22 (remarking that a hospital's cash reserves must be able to cover these expenses). IBNR refers to the cost of care delivered by other providers for which a capitated physician is financially responsible. Borzo, *supra* note 30, at 20.

98. Cf. Ryan & Clay, *supra* note 92, at 22 (indicating that increased certainty requires increased cash reserves or increased income). Because the uncertainty associated with capitation-based cash flow drives a physician to reduce his costs, the uncertainty factor is directly correlated with the strength of a financial incentive program. Lawmakers could mandate that MCOs reduce the uncertainty associated with capitation by adjusting their capitation rates to the point that the likelihood that the physician will obtain a positive net cash flow is reasonably certain over the course of time. Once this required degree of certainty is established, each MCO would increase its capitation rate in direct proportion to the variance of costs incurred by its physicians. This system would encourage physicians to act reasonably under any capitated system. In this way, the net present values associated with a patient base would become standardized across the industry.

This approach is similar to the approach financial analysts use to determine the price they are willing to pay for a stock based on how the risk of a stock compares to the general level of risk present in the market. See BREALEY & MYERS, *supra* note 11, at 161 (describing the capital asset pricing model). The capital asset pricing model standardizes the net present value of investments throughout the industry. Just as SEC regulatory laws mandating disclosure have created the type of efficient, American markets in which the capital asset pricing model has validity, laws requiring the standardization of risk premiums would also promote efficiency. Such laws could cure present market distortions characterized by a lack of an exchange of information regarding risk between MCOs and physicians. See

minimum capitation rate should reflect the ability of the group to regulate its members' cash flow through diversification.⁹⁹ Furthermore, the probable income from risk-free financing sources must be factored into the equation before an accurate minimum capitation rate can be determined.¹⁰⁰ Once sound actuarial principles lead to the derivation of a formula, legislators should rely on it as a benchmark of the legality of a capitation system.¹⁰¹ In the absence of statutory provisions, courts and juries should place great weight on actuarial evidence of the soundness of a capitation rate in determining the likelihood that an MCO's rate was a substantial factor in its physician's malpractice.

An analysis of the physician's capitated income, however, is not sufficient *per se*. Usually capitation occurs in conjunction with many other forms of financing. In combination with other payment mechanisms, the risk imposed by capitation can be truncated significantly.¹⁰² Thus, the aggregated periodic payment rate should be used to determine the adequacy of MCO disbursements to physicians. Some of the more common reimbursement systems include: 1) bonuses;¹⁰³ 2) withholds;¹⁰⁴ 3) stop-

LEE, *supra* note 30, at 49-50 (describing how some MCOs are reluctant to share actuarial information with providers).

99. See *supra* notes 36-39 and accompanying text (describing the effects of diversification).

100. See *supra* text accompanying notes 40-41 (illustrating the advantages of risk free income).

101. Although mandating an increase of capitation rates to match the level of risk inherent in a patient base removes much of the danger of capitation disincentives from physicians, legislators should also mandate that physicians maintain capital reserves that match the level of risk inherent in their cash flows. Even if a high capitation rate compensates for a high risk level by assuring a positive cash flow over time, the physician practicing in such an environment is subject to great volatility on a month to month basis. To protect the physician and the patient under these circumstances, legislators should develop standards for mandatory, risk-based capital reserves, as suggested by the NAIC. See *supra* notes 57-58 and accompanying text (discussing recent NAIC activities).

102. See LEE, *supra* note 30, at 5 (emphasizing the need to look at payments in their totality to better understand their ramifications on physician income).

103. Bonuses are payments made to a physician at the end of a set period. RODWIN, *supra* note 4, at 140. Sometimes these payments are used as an incentive to keep referrals down and are thus tied to individual performance. *Id.* In other systems, bonuses might be distributed as a function of the MCO's overall profits, which therefore have only a diluted incentive effect. *Id.* (citation omitted).

104. Withholds are the converse of bonuses. A portion of the capitated payments is withheld until the end of a period as a reserve for referral and other expenses. Walker, *supra* note 41, at 68. The unused portion is returned to the physician. *Id.* Like bonuses, these can be based on individual performance or the performance of larger physician groups within the MCO. *Id.*

loss payments,¹⁰⁵ and, 4) carve-out fee-for-service payments.¹⁰⁶ Because these other mechanisms can alter significantly the distribution of costs facing a physician, courts and legislatures must assure that there are variables in any formula interpreting the adequacy of capitated payments that consider these other cash flows where they are used.

V. CONTROL ARISING FROM CAPITATION

MCOs that use capitation might attempt to exert direct control over physician decision-making through payment mechanisms in addition to providing physicians with an incentive to reduce costs by placing them at financial risk. MCOs realize that financial incentives are not always strong enough to lead to cost-effective physician behavior. Hence, MCOs have sought to play an even more active role in health care delivery. Although fee-for-service financing agents rarely have placed limits on the kinds of treatment-related expenditures for which they provide reimbursement,¹⁰⁷ MCOs set their capitation rates based on their own estimates of the amount of reasonable expenditures a cost-conscious physician would make.¹⁰⁸ Thus, physicians who rely on capitated pay-

105. These are payments that are triggered by excess expenditures. *RODWIN, supra* note 4, at 142. They can be based upon excess expenditures to a patient in each pay period, or on the basis of the costs of referrals. *Id.*

106. Because certain services, such as chemotherapy and neonatal intensive care, can be very expensive, physicians sometimes arrange for these to be reimbursed on a fee-for-service basis while remaining under capitation for all other services. *See, e.g.,* Stephen E. Jacobs, M.D., *Why We Love Capitation*, *MED. ECON.*, Apr. 24, 1995, at 51, 56 (describing one physician group's experiences with capitation). Certain patients could also be subject to a carve-out provision. *LEE, supra* note 30, at 16. For instance, treating diabetic patients can lead to costs for a physician that are as much as four standard deviations greater than those of an average family physician. *Page, supra* note 9, at 4. Inadequate capitated compensation for sicker diabetic patients often results in inadequate referrals and various types of harm to patients, such as blindness. *Id.* Because of the severity of financial incentives under capitation with these kinds of patients, fee-for-service better ensures the safety of these patients.

107. Typically, a fee-for-service plan reimburses members for all medically necessary services. *BERMAN & ROSE, supra* note 5, at 29. However, unnecessary services and experimental treatments are usually not covered. *Id.* at 29-30.

108. *See Walker, supra* note 41, at 64 (claiming that HMOs try to implement their goals of reducing care through their capitation rates). Utilization review is another system relied on by many MCOs to control expenditures. Robert J. Conrad, Jr. & Patrick D. Seiter, *Health Plan Liability in the Age of Managed Care*, 62 *DEF. COUNS. J.* 191, 191 (1995). Within this system, the plan looks at a request for reimbursement for services either prospectively, concurrently, or retrospectively. Based on its evaluation, it renders a decision as to whether it will reimburse the health care delivery agent for its services. *Id.* Whereas retrospective utilization review simply results in a dispute between the provider and the payor, concurrent and prospective review can result in denial of a patient's access to serv-

ments are forced to practice more cost effectively. By controlling a physician's health care related expenditures, however, the MCO restrains the physician from practicing in the same manner as he would under conditions of full autonomy.¹⁰⁹ When capitation leads to such control, the law should consider whether the MCO and the physician have *de facto* become one entity for the purposes of evaluating malpractice liability.

A. Economic Model of Control

In a market with equilibrium conditions, buyers and sellers form a consensus regarding a good.¹¹⁰ They make decisions about the good's price as well as the particular features included in the production of the good.¹¹¹ Yet transaction costs sometimes cause sellers and buyers to enter into some form of integration that alleviates some of their costs.¹¹² Once the buyer and seller enter into some form of integration, all resource allocation decisions are controlled centrally within the firm.¹¹³ When the transaction costs leading to the integration are asymmetrical, the more powerful party tends to behave opportunistically.¹¹⁴ This opportunistic behavior within the integrated unit could manifest itself in the stronger party claiming the right to control the joint resources necessarily resulting in its control over the price and the characteristics of the seller's

ices. *Id.* See also *supra* part III.B (discussing the role of utilization review in both the *Wickline* and the *Wilson* decisions).

109. Because of the importance of cost control to MCOs, they often terminate physicians from their network who fail to lower costs, even when those costs legitimately are related to the treatment of sicker patients. Julie Johnsson & Mike Mitka, *Managed Care Maelstrom: Physicians are Seeing Their Practices Dwindle When Insurers Use Economic Criteria to Bar Them from Networks*, AM. MED. NEWS, July 25, 1994, at 1, 17. This threat of termination leads many physicians to act in ways that are medically questionable. Howard Larkin, *Lurking Liabilities: Managed Care Can Add an Unforeseen Layer of Risk*, AM. MED. NEWS, June 26, 1995, at 9, 9.

110. See ROGER D. BLAIR & DAVID L. KASERMAN, *LAW AND ECONOMICS OF VERTICAL INTEGRATION AND CONTROL* 11 (1983) (indicating that individual buyers and sellers determine market supply and demand in the aggregate).

111. See *id.* (stating that market supply and demand govern resource allocation).

112. *Id.* at 12 (defining transaction costs as "any expenditure of resources associated with the use of the market in transferring a good service from one party to another"). Blair and Kaserman assert that total merger might not be necessary to achieve the benefits of integration, as many parties have found contract formation to be an easier way to accomplish the same goal of avoiding market transactions. *Id.* at 26.

113. *Id.* at 11.

114. See BLAIR & KASERMAN, *supra* note 110, at 22 (suggesting that limited number of potential contract partners could lead to an imbalance of power).

output.¹¹⁵ Although nominally the buyer and seller might remain separate firms, the relationship between them indicates that for some purposes, they should be considered one unit.

B. *Application of the Economic Model of Control to Capitation*

In an optimal health care market, an MCO and a physician will agree to a reimbursement schedule under which the physician receives market rates for the delivery of a standard set of services. Sometimes, however, the parties experience transaction costs that cause them to integrate, which results in centralized decisions regarding resource allocation. Within this integration process, the physician may have less bargaining power than the MCO, which can lead the MCO to behave opportunistically. The MCO might take advantage of its power by extracting the right to make all the decisions regarding the allocation of resources within the network.¹¹⁶ This allocation likely would entail the MCO's unilaterally setting the physician's rate of capitation, which would limit the physician's ability to consume resources in his practice.¹¹⁷ By restricting purchases of goods and services used in a physician's practice, the MCO exerts control over the range of services he can provide.¹¹⁸ Consequently, capitation results in this type of control over the physician's practice. Therefore, courts should look beyond the form of the relationship to its substance, and find that the MCO and the physician are part of the same unit.

VI. POTENTIAL LEGAL LIABILITY ARISING FROM CONTROL

Whereas improper risk sharing could lead to the MCO's direct liability

115. See *id.* at 11 (quoting Coase's economic definition of the firm as "the supersession of the price mechanism").

116. *Id.*

117. See LEE, *supra* note 30, at 51 (stating that powerful MCOs sometimes refuse to negotiate capitation contracts with providers).

118. Specialists' practices especially are affected by HMO capitation levels. They have high equipment costs, and thus an HMO with a high share of their patient base can cause specialists to forego buying or replacing equipment. See, e.g., *Managed Care . . . A View from the Inside*, *supra* note 27, at 28 (discussing one radiologist's fears about his continued ability to buy equipment needed in his practice in the face of a potential ratcheting down of his capitation level). Although primary care physicians do not rely as heavily on expensive equipment in their practices, constraints on financing can alter their decisions as well. For instance, if they are responsible for referral costs, an MCO could control the extent that they rely on specialist services by adjusting their capitation payment to meet only the referral needs that the MCO would find legitimate. Cf. *supra* note 35 and accompanying text (describing the effects on a physician's risk level of capitating him for referral services).

for inadequate medical treatment, controlling a physician's practice might lead to imposition of vicarious liability on the MCO for the physician's treatment. Under the doctrine of *respondeat superior*, the establishment of a master-servant relationship causes the master to assume liability for the servant's conduct when acting within the scope of his employment.¹¹⁹ There is no single factor that is dispositive of a master-servant relationship, but courts often place emphasis on the degree of control the alleged master exerts over the alleged servant's work.¹²⁰ Although an MCO that employs its physicians has sufficient control over them to establish an agency relationship, courts have been less consistent, however, in determining if this requisite level of control is present where the MCO has a contractual relationship with the provider.¹²¹ No court has considered the capital restraints, imposed by capitation, as the source of control over the physician's behavior in a contractual relationship between the MCO and physician; but several cases have examined the existence of a master-servant relationship between contracting parties in the managed care context with varying outcomes.¹²²

One of the first cases to examine MCO liability under the doctrine of *respondeat superior* for the negligence of a physician with whom the MCO had only contractual relations is *Schleier v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.*¹²³ In this case, Kaiser contracted with a cardiologist to examine one of its patients.¹²⁴ As a result of the physician's misdiagnosis, the patient died.¹²⁵ Despite the fact that the parties were only joined together through a contract, the court held that a master-servant relationship existed.¹²⁶ The court found that the requisite control existed based on the fact that the doctor could not act independently of the Kaiser physician who engaged his services.¹²⁷ By looking at the substance, as opposed to the mere form, of the relationship, the court established precedent for finding an MCO vicariously liable for a contracting physician where the MCO controls his conduct.

119. PROSSER & KEETON, *THE LAW OF TORTS* § 70 (5th ed. 1984).

120. Chittenden, *supra* note 2, at 454.

121. See *infra* discussion of the *Schleier*, *Dunn*, *Raglin*, *Mitts*, and *Propst* decisions and accompanying notes.

122. See *infra* discussion of the *Schleier* and *Dunn* decisions and accompanying notes.

123. 876 F.2d 174 (D.C. Cir. 1989).

124. *Id.* at 176.

125. *Id.*

126. *Id.* at 178.

127. *Id.* at 177. Other evidence of a master-servant relationship that the court relied on includes: Kaiser having selected the physician; it retaining the ability to dismiss him; and the physician and Kaiser being in the same line of business. *Id.* at 177-78.

In a similar examination of the doctrine of *respondeat superior* in the context of a contractual relationship, a New Jersey court also found liability of the defendant HMO in *Dunn v. Praiss*.¹²⁸ In this case, the court held that the HMO was liable under the doctrine of *respondeat superior* for a urological group's failure to diagnose and treat testicular cancer.¹²⁹ This liability attached to the HMO despite the fact that the urologists had only contractual relations with the entity.¹³⁰ The court found it particularly relevant that the urology clinic was paid on a capitated basis, which in some way exercised control over its physicians' practice.¹³¹ Although this court did not state the reason why it believed capitation controlled the physician's practice, its precedent makes it easier to find vicarious liability for an MCO that uses capitation to control a physician by constraining his health care expenditures.

In contrast to these precedents, other courts investigating similar relations have declined to find a master-servant relationship in similar cases. In *Raglin v. HMO Illinois Inc.*,¹³² the court refused to go beyond the form of the independent contractor relationship to investigate whether the HMO had in fact exerted sufficient control over its physicians to find vicarious liability.¹³³ In *Mitts v. H.I.P. of Greater N.Y.*,¹³⁴ the court affirmed the lower court's finding that the HMO was not involved in the delivery of health care because it was merely the financing agent.¹³⁵ Accordingly, the different lines of business of the two parties meant that there was no agency relationship.¹³⁶ Similarly, in *Propst v. Health Maintenance Plan, Inc.*,¹³⁷ the court claimed that the state's prohibition against the corporate practice of medicine meant that the HMO was not involved in health care delivery, which resulted in an absolute bar to finding HMO liability for a physician's malpractice.¹³⁸ For these courts, therefore, there are legal principles that override the weight usually accorded evidence of an MCO's control over its contracting physicians. Because legal

128. 606 A.2d 862 (N.J. Super. Ct. App. Div. 1992), *rev'd on other grounds*, 656 A.2d 413 (N.J. 1995).

129. *Id.* at 868.

130. *Id.*

131. *Id.* The court also found evidence of control in the HMO's ability to restrict referrals by the urologists. *Id.*

132. 595 N.E.2d 153 (Ill. App. Ct. 1992).

133. *Id.* at 156.

134. 478 N.Y.S.2d 910 (N.Y. App. Div. 1984).

135. *Id.* at 911.

136. *Id.*

137. 582 N.E.2d 1142 (Ohio Ct. App. 1990).

138. *Id.* at 1143.

analysis does not always correspond to economic analysis, some jurisdictions might choose to ignore the integrated nature of the payor and provider and thus decline to find *respondeat superior* liability for the MCO.

Yet even where courts are willing to prioritize the substance of an MCO/provider agreement over its form, they might find that ERISA preempts them. If the claim relates to a plan that is of the type usually regulated by ERISA, a plaintiff might find himself limited to only ERISA remedies.¹³⁹ However, claims involving vicarious liability of an MCO are related only peripherally to the insurer's role as plan administrator, and thus they are less susceptible to ERISA preemption than cases involving direct liability.¹⁴⁰ Thus, the success of a vicarious liability claim based on the MCO's control over a physician's practice through its capitation rates likely is to be determined by the legal climate of the jurisdiction in which the case is brought.

VII. ASSESSING THE DEGREE OF CONTROL EXERTED THROUGH CAPITATION

An analysis of an MCO's control over its physician's mode of practice through its capitation rates can greatly help those courts that are determined to understand the degree of payor/provider integration in assessing vicarious liability. To find control, it is first necessary to discover if the MCO set the physician's capitation rates unilaterally. Thus, whenever possible, courts should look at direct evidence indicating the MCO's role in setting the physician's capitation rates. When this evidence is either not available, or ambiguous, courts can benefit from an understanding of the economic conditions that predispose an MCO toward controlling its provider's capitation rate. Accordingly, courts should examine whether the balance of power within the MCO/physician relationship is one where there is a high probability that the MCO unilaterally set the rate.¹⁴¹ If either of these factors point to the MCO's responsibility for the physician's capitation rate, the court should then determine whether the rate set by the MCO is intrinsically fair and nonrestrictive of the physician's

139. See *supra* notes 82-87 and accompanying text (discussing ERISA's effect on claims surrounding an entity's direct liability for the administration of its plan).

140. See, e.g., *Independence HMO v. Smith*, 733 F. Supp. 983, 989 (E.D. Pa. 1990) (rejecting ERISA preemption of a malpractice claim against an IPA model HMO, which was being held vicariously liable for its participating physician's conduct); cf. *DeGenova v. Ansel*, 555 A.2d 147, 150 (Pa. Super. Ct. 1988) (overturning a lower court's ruling that a claim of vicarious liability for a group insurer was preempted by ERISA).

141. See *supra* Part V.B (asserting that a strong MCO could demand the right to set a physician's capitation rate).

practice. Where the court determines that the MCO defined its provider's practice parameters through its rate of capitation, it should deem this economic control sufficient for finding the MCO legally liable for its physician's malpractice under the doctrine of *respondeat superior*.

The clearest evidence of whether the MCO places financial restraints on its physicians comes from direct evidence that the MCO sets its capitation rates unilaterally. In some instances, there might be direct evidence that a powerful MCO refused to negotiate its capitation terms with its providers. Such evidence might include uniform capitation rates by area of practice imposed on all MCO's physicians, or a form letter sent to all physicians explaining that the capitation terms are not subject to negotiation.¹⁴² When such evidence appears, the court should presume that the capitation rate set by the MCO represents a constraint on a physician's practice-related expenditures, that also has the effect of controlling his mode of practice. It is unlikely that such evidence will be readily accessible in most cases. Thus, a court should not consider its existence dispositive of the question of an MCO's control over its physicians.

Even if there is little or no evidence regarding the party responsible for setting capitation rates within a network, courts should look further into the nature of the relationship between the MCO and the physician to infer if the MCO is likely to set the capitation rate unilaterally because of its power in the relationship. This imbalance of power most probably arises when the physician has few entities with whom he can contract.¹⁴³ To find that the balance of power sways toward the MCO, courts should thus look for two conditions: 1) whether the MCO occupies a large percentage of the physician's practice;¹⁴⁴ and, 2) whether the physician experiences barriers to selling his services to other purchasers.¹⁴⁵ Taken together, these two conditions result in a lack of access either to actual or potential payors outside of the controlling MCO. Hence, the physician in this situation depends on the MCO's capitation to remain solvent, and is likely to yield to the MCO regarding capitation rate decisions. When the practice environment fulfills both of these conditions, courts should decide that the MCO has set the physician's capitation rates. Based on this

142. See LEE, *supra* note 30, at 49 (stating that some MCOs have standard contracts in which they refuse to negotiate on a physician by physician basis).

143. BLAIR & KASERMAN, *supra* note 110, at 22.

144. Cf. PHILLIP AREEDA & LOUIS KAPLUM, *ANTITRUST ANALYSIS* 567 (discussing how the conventional approach to measuring market power is to look at the market share of a firm, in the relevant market).

145. Cf. *id.* at 21 (pointing out that monopoly power requires the reinforcement of barriers to entry).

decision, courts should presume MCO control over both the physician's health care-related expenditures and his style of practice through its rates.

Unless the MCO accounts for a significant percentage of the physician's practice, it could not possibly control the physician's income sufficiently to determine his choice of resources consumed in his practice. Until a certain point, the physician can terminate his agreement with the MCO without serious ramifications to his own financial well-being. This lack of dependence on the MCO means that he is less likely to allow the MCO to control the negotiating process. However, once the MCO becomes critical to his solvency, by occupying a large percentage of his practice, the physician is more likely to make concessions to this powerful financing agent.¹⁴⁶ Thus, an MCO's high share of a physician's practice should trigger a court's heightened scrutiny when investigating a claim of vicarious liability.

Yet even when an MCO accounts for such a large portion of a physician's practice, it cannot successfully control his consumption of resources unless the physician has no other financing options. Otherwise, the physician likely would switch to another reimbursement entity before sacrificing his autonomy. There are many reasons why a physician could lack access to other financing. For instance, the MCO might be the dominant force in the health care financing market because of its enrollment of a high percentage of the patient population.¹⁴⁷ In such a case, the provider would have no choice but to accept the MCO's agreement terms.¹⁴⁸ Conversely, the MCO would also have leverage where there are many com-

146. See Walker, *supra* note 41, at 71 (describing how one physician group that became dependent on an HMO who controlled 35% of its patient base could not quit the plan despite that it was losing money because of its declining capitation rate). See also Joseph Mack, *Managed Care Relationships from the Physician's Perspective*, TOPICS IN HEALTH CARE FIN., Winter 1993, at 38, 41 (claiming that physicians cannot easily leave an HMO that accounts for approximately 40% of their practice revenue because of their reliance on the capitation payments). Although reliance on an MCO that accounts for a large share of a physician's income could lead physicians to make increased concessions to the entity, many physicians eventually reach a point where the financial loss is better than the growing intrusion into their practice. This widely felt sentiment probably explains why the rate of physician turnover ultimately increases as a function of the HMO's share of the physician's patient base. Joseph Kerstein et al., *Primary Care Physician Turnover in HMOs*, HEALTH SERVICES RES., Apr. 1994, at 17, 35.

147. LEE, *supra* note 30, at 6.

148. LEE, *supra* note 30, at 6. Similarly, there could be a financing market with only a few insurers. In this situation, the insurers could all tacitly agree on a low capitation rate, which would also lead to a physician's restricted access to a sufficient amount of capital to run his practice in a way he considers standard. Cf. PHILLIP AREEDA & LOUIS KAPLOW,

peting providers in the physician's geographic and practice area.¹⁴⁹ If the market has experienced high HMO market penetration, the MCO could limit severely the physician's options by placing exclusionary restraints on the physician that would prohibit him from offering his services to other MCOs.¹⁵⁰ Further, a physician's reputation could be tied to the MCO's reputation that no patients with fee-for-service insurance would consider using his services.¹⁵¹ Once the court finds that an MCO exerts strength through its large share of the physician's practice, it should decide that the MCO set the physician's capitation rate unilaterally, which should lead to the presumption of MCO control over the physician's practice.

To further reinforce a presumption of control through capitation, a court may examine if the MCO has reshaped the physician's practice to help him adjust to his reduced income. For instance, the MCO might engage in such practices as: 1) training physicians on how to practice in a capitated environment;¹⁵² 2) issuing practice guidelines that help physicians stay within their budgets;¹⁵³ or, 3) making decisions as to which physicians in a network are responsible for the provision of certain services.¹⁵⁴ These measures all seek to show the physician how to prac-

ANTITRUST ANALYSIS 278 (4th ed. 1988) (describing the way an industry that has only a few firms predisposes the firms within it towards engaging in subtle price coordination).

149. Cf. Glenn A. Melnick et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217, 227 (1992) (explaining that among hospitals, excess capacity in a market has an inverse correlation with the bargaining power of any individual hospital).

150. See LEE, *supra* note 30, at 30 (noting that MCO's exclusive agreements with specialists limit their ability to negotiate higher capitation rates). Cf. Julie Johnsson, *Magic Carpet Ride? An Exclusive Provider Deal May Seem Enchanted - Until the Insurer Pulls the Rug Out*, AM. MED. NEWS, June 13, 1994, at 37, 37 (illustrating one hospital's problem of retaining control over its practice when a contracting HMO extracted an exclusionary restraint over the hospital and accounted for 65% of its patient base).

151. See, e.g., Walker, *supra* note 41, at 71 (describing how one physician practice faced difficulty rebuilding its fee-for-service practice because the community believed that it was exclusively an HMO clinic).

152. See Alan L. Hillman, M.D., M.B.A., *Cost-Containment Incentives in HMOs: What's Known, What's Not Known*, CONSULTANT, July 1989, at 84, 88 (discussing how HMOs routinely educate physicians about efficient resource utilization).

153. See Charles Culhane, *Streamlining for Managed Care*, AM. MED. NEWS, Apr. 11, 1994, at 21, 22 (remarking that MCOs often formulate guidelines for their physicians). The author further states that many physicians in managed care environments rely on these guidelines to stay within budgetary constraints. *Id.* at 21. Chittenden asserts that the controlling force of these guidelines could negate a physician's status as an independent contractor. Chittenden, *supra* note 2, at 456-57.

154. See, e.g., Findlay, *supra* note 90, at 50 (explaining that there is a trend in managed care toward expecting general practitioners to provide services for which they have inadequate training). As a result of this increased burden on primary care physicians to provide

tice medicine under his new constraints resulting from his capitation level. By using capitation as a tool to reformulate the physician's decision-making process, the MCO has, in effect, usurped a physician's role as the care provider. Accordingly, when a court finds direct or indirect evidence that the MCO has set the physician's capitation rates unilaterally, as well as evidence of these further intrusions into a physician's practice style, it should consider the presumption of control over the physician to be very strong.

After a court finds a presumption of the MCO's exercise of control over a physician's practice, the court should examine the capitation rate to determine both its fairness and the extent to which it actually limits the physician's expenditures on his practice. Even if the MCO seems to exert control over a physician by dictating his capitation rate and by making recommendations as to how to practice under capitation, substantively it may have decided on a rate that is both fair and relatively similar in amount to the payments the physician was receiving before capitation.¹⁵⁵ Thus, courts would need to determine both the fair market value of the physician's capitated services as well as the physician's traditional level of reimbursement. When these measures indicate that the MCO did not take advantage of its bargaining power in deciding the physician's capitation rate, courts should decline to find control through capitation. However, when a court lacks evidence on the fairness of the capitation rate, which would rebut the court's presumption of the MCO's control through capitation, the court should consider its presumption of control confirmed. In such cases, the court would be justified in attaching vicarious

more services, there has been a rise in the number of malpractice claims against these doctors for errors in diagnosis that could have been avoided through referrals to a specialist. Dolores Kong, *Diagnosis Lawsuits Up*, BOSTON GLOBE, Mar. 28, 1995, at 10E.

155. This analysis is similar to many corporate "duty of loyalty" statutes. Many of these statutes require examination of the process followed by a determination whether a corporate decision was made by disinterested parties. *See, e.g.*, DEL. CODE ANN. tit. 8, § 144(a)(1),(2) (1991) (demanding informed consent of a quorum of disinterested directors or shareholders to validate a contract tainted with a director's conflict of interest). Then, statutes continue on to determine if the substance of a decision was nevertheless fair, despite the role of interested parties in the decisions. *See, e.g., id.* § 144(a)(3) (allowing a transaction that was fair at the time of execution to remain valid despite not being ratified by disinterested parties). Similar to the fiduciary relationship between corporate executives and stockholders, doctors have a fiduciary relationship with their patients. Because an agency relationship with an MCO creates a conflict of interest, it places the doctor in a similar position to that of a corporate executive with conflicting goals. Just as a procedural and substantive analysis of a corporation's decision protects the corporation's stockholders, the procedural and substantive analysis suggested here protects the physician's patients.

liability to the MCO for the substandard care provided by its physician-agents.

VIII. CONCLUSION: OTHER PAYMENT POSSIBILITIES

Capitation partially solves some of the significant problems confronting today's health care industry, but its resulting interference with physician decision-making suggests that other payment mechanisms might better achieve the same goals. One method of payment that has received some acceptance recently is the resource based relative value scale ("RBRVS"). Invented by HCFA, this mechanism pays physicians a rate based on the number of relative value units earned through their services.¹⁵⁶ These units are determined by a physician's use of "physical and mental effort, technical skill, and practice experience."¹⁵⁷ Thus, more arduous tasks are rewarded with higher reimbursement. After setting this baseline rate, HCFA makes adjustments for geographic practice costs.¹⁵⁸ It then multiplies this figure with a conversion factor that turns each service into a dollar figure.¹⁵⁹ HCFA has different conversion factors for primary care, nonsurgical services, and surgical services, and it has tried to encourage evaluation and management services by shifting income from surgical services, to primary care and nonsurgical services.¹⁶⁰ This plan is also budget neutral so that overutilization one year results in a lower conversion factor the next year.¹⁶¹ In this way, HCFA has used RBRVS to contain costs while avoiding the intrusions into the medical treatment process caused by capitation.

Because of all the benefits this kind of system could offer MCOs, it merits serious consideration as a substitute for capitation. By shifting to an RBRVS system, MCOs would create a new set of incentives. Whereas capitation discourages all costly services regardless of their value to the patient,¹⁶² RBRVS's relative value units create value by rewarding a physician for hard work. Hence, by shifting reimbursement methods, MCOs

156. David Azevedo, *How Many Third Parties Will Buy Into RBRVS*, MED. ECON., July 25, 1994, at 88, 88.

157. *Id.*

158. Greg Borzo, *Medicare to Cut Payments to Physicians*, AM. MED. NEWS, Dec. 25, 1995, at 1, 19.

159. Azevedo, *supra* note 156, at 88.

160. *Id.*

161. Borzo, *supra* note 158, at 19.

162. See RODWIN, *supra* note 4, at 136 (disputing that HMOs' risk sharing creates only an incentive to eliminate wasteful services, and arguing that physicians have an incentive to cut back on *all* services).

can shift from cost based incentives to value based incentives, which probably better accord with patient expectations.¹⁶³ Just as the government makes allowances for physicians with high practice costs, MCOs can safeguard the solvency of the physician practices with whom it contracts by adjusting its relative value units to accommodate legitimately higher costs.¹⁶⁴ Without onerous restraints on a physician's access to capital, this payment system protects a physician's autonomy in his choice of practice techniques.¹⁶⁵ RBRVS conversion factors allow MCOs to prioritize primary care over specialty services by using different conversion factors for the different types of services, and thus is similar to capitation in its goal of incentivizing preventive care. MCOs can even achieve the goal of cost containment through implementing a budget-neutrality policy in their RBRVS systems.¹⁶⁶ Although some MCOs already are working with RBRVS,¹⁶⁷ many more should consider it because of its ability to create value additivity, and to protect physician autonomy without sacrificing preventive care incentives and cost containment.

Just as MCOs presently combine capitation with other payment mechanisms to increase its effectiveness, RBRVS can also achieve greater success when combined with other payment programs. Further cost reduction can be achieved by rewarding physicians who follow guidelines when a certain prognosis indicates its appropriateness.¹⁶⁸ Quality also should be prioritized; each physician should have a certain percentage of

163. It also would greatly decrease the danger of being found liable for improper risk sharing. See Part III.B (showing how a court might find liability for imperfections in the design of a risk-sharing program).

164. See PAULY ET AL., *supra* note 1, at 107 (claiming that although it is fair to penalize physicians whose practice style is especially lavish, it is inequitable to penalize a physician whose sicker patients require increased expenditures).

165. See *supra* Part VI (demonstrating that encroachment into a physician's autonomy might lead to an MCO's assumption of the physician's liability in some jurisdictions).

166. See *supra* Part I (describing capitation's role in managed care).

167. See, e.g., *Capitation: Twin Cities Market Seen Moving Away from Capitation of Health Providers*, HEALTH CARE DAILY (BNA), Dec. 4, 1995, available in LEXIS, Nexis Library, BNA file (stating that some MCOs in the Twin Cities are moving from capitation to a budget-neutral form of RBRVS).

168. See Herrle & Pollock, *supra* note 94, at 39 (asserting that making adjustments for complying with guidelines can encourage efficiency in a setting that compensates physicians based on their productivity). See also Leigh Page, *Will Too Many Mergers Stifle Competition*, AM. MED. NEWS, July 11, 1994, at 1, 7 (describing how Twin City employers have funded an institute where physicians can develop practice guidelines). By allowing physicians to develop their own guidelines, an MCO greatly could diminish the risk of exerting too much control over its physicians. See *supra* note 153 and accompanying text (suggesting that guidelines might be problematic if imposed upon providers by an MCO).

his pay connected to a measurement of the quality of his outcomes.¹⁶⁹ Through the combination of these techniques, utilization management and quality health care can be achieved without the dangers of improper risk shifting and intrusion into physician autonomy brought about by capitation. Without these dangers, MCOs can be more certain that they will not be exposed to liability for physician treatment decisions.

169. *Cf., e.g.*, Cleveland Health Quality Choice, Summary Report, Dec. 7, 1994, at 2-3 (describing how the quality of treatment at each Cleveland hospital is evaluated periodically by a neutral organization that uses outcome measurements, patient surveys, and severity adjustments in its assessments). Outcome measurements can also be used in connection with capitation, but only a few plans have, as yet, implemented such a program. Findlay, *supra* note 90, at 51.

