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IS ETHICS FOR SALE? ... JUGGLING LAW AND ETHICS IN MANAGED CARE

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I. INTRODUCTION

The need for fundamental changes within the healthcare arena has long been recognized and accepted. However, the debate as to the role that managed care should play in determining patient treatment and the interplay between ethics, law and the managed care of patients, remains the subject of persistent and intense debate. Corporate business practices, including cost-containment, are antithetical to the traditional medical ethics that are the framework of the medical profession, and the ever-encroaching corporate culture is on a dangerous collision course with both medical ethics and the legal tenets that have offered it support.

This Note will address the various facets of medical and legal ethics in the courts and health care system. It will be divided into three major sections. Sections II will provide a brief overview of the basic principles of medical ethics and their common applications in the managed care setting. Attention will be given to an overview of relevant, ethical guidelines that are instructive in the context of managed care decision-making. These sections will also identify and analyze ethical issues raised by key court cases, outline collaborative and practical attempts to improve fairness in coverage decisions within managed care as a starting point for discussions on ethics in managed care, and will discuss the issue of resource allocation and ethics in managed care including ideas and principles identified in the newly released 2004 Institute of Medicine report, *Insuring America's Health: Principles and Recommendations*. Section III will also evaluate professional obligations, recent problems based on the complex relationship of medical directors to contract law, and the application of various codes of ethics to these circumstances to illustrate intersection between medical ethics and legal ethics in managed care. Specifically, the section will provide a brief overview of the traditional obligations inherent in the physician-patient relationship, examine the interplay between contract law and ethics, and evaluate the concept of the Plan as a contract. Attention will then turn to an overview of the conflict between the physician's fiduciary duty to the patient, and his/her fiscal responsibility to the managed care organization (MCO), particularly the

physician's professional obligations and contractual responsibilities within the managed care environment. This section will conclude with a brief discussion of the efforts by organized medicine to meet the challenges of the physician's competing obligations both within the boundaries of the managed care contract and within the ethical framework of the medical profession. Section IV will evaluate regulatory oversight and investigation within the managed care environment, in addition to exploring the standard and scope of review of medical licensing boards. By analyzing standards of professional conduct, this section will provide additional insight into the thorny issue of medical ethics in the regulatory arena and legal ethics in the managed care organization.

II. ETHICS, BIOETHICS, AND APPLIED ETHICS

The advent of managed care is commonly portrayed as improperly supplanting the principle that physicians consider the interests of individual patients above all else to a perfectly functional and consistent 2,000 year-old Hippocratic ethic. Since the time of Plato it has been recognized that physicians oftentimes face intractable situations of dual loyalties and competing obligations.¹ Physicians' obligations toward public health may be the best-recognized example.² In this respect, managed reintroduces to physicians an ancient ethical dilemma -- how to serve as trusted intermediaries between ill individuals and our communities while sharing limited health care resources.

¹ Plato bluntly recognized this balancing act when he wrote that physicians were "statesmen" who were to do what "is best for the patients *and* for the state." The original 1847 Code of Medical Ethics of the American Medical Association also noted that a physician's skills "are qualities which he holds in trust for the general good," and one of its three chapters -- entitled, "Of the Duties of the Profession to the Public, and of the Obligations of the Public to the Profession" -- dealt explicitly with physicians' social duties. More recently, Cruess and Cruess note that during the 19th century, "legal measures for the first time granted medicine a broad monopoly over health care -- along with both individual and collective autonomy -- with the clear understanding that in return medicine would concern itself with the health problems of the society it served and would place the welfare of society above its own." See generally RL Cruess and SR Cruess, Teaching medicine as a profession in the service of healing, 72(11) ACAD MED. 941-52 (Nov. 1997).

² M.G. Bloche, *Clinical loyalties and the social purposes of medicine*, 281 JAMA 268-74 (1999).

A. The Origin of Ethics and Medical Professionalism

Until the creation of the American Medical Association's Code of Medical Ethics in 1847, there was no consistent ethical construct in which to place the obligations of "medical professionals" or, for that matter, any other professionals.³ The Code of Ethics contained, for the first time, a set of specific and widely recognized expectations that applied to every American physician. Unlike the Hippocratic Oath that represents a personal promise, the Code of Ethics was collective and did not rely on appeals to personal virtue or to a deity.⁴ Instead, it accepted and even promoted the idea that a claim of "professionalism" entails a special social role governed by an explicit social contract.⁵ It was only after the creation of this Code, that social scientists could, and did, begin to explore the meaning and role of medical professionals in society.

In the early part of the 20th century, medical professionalism was understood according to the structuralist-functionalist school of Talcott Parsons and his students.⁶ This approach listed distinctive characteristics of professions and sought to delineate socially desirable rationales for each characteristic.⁷ For example, medical professionals tend to take obligations of confidentiality very seriously because this allows individuals to disclose sensitive information, such as data about infectious disease exposures, which might prove useful in halting the spread of disease. Another example is the value professionals place on cooperation rather than competition since this trait speeds dissemination of new and useful knowledge. When questioned as to why physicians might not follow self-interest to maximize profits, Parsons postulated that physicians did follow selfish interests, but fortunately for society, their self-interests lie not in making money but in improving status amongst peers.⁸

The structuralist-functionalist conception of the professions came under attack from academic sociologists, such as Elliott Friedson and Paul Starr, in the 1960s. These so-called "critical power theorists" suspected that professionals were not as altruistic as had been claimed

³ See generally ROBERT B. BAKER ET AL., *THE AMERICAN MEDICAL ETHICS REVOLUTION: HOW THE AMA'S CODE OF ETHICS HAS TRANSFORMED PHYSICIANS' RELATIONSHIPS TO PATIENTS, PROFESSIONALS, AND SOCIETY* (Johns Hopkins Univ. Press 1999) (A major theme is the novelty of the AMA Code for its time).

⁴ *Id.*

⁵ *Id.*

⁶ Talcott Parsons, *The professions and social structure*, 17 *SOC. FORCES* 457, 457-67 (1939).

⁷ *Id.*

⁸ *Id.*

and they collected data that, at least partially, supported this assertion.⁹ These critics starkly challenged physicians' ethics, claiming that medical ethics were largely a cynical ploy to profit from monopoly power in the market.¹⁰ While some of these sociologists, most notably Friedson, subsequently asserted the value of medical professionalism, such as self-regulation and the norms created through codes of ethics,¹¹ their fundamental criticism remains powerful, widely held, and underlies landmark legal actions against physicians under antitrust statutes.¹²

But, the criticism that medical professionals are not civic-minded did not arise in a vacuum. As medicine perceived the possibility of government interventions in medical care in 1912, medical ethics increasingly stressed professional autonomy and de-emphasized social obligations.¹³ This trend was strengthened by events during World War II, as well-known horrors became strongly associated with physicians acting as agents of the state.¹⁴ Add to this an underlying American predilection towards individual rights and it is not surprising that, by 1955, the AMA's Code proclaimed that it was ethically imperative that a "physician... be free to choose whom to serve and the environment in which to practice."¹⁵ Indeed, many medical ethicists urged physicians to completely ignore civic considerations and consider only the welfare of the individual patient before them. In 1984, Norman Levinsky wrote, "...physicians are required to do everything that they believe may benefit each patient,

⁹ See generally PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (Basic Books 1982) (documenting this assertion regarding altruism was a broad theme of the book).

¹⁰ *Id.*

¹¹ ELIOT FRIEDSON, PROFESSIONALISM REBORN: THEORY, PROPHECY AND POLICY 184-198 (University of Chicago Press 1994) (See Chapter 11: The Centrality of Professionalism to Health Care).

¹² RICHARD CURREY, MEDICINE FOR SALE 32-43 (Grand Rounds Press 1992).

¹³ William Sage, *Physicians as advocates*, 35 HOUS. L. REV. 1529, 1529-1630 (1999).

¹⁴ See Edzard Ernst, *Killing in the Name of Healing: The Active Role of the German Medical Profession During the Third Reich*, 100 Am. J. Med. 579, 579-80 (1996); see also United States Holocaust Memorial Museum, *Deadly Medicine: Creating the Master Race*, available at <http://www.ushmm.org/museum/exhibit/online/deadlymedicine/> (last accessed August 1, 2005).

¹⁵ AMA Code of Medical Ethics §5 (1955), Principle of Medical Ethics, available at http://www.ama-assn.org/ama/upload/mm/369/1957_principles.pdf (last visited Aug. 1, 2005).

without regard to costs or other societal considerations.”¹⁶ These trends illustrate the loss of a cardinal role of physicians as professionals in mediating private and community interests.¹⁷

Originally, medicine was granted professional independence largely based on its promise to carefully protect the health of patients and the public. But by the 1960’s, physicians came to rely almost solely on their claims of technical expertise to justify professional independence because of a societal tilt towards individual autonomy.¹⁸ However, while technical skill and knowledge are crucial to medical care, they are not sufficient to justify monopoly power, self-regulation, and the other social privileges granted to the medical profession. As Wynia and Gostin note, since the 1950’s medicine has become “bereft of its role as a social protector, ... left with only technical expertise to support its claims to professional prerogatives that are granted by society and which have since steadily eroded.”¹⁹ Indeed, recent scholars of the medical profession suggest that a civic understanding of professionalism is necessary to maintain public trust as well as professional privileges.²⁰ The turn away from civil obligations may have led to the birth of bioethics, which was largely founded to enhance individual rights often against paternalistic physicians.

B. The Emergence of Bioethics

The field of ethical inquiry that forms the foundation for the subject of bioethics is rooted in philosophy, law, medicine, and other humanities such as sociology, psychology, and anthropology. Ethics is defined as the philosophical study of moral values and rules in society to discern morality and acceptable conduct.²¹ However, as technology surpassed

¹⁶ Norman G. Levinsky, *The doctor’s master*, 311 NEW ENG. J. MED. 1573, 1573-1575 (1984).

¹⁷ M.G. Bloche, *Clinical loyalties and the social purposes of medicine*, 28 JAMA 268, 268-74 (1999); Matthew K. Wynia, et al., *Medical professionalism in society*, 341 NEW ENG. J. MED. 1612, 1612-1616 (1999).

¹⁸ See David M. Mirvis, *Physicians’ Autonomy - The Relation Between Public and Professional Expectations*, 328 NEW ENG. J. MED. 1346 (1993).

¹⁹ Matthew Wynia and Lawrence Gostin, *Ethical challenges in preparing for bioterrorism: the role of the health care system*, 94 AM J PUBLIC HEALTH 1096, 1096-1102 (2004); William M. Sullivan, *What is left of professionalism after managed care?* 29 HASTINGS CENTER REP. 7, 7-13 (1999); and Mark Schlesinger, *A loss of faith: the sources of reduced political legitimacy for the American medical profession*, 80 MILBANK Q. 185, 185-235 (2000).

²⁰ Herbert M. Swick, *Toward a normative definition of medical professionalism*, 75 ACAD. MED. 612, 612-616 (2000); Stephen R. Latham, *Medical professionalism: a Parsonian view*, 96 MOUNT SINAI J. MED. 363, 363-369 (2002).

²¹ See generally, ALBERT R. JONSEN, *A SHORT HISTORY OF MEDICAL ETHICS* (2000).

the social, political, and ethical parameters of human understanding, a new field of academic discourse was required that encompassed all facets of the changing face of medicine. This field became bioethics, the study of value judgments pertaining to human conduct in the area of biology and those related to the practice of medicine and medical research.²² Bioethics emerged as a discipline in the early 1970s, but is believed to date to the Hippocratic Oath and its admonition to “do no harm.”²³

Applied ethics became normative theory and practice as bioethics evolved and became more broadly applied in medicine, law, and philosophy. In its basic form, applied ethics seeks to create case studies, models, or examples that can address or provide a procedural framework for addressing ethical dilemmas and questions.²⁴ The simplest version of applied ethics involves patient care decisions that present a conflict of values between decision-makers. This can occur where an elderly patient has a living will stating she wishes to be sustained on life support indefinitely regardless of her negative prognosis or financial stability, and the health care team disagrees. The common solution to this ethical dilemma is to assemble a health care ethics team to consult and advise on the best course of action. A mediated, consensus-building response between competing ethical values represents the core of applied ethics.

C. The Principles of Biomedical Ethics

Tom Beauchamp and James Childress, in their *Principles of Medical Ethics*,²⁵ derive a set of prescriptive standards that legal and medical professionals may look to for guidance. They identified the principles of autonomy,²⁶ beneficence,²⁷ nonmaleficence,²⁸ and justice, which are

²² See generally A.R. Jonsen, *The Birth of Bioethics*, 23(6) HASTINGS CENTER REPORT S1-4 (1993).

²³ See *Hippocratic Oath*, in 1 OXFORD COMPANION TO MED. 545 (Paul B. Beeson et al. eds., 1986).

²⁴ TL BEAUCHAMP AND JF CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 4 (3d ed. Oxford University Press 1989).

²⁵ *Id.*

²⁶ *Id.* at 121 (Autonomy is generally defined as personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding. In this sense, consent is derivative from fundamental notions of autonomy).

²⁷ *Id.* at 259. (Principles of beneficence demand positive steps to help others to prevent and remove harm, including positive beneficence and assigning utility and value. Rules of beneficence include: 1) protecting and defending the rights of others, 2) preventing harm from occurring to others, 3) removing conditions that will cause harm to others, 4) helping persons with disabilities, 5) rescuing persons in danger).

relevant to the managed care context. In various practical situations, one or all of these principles must be weighed against the other, resulting in a determination based on the balancing of often competing factors. For instance, justice as a principle requires the equitable and fair distribution of goods and services, especially medical services and goods. The ethical principle of justice is achieved through the virtues of treating similar individuals similarly. Justice, for Beauchamp and Childress, is not simply individual justice but social justice that can be divided into three, neither exclusive nor inclusive, levels: national, institutional, and individual.²⁹

D. Bioethics in Practice: Resource Allocation

Concern about the distribution and allocation of scarce medical resources is a natural outgrowth of the four basic principles of bioethics. Despite the constant advent of new technologies and medical procedures, there are simply not enough health care dollars to provide every procedure and technology for every person who may medically require them.

Economic models explain scarcity as a function of needs, demands, and available supply.³⁰ In a free market economy, the balance between scarcity of goods and the supply ideally should fall at zero, thus the demands for goods or services equals the corresponding available supply.³¹ When one function is greater than the other, scarcity is said to exist for either the supply or demand.³² Usually, if demand is lower, it may be driven by a combination of marketing practices or tactics designed to encourage consumption.³³ However, when the scarcity involves the supply of goods or services, it becomes more difficult to create a zero balance by marketing and regulatory mechanisms and/or governmental intervention may instead be required.³⁴

Because the United States' health care system is based on privatization and free market enterprise for the delivery and

²⁸ *Id.* at 189 (The principle of nonmaleficence asserts an obligation not to inflict harm intentionally, such as a duty of care, and may be divisible into four general obligations: 1) not inflicting evil or harm, 2) prevention of evil or harm, 3) removal of evil or harm, 4) doing or promoting good).

²⁹ See Beauchamp, *supra* note 24, at 189.

³⁰ See generally, LES SELPHAKI, ECONOMIC SCARCITY AND HEALTHCARE QUALITY: TRADEOFFS IN DELINEATION AND DEMARCATION (1997).

³¹ See *id.*

³² See *id.*

³³ See *id.*

³⁴ See *id.*

consumption of health care, it should not be surprising that there will inevitably come a point where the demand for health care services simply outweighs the supply of available health care finances (i.e., the total pool of revenue available to pay for all health care services, procedures, or technologies).

E. Ethics of Managed Care

Corruption and impropriety are common criticisms of the third-party payor system, particularly in the managed care sector. Various arguments allege that the underlying economic concept of managed care provides incentives to withhold care or provide suboptimal care resulting in inured benefits to the provider of increased reimbursements or bonuses. This skepticism, coupled with the rise in medical malpractice litigation, provides fertile ground for various legal challenges and arguments, culminating in a legacy of countervailing policy debates and efforts to reform the health care reimbursement system. Typical MCO efforts to influence the cost-benefit calculus of health plans include the practice of attempting to curtail the cost of medical treatment by offering providers financial incentives to limit costly procedures. However, even more troubling than shortcomings in health care reimbursement is the financial collapse of managed care companies and health insurance systems due to large jury verdicts or non-profitability, leaving more individuals with the dilemma of being uninsured. Not only do individuals find it difficult to obtain health insurance coverage due to costs, but many MCOs are reluctant to embrace Medicaid program enrollees.

In *Rush v. Moran*, the United States Supreme Court held that health plan benefit decisions are not preempted by the Employee Retirement Income Security Act (ERISA).³⁵ At issue in this case was whether an independent medical review was required where a primary care physician disagreed with the MCO's determination that requested treatment was not "medically necessary."³⁶ In ruling against ERISA preemption, the Court stated that the Illinois Health Maintenance Act was a law directed specifically toward the insurance industry.³⁷ This determination was significant because not only did it allow Illinois to retain its ability to regulate managed care entities within its border, but it also allowed the state to use its statute to force managed care health plans to accept an independent second opinion before refusing coverage for certain medical and surgical treatments under ERISA.

³⁵ *Rush v. Moran*, 536 U.S. 355 (7th Cir. 2002).

³⁶ *Id.* at 359-61.

³⁷ *See Id.*

Unfortunately, despite the passage of two years, reliance on the principles of medical ethics and the fundamental obligations of medicine are relegated to secondary status.

The court's decision was also speculated to directly impact the future viability of current state laws drafted to assist physicians in their interface with defiant MCOs. Provisions that attempt to prevent physicians from providing medically necessary treatments to their patients, such as those provided under ERISA preemption, often force physicians to behave unethically. In a report in the *Journal of the American Medical Association (JAMA)*, a random national survey of practicing physicians found that more than 39 percent of physicians polled stated that within the last year they had exaggerated the severity of patients' conditions, adjusted a patient's billing diagnosis, or fabricated patient symptoms in order to secure coverage for a desired treatment.³⁸

F. Principles of Medical Ethics

As exemplified in the Hippocratic Oath, the foundation of medicine rests with the historical notions of the physician as healer.³⁹ This code has been integrated in contemporary form as the American Medical Association's Code of Medical Ethics.⁴⁰ However, the commonly understood goal of medicine, healing and improved health for the patient, often conflicts with managed care's cost containment principles. Therefore, the AMA Council on Ethical and Judicial Affairs (CEJA) sets out various ethical guidelines and opinions within in the context of managed care regarding restrictions on disclosure in managed care contracts and financial incentives in the practice of medicine, with particular emphasis on appropriate patient care not cost-containment.⁴¹ Physicians assume ethical obligations in their care of patients that should supercede financial, personal, or institutional motivations.⁴² The treating physician serves as both a steward and fiduciary for the patient, which often oppose his responsibility to the

³⁸ See Matthew K. Wynia, et al. *Physician Manipulation of Reimbursement Rules for Patients*. 283 J. AM. MED. ASS'N 1858 (2000).

³⁹ See LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH: TEXT, TRANSLATION, AND INTERPRETATION* (1943).

⁴⁰ See *The American Medical Association Code of Ethics 1847, adopted from THOMAS PERCIVAL, MEDICAL ETHICS, OR A CODE OF INSTITUTES AND PRECEPTS, ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS* (1803).

⁴¹ See AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, *CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS* 157 (2001) [hereinafter CEJA 2001] (Council opinions related to managed care).

⁴² See *id.*

community.⁴³ This complex relationship frequently produces conflict and requires further discussion.

1. Fiduciary vs. Stewardship Obligations

A historical background is necessary to provide the context within which to evaluate the ethical obligations of physicians as professionals within a managed care organization (MCO). Physicians are said to serve as quasi-fiduciaries for their patients.⁴⁴ As such, they are ethically, and sometimes legally, obliged to put the interests of patients above most personal interests, since they serve an important role as patient advocates.⁴⁵ This advocacy role becomes especially important when patients are either not able, or not in a position, to advocate for themselves due to illness, impoverishment, or social status. Yet physicians are also stewards of shared resources and protectors of the public's health. While this tension has long existed between individual and group responsibilities, managed care has brought it into sharp relief through the use of strong financial incentives to physicians that serve as more conservative stewards. For example, managed care policies aimed at discouraging physicians from informing patients about services not covered, known as "gag clauses," were strongly opposed by physicians and patients who believed it unethical and contrary to a physician's fiduciary role withhold information from patients.⁴⁶ Similarly, early capitation payment schemes were criticized for providing too great a financial incentive for physicians to skimp on care.⁴⁷

2. Consumerism vs. Limits of Contractual Justice

Consumerism is another important theme in managed care. Consumerism asserts that "the possession and use of an increasing number and variety of goods and services is the principal cultural aspiration and the surest perceived route to personal happiness, social

⁴³ See generally Edmund D. Pellegrino, *Societal Duty and Moral Complicity: The Physician's Dilemma of Divided Loyalty*, 16 INT'L J.L. & PSYCHIATRY 371 (1993).

⁴⁴ Marc Rodwin helpfully notes that while physicians often espouse a "fiduciary ethic," they are not often held to legal fiduciary standards, especially regarding the proscription of most financial conflicts of interest. Hence, the use of the term "quasi-fiduciary." See MARC RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* (Oxford University Press 1993).

⁴⁵ See *id.*

⁴⁶ See David S. Kaplan, *Managed care: Gag clauses and doctor-patient communication: State responses*, 25(2-3) J Law Med Ethics 213-18 (1997).

⁴⁷ See Matthew K. Wynia, *The Oregon Capitation Initiative: Lessons and Warnings, from the Forefront of the Backlash*, 276 JAMA 1441, 1441-1444 (1996).

status and national success.”⁴⁸ As consumers demand more services, healthcare cost rises exponentially. This leads to the formulation of cost containment measures to offset these costs. Although these cost-containment measures are enacted to protect the financial health of managed care entities, they can have the unfortunate effect of restricting needed healthcare services and creating claims for contract violation.⁴⁹

In an idealized market-based and consumer-driven health care system, MCO enrollees are viewed as rational economic actors capable of making reasonable choices regarding health insurance coverage and living with their consequences. To foster rational choice, enrollees are given information about prices and quality. Unfortunately the results are not always ideal because most people do not use this information; are not given meaningful choices between various health plan offerings; have difficulty anticipating their medical needs; or simply cannot afford to purchase health insurance in the first place. Partly for these reasons, many physicians find it appropriate to treat those in their care as vulnerable patients rather than informed healthcare consumers. Problems arise, however, when a patient's health plan does not cover a service that a physician believes her patient needs. If health insurance is perceived as a normal good in a typical market, a consumer who purchases an insurance contract that does not cover a service must live or die with this decision, literally and figuratively, regardless of its importance to her well being. To draw a corollary to the automobile insurance industry, no automobile insurer would cover the costs of replacing a car in a liability-only policy simply because a person desperately needs transportation. Physicians, however, are uncomfortable dispensing, or enforcing, such harsh contractual justice in medical care. Thus, some physicians report manipulating reimbursement rules for patients rather than telling them they cannot have, or must pay out of pocket for, medically necessary but uncovered medical services.⁵⁰ In a national survey of physicians, 31 percent

⁴⁸ See ALAN THIEN DURNING, HOW MUCH IS ENOUGH? THE CONSUMER SOCIETY AND THE FUTURE OF THE EARTH 34 (1992) (quoting British economist Paul Ekins, *The Sustainable Consumer Society: A Contradiction in Terms?*, INTERNATIONAL ENVIRONMENTAL AFFAIRS, Fall 1991).

⁴⁹ See Harold S. Luft, *Why Are Physicians So Upset About Managed Care?*, 24 J. POL., POL'Y & L. 957, 962-63 (1999); see also Joseph B. Treaster, *Aetna Agreement with Doctors Envisions Altered Managed Care*, N.Y. TIMES, May 23, 2003, at A1.

⁵⁰ See generally, Matthew Wynia, et al., *Physician Manipulation of Reimbursement Rules for Patients: Between A Rock and A Hard Place*, 283 JAMA 1858, 1858-1865 (2000); see also Matthew Wynia, et al., *Do Physicians Not Offer Useful Services Because of Coverage Restrictions?* 22 Health Affairs 190 (2003); see also Matthew

reported having sometimes not offered their patients useful services because of perceived coverage restrictions.⁵¹ Of these physicians, 35 percent reported taking this approach more frequently in 1998-99 than they had in the past, which suggests a rising trend.⁵² Though physicians have an ethical obligation to discuss all medically appropriate services with patients, empirical data demonstrates that coverage restrictions in health plans may make such discussions difficult.⁵³

Therefore, it is imperative that the relationship between physicians, patients, and the managed care organization is clearly identified and explored. The nature and extent of such relationships may be material in drafting comprehensive contracts, agreements, and in controversies concerning remuneration for managed care services.

G. The Intersection of Ethics and Managed Care

Within the context of managed care, the concepts of informed consent and financial conflicts of interest fall within the purview of medical ethics.

1. Informed Consent

The doctrine of informed consent is recognized in legal and medical traditions as “every human being of adult years and sound mind [having] the right to determine what shall be done with his own body.”⁵⁴ This doctrine has been expanded to include a duty of due care to inform the patient of both material and relevant information, especially information that pertains to risks that are explicit or inherent in the proposed therapy.⁵⁵ By emphasizing patient rights, informed consent litigation transformed the existing profession-based standard into a patient-based standard, and finders of fact were asked to

Wynia, *When the quantity of mercy is strained: US physicians' deception of insurers for patients*, in MALINGERING AND ILLNESS DECEPTION (Halligan et al. eds., Oxford Univ. Press 2003).

⁵¹ Wynia Health Affairs, *supra* note 50.

⁵² *Id.* at 194.

⁵³ *Id.*

⁵⁴ See *Schloendorff v. New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (Ct. App. 1914).

⁵⁵ See *Informed Consent*, available at <http://www.ama-assn.org/ama/pub/category/4608.html> (last visited Feb. 2, 2005).

determine whether a patient was adequately informed about matters relating to her healthcare choice.⁵⁶ As one court recognized:

[T]rue consent ... is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each...[thus] springs the need, and in turn the requirement, of a reasonable divulgence by [a] physician to [a] patient to make such a decision possible.⁵⁷

Managed care creates conflict within informed consent because the financial priorities of a managed care organization and/or treating physician may shadow, infringe, or unduly influence the patient's "informed decision."

2. Financial Conflicts of Interest

Financial incentives are generally classified as tools, techniques, or mechanisms used by physicians or group practices to manage and/or control healthcare costs. These incentives may include items such as shared risk pools, where the insurance company or provider sets the amount or limit they will pay per patient pool and a patient's care is derived from that general risk pool, or capitation plans, where the insurance company or provider sets a fixed amount per patient per year and any medical treatment costs above or below that amount are either liabilities or assets for the physician/provider.

Practicing medicine involves accepting the rule that "a patient's reliance upon the physician ... traditionally has exacted obligations beyond those associated with arms length transactions."⁵⁸ Physicians have both an ethical and a legal responsibility to satisfy the patient's vital need for information regarding her therapy.⁵⁹ However, managed care operates by focusing on the bottom line, a business plan that contradicts the fundamental nature of informed consent and patient care.

In 1998, a New England Journal of Medicine study found that nearly 40 percent of primary care physicians affiliated with managed care organizations in urban California were aware of financial

⁵⁶ See Michelle Mello, et al., *The Rise of Litigation in Human Subjects Research*, 139 ANN. INTERN. MED. 40 (2003) (citing TROYEN BRENNAN, JUST DOCTORING: MEDICAL ETHICS IN THE LIBERAL STATE (1991)).

⁵⁷ *Canterbury v. Spence*, 464 F.2d 772, 780 (1972).

⁵⁸ See *Canterbury*, 464 F. 2d at 782.

⁵⁹ See CEJA 2001, *supra* note 41, at 165 (ethical obligation of informed consent); see also *Canterbury*, 464 F.2d at 782 (holding a legal obligation imposed upon physicians for informed consent).

incentives.⁶⁰ Furthermore, approximately “half [of] these physicians indicated that such incentives depended on their performance in retraining the use of referrals or hospital services.”⁶¹ “Empirical data or survey data raise concerns regarding the extent to which financial incentives appear to influence physicians’ experiences of undesirable pressure in their practices.”⁶² The suggestion is that bonuses based on limiting referrals or increased patient “productivity heighten[s] physicians’ ‘performance anxiety’ and their perception that care may be compromised.”⁶³ Since financial schemes can compromise medical ethics, the American Medical Association’s policy-making bodies and processes have issued guidance on the topic of physician ethics and financial incentives. AMA CEJA Opinion 8.054 specifically comments that physicians “should evaluate the financial incentives associated with participation in health plans before contracting with that plan.”⁶⁴ Although a plan’s incentives may range from monetary payments to flat bonuses paid to physicians, ethical concerns are raised where a physician may be motivated to withhold care for covered services in order to retain that windfall.

Pursuant to various state statutory schemes, most states now impose upon HMOs an ethical duty to disclose financial incentive schemes that may impair patient care or treatment decisions.⁶⁵ Although it is generally difficult to plead breach of fiduciary duty for adverse benefits decisions,⁶⁶ some courts recognize that a plaintiff may state a cause of action, under ERISA, against an HMO that fails to disclose physician incentives schemes.⁶⁷ Specifically, the Eighth Circuit in *Shea v. Esensten* noted that “ERISA should not be construed to permit the fiduciary to circumvent [its] ERISA-imposed fiduciary duty in this manner.”⁶⁸ The court found that a physician’s financial

⁶⁰ See Kevin Grumbach, et al., *Primary Care Physicians’ Experience of Financial Incentives in Managed-Care Systems*, 339 NEW. ENG. J. MED. 1516 (1998).

⁶¹ *Id.* at 1520

⁶² *Id.*

⁶³ *Id.*

⁶⁴ See CEJA 2001, *supra* note 41, at 157.

⁶⁵ See, e.g., Illinois Managed Care Act, 215 ILL. COMP. STAT. § 134/15(b) (1999). (currently, 42 states have passed some form of legislation involving HMO or managed care regulations).

⁶⁶ See, e.g., *Neades v. Portes*, 193 Ill. 2d 433, 445, 739 N.E.2d 496, 503 (2000).

⁶⁷ See *Shea v. Esensten*, 107 F.3d 625, 628 (8th Cir. 1997) (holding that if a fiduciary alleges that an ERISA violation caused a former employee to lose plan participant status, then standing is established to challenge that fiduciary violation).

⁶⁸ *Id.* at 628 (noting that in this case, but for the health plan’s failure to disclose the physician’s financial interest in discouraging specialty referrals, the plaintiff’s husband would be alive and a plan participant).

arrangement is material information on which a patient relies, and the patient must be able to know if her physician's advice is influenced by self-serving considerations created by the health insurance provider.⁶⁹ Thus, a claim for breach of ERISA fiduciary duty exists when a health plan fails to disclose all material facts affecting a beneficiary's health care interests, including payment incentives.⁷⁰

H. Utilization Review and Medical Necessity

As part of cost-containment techniques, only those procedures that meet contractual definitions of "medical necessity" will be covered in managed care. Legal challenges involving questions of medical necessity typically require a clearly demarcated distinction between ERISA preempted claims and traditional state law claims of medical malpractice.⁷¹

In *Pegram v. Herdrich*, Pegram appealed a 7th Circuit decision that found Herdrich's argument that the HMO and its physician violated their ERISA-imposed fiduciary duty by delaying her medical treatment in order to increase their incentive bonuses to be without merit.⁷² Cynthia Herdrich presented to her physician, Dr. Lori Pegram, for evaluation of sharp left groin pain. Physical examination revealed a swollen mass, but Dr. Pegram declined to order an ultrasound since the nearest hospital where this diagnostic study could be done was not within the HMO network. Herdrich subsequently suffered a ruptured appendix with attendant bowel infection.⁷³ In finding for the HMO, the Court rejected the assertion that an HMO structure that provided an inherent financial incentive to limit patient care breached the plan's fiduciary duty to its beneficiaries.⁷⁴ The Supreme Court identified three categories of managed care decisions: 1) pure eligibility;⁷⁵ 2)

⁶⁹ *See id.*

⁷⁰ *Id.* at 629 ("we believe Mrs. Shea has stated a claim against Medica for breaching the fiduciary obligation to disclose all the material facts affecting her husband's health care interests. When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties").

⁷¹ *See, e.g.,* *Cicio v. Does*, 321 F.3d 83, 99, 2003 U.S. App LEXIS 2925 (2d Cir. 2003).

⁷² *See Pegram v. Hedrich*, 120 S. Ct. 2143 (2000).

⁷³ *Id.* at 2145.

⁷⁴ *Id.* at 2158.

⁷⁵ Pure eligibility decisions are conditions directly covered by the plan that are clearly subject to ERISA preemption. *Id.* at 2154-55.

medical treatment decisions;⁷⁶ and 3) mixed eligibility and treatment decisions.⁷⁷ The Court was unwilling to allow ERISA to apply to a suit involving mixed eligibility and treatment decisions since such suits had existing applicable remedies in state court.

The decision in *Cicio v. Vytra Healthcare* follows the same logic. Here, the plaintiff's ERISA claims were joined with allegations of negligent medical decision-making.⁷⁸ The plaintiff argued that her medical malpractice claims were not preempted by ERISA because they concerned "mixed eligibility and treatment decisions," as described in *Pegram*.⁷⁹ The Second Circuit agreed that the plaintiff's claim was not preempted by ERISA, reasoning that the plaintiff had "alleged that the defendants made a decision that could implicate a state law duty concerning the quality of medical decision-making, in addition to and independent of her claims concerning the administration of benefits with respect to her late husband's course of care."⁸⁰

Applying the ethical considerations of justice, fairness, and beneficence to the utilization review process will yield optimal benefit ratios and marginal cost for the patient, provider, and insurer. However, HMOs make mixed eligibility and treatment decisions that are often based on biased opinions. These decisions favor the health plan with cost-benefits displaced toward cost-containment and upholding broad-scale utilitarianism and operational effectiveness of the plan, i.e. providing less comprehensive and sophisticated plans for more people, to the detriment of individual patient autonomy, fairness, and individual choice. An awareness of the contributing factors to litigation (including, denial of services, delay in approving services and failure to refer emergency cases outside of health plan network) of adverse managed care decisions is both prudent and necessary. In a mixed eligibility and treatment decision, focus should be directed to the ethical component of "quality of care,"⁸¹ not "quantity of care."⁸² This

⁷⁶ Medical treatment decisions involve diagnosing the patient's condition and deciding on management, subject to state malpractice theories. *Id.*

⁷⁷ Mixed eligibility and treatment decisions occur when coverage and medical judgment determinations are intertwined and may be subject to either state law or ERISA preemption. *Id.*

⁷⁸ See *Cicio*, 321 F.3d 83.

⁷⁹ *Id.* at 101 (citing *Pegram*, 120 S. Ct. 2154, 530 U.S. 229).

⁸⁰ *Id.* at 91-92.

⁸¹ Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. *Crossing the Quality Chasm: The IOM Health Care Quality Initiative*, available at <http://www.iom.edu/focuson.asp?id=8089> (last visited Aug. 1, 2005).

shifts attention away from issues of physician/practitioner negligence and avoids the problem of ERISA preemption. To help illustrate this distinction, consider the claim that health plans commit negligence by instituting financial incentives that induce medical malpractice by plaintiff's health care providers. Many MCOs offer bonuses to physicians in order to encourage efficiency through use of "utilization management" guidelines, which aim at keeping use of health care services by both physicians and patients within prescribed parameters. Although treatment decisions involve medical decisions by physicians, directing our attention to just the medical profession ignores the role of the health care company in managed care.

1. Safe Medical Care and ERISA

Courts recognize the ethical and legal dilemmas when physicians make mixed treatment and health insurance eligibility decisions. One specific area of overlap between ethical and legal dilemmas exists in certain emergency situations.⁸³

In *Pappas v. Asbel II*, the court reconsidered its earlier decision in light of the US Supreme Court decision of *Pegram v. Herdrich*. The plaintiff-patient ("Pappas") was admitted to a Pennsylvania community hospital emergency room at 11 am complaining of paralysis and numbness in his extremities.⁸⁴ The emergency room physician concluded that the plaintiff was suffering from an epidural abscess on the spinal column, a condition that constituted a neurological emergency.⁸⁵ The emergency room physician immediately made arrangements for transfer to a university hospital, but when the ambulance arrived at 12:40 pm the physician received notice that the health insurance company was denying authorization for treatment at Jefferson University Hospital.⁸⁶ The health insurance company then notified the physician that Pappas could be transferred to three other university hospitals.⁸⁷ But by the time the physician contacted Medical College of Pennsylvania, a hospital that agreed to accept transfer of the

⁸² See *Dukes v. U.S. Healthcare*, 57 F.3d 350, 355 (3rd Cir. 1995) (Federal courts have consistently used a "quantity" versus "quality" analysis to determine if a claim is completely preempted by ERISA; quantity of care diverts the focus from a patient-centered context to a contractual and legally defined one, thus implicating health insurance implementation and administration as areas preempted by ERISA).

⁸³ See *Pappas v. Asbel*, 564 Pa. 407, 419 (Penn. 2001).

⁸⁴ *Id.* at 410.

⁸⁵ See *id.*

⁸⁶ *Id.* at 410-11.

⁸⁷ *Id.* at 411.

patient, three hours had passed.⁸⁸ Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.⁸⁹ Plaintiff Pappas sued the community hospital and his primary care physician alleging medical malpractice and hospital negligence in causing an “inordinate delay in transferring him to a facility equipped and immediately available to handle the emergency.”⁹⁰ The community hospital subsequently filed a third-party complaint against the health insurance company, joining it as a defendant for its refusal to authorize the transfer of Pappas to the hospital selected by the emergency room physician. In addition, the primary care physician filed a cross-claim against the health insurance company for contribution and indemnity.

The issue before the Court in *Pappas II* was whether ERISA preempted the state law claim of medical malpractice. The Court, looking to *Pegram*, noted that the Supreme Court set forth two guiding principles for ERISA preemption in state law medical malpractice cases.⁹¹ The first is that HMO physicians occupy dual roles: they act like plan administrators when determining if a patient’s condition is covered, and like health care providers when deciding upon the medical treatment a participant will receive.⁹² Second, HMO physicians make three types of decisions: pure eligibility, treatment decisions, and mixed eligibility and treatment decisions.⁹³ The Court noted that negligence claims are not governed by ERISA provisions when a “defendant’s allegedly dilatory delivery of contractually-guaranteed medical benefits were intertwined with the question of safe medical care” because “Congress did not intend to preempt State law aimed at regulating health care.”⁹⁴ Here, the emergency room physician immediately determined an appropriate transfer facility, but the HMO did not approve. The emergency room physician then telephoned the HMO for reconsideration and emphasized that this was a neurological emergency that required immediate attention, but still the referral was denied. Although the health insurance company attempted to classify this as a “quintessential coverage decision,”⁹⁵ the Court held that the case involved a mixed eligibility and treatment

⁸⁸ See *id.*

⁸⁹ *Pappas*, 564 Pa. at 411.

⁹⁰ *Id.* at 411.

⁹¹ *Id.* at 415.

⁹² See *id.* (citing *Pegram*, 120 S. Ct. at 2153-54).

⁹³ *Id.* at 413.

⁹⁴ *Pappas*, 564 Pa. at 415.

⁹⁵ *Id.* at 419.

decision, which, under Pegram, may be properly redressed through state medical malpractice law.⁹⁶

2. Medical Necessity as Preempted by ERISA

In contrast to *Pappas*, in *Calad v. Cigna Healthcare* a Texas Court concluded that an HMO's strict adherence to existing medical necessity criteria was a consideration completely preempted by ERISA, despite injury to the patient/insured member.⁹⁷ In *Calad*, patients brought state claims against their HMO under the Texas Health Care Liability Act (THCLA), which allowed patients to sue their health plans if the patient was injured because a plan denied coverage for medical care. Calad had been informed during pre-authorization and coverage procedures that CIGNA only authorized one day of hospitalization following her scheduled hysterectomy surgery. On the second day following surgery, Calad's treating physician was told to discharge her if she did not have hemorrhaging, fever, or high blood pressure; she could only extend her stay if she assumed the cost.⁹⁸ Unable to incur the personal expense of a longer hospital stay, Calad went home on the second day post surgery.⁹⁹ She alleged that Cigna HMO "failed to use ordinary care in influencing, controlling, participating, and making medically necessary decisions which affected the quality of the diagnosis, care, and treatment provided to plaintiffs."¹⁰⁰ Plaintiffs specifically alleged that defendants had a calculated scheme to increase profits by adversely affecting medical care for patients through HMO medical necessity decision-making, thereby wrongfully interfering with the recommendations of plaintiffs' treating physicians.¹⁰¹

The *Calad* Court recognized that medical necessity and utilization review serve as the crossover between pure coverage claims and state law quality of care claims.¹⁰² At issue was whether ERISA preemption applied when a plaintiff sues her HMO, not the ERISA plan itself, and when the utilization review function is performed by HMO personnel rather than a third party entity. Calad brought a cause of action solely under the THCLA, expressly denying recovery of benefits under her ERISA plan. The Court held that Plaintiff Calad made a

⁹⁶ *Id.* at 419-20.

⁹⁷ *Calad v. Cigna Healthcare*, 2001 U.S. Dist. LEXIS 8538 at *19 (N.D. Tex. 2001) (holding that plaintiff's challenge to quantity of care received as a result of utilization review was completely preempted by ERISA).

⁹⁸ *See id.* at *10.

⁹⁹ *See id.*

¹⁰⁰ *Id.* at *3.

¹⁰¹ *See id.*

¹⁰² *Calad*, 2001 U.S. Dist. LEXIS 8538 at *8.

quality of care claim against her HMO, which is completely preempted by ERISA.¹⁰³ The Fifth Circuit employed a two-step ERISA analysis, “considering first whether a claim is subject to ordinary preemption,” and “then whether the claim falls within the” civil enforcement mechanisms for denial of benefits and coverage determination decisions.¹⁰⁴ As with several other jurisdictions, “claims challenging health care treatment decisions or the quality of care fall within the realm of [state law] negligence and medical malpractice.”¹⁰⁵ Relying on *Pegram*, plaintiff attempted to argue that Cigna’s determination was a “mixed medical decision” beyond the purview of ERISA preemption. However, the Court held that “*Pegram* does not require that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment.”¹⁰⁶

I. Physician Actions: Malpractice or ERISA Preemption

As the above cases demonstrate, ERISA preemption and federal law is invoked when alleging negligent adherence to “medically necessary” criteria or improper utilization review. However, if an issue of malpractice exists, courts should examine the ethical duties of physicians in the delivery of the quality and/or type of care for that patient. For example, the facts in *Pappas* indicate that the emergency room physician acted within prescribed ethical guidelines.¹⁰⁷ The physician made an appropriate medical assessment of the emergency medical condition, initiated and completed a transfer to a specialty hospital, and further advocated on behalf of the patient when the health insurance company denied transfer to that particular hospital.¹⁰⁸ It is, however, somewhat incongruous when a physician’s ethical obligations to advocate and provide the best care and options for the patient translates into spending hours convincing managed care to effect a transfer, particularly when time is of the essence.

In contrast, *Calad* represents a failed attempt to directly sue an HMO for administrative and utilization review pursuant to a Texas law permitting negligence and quality of care suits against HMOs. Here, the treating physician was subject to an HMO administrative determination that found Calad ineligible for additional hospital inpatient stay based on her medical condition and criteria. Although

¹⁰³ *Id.* at *9.

¹⁰⁴ *Id.* at *8.

¹⁰⁵ *Id.* at *9.

¹⁰⁶ *Id.* at *14.

¹⁰⁷ *Pappas*, 564 Pa. at 410-11.

¹⁰⁸ *See id.*

forcing a patient to leave a hospital within one day of fairly invasive surgery appears indicative of negligence and poor quality of care, the Court in *Calad* clearly demarcated that most, if not all, treatment review, eligibility, and utilization review activities remained within the purview of ERISA preemption.¹⁰⁹ Therefore, despite a physician's duties and ethical obligations to the patient, which may include extending that patient's hospital stay, the physician is still subject to the rigorous scrutiny of utilization review and managed care limitations.¹¹⁰

J. Illustrative Cases

By analyzing each of the above legal issues within an ethical framework, various strategies and practical frameworks emerge that may be useful for a wide array of individuals.¹¹¹ Two recent United States Supreme Court cases illustrate how the above legal issues in managed care are infused with ethical themes and frequently become factors in benefit determination decisions.

1. Rush Prudential HMO v. Moran

The U.S. Supreme Court held that ERISA does not preempt provisions of the Illinois HMO Act, and that a health plan's failure to provide independent medical review (availability for a non-plan health care provider to review the determination of medically necessary care) is a justiciable cause of action.¹¹² In *Rush Prudential HMO v. Moran*, the beneficiary-insured sought a physician-recommended surgical that was materially different from the surgical procedure that her HMO would cover as medically necessary.¹¹³ This difference of opinion suggests that the common ethical approach of balancing the patient's autonomy, quality of life predictors, outcomes, and transparency of the process, may have produced materially different outcomes. One of the goals of ethics in practice is to benchmark or determine ideal outcomes for the patient and the physician based on a theoretically mutual collaboration in the decision-making process. Thus, in *Moran*, perhaps direct

¹⁰⁹ *Calad*, 2001 U.S. Dist. LEXIS 8538 at *21.

¹¹⁰ *Pappas*, 564 Pa. at 418-20.

¹¹¹ As a general matter, the intersection of managed care, medical ethics, and legal ethics is relevant to practicing attorneys, litigators, in-house counsel, policy analysts, political decision-makers, and health insurance providers. Each stakeholder must be aware and accountable for his or her actions and justifications. Such obligations are grounded in ethical principles, as well as increasing legal liability circumstances.

¹¹² See *Rush*, 536 U.S. 355 (2002). (For a more detailed discussion on the intricate legal and health law issues involved with the *Moran* case, see other sections of this chapter.)

¹¹³ *Id.* at 360-61.

communication between the health insurance plan and the patient, clearly articulated educational materials, or discussions between plaintiff and her physician to discuss prognosis and treatments, may have avoided protracted litigation.

2. **Black and Decker Disability Plan v. Nord**

In *Black and Decker Disability Plan v. Nord*, the Supreme Court analyzed another ethical theory -- whether physicians should provide continuity of care.¹¹⁴ In *Nord*, the Court held that the treating physician rule (a professional deference to the physician who first treats the patient) is inapplicable to ERISA determinations for disability benefits.¹¹⁵ Under ERISA, the employers design the plan, the employees accept the plan, and a contractual situation is formed. The Court held that the treating physician rule, which provided professional deference to the medical opinion of the first physician to treat a patient, would be difficult to administer due to the variability and diversity of judicial interpretation of each case and is therefore inapplicable to ERISA disability benefits determinations.¹¹⁶ In contrast, the treating physician rule is applicable under the Social Security plan because it is a national, federal-funded benefits plan adjudicated by an administrative law judge (ALJ) that requires uniformity. It is appropriate because ALJs can interpret it in a consistent manner subject to specific guidelines and not to the variabilities inherent in differing federal jurisdictions that hear potential ERISA claims.¹¹⁷

The *Nord* case exemplifies the tension between traditional notions of medical ethics, deference to the physician's decisions regarding diagnosis and management, and the integration of medical practice into legal interpretations of benefit determinations. As a practical ethical value in all benefit or managed care situations, it may be appropriate for courts to adopt policy positions based on generalized and consistent administrability to comport with notions of fairness and justice. This may result in greater uniformity and predictability in court decisions.

K. **Fairness in Coverage Decisions**

¹¹⁴ See generally *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003).

¹¹⁵ *Id.* at 828-31 (holding that no heightened evidentiary standard exists and that the proper guidance is to follow interpretation of the terms of the plan or contract language. A distinction was thus made between Social Security determinations that "give more weight to medical opinions from treating sources.").

¹¹⁶ *Id.* at 831.

¹¹⁷ See *id.*

The complexities of managed care litigation involve, *inter alia*, interpretation of plan language and the dichotomy between benefit determination decisions and medical necessity. Education and elucidation of these distinctions must continue to occur within the legal environment. Improving or establishing a sense of fairness in coverage decisions is a lofty goal for many stakeholders in the managed care system. One collaborative group comprised of health care executives, physicians, nurses, and insurance companies,¹¹⁸ has developed a comprehensive framework that highlights and builds upon the ethical principles of fairness, justice, and beneficence.¹¹⁹ The group has identified five content areas¹²⁰ for designing and administering health care benefits, and recommend the process be: participatory, compassionate, equitable and consistent, sensitive to value, and transparent.¹²¹ Such an ethical approach, when applied to a factual situation such as that in *Moran*, might produce a materially different outcome since attention might have been devoted to discussing the procedures covered and the treatment decision with the patient, rather than utilizing a formalistic and mechanic appeals process. In any event, as managed care litigation continues to develop, it is worth acknowledging that a consensus of key participants suggests that a systems-approach to recognizing common criticisms and concerns that integrates the expectations of all stakeholders may yield a more legitimate health care financing system with an increased perception of fairness.

The intersection between managed care, medical ethics, and the law is established by a myriad of competing, yet important, factors. When dealing with the managed care environment, it is important to realize that medical ethics, physician ethics, and the health care system must be unified in all evolving discussions.

III. PROFESSIONAL OBLIGATIONS: THE INTERSECTION BETWEEN MEDICAL ETHICS AND LEGAL ETHICS IN MANAGED CARE

¹¹⁸ AMA Institute for Ethics, Ethical Force Program™, at <http://www.ama-assn.org/ama/pub/category/3592.htm> (restricted to AMA members).

¹¹⁹ *Id.*

¹²⁰ These content areas were developed after an extensive review of literature, various meetings and intricate ranking and voting procedures. See Matthew Wynia et al., *Improving Fairness in Coverage Decisions: Performance Expectations for Quality Improvement*, 4(3) AM. J. BIOETHICS 87 (2004).

¹²¹ *Id.*

The word “ethics” derives from the Greek word “ethos,” meaning character.¹²² The Hippocratic Oath embraces this “ethos,” and establishes a number of fundamental principles that form the skeleton of the medical profession which remain true in contemporary society.¹²³ Unfortunately, the advent of managed care organizations and their burgeoning growth has eroded the cloistered relationship traditionally enjoyed between patients and physicians and has shaken the very foundation of this Oath. The relationship is no longer restricted to the patient and the physician, it has now been enlarged to embrace administrators and operators of these health plans.

A. American Medical Association (AMA) Code of Medical Ethics

The medical profession prides itself on adhering to the highest standards of professional conduct. Recently, however, its ethics have been scrutinized as physicians in increasing numbers have moved from being self-employed to being employees of managed health care entities. This disconcerting alliance between physicians and managed care organizations has raised various ethical concerns and has forced the AMA to revise its code of medical ethics. Within the code, the Council on Ethical and Judicial Affairs (CEJA), the body that interprets and references the principles, has outlined seven aspirational principles and ninety-one “Opinions.”¹²⁴ Although only 28% of physicians in the United States are members of the American Medical Association (AMA), every physician is subject to its code of ethics.¹²⁵ The AMA, through CEJA, mandates that the physician’s ethical duty should not be influenced by his place of employment.¹²⁶ CEJA Opinion 5.01 notes,

¹²² 2 ARISTOTLE, NICOMACHEAN ETHICS 1103a15-b25 (Martin Ostwald trans., 1962).

¹²³ Judith Areen et al., *Hippocratic Oath*, LAW, SCIENCE AND MEDICINE 273 (1984) (“I will keep them from harm and injustice”).

¹²⁴ AMA Principles of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs (1989) *reprinted in* Codes of Professional Responsibility 189-221 (R. Gorlin 2d ed. 1990).

¹²⁵ Stokely Baksh, *AMA gets facelift to attract new members*, (Jun. 22, 2005) available at <http://www.washingtontimes.com/upi/20050616-033709-7222r.htm> (last visited August 1, 2005) (quoting AMA executive vice president and chief executive officer, Dr. Michael D. Maves, “AMA membership has been declining since the 1960s”); see generally AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 2004-2005 EDITION (AMA Press 2004) [hereinafter CEJA 2005].

¹²⁶ See AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 129 (AMA Press 1996) [hereinafter CEJA 1996].

“Physicians practicing in prepaid plans or managed care organizations are subject to the same ethical principles as are other physicians.”¹²⁷ According to these overriding principles, the interests of the patient supercede those of the physician.¹²⁸ Still, managed care entities generally expect physicians to have dual, but competing, loyalties to the patient and to the MCO. This dual role creates conflict-ridden tension between the physician and the patient that further erodes the patient-physician relationship and may negatively impact treatment/benefit decisions.

This expansion of financial incentives within the managed care industry also motivated the AMA Council on Ethical and Judicial Affairs to issue Opinion 8.13 in 1996.¹²⁹ This declared financial incentives to be ethically permissible “only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.”¹³⁰ The AMA stressed the importance of full disclosure of financial incentives to potential enrollees not just before enrollment in a MCO, but also every year post-enrollment.¹³¹ Additionally, CEJA underscored the importance of limiting the scope of financial incentives and aligning the economic consequences of these incentives with the practice patterns of large physician groups rather than with individual physicians because individual physician treatment decisions may not be sufficient to delineate patterns of care.¹³²

B. American College of Physicians (ACP) Ethics Manual

Prior to the advent of managed care organizations, individual physicians not only made diagnostic and therapeutic decisions, but also assumed responsibility for those decisions. However, with the proliferation of managed care entities, that traditional relationship between physician and patient now occurs within parameters established by MCO administrative brokers.¹³³

One of the policies of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) is to promote

¹²⁷ *See id.*

¹²⁸ *See id.* at 105 (“Under no circumstances may physicians place their own financial interests above the welfare of their patients.”); *see also id.* at 126 (In a managed care system, “physicians must continue to place the interests of their patients first.”).

¹²⁹ CEJA 1996, *supra* note 127, at 72.

¹³⁰ *See id.*

¹³¹ *See id.*

¹³² *See id.* at 128.

¹³³ *See generally* Clifton B. Perry, *Conflicts of Interest and the Physician's Duty to Inform*. 96(4) AM. J. of MED. 375 (1994); *see generally* SM Wolf, *Health Care Reform and the Future of Physician Ethics*. Hastings Center Report 26-41 (1994).

high ethical standards for physicians and managed care organizations. Accordingly, the ACP-ASIM developed its Ethics Manual to encourage physicians to promote their patients' welfare and make the physician-patient relationship central to patient care.¹³⁴ Mirroring the AMA's Code of Medical Ethics, the ACP-ASIM's Ethics Manual encourages resisting the temptation to base medical treatment on financial incentives rather than medical merit and scientific evidence.¹³⁵

The Ethics Manual specifically intended to facilitate the process of making ethical decisions in clinical practice and medical research. It explains how medicine must take a proactive approach to regulate physicians because the ethics and positive duties established by law oftentimes lags behind professional ethics.¹³⁶ In its most recent fourth edition, the Ethics Manual includes a specific section entitled "The Ethics of Practice" and discusses pertinent managed care topics, including the changing practice environment, financial arrangements, financial conflicts of interest, and advertising.¹³⁷ In addition, the Manual directs physicians to promote their patients' welfare by managing conflicts of interest and ensuring stewardship of health care resources so that finite resources can meet as many health care needs as possible.¹³⁸ It emphasizes that the "patient-physician relationship and [its] governing principles should be central to the delivery of care...physicians must not allow financial considerations to affect their clinical judgment or counseling, including referrals for the patient."¹³⁹ This discussion is striking because the ethical guidance is recommended while recognizing that a patient's preferences or interests may conflict with the motivations of the physician, institution, payor, or other member of a managed care plan. The physician must also contribute to the responsible stewardship of health care resources by disclosing any conflicts of interest and providing all necessary information and counsel for patients regarding treatment options and referrals. And finally, the Manual encourages physicians to be conscious of all potential influences and to guide actions by appropriate utilization while promoting the provision of services to uninsured and underinsured patients.¹⁴⁰

¹³⁴ See *American College of Physicians Ethics Manual*, 3rd ed., 117 ANN. INT. MED. 947 (1992).

¹³⁵ See generally *id.*

¹³⁶ See *id.*

¹³⁷ *Id.* at 587-87.

¹³⁸ *Id.* at 586.

¹³⁹ *Id.*

¹⁴⁰ See generally *American College of Physicians Ethical Manual*, *supra* note 134.

C. The Physician and the Managed Care Contract

Due to considerable structural and content changes in the health care financing and delivery system, the relationship between physicians and managed care organizations is in a state of constant flux. In fact, courts must now become “increasingly aware of complex economic arrangements in order to discern the nature of the organization and to frame the relevance of the pending legal issues.”¹⁴¹ The following is a brief discussion of the conflicts, challenges, and liabilities for physicians within the managed care environment. Particularly interesting is the observation regarding heightened judicial attention to scrutinizing and interpreting managed care contracts – adding a further complexity to identifying clear boundaries of physicians’ ethical and professional obligations.

1. Conflict and the Contract

A contract denotes a meeting of minds, as commonly referred to the phrase “manifestation of mutual assent.”¹⁴² But as an increasing numbers of conflicts arise within the managed care setting, traditional contract principles are ignored while resolution is sought in the courts. The relationship between physician credentialing, exclusive physician contracts, and professional competence has long been a subject of health care and managed care litigation.¹⁴³ For example, physicians are sometimes forced to litigate against their health plans when they believe their ethical duty to their patients is seriously compromised by contractual provisions.

In *Grossman v. Columbine Medical Group*, a physician challenged a service agreement contract drafted by a health insurer and the medical group with which he was affiliated.¹⁴⁴ Grossman alleged

¹⁴¹ See E.H. Morreim, *Confusion in the Courts: Managed Care Financial Structures and Their Impact on Medical Care*, 35 TORT & INS. L.J. 699 (2000) (citing Petrovich v. Share Health Plan of IL, 719 N.E.2d 756, 763 (1999)).

¹⁴² See Restatement of Contracts, 2d, § 20 (Requirement of manifestation of mutual assent).

¹⁴³ For a general overview, see John D. Blum, *The Evolution of Physician Credentialing in Managed Care Contracting*, 22 AM. J. LAW AND MED. 173 (1996) (detailing the evolution and practical implications on the hospital credentialing process and exclusive physician contracts with managed care plans designed to create arrangements with particular physician networks. Also noting the growing body of case law on exclusive physician contracts and the issue of medical staff privileges and professional competence).

¹⁴⁴ See *Grossman v. Columbine Medical Group*, 12 P.3d 269, 273 (Colo.App. 1999).

that the “termination without cause provision in the physician service contract was void as against public policy due to its negative impact on the physician-patient relationship and disruption of the continuity of patient care.”¹⁴⁵ Although recognizing the importance of maintaining stability in physician-patient relationships, the Court held that the clause cannot be against public policy because the Colorado legislature permits termination clauses in contracts between physicians and health care providers.¹⁴⁶ The *Grossman* Court focused on the fact that the termination clause expressly sets forth the right of both parties to terminate the contract at-will; therefore the physician service agreement was valid.¹⁴⁷

Despite the result, this decision raises an interesting issue as to the ethical obligations of physicians: Are physician-employees, subject to service or payment contracts, obligated to accept terms as written regardless of the negative implications on patient care?¹⁴⁸ Future challenges by physicians to the language contained in managed care contracts will likely offer additional insight into the scope and implications of competing ethical obligations.

3. Physicians May Challenge Managed Care for Malpractice Issues

Physicians are also willing to sue health insurance providers when malpractice claims arise, as seen in *Pappas*.¹⁴⁹ The AMA and state medical associations have challenged the Aetna/U.S. Healthcare physician contract for lack of transparency. The challenge was based on grounds that it gives the company unilateral authority to change material terms of the contract and to make determinations of medical necessity.¹⁵⁰ The AMA perceives physicians’ bargaining power as restricted and some of their contracts as being akin to adhesion

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ The dissent in *Grossman* demarcates that “the termination without cause provision significantly impacts detrimentally on the integrity, stability, and maintenance of the patient-physician relationship...[and] the provision is clearly outweighed by the public policy of the state to protect that relationship.” *Grossman*, 12 P.3d at 273.

¹⁴⁹ *Pappas*, 564 Pa. at 419.

¹⁵⁰ See Anthony L. DeWitt, *HMOs Won't Look Twice At AMA's Model Agreement* (Apr. 1998), available at http://www.managedcaremag.com/archives/9804/9804.ama_contract.shtml (last visited Aug. 1, 2005).

contracts.¹⁵¹ Its model agreement is therefore meant to reduce inequalities in bargaining power and includes model language for addressing legitimate physician concerns in several areas, including autonomy and patient rights. It provides a measure of standardization, defines commonly used contracting terms, and, most importantly, the model restricts interference with the delivery of care by the physicians.¹⁵² Aetna's contract and others of a similar nature led to the birth of the AMA's Model Managed Care Medical Services Agreement and other that strives to enhance fairness for physicians contracting with MCOs.¹⁵³

4. MCO Liability Under Negligence Theories

Although contract law does not require the parties to behave altruistically toward each other, physicians by their very nature are altruistic beings.¹⁵⁴ While their contractual relationships and duty to provide a reasonable standard of care have traditionally made them fiduciaries, in its purest sense, *Pegram* reveals that the role of the physician as a fiduciary has been replaced by the managed care entity.¹⁵⁵ Within the confines of the MCO, the principle of freedom of contract is inapplicable to the physician-patient relationship, primarily because the superior bargaining power of the MCO creates an adhesion contract.¹⁵⁶ Therefore a MCO that contracts with a physician to

¹⁵¹ See BLACK'S LAW DICTIONARY 342 (8th ed. 2004). (Adhesion contract is a contract balanced in favor of one party over the other that one can assume it was not entered into on equal bargaining grounds. Adhesion contracts are usually formed when one person is in a superior bargaining position and pressures the other party into a contract with unfair or oppressive terms).

¹⁵² See DeWitt, *supra* note 151 ("Noninterference with Medical Care: Nothing in this Agreement is intended to create ... any right of Company or any other Payor to intervene in any manner in the methods or means by which Medical Services Entity renders health care services ... to Enrollees. Nothing herein shall be construed to require Medical Services Entity to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Enrollees").

¹⁵³ American Medical Association, Model Managed Care Agreement (1997) (availability online restricted to AMA members).

¹⁵⁴ See Frank H. Easterbrook and Daniel R. Fischel, Contract and Fiduciary Duty, 36 (1) J.L. & ECON. 425, 427 (1993); see also *Pegram v. Hedrich*, 120 S. Ct. 2143, 2158 (2000) (determining that HMO physicians are not fiduciaries to beneficiaries).

¹⁵⁵ *Pegram*, 120 S. Ct. at 2158.

¹⁵⁶ See BLACK'S LAW DICTIONARY, *supra* note 153 (The term 'contract of adhesion' signifies a standardized contract, which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere

provide medical care at a discounted rate can be held liable for the negligent acts of that physician since the physician is in such a weakened contractual position that his acts are essentially vicariously those of the MCO.

In *Sloan v. Metropolitan Health Council*,¹⁵⁷ a staff model MCO was found to be liable for a physician's negligent failure to diagnose under the doctrine of *respondeat superior*.¹⁵⁸ In reversing the trial court's granting of summary judgment in favor of the MCO, the appellate court noted that enrollees in the HMO paid a monthly charge in return for specifically enumerated medical services.¹⁵⁹ The court further noted that the treating physicians contracted with the MCO under an "employment contract," received annual salaries, and were barred from working for another employer without consent of the HMO.¹⁶⁰ Under the provisions of the physician's employment contract, final authority for all medical policy matters was assigned to the medical director whose decision prevailed over the treating physicians in the event of a dispute between both parties.¹⁶¹ Reasoning that an HMO was vicariously liable if the plaintiff could establish negligence on the part of its employees in the performance of their duties under control of the HMO, the court determined that the HMO was vicariously liable for its physicians' malpractice.¹⁶²

Similarly, *Jones v. Chicago HMO Ltd of Illinois*¹⁶³ underscores the preceding ethical-legal discourse and makes more transparent the radically foreign position in which physicians find themselves in the managed healthcare setting. Here, a three-month-old child presented with constipation and fever.¹⁶⁴ She was taken by her mother, Sheila Jones, for evaluation by a physician employed by the Chicago HMO Ltd. of Illinois (hereinafter Chicago HMO), with whom she was a member.¹⁶⁵ The child's assigned physician was unavailable and an

to the contract or reject it; adhesion contracts are legally enforceable. It is a standardized contract drafted by the party of superior bargaining strength that relegates to the weaker party only the opportunity to adhere to the contract or reject it; these contracts have been denounced by the AMA); see also American Medical Association Model Managed Care Medical Services Agreement (2000).

¹⁵⁷ *Sloan v. Metropolitan Health Council*, 516 N.E.2d 1104 (Ind. Ct. App. 1987).

¹⁵⁸ *Id.* at 1109.

¹⁵⁹ *Id.* at 1105.

¹⁶⁰ *See id.*

¹⁶¹ *See id.*

¹⁶² *See Sloan*, 516 N.E.2d at 1108.

¹⁶³ *See Jones v. Chicago HMO Ltd. of Illinois*, 730 N.E.2d 1119 (Ill. 2000).

¹⁶⁴ *Id.* at 1123.

¹⁶⁵ *See id.*

assistant advised the mother to administer castor oil to the child.¹⁶⁶ Later that evening Jones spoke with the plan physician who recommended no change in treatment.¹⁶⁷ When the infant's condition failed to improve, the mother took her to the hospital where she was subsequently diagnosed as having bacterial meningitis, from which she suffered permanent brain damage.¹⁶⁸

The paramount issue revolved around the point at which a MCO should accept liability under the doctrine of institutional negligence. Rather than relying solely on ethical principles such as justice, autonomy and beneficence, physicians contracting with MCO must blend these ethical principles with legal safeguards and use them to advocate on behalf of patients. In *Jones*, the court held that an HMO could be held liable under the doctrine of direct corporate negligence, also known as institutional negligence.¹⁶⁹

The *Jones* case provides a striking example of the scope and broad judicial application of the principle of institutional negligence in managed care. The Court found the plaintiff had properly alleged a cause of action against the HMO by focusing on the administrative and managerial activities of Chicago HMO versus the professional conduct or activities of the individual physician.¹⁷⁰ Dr. Jordan, the primary care physician, had between 2,500 to 5,000 patients and an average capitation rate of \$34.19 per patient per month regardless of services he rendered.¹⁷¹ The Court bifurcated the dual ethical-legal issue presented into two separate issues: a) patient load and b) appointment procedures.¹⁷² This distinction is important for managed care litigation and ethics in that both aspects of patient clinical care were scrutinized by the Court. In *Jones*, the physician breached his professional obligation by taking responsibility for an excessive number of Medicaid patients in violation of established customary guidelines. Additionally, the defendant physician's failure to schedule an immediate appointment to see the sick infant or instruct the parent to obtain immediate medical care elsewhere was both a deviation from the standard of care as well as unethical.

¹⁶⁶ *See id.*

¹⁶⁷ *See id.*

¹⁶⁸ *See Jones*, 730 N.E.2d at 1123.

¹⁶⁹ *See id.*

¹⁷⁰ *Id* at 1132.

¹⁷¹ *Id* at 1123.

¹⁷² *Id.*

D. The Plan as a Contract

The basic tenets of general contract law apply to the covered benefits available to plan enrollees, although plan contracts are heuristic at best. By offering a set of benefits and a list of excluded services, the MCO seeks to limit its exposed risks and to curtail costs. It is well settled that experimental or investigational services are universally excluded by health plans, a fact that usually angers the public. However, the so-called medically unnecessary or inappropriately provided services often provoke much conflict and debate.¹⁷³ As noted previously, when disputes arise regarding covered benefits, ERISA review standards apply with special emphasis on the role of the plan administrator; otherwise the review is done *de novo*.¹⁷⁴

1. Plan Contract and Physicians

Physicians may be legally liable for failing to zealously advocate their patients' cases to insurers. The sentinel case that attached legal force to this ethical obligation is *Wickline v. State of California*.¹⁷⁵ Here, the plaintiff, Ms. Wickline, was discharged four days after surgery based on a Medi-Cal coverage decision, despite her surgeon's request for eight additional days of hospitalization due to post-operative complications.¹⁷⁶ Ms. Wickline subsequently developed compounded post-operative complications that resulted in amputation of her leg.¹⁷⁷ Although the resulting malpractice complaint against Medi-Cal was dismissed, the court noted *in dicta* that "the physician who complies without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care."¹⁷⁸ The court's reasoning and reference to adverse medical coverage decisions places physicians

¹⁷³ See President's Advisory Committee on Consumer Protection & Quality in the Health Care Industry: Consumer Bill of Rights and Responsibilities: Report to the President of the United States (1997), available at <http://www.hcqualitycommission.gov/cborr/> (last visited August 8, 2005).

¹⁷⁴ See, e.g., *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) (holding that where an employer was the fiduciary and administrator of an un-funded benefit plan covered by ERISA, the plan's decision to deny benefits was subject to *de novo* review.... unless the plan gave the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan).

¹⁷⁵ See *Wickline v. State of California*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

¹⁷⁶ *Id.* at 812-14 (the state's utilization review personnel cut the requested eight additional days in half).

¹⁷⁷ *Id.* at 815-16.

¹⁷⁸ *Id.* at 819.

on notice of their fiduciary duty to advocate for their managed care patients where quality of care and medical necessity are at issue.¹⁷⁹

2. Plan Contract and Patients

In regard to perceived fiduciary obligations and concomitant notification responsibilities, courts have also expressed concerns regarding the lack of transparency in healthcare contracts between MCOs and patients. In *Grijalva v. Shalala*, the court ordered the U.S. Department of Health and Human Services (HHS) to require Medicare-contracting HMOs to give their enrollees written notice and appropriate reconsideration when services are denied, reduced, or terminated.¹⁸⁰ Medicare statute and regulations mandate that HMOs provide a procedural framework for resolution of grievances and for reconsideration hearings when enrollees are denied services.¹⁸¹

E. A Comment to the Law

In 1957, the American Medical Association noted that “the honored ideals of the medical profession implied that the responsibility of the physician extend not only to the individual, but also to society.”¹⁸² Decades earlier, one of society’s greatest legal minds characterized the law as “...the witness and external deposit of our moral life. Its history is the history of the moral development of the race.”¹⁸³ As the juxtaposition of law to ethics becomes increasingly evident, the physician employed by a managed care entity looks to the law for solutions within the framework of his/her contractual obligations and her ethical dilemma(s).

Unfortunately, the law has been slow to proceed. And, some commentators have noted that “the coercive strategies of MCOs have been relentless and their continued control over physicians’ access to both patients and payment continue to stifle or subdue the physician’s

¹⁷⁹ *Id.* at 819 (dicta) (“...he [the physician] cannot point to the health care payer as the liability scapegoat when the consequences of his own determinative medical decisions go sour”).

¹⁸⁰ *Grijalva v. Shalala*, 946 F.Supp. 747, 754 (D.Ariz. 1996).

¹⁸¹ *See generally*, 42 U.S.C. 1395 § mm (c)(5)(A) (1994); 42 C.F.R. §405, 701-30., 405.801-12, 417.600-94 (1994). (Medicare regulations governing termination and resolution for enrollees).

¹⁸² American Medical Association, *Principles of Medical Ethics* (1957), reprinted in *ETHICS IN MEDICINE: HISTORICAL PERSPECTIVES AND CONTEMPORARY CONCERNS* 38-39 (Stanley J. Reiser et al. eds., 2nd ed. 1977).

¹⁸³ *See* Oliver Wendell Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457 (1897).

zeal to exercise unfettered advocacy for patients.”¹⁸⁴ As evidenced by the next discussion, the managed care environment necessarily creates a different perspective on the relationship between individual physician obligations and state regulation of professional competence.

IV. STATE MEDICAL LICENSING BOARDS: OVERSIGHT AND INVESTIGATION IN MANAGED CARE

State licensing boards have assumed a prominent role within the managed care environment, especially as states have attempted to regulate the practice of medicine and alleviate public perceptions and concerns that managed care is lower quality care. Through medical practice and managed care acts, state legislatures have enacted statutory provisions to regulate and guide the conduct of all stakeholders in managed care transactions, including patients, providers, and payers.¹⁸⁵

A. Jurisdiction of Medical Licensing Boards

Pursuant to their broadly enumerated police powers, states have broad latitude to regulate the practice of medicine. Commentators have noted that “Congress has provided few limitations on this power...and the United States Supreme Court has only limited it when it directly conflicts with certain limited constitutional rights of patients.”¹⁸⁶ Each state utilizes medical licensing boards to wield this power over medical professionals through medical practice acts. The purpose of these acts is to provide laws and regulations that govern the grant and use of the privilege to practice medicine in the interest of public health, safety, and welfare; the acts also protect the public from the unprofessional, improper, unlawful, fraudulent and/or deceptive practice of medicine.¹⁸⁷ These laws generally invest broad powers in the boards

¹⁸⁴ MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS’ CONFLICTS OF INTEREST* 8 (1993) (“The central canon of medical ethics... emphasizes that physicians have a duty to be loyal to patients; to act in their patients’ interests; to make their patients’ welfare their first consideration, even when their own financial well-being is opposed; and to keep patient information confidential”).

¹⁸⁵ See, e.g., Illinois Managed Care Reform and Patient Rights Act, 215 ILL. COMP. STAT. § 134/1 (2003).

¹⁸⁶ See Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANN. HEALTH L. 201 (1999).

¹⁸⁷ Federation of State Medical Boards of the United States, *A Guide to the Essentials of a Modern Medical Practice Act*, at § 1 (Apr. 2000); see also Al. Code § 32-24-50 et seq. (2002), As. Stat. § 08.64.010 et seq. (2004), 13 Az. Stat. § 32-1401 et seq. (2004), Calif. Bus & Prof. Code § 2000 et seq. (2004), 17 Ark. Code Ann. § 95 et seq.

by stating that the “primary responsibility and obligation of the state medical board is to protect the public.”¹⁸⁸

The broad and general language in the various medical practice acts reflects a growing trend to expand the jurisdiction of state medical licensing boards to regulate the activities of MCOs, corporate entities that cannot, by definition and statutory proscription, practice medicine.¹⁸⁹ However, medical licensure boards face resource constraints that affect their ability to take formal action.¹⁹⁰ Therefore, since many licensure boards lack financial resources, information action may be a more rational strategy for boards to pursue in some cases.¹⁹¹ For example, although state medical boards increasingly seek to discipline health plan medical directors who deny coverage of treatment recommended by a treating physician, the required

(2003), 12 Col. Rev. Stat. § 36 et seq. (2004), 24 Del. Code § 1702 et seq. (2004), 10 Guam Code Ann. § 12203 et seq. (2004), 32 Fla. Stat. § 458 et seq. (2004), 360 Ga. Stat. § 2 et seq. (2004), 453 Hawaii Rev. Stat. (2004), 225 Ill. Comp. Stat. § 60/1 et seq. (2004), 653 Ia. Code § 1.1 et seq. (2004), 6 Kan. Stat. Ann. § 100-6.1 et seq. (2004), 218 Kent. Rev. Stat. § 31.550 et seq. (2004), 37 La. Rev. Stat. §1261-1291 et seq. (2004), 1 Maine Stat. § 373 (2004), Md. Stat. § 14-101 et seq. (2004), 243 Code Mass. Rev. § 1.0 et seq. (2004), 147 Minn. Stat. § 147.001 et seq. (2003), Miss. Rev. Stat. § 1 et seq. (2003), 334 Missouri Stat. §334.002 et seq. (2002), 37 Mont. Code Ann. § 3-101 et seq. (2003), 172 Neb. Ad. Code § 001.01 et seq. (2004), 630 Nev. Rev. Stat. § 3 et seq. (2004), 329 New Hamp. Rev. Stat. § 1 et seq. (2004), 45 New Jers. Stat. § 1-1 et seq. (2002), 61 New Mex. Stat. Ann. § 6-1 et seq. (2003), 131 New York Stat. § 6520 et seq. (2004), 90 No. Car. Gen. Stat. § 1 et seq. (2004), 43 N. Dak. Stat. § 17-01 et seq. (2004), Ohio Rev. Code § 4731.01 et seq. (2004), Or. Rev. Stat. § 644.010 et seq. (2004), 63 Penn. Stat. § 422.6 et seq. (2004), 5 Gen. Laws of Rh. Is. § 37-1 et seq. (2004), 40 S. Car. Code § 47-5 et seq. (2004), 63 Tenn. Code Ann. § 6-101 et seq. (1999), Tex. Stat. § 151 to 165 (2003), 58 Ut. Stat. § 67-101 (2004), 26 Vt. Stat. Ch. 23, § 1311 et seq. (2004), 29 Va. Code § 54.1-2900 et seq. (2004), 3 W. Va. Rev. Stat. § 30-3-1 (2004), 26 Wy. Code § 33-101 et seq. (2004).

¹⁸⁸ See generally *The Special Committee on Managed Care, Recommendations adopted by the House of Delegates of the Federation of State Medical Boards of the United States, Inc.* (May 1998), available at <http://www.fsmb.org>.

¹⁸⁹ See *id.*

¹⁹⁰ Damon Adams, *Texas medical board funding will help root out bad doctors* (July 21, 2003), available at <http://www.ama-assn.org/amednews/2003/07/21/prsb0721.htm> (last visited Feb 28, 2005) (noting many physicians’ belief that the legislation that allowed for increased funding to the medical board would greatly improve the board and allow it to better regulate physicians and protect patients).

¹⁹¹ Richards, *supra* note 192, at 201-02 (citing Timothy S. Jost, et al., *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, 309 Health Matrix 335-36 (1993)); see also Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulations, Management, or the Market?*, 37 ARIZ. L. REV. 825 (1995).

concomitant increase in revenue funding and/or staff resources necessary to increase coverage may not occur. As a result, medical directors not only face a conflict between their duties as a health plan director and their ethical responsibilities to provide necessary and effective treatment to patients, they must also mediate such conflicts within a risk calculus to determine the probability of licensing board intervention and action. In short, the overall value of medical boards acting on information received about a physician under review and proceeding with costly independent investigations is dubious, at best. However, to better understand the limits of state licensing board intervention, the following is a brief analysis of the components of select cases involving medical determination decisions and state licensing board investigations.

2. Medical Necessity Decisions

A medical licensing board may choose to review medical necessity decisions or denial of covered benefits. Medical necessity decisions by health plan directors encompass one category of state medical licensing board disciplinary activities. In *Murphy v. Board of Medical Examiners of Arizona*, the Arizona Supreme Court held that John F. Murphy, Medical Director for Blue Cross/Blue Shield of Arizona, made a “medical decision” when he denied pre-certification for a patient’s surgery and was thus subject to review of professional conduct by the Arizona Board of Medical Examiners (BOMEX).¹⁹² In this case, Dr. Murphy had refused to pre-certify, or authorize, a patient’s gallbladder surgery because it was not medically necessary, however, this denial of pre-certification was contrary to the advice of the patient’s surgeon.¹⁹³ Further, Dr. Murphy offered to submit the matter to a third party specialist for review at Blue Cross’s expense, but both the patient and surgeon declined.¹⁹⁴ Despite the denied pre-certification, the surgeon performed the operation and the patient subsequently filed a complaint with the Arizona Department of Insurance asserting that Dr. Murphy and Blue Cross failed to honor the insurance contract.¹⁹⁵ The surgeon also submitted a complaint to the BOMEX regarding Dr. Murphy’s unprofessional conduct and medical incompetence arguing that [Murphy’s decision] caused the patient to question the surgeon’s judgment and dangerously affected the

¹⁹² *Murphy v. Board of Medical Examiners of Arizona*, 949 P.2d 530, 531(Ariz. Ct. App. 1997).

¹⁹³ *Id.* at 532.

¹⁹⁴ *Id.* at 533.

¹⁹⁵ *Id.*

physician-patient relationship.¹⁹⁶ Although Dr. Murphy argued that the Board could not review his action because he was "not involved in patient care and not involved in the practice of medicine,"¹⁹⁷ the Court ruled that such decisions were not *insurance* decisions but *medical* decisions.¹⁹⁸ The Court reasoned that Dr. Murphy, in making his determination to deny pre-certification, was required to consider whether the procedure was 1) "appropriate for the [patient's] symptoms and diagnosis of the condition;" 2) "provided for the diagnosis, care or treatment;" and 3) "in accordance with standards of good medical practice in Arizona."¹⁹⁹

Typically, when the Arizona Board of Medicine receives a complaint against a physician, there are three options: dismiss the complaint, file a letter of concern,²⁰⁰ or file a letter of reprimand. In this case, the Board voted to issue an advisory letter of concern. Since the letter of concern did not materially affect Dr. Murphy's legal rights, duties, or privileges, it was not a final decision subject to review before the Court.²⁰¹

In his defense, Dr. Murphy made a compelling argument that such jurisdiction would lead to a flood of complaints against medical directors by treating physicians and patients who dispute medical necessity decisions. However, the Court opted to defer to the legislature to consider these practical consequences and to resolve any underlying policy conflicts.²⁰² In any event, the *Murphy* case gives rise to questions regarding the appropriateness of assigning responsibility to medical directors of managed care organizations to make coverage determinations. Physicians opting to serve as medical directors should carefully review and seek partial or full indemnification or liability coverage from the managed care organization, and must be acutely aware of the complex relationship between coverage determinations, the practice of medicine, and professional competence.

3. Denial of Covered Benefits

Another area that may subject a physician/health plan medical director to medical licensing board review is a determination or denial of

¹⁹⁶ *Id.*

¹⁹⁷ *Murphy*, 949 P.2d at 533.

¹⁹⁸ *Id.* at 536.

¹⁹⁹ *Id.*

²⁰⁰ A letter of concern is a public document and may be used in future disciplinary actions against a physician. *Id.* at 536.

²⁰¹ *Id.* at 537-538.

²⁰² *Murphy*, 949 P.2d at 538.

covered benefits contrary to the clinical case presentation. In the case of *United Healthcare Insurance Co. v. Levy*,²⁰³ the Texas Board of Medical Licensure initiated an action to suspend an HMO medical director's license to practice after he made a determination that the care provided to ventilator dependent patients was not "therapeutic" but "custodial," not "therapeutic" and therefore not a covered benefit under the contractual terms of the plan.²⁰⁴ The case involved a thirteen-year-old boy with a critical respiratory condition who was discharged from Fort Worth Cook Children's Hospital after a five-week stay despite his physician's recommendation that he be placed on a home mechanical ventilator and receive nursing care from providers trained in cardiopulmonary resuscitation and ventilator care.²⁰⁵ Although United's medical director consulted with the child's physician, he [the director] interpreted the recommended service as a non-covered service under the benefit plan.²⁰⁶ Thereafter, the father filed a complaint with the Texas State Board of Medical Examiners ("the Board") stating that the director's decision to deny care jeopardized his son's life.²⁰⁷

The Board held an informal settlement conference to determine whether the medical director's benefit determination was in violation of the Texas Medical Practice Act.²⁰⁸ The Board concluded that the medical director was practicing medicine when he made the benefit decision and that the Director violated the applicable standard of care in denying the benefit sought.²⁰⁹ The Board recommended that the medical director be publicly reprimanded, have his medical license suspended for two years, pay a five thousand dollar fine, and perform twelve hours of home training on a mechanical ventilator.²¹⁰

United Healthcare appealed the Board's decision arguing that the director's benefit determination did not constitute the practice of medicine, and thereby precludes the Board's jurisdiction over the matter.²¹¹ United also argued that the Board's attempt to discipline the

²⁰³ See *United Healthcare Insurance Co. v. Levy*, 114 F. Supp. 2d 559 (N.D. Tex. 2000) (In this case, Levy served as a utilization review agent for United Healthcare, a managed care company that acts as a third-party administrator and reviews and makes medical necessity determinations for self-funded ERISA plan sponsored by Allstate Insurance).

²⁰⁴ *Id.* at 560.

²⁰⁵ *Id.* at 561.

²⁰⁶ *Id.* at 561.

²⁰⁷ *Id.* at 561.

²⁰⁸ *Levy*, 114 F. Supp 2d at 561.

²⁰⁹ *Id.*

²¹⁰ *Id.*

²¹¹ *Id.*

medical director over a benefit determination amounted to improper regulation of an employee benefit plan governed by ERISA and sought a temporary restraining order and an injunction enjoining the Board from enforcing its recommendations.²¹²

However, the Board filed a motion to dismiss arguing that Congress did not intend for ERISA to preempt a state's ability to regulate the practice of medicine within its borders and that ERISA did not confer jurisdiction on the Court to substitute its judgment for that of the Board.²¹³ In response, Levy and the HMO filed suit in federal district court to block the suspension actions of the Texas Board of Medical Licensure asserting that ERISA applied, the Board's efforts constituted an attempt to regulate an ERISA-governed plan, and that such conduct is preempted under ERISA.²¹⁴ The court held that the federal Employment Retirement Income Security Act of 1974 (ERISA) preempted the Board from taking action against Levy who was acting as a "utilization review agent" when he determined what qualified as custodial care under the Plan.²¹⁵

Typically, in deciding ERISA cases, courts assess whether a medical treatment decision is made affecting the quality of a healthcare service or an administrative benefits determination affecting the quantity of a healthcare service. Because the scope of medical practice has broadened as a result of rapidly advancing medical technology, physician's ethical obligations have also expanded, and as such courts have increasingly equated "coverage denial" with "medical decision" even where the medical doctor never diagnosed, examined, or proffered treatment.²¹⁶

The Court in *Levy* is distinguishable from courts that increasingly equate coverage denial with medical decision. The Court in *Levy* first considered whether United Healthcare's medical director's benefit determination should be considered a medical decision, since it could be subject to the Board's regulatory authority if identified as such.²¹⁷ The Court concluded that the medical director's decision was a "pure coverage determination" since the director never "diagnosed, treated, or offered to treat" the child in question.²¹⁸ The medical director did not independently exercise medical judgment when he

²¹² *Id.* at 561.

²¹³ *Levy*, 114 F. Supp. at 562.

²¹⁴ *Id.*

²¹⁵ *Id.*

²¹⁶ See generally *Calad*, 2001 U.S. Dist. LEXIS 8538.

²¹⁷ *Levy*, 114 F. Supp. at 562.

²¹⁸ *Id.* at 564.

decided that the recommended treatment fell within the Plan's definition of "custodial care" and thus was not a covered benefit.²¹⁹ However, the Court specifically refused to decide the question of whether a physician, who otherwise engages in the practice of medicine, is subject to the Board's authority if s/he acts as a utilization review agent and exercises medical judgment to determine what is medically necessary for a patient's care.²²⁰ The Court's refusal to address this issue leaves the door open for boards of medicine to hold plan administrators liable for benefit decisions predicated on a determination of medical necessity.

The second question before the Court in *Levy* was whether ERISA preempted the Board's regulation of a coverage determination by a physician acting for a third-party health care administrator.²²¹ The Court found when the Board independently reviewed the requested services and determined they were "not custodial," it, in effect, "substitute[ed] for the administrator's decision its own judgment of whether requested services fall within the Plan."²²² The Court further noted that "[s]hould [United's medical director], or any other doctor, elect not to follow the mandates of the Board's determination of what is "custodial care," license suspension or other penalties will presumably result."²²³ The Court ruled that this "result create[d] inconsistent and conflicting state regulation which ERISA's drafters sought to avoid."²²⁴ Accordingly, the Court held that the Board's action effectively called for "a *de facto* mandatory guideline for the determination of custodial care" under the Plan in question, which is prohibited by ERISA.²²⁵

The Court was also persuaded by United Healthcare's argument that the Board disregarded the statutory mechanism for the review of denied claims by setting forth its own rules for how an ERISA plan should be administered.²²⁶ Noting that the federal courts have held that ERISA and federal regulations alone govern the review of such plan benefit denials, the Court held that the Board's conduct improperly offered an alternative enforcement mechanism to the federal system already in place.²²⁷ Indeed, rather than filing claims via ERISA-mandated mechanisms, plan participants could simply complain to the

²¹⁹ *Id.* at 564.

²²⁰ *Id.* at 564-65.

²²¹ *Id.* at 565.

²²² *Levy*, 114 F. Supp. 2d at 565.

²²³ *Id.* at 564.

²²⁴ *Id.* at 564.

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Levy*, 114 F. Supp. 2d at 566.

Board about an adverse coverage determination.²²⁸ The Court furthered that the Board's authority to suspend medical licenses made its review have a "binding effect on the Plan, ensuring that the Plan will be interpreted and administered in a way dictated by the Board" and this outcome would be "in direct contravention to ERISA's objective of avoiding a 'multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.'"²²⁹

Still, the court's opinion never addressed whether benefit decisions predicated upon a medical necessity determination fall within the same safe harbor. For instance, physician-medical directors who substitute a treating physician's recommendation with an alternative treatment plan, or deny coverage because it is "not medically necessary" remain subject to a medical board's disciplinary decision. In such a situation, medical directors are afforded the greatest protection if the health plan brings suit against the disciplinary board, as in *Levy*, since a health plan, unlike individual physicians, may invoke the ERISA preemption doctrine.

B. Recent Case Developments

In *Levy*, the Court limited its decision to the narrow facts of this particular case and specifically reserved decision on whether a physician who acts as a utilization review agent and exercises judgment to determine medical necessity is covered by the Board's regulatory authority.²³⁰ However, the validity of this limited ruling may be challenged in light of recent developments in case law. Traditionally, ERISA allowed medical directors to avoid liability for their coverage decisions because such determinations were considered a "determination of benefits" rather than the "practice of medicine."²³¹ As a general matter detailed throughout this paper, the recent United States Supreme Court decision of *Rush Prudential HMO, Inc. v. Moran* has altered the legal landscape in terms of managed care litigation and ERISA preemption, and has left the matter of "determination of benefits" versus "practice of medicine" to be addressed by individual states.²³² The United States Supreme Court determined in *Rush* that state laws mandating external review of certain denials were not preempted by ERISA.²³³ In a 5-4 decision, the Court ruled that these

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.* at 562.

²³¹ See 29 U.S.C. § 1144(a) (1998).

²³² See *Rush Prudential HMO v. Moran*, 122 S. Ct. 2151 (2002).

²³³ *Id.* at 2151.

laws regulated insurance and therefore were not subject to preemption.²³⁴

Rush is significant for several reasons. First, this decision validates a number of state laws that establish procedures for claimants to obtain neutral, third party reviews for certain types of coverage denials. While the laws regarding the procedures vary widely from state to state, the denials are often on the grounds of “medical necessity” or “experimental or investigational” procedures.²³⁵ Had the Court found that the procedures were subject to preemption, all of these laws would have become, in effect, unenforceable.

Second, this decision elucidates the argument that HMOs (and therefore, MCOs) are to be treated as insurance companies, and therefore subject to the same state laws and regulations that apply to insurance companies. The Court rejected the HMO’s claims that it was not an insurance company but a contractor providing administrative services, and any notions that an HMO was “a medical matchmaker, bringing together ERISA plans and medical care providers.”²³⁶ The Court further noted that HMOs have assumed much of the business formerly performed by traditional indemnity insurers, and thus held that HMOs must be viewed as insurance companies for regulatory purposes.²³⁷

Third, this decision is important in that it arguably reflects a U.S. Supreme Court trend to narrow the scope of ERISA preemption. In both *Pegram* (holding that state malpractice laws are not preempted by ERISA) and *Rush*, the availability of ERISA preemption is less favorable to claimants and more advantageous for managed care organizations because: 1) ERISA does not permit the award of damages; 2) the only remedies allowed are payment of benefits that were wrongfully denied, equitable relief, and attorneys fees; 3) there is exclusive federal court jurisdiction; and 4) there is no right to trial by jury.

At this point, a brief comparative discussion of cases and concepts will elucidate the integral dichotomies between physician’s ethical responsibilities, ERISA, managed care, and patient care. The *Murphy* case differs from *Levy* in a fundamental way -- the physician in *Murphy* brought the lawsuit independent of the health plan. Therefore, ERISA preemption was not a consideration in this case and Dr. Murphy was not subjected to sanctions. However, both cases hinge on an

²³⁴ *Id.*

²³⁵ *Id.* at 2171.

²³⁶ *Id.* at 2162.

²³⁷ *Moran*, 122 S. Ct. at 2163.

important procedural question – whether the state licensing boards have jurisdiction to oversee a medical director’s benefit decisions.

Historically, the federal government has left the definition of medical practice and the extent of licensing to the states.²³⁸ According to the Federation of State Medical Boards, sixteen (16) states have recently promulgated laws explicitly requiring HMO medical directors to be licensed physicians in the state where the health plan is located. However, since ERISA preempts all state laws that relate to an employee benefit plan, courts must determine whether coverage denials may be considered the “practice of medicine” or as merely administrative decisions governed by ERISA.

C. ERISA and Investigation of Medical Directors

Recognizing that the facts of each individual case are outcome-determinative, the U.S. Supreme Court has provided minimal guidance by refusing to certify or address the issue of medical practice and medical benefit determinations.²³⁹ Nowhere is this more evident than in the Missouri case of *State Board of Registration for the Healing Arts v. Fallon*. Here, Dr. Fallon, a physician and surgeon licensed in Missouri, was employed as the Medical Director of Prudential Health Care.²⁴⁰ The Board began an investigation into a complaint against Dr. Fallon regarding his determination that a requested surgical procedure “was not medically necessary.”²⁴¹ Dr. Fallon’s defense was three-fold: 1) ERISA supercedes Missouri law to the extent that it authorizes the Board to investigate matters related to an employee benefit plan; 2) Missouri law does not authorize the Board to investigate “utilization review” cases; and 3) his decisions as a medical director did not involve the “practice of medicine.”²⁴² The Missouri Supreme Court determined that ERISA did not preempt state law, and held that:

[T]he determinations at issue in this case fall outside the scope of plan administration. Dr. Fallon did not simply look to a

²³⁸ See U.S. CONST. Amend. X; see generally GERALD GUNTHER, CONSTITUTIONAL LAW 65 (12th ed. 1991) (noting that the Constitution specifies federal powers while leaving non-delegated powers to the states).

²³⁹ See *State Board of Registration for the Healing Arts v. Fallon*, 41 S.W.3d 474, 25 Employee Benefits Cas. (BNA) 2547 (Mo. 2001); *Fallon v. Mo. Bd. of Registration for the Healing Arts*, cert. denied, 534 U.S. 993, 122 S. Ct. 459, 26 Employee Benefits Cas. (BNA) 2920 (2001).

²⁴⁰ *Fallon*, 41 S.W.3d at 476.

²⁴¹ *Id.*

²⁴² *Id.* at 476.

predetermined list of covered procedures to arrive at his conclusions. He used medical training and judgment to make a decision... analytically distinct from the coverage policies adopted by the employee benefit plan.²⁴³

Accordingly, the Court concluded that Dr. Fallon's actions were subject to the oversight of the Board.²⁴⁴ The United States Supreme Court denied *certiorari*, leaving the Missouri Supreme Court's decision intact.²⁴⁵

1. *Fallon Compared to Murphy and Levy*

The *Fallon* decision is consistent with both *Murphy* and *Levy*. The Court in *Fallon* underscored the importance of the distinct nature of the two determinations in this case.²⁴⁶ The Court explained that Prudential, the insurance company, made an administrative decision when it determined that the plan would not extend benefits to cover the elective surgery unless the medical director found it to be needed and appropriately provided.²⁴⁷ Dr. Fallon, however, made a purely medical decision when he determined that the procedure was not medically necessary.²⁴⁸ Relying on the reasoning set forth in the *Murphy* case, the Court ruled that this administrative decision led to a denial of coverage but embodied the medical judgment of a licensed professional who determined the necessity of a procedure for a specific patient.²⁴⁹ This outcome reflects the tendency of courts to equate coverage denials with medical decision-making despite the fact that the doctor, against her ethical obligations as a treating physician, may never have diagnosed, examined, treated, or offered to treat a patient.

D. Physician Application for Licensure and Managed Care

In another case involving managed care and licensing boards, *Morris v. District of Columbia Board of Medicine*, the Court of Appeals reversed the decision of a board that denied a physician's application to be licensed in the District of Columbia.²⁵⁰ Dr. Morris was hired by Blue Cross Blue Shield to serve as the Vice President and Medical Director

²⁴³ *Id.* at 477.

²⁴⁴ *Id.* at 478.

²⁴⁵ *Fallon*, 534 U.S. at 993.

²⁴⁶ *Fallon*, 41 S.W. 3d at 476.

²⁴⁷ *Id.* at 476.

²⁴⁸ *Id.* at 477.

²⁴⁹ *Id.*

²⁵⁰ See *Morris v. District of Columbia Board of Medicine*, 701 A.2d 364 (D.C. 1997).

of the National Capitol Area.²⁵¹ But because Dr. Morris, a licensed physician in three other states, signed letters as “Gregory K. Morris, M.D., Vice President and Medical Director” in his position at Blue Cross, his application for a license was denied.²⁵² The board took the position that by affixing “M.D.” to his name and title he was representing to the public that he was licensed to practice medicine within the District of Columbia.²⁵³

In reversing the Board’s decision, the Court of Appeals pointed out that Dr. Morris’ duties and responsibilities were “exclusively administrative.”²⁵⁴ Limiting its decision to the facts of that case, the court commented:

This does not mean, of course, that on other facts a medical administrator of a health insurer such as Blue Cross which monitors and regularly questions treatment decisions by physicians, may not be found to have practiced medicine ...The focus must be on the actions of the individual administrator, not his job title or identification as ‘M.D.’²⁵⁵

At this juncture, it appears from a case law perspective, that physicians serving as medical directors have a panoply of competing legal duties and ethical obligations. Interestingly enough, other third parties involved in the regulatory and oversight arena, have asserted different positions regarding medical determination decisions and the practice of the medicine.

E. Statutory and Regulatory Guidelines

Given the variety of existing case law on the subject of physician obligations, competence, medical judgments, and managed care decisions, a fundamental need exists for concrete and regulatory guidelines. The following are a few examples of statutory and/or regulatory attempts to provide useful reference points for law, ethics, medicine, and managed care.

1. State Attorney General Opinions

The Attorneys General of Ohio, Mississippi, and North Carolina, have issued opinions that utilization reviews do not constitute the practice of

²⁵¹ *Id.* at 365.

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ *Id.* at 366.

²⁵⁵ *Morris*, 701 A.2d at 368.

medicine.²⁵⁶ Although Attorneys General opinions are not binding as law, they are written interpretations of existing law and will usually be honored by state agencies' as advice from their legal counsel.²⁵⁷ Ultimate determination of a law's applicability, meaning or constitutionality is left to the courts. Currently, the impact and interpretation of such states' opinions have yet to be litigated in the managed care arena.

2. Federation of State Medical Boards

The Federation of State Medical Boards (FSMB) is a non-profit entity that serves as the umbrella organization for all state medical boards, and provides strategic policy advice, recommendations, and guidance for medical licensing of physicians. In 1996, then Federation President James E. West, MD, established a Special Committee on Managed Care in order to evaluate the impact of managed care on the medical regulatory system. The Committee was charged with specific tasks, summarized from the Policy Recommendations:

- Evaluating the current relationships between managed care organizations (MCOs) and state medical boards to determine the required amount of public protection;
- Determining what data collected by managed care organizations may be used by state medical boards in assessing quality of care by physicians;
- Reviewing the different forms of contractual relationships between managed care organizations and physicians to determine which types of contracts, if any, might endanger public health and welfare; and
- Evaluating methods used by managed care organizations in selecting/deselecting physicians for participation and the effects of minor

²⁵⁶ See generally 1999 Ohio Op. Atty. Gen. No. 99-044, 1999 WL 692623 (Ohio A.G. August 31, 1999); 1993 WL 207359 (Miss. A.G. 1999); 60 N.C. Op. Atty. Gen. 100 (1999) (Attorney General Opinions regarding the practice of medicine).

²⁵⁷ See generally COMMITTEE ON THE OFFICE OF ATTORNEY GENERAL, THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL (1980) (outlining the historical development of the office of attorney general and its specific common-law powers).

disciplinary actions taken by state medical boards.²⁵⁸

As a direct result of the information gathered by the FSMB Special Committee on Managed Care, the FSMB adopted a policy urging licensing boards to require all medical directors of managed care organizations to hold current and unrestricted medical licenses in states where patients in the plan reside.²⁵⁹ The rationale for this policy was to allow state medical boards to gain jurisdiction over plan medical directors to ensure accountability and promote professionalism among physicians.²⁶⁰ Moreover, individual states have imposed specific statutory requirements and obligations upon managed care organizations and physicians serving as directors of MCO's.

3. State Licensing Requirements for HMO Medical Directors

In response to such policy recommendations, various states²⁶¹ adopted statutes requiring HMO/managed care medical directors to be licensed physicians with valid licenses. These states include: Delaware,²⁶² New Jersey,²⁶³ Virginia,²⁶⁴ Florida,²⁶⁵ Missouri,²⁶⁶ Vermont,²⁶⁷ Georgia,²⁶⁸

²⁵⁸ See 240.006, FSMB Special Committee Report on Managed Care, available at <http://www.fsmb.org> (adopted as policy recommendations in April 1998, *reaff'd* April 2001).

²⁵⁹ See generally *Special Committee on Managed Care, Recommendations Adopted by the House of Delegates of the Federation of State Medical Boards of the United States, Inc.* (May 1998), available at <http://www.fsmb.org>.

²⁶⁰ *Id.*

²⁶¹ Not an exclusive listing. At press date, states do not have uniform requirements on licensing for managed care medical directors. For more information on up-to-date legislative activity in the states, see National Conference on State Legislatures, at www.ncsl.org.

²⁶² See 16 Del. Code § 9112 (2004) (Managed care organization directors and licensing requirement).

²⁶³ See N.J. Stat. § 26:2S-6 (2004) (Designation of licensed physician as medical director for managed care organization).

²⁶⁴ See Ch. 43, Vir. Code Ann. § 38.2-4319 (2005) (Health maintenance organizations; medical directors). See also Ch. 43, Vir. Code Ann. §38.2-4305 (2005) (Health maintenance organizations; medical directors and fiduciary responsibilities).

²⁶⁵ See 32 Fla. Stat. § 456.0375 (2004); Repealed 3/1/2004. (Registration of certain clinics; requirements; discipline; exemptions).

²⁶⁶ See 23 R.S.Mo. § 354.400 (2004) (Health maintenance organizations).

²⁶⁷ See 26 Vt. Stat. An. § 1851 (2003) (License requirements).

²⁶⁸ See 33 OCGA § 20A-5 (2002) (Standards for certification).

North Carolina,²⁶⁹ and California.²⁷⁰ For example, the State of Delaware²⁷¹ adopted this requirement using the following language:

(b) A managed care organization shall have a medical director. The medical director shall be licensed to practice medicine in Delaware in accordance with § 1702 of Title 24. The medical director's duties shall include, at a minimum, those specified in regulations promulgated by the Department pursuant to the authority granted in § 9110 of this title. The medical director may assign duties to other physicians and non-physician personnel employed by, or under contract to, the managed care organization, provided, however, that the medical director shall retain responsibility for assigned duties. Any decision to deny a covered service shall be rendered by a physician.

By identifying a medical director as a licensed physician who may issue coverage denial decisions, the statute creates accountability otherwise not present with managed care decision-making. Furthermore, by framing the denial of services by a managed care medical director as a legislative mandate, the issue of professional obligation following ethical guidelines is also turned into a legal imperative.

The final example of physicians' fiduciary obligations clashing with the managed care environment regard disclosure to patients and contractual "gag" clauses.

G. Disclosure and Gag Clauses

Gag clauses²⁷² are provisions in the contract between the physician and the health plan that limit the amount of information a provider may tell a patient-enrollee about treatments and services offered by the plan.²⁷³ These clauses often embody conflicting obligations when a procedure or treatment may be medically necessary or medically indicated for a

²⁶⁹ See 17 NC Gen. Stat. § 131E-280 (2004) (Applicants for license).

²⁷⁰ See Cal. Health & Saf. Code § 1367.01 (Health care plans; licensing provision).

²⁷¹ See 16 Del. Code § 9112 (2004).

²⁷² Gag clauses may be categorized into three areas: 1) discussion of non-covered medical treatment options; 2) anti-disparagement clauses prohibiting the physician from criticizing the managed care organization; and 3) confidentiality clauses prohibiting the physician from disclosing any proprietary information or confidential trade secrets, which may broadly encompass financial incentives and conflicts of interests. See Nancy J. Picinic, *Physicians, Bound and Gagged: Federal Attempts to Combat Managed Care's Use of Gag Clauses*, 21 SETON HALL LEGIS. J. 567 (1997) (provides an excellent overview and background on gag clauses, physicians, and managed care contracts).

²⁷³ *Id.*

particular patient-enrollee, but cannot be mentioned or discussed due to health plan limitations.

1. Gag Clauses, Fraud, and Class Actions

As a result of competing professional obligations, subsequent litigation has begun to focus on substantive challenges to the language contained in managed care contracts. For instance, in *Humana v. Castillo et al.*,²⁷⁴ a group of individuals enrolled in the Humana Gold Plus Plan filed suit against Humana based on claims of fraud, unjust enrichment, money had and received, and to the “gag clause” language.²⁷⁵ The plaintiffs alleged that Humana misrepresented and/or failed to disclose the terms of its arrangements with affiliated primary care physicians.²⁷⁶ Plaintiffs directed attention to the contract language disclosing that the physicians were paid a flat rate per member per month (capitation); that Humana had financial arrangements with physicians to create an incentive not to treat or refer to specialists; that Humana required physicians to obtain authorization before hospital admissions or before discussing hospitalization; and that the contracts contained gag clauses which restricted the physicians’ ability to discuss treatment options with members.²⁷⁷ The allegations noted that the gag clauses “prohibited [physicians] from disclosing or advising the member of certain medical treatments Humana would not cover, or did not want to cover, regardless of whether the treatments or procedures might be medically advisable or necessary.”²⁷⁸

Unfortunately, the issues before the reviewing court in *Humana* were whether the class certification was proper based upon the alleged counts of fraud and whether the class represented the claims and allegations of all enrollees similarly situated. The Court held that certification of the class was improper, but did not address the individual gag clause allegations against Humana. Regardless, it is striking to note that *Humana* serves as an example of an enrollee’s attempts to challenge the outcomes of managed care based upon contractual obligations her physician must assume to participate in managed care.

2. Gag Clauses, Fiduciary Duty, and ERISA

²⁷⁴ See *Humana v. Castillo*, 728 So. 2d 261 (1999).

²⁷⁵ *Id.* at 263.

²⁷⁶ See *Humana*, 728 So. 2d at 262.

²⁷⁷ *Id.*

²⁷⁸ *Id.* at 263.

Additionally, in *Weiss v. Cigna Healthcare*,²⁷⁹ the Court held that allegations about managed care gag clause language was preempted by ERISA but nevertheless a viable claim.²⁸⁰ Here, a plaintiff filed a putative class action lawsuit seeking declaratory and injunctive relief pursuant to ERISA. Weiss was a participant in an employee benefit plan operated and administered by CIGNA, and alleged that CIGNA breached various fiduciary duties required under ERISA. Weiss specifically alleged that CIGNA engaged in an undisclosed policy of preventing its physicians from advising patients of treatment options which were not compensable by the HMO; it enforces this “gag order” policy by reprimanding or terminating physicians who disclose that CIGNA will not cover treatments that might be useful to the patient.²⁸¹ Plaintiff further claimed that by implementing this policy, CIGNA, as an insurer, breached its fiduciary obligations and breached its implied covenant of good faith and fair dealing.²⁸²

Pursuant to ERISA, a person is a fiduciary of a benefit plan if she exercises any discretionary authority over management of such plan.²⁸³ Plan fiduciaries must discharge their duties with respect to a plan solely in the interest of the participants and beneficiaries.²⁸⁴ Therefore, an HMO can be an ERISA fiduciary when it exercises such discretionary management over a qualified health benefit plan.²⁸⁵ The substantive issue was thus whether CIGNA’s fiduciary capacity and obligations of loyalty was breached by their policy of restricting the disclosure of non-covered treatment options. The Court first noted that physicians have “independent duties to provide full information to their patients which is not altered by the coverage limitations in the patient’s managed care plan.”²⁸⁶ It then concluded that “patients cannot be deprived of such information absent an ethical breach on the part of the physician and therefore such a rule would provide physicians with no meaningful choice and would effectively limit the amount of information available to plan participants.”²⁸⁷

²⁷⁹ See *Weiss v. Cigna Healthcare*, 972 F. Supp. 748, 21 Employee Benefits Cas. (BNA) 1843 (S.D.N.Y. 1997).

²⁸⁰ *Id.* at 751.

²⁸¹ *Id.*

²⁸² *Id.*

²⁸³ See 29 U.S.C. § 1002 (21)(A) (1997).

²⁸⁴ See 29 U.S.C. § 1004 (21)(a)(1) (Lexis 2003).

²⁸⁵ See *Weiss*, 972 F. Supp. at 751 (citing *O’Reilly v. Ceuleers*, 912 F.2d 1383, 1385 (11th Cir. 1990); *Morales v. Health Plus*, 954 F. Supp. 464 (D.P.R. 1997)).

²⁸⁶ *Id.* at 752 (citing American Medical Association Council on Ethical and Judicial Affairs, *Council Report: Ethical Issues in Managed Care*, 273 JAMA 330 (1995)).

²⁸⁷ See *Weiss*, 972 F. Supp. at 752.

3. Federal Legislation on HMO Gag Clauses

In 1997, federal legislation prohibiting HMO gag clauses, entitled "the Patient Right to Know Act,"²⁸⁸ was introduced before the House and Senate. The legislation was sponsored by Sen. Jon Kyle (R-AZ) and was referred to the Senate Committee on Labor and Human Resources. Legal justification for such federal legislation stemmed from the doctrine of informed consent, the fiduciary nature of the physician-patient relationship, and the liability of managed care organizations under *respondeat superior*.²⁸⁹ The SB 449, excerpted in part:

Prohibits any contract or agreement, or the operation of any contract or agreement, between an entity operating a health plan (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) from prohibiting or restricting the provider from engaging in medical communications with his or her patient. It requires that each State shall enforce this Act with respect to health insurance issuers that sell, renew, or offer health plans in the State. It provides for enforcement of this Act by the Secretary of Health and Human Services if the Secretary, after consultation with the chief executive officer of a State and the insurance commissioner or chief insurance regulatory official of the State, determines that the State has failed to substantially enforce the requirements. It also mandates a civil money penalty and allows State requirements equal to or more protective of medical communications than the requirements of this Act.²⁹⁰

A sister bill with mirrored language was also introduced in the House during the 105th Congress. HR 565²⁹¹ was sponsored by Rep. Greg Ganske (R-IA) and had numerous co-sponsors. However, HR 565 had a similar fate as SB 449 and was referred to the House

²⁸⁸ See generally Patient Right to Know Act, H.R. 586 and S. 449, (105th Cong., 1997) (these measures were referred to House and Senate Committees; no further action was taken during the 105th Congressional session).

²⁸⁹ See generally Picinic, *supra* note 278).

²⁹⁰ See SB 449, 1997 Bill Tracking SB 449, 105 Bill Tracking SB 449 (105th Cong., 1st Session, 1997).

²⁹¹ See HR 586, 1997 Bill Tracking HR 586, 105 Bill Tracking HR 586 (105th Congress, 1st Session, 1997).

Committee on Education and the Workforce. In 1998, legislation on this topic was again introduced in the House as HR 2095,²⁹² a bill sponsored by John Boehner (R-OH), which sought to amend ERISA to make needed reforms to group health plans. Again, the bill was referred to the House Committee on Education and the Workforce.

Overall, federal legislative efforts to prohibit gag clauses in managed care contracts were cumulative because the health care industry and individual states intervened to regulate the use of gag clauses. As of early 1997, most states had already adopted laws nullifying gag clauses by MCOs on physicians.²⁹³ Those states that do not adopt independent state legislation may simply adopt the National Association of Insurance Commissioners (NAIC) proposed Managed Care Plan Network Adequacy Model Act, which applies to all managed care plans and provides patients with protections through gag clause prohibitions, utilization review, and grievance procedures.²⁹⁴

²⁹² See HR 2095, 1999 Bill Tracking HR 2095, 106 Bill Tracking HR 2095 (106th Congress, 1st Session, 1998).

²⁹³ *Id.* (citing Colorado: Insurance-Contracts Between Carriers and Health Care Providers - Required Provisions, Termination of Contract, Dispute Resolution *Colo. Rev. Stat. 10-16-102, 10-16-121* (West 1996) (providing that physicians shall not be terminated for discussing the patients medical condition including treatment options or recommendations); Wyoming: Insurance - Health Care *Wyo. Stat. Ann. 26-22-504, 26-34-117* (f)(g) (West 1997); Georgia Insurance - Patient Protection Act, *Ga. Code Ann. 33-20A* (West 1996) (indicating that an MCO can not penalize a physician for discussing medically necessary information with patients); Indiana: Insurance - Referrals to Women's Health Care Providers, *Ind. Code. Ann. 27-8-11-4.5* (West 1996) (providing that physicians may disclose financial incentives and all treatment options with the patient including those not covered under the plan); Virginia: Accident and Sickness Insurance - Health care Provider Panels, *Va. Code. Ann. 38.2-3407.10* (West 1996) (providing that "no contracts between a carrier and a provider shall prohibit, impede, or interfere in the discussion of medical treatment options between a patient and a provider.") In addition, in August of 1996, California enacted gag clause legislation as an amendment to the Business Code which prohibits an MCO from retaliating against a physician for advocating on behalf of a patient. See Status Report-State Legislation, *Gag Clauses*, American Medical Association [hereinafter Status Report]. In September of 1996, California also enacted legislation prohibiting gag clauses, which restrict such information concerning treatment options, alternative health plans, coverage arrangements and other relevant medical information. *Id.* On March 19, 1997, Idaho enacted gag clause legislation, which prevents managed care from restricting doctor-patient communication. *Id.* Other states that have proposed legislation prohibiting gag clauses include Delaware, Maine, Maryland, New Hampshire, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington and Wyoming. *Id.*)

²⁹⁴ *Id.*

To address such situations, medical codes of ethics call on physicians to recognize the distinction between law and ethics, and allow ethics to take priority in cases of direct conflict. The Code of Ethics of the AMA states, for example, "In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations."²⁹⁵ Despite the past utilization of gag clauses by MCOs, the strength of the physician's ethical duties and obligations to the patient help provide the strongest arguments against otherwise business and proprietary practices.

V. CONCLUSION: THE BUSINESS CASE FOR ETHICS

This Note has covered the panoply of information on the ethics of managed care in the medical environment, as well as the relationship between medical ethics and attorneys who practice within the managed care environment. The broad applicability of the basic principles of biomedical ethics is factored into the reasoning and analysis by Courts in managed care litigation involving benefit determinations, claim denials, and/or medical necessity determinations.

Physicians have ethical duties, as embodied in professional association codes of ethics and conduct, to protect the patient's best interests and ensure appropriate patient care even if adverse to the interests of managed care organizations. Similarly, the physician has a clear obligation to act in a professional capacity as a fiduciary and is subject to state medical licensing board regulation. As discussed, the physician who serves as medical director of a managed care organization has dual, and often conflicting, roles – that of physician as well as that of MCO employee. Finally, the history and tradition of managed care, physicians, and professionalism elucidates the striking balance between consumerism, justice, and contractual obligation. Despite managed care organizations' attempts to control the communications between physicians and patients on treatment options with regard to cost-containment, such gag clauses were ultimately discarded as an ineffective mechanism.

Ethical issues within the managed care environment are a condition subsequent in health law. Since most jurisdictions mandate that health plan medical directors be licensed physicians, subsequent coverage decisions by medical directors are increasingly interpreted to

²⁹⁵ AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 2004-2005 EDITION 1 (AMA Press 2004) (Opinion 1.02: The Relation of Law and Ethics).

be the practice of medicine by medical boards and the courts. Balancing competing considerations, such as cost containment and quality patient care, includes recognizing that they are neither exclusive nor inclusive within all managed care situations. Some experts have noted that business strategies within managed care may be more beneficial and yield greater acceptance if the ethical values of treatment staff are consolidated.²⁹⁶

To respond to stakeholder issues and concerns, several health care and managed care organizations have adopted formal organizational codes of ethics. The American Association of Health Plans, representing approximately 1,000 HMOs, MCOs, and similar organizations, has created a Philosophy of Care statement.²⁹⁷ This statement articulates a set of principles regarding patient access to affordable quality care. Incorporating ethical principles into an organization's culture, rather than treating such issues as an afterthought or as unrelated to the business of providing health care, is a major step towards addressing and avoiding potential conflicts.

The responsibility of ensuring ethics in managed care must be divided between the medical director and the MCO plan. Although litigation in the managed care setting may be inevitable, the consequences of any claims brought may be minimized if the Medical Director is familiar with the laws regarding appropriate licensing protocols and state Medical Licensing Board jurisdiction, and if the MCO incorporates an ethical strategy into their business plan.

As a final thought, perhaps ethics and managed care are simply asymbiotic – given the competing forces of medical review/eligibility determinations and patient care. Consider, as a final example, the case of Dr. Sean Tunis, former chief medical officer and director of the Office of Clinical Standards and Quality at the Centers for Medicare and Medicaid (CMS). As the chief medical officer, Dr. Tunis had direct authority over an agency that determines eligibility and certification of medical services, therapies, and procedures for over 40 million individuals enrolled in the Medicare program -- a position analogous to that of a medical director of a managed care organization.²⁹⁸ In June 2005, Dr. Tunis agreed to a one-year suspension of his medical license for falsification of documents related

²⁹⁶ See Wynia et al., *supra* note 120.

²⁹⁷ See, e.g., www.aahp.org.

²⁹⁸ C. Connolly, *Noted With Interest*, WASHINGTON POST, August 9, 2005, available at http://www.washingtonpost.com/wp-dyn/content/article/2005/08/08/AR2005080801222_pf.html (last visited August 9, 2005).

to the completion of continuing medical education courses.²⁹⁹ The Maryland Board of Physicians accused Dr. Tunis of unprofessional conduct when he falsely claimed to have completed continuing medical education credits and submitted altered credentialing documentation.³⁰⁰

As a licensed physician and federal employee, Dr. Tunis took a pledge to work for the betterment of his patients as well in furtherance of the common good of the United States of America. All federal employees are required to take an affirmation oath upon entering their first day of service and are required to comply with various federal rules and regulations governing employee conduct and ethics to avoid conflicts of interest and appearances of impropriety.³⁰¹ Thus, even a high-ranking federal government official, who has taken an explicit ethical oath and who is deemed to have only the best interests of the public good at heart, is subject to the dilemmas of balancing compliance with professional duties, ethics, professional judgment, and the pressures of managed care principles and medical determination decisions.

Without a doubt, the competing forces of law, medicine, and ethics will continue to be intertwined within the managed care environment. The practice of medicine, the standard of care for patients, and medical determination decisions will continue to be mediated against the legal system and codes of ethics so as to protect patients and all interested stakeholders in the health care system. Is ethics for sale? The short answer appears to be, within the managed care context, "It depends on if you're caught."

²⁹⁹ *Id.*

³⁰⁰ *Id.*

³⁰¹ See generally 18 U.S.C. § 201 et seq. (2004) (conflicts of interest for federal employees); see also 5 U.S.C. § 101-505, et seq. (2004) (Ethics in Government Act of 1978).

