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INTRODUCTION

Market trends have dramatically altered the dynamics of traditional health care relationships. Advanced forms of managed care organizations (AMCOs),[1] such as large group and staff-model health maintenance organizations (HMOs), precipitated this shift. These organizations have significantly changed the relationships among health plans,[2] beneficiaries of health plans, and physicians.[3] Specifically, AMCOs shift the power over medical decision making from patients and their physicians to the AMCO managers.[4]

AMCOs use this shift in power to reduce costs through intensive management of the health care rendered by multiple health care providers. By moving the medical management of patients away from physicians and patients to organized health care delivery systems, AMCOs introduced a new element into the medical management of patients: while traditionally physicians focused only on the needs of the patient, they must now also consider the effect their decisions will have on the financial via-

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1. "AMCO" is not an acronym used in the health care market. It is used in this article for ease of expression. There is a lack of common nomenclature that accurately describes the various organizations that are being assembled. What are called AMCOs in this article may be referred to as "vertically integrated managed care plans," "advanced integrated health plans," or something else. All of these names are used to refer to large group or staff model HMOs that have enough beneficiaries to justify the creation of a health care delivery network that is dedicated to the care of the HMO beneficiaries.

2. In this article, the term "health plan" refers to any kind of health care insurance plan or prepaid health care plan.

3. *See* Alan L. Hillman, *Managing the Physician: Rule Versus Incentives*, HEALTH AFF., Winter 1991, at 138 (discussing the impact managed care has had on traditional roles in medicine).

4. *See id.* at 138-39.

bility of the managed care organization, continuously improving the overall "value"[5] of the care provided.

Some AMCOs have been able to significantly reduce costs while maintaining a high level of quality,[6] successes noted by private payers and government policymakers. Thus, more AMCOs are being developed.[7] Many health care economists believe that these AMCOs have such a compelling economic advantage over other health plans, including other "managed care"[8] organizations (MCOs),[9] that they will soon become the prevailing type of health plan in the United States, with only a

5. The term "value" generally refers to the results achieved for the resources expended, or "a fair return in goods, services, or money . . . ." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 2531 (1986). Maximizing the value of health care services can be defined as the process of 1) maximizing quality and 2) maximizing patient service while 3) minimizing per patient cost per year. DAVID E. VOGEL, THE PHYSICIAN AND MANAGED CARE 3 (1993).

6. *See generally Parker Hannifin's Health Benefits Program: Self-Management*, 1 MANAGED CARE Q., Autumn 1993, at 1 (evaluating several managed care initiatives and their successes); Gerald L. McManis & Jerrie A. Stewart, *Hospital-Physician Alliances: Building an Integrated Medical Delivery System*, HEALTHCARE EXEC., Mar.-Apr. 1992, at 18 (commenting on the effectiveness of managed care methods of health care delivery).

7. CONGRESSIONAL BUDGET OFFICE, CBO STAFF MEMORANDUM: THE EFFECTS OF MANAGED CARE ON USE AND COSTS OF HEALTH SERVICES 5-22 (June 1992).

8. The term "managed care" refers to a broad spectrum of activities. Various definitions have been developed, but no single definition exists. The American Medical Association (AMA) defines managed care as "systems or techniques that are used to affect access to and control payment for health care services." DEPARTMENT OF MEDICAL REVIEW, AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MANAGED CARE—A SUMMARY OF AMERICAN MEDICAL ASSOCIATION POLICY 1 (1993). The AMA further specifies that

> [m]anaged care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services and/or site of services; contracts with selected health care professionals or providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patients (i.e., high-cost case management).

Id.

9. For purposes of this article, the terms "managed care organizations" (MCOs) or "managed care plans" are used to refer to the entire spectrum of health insurance plans or prepaid medical care plans that use managed care techniques, including traditional indemnity health insurance plans that use managed care techniques such as "utilization review." MCO also includes the full spectrum of organizations created to apply managed care techniques, such as, but not limited to, health maintenance organizations (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), designated provider organizations (DPOs), point of service plans (POSs), and competitive medical plans (CMPs).

few large AMCOs providing care for most of the population in each market area in the country.[10]

If AMCOs do achieve this advantage, the result will be an extraordinary concentration of power over the medical management of patients within a few AMCOs in each regional market. Such tremendous concentration of power over medical management is unprecedented in the history of health care. Equally unprecedented is the ultimate power over medical management decisions residing in a few managers or executives, most of whom are likely to be nonphysicians.

This article argues that the shift in power to nonphysician managers is only acceptable in the highly pluralistic market that we have today, where patients and providers have many alternatives to AMCOs. However, the shift will be detrimental if a few large AMCOs controlled by nonphysician managers dominate the market. That would result in less than optimal performance by AMCOs, where performance is measured by the overall "value" achieved. Management by nonphysicians could also result in the loss of patient-centered values in medical management, and could transform the patient-physician relationship from one of trust, where the physician is the unquestioned advocate of the patient's well-being, into an arm's length business relationship.

This article also argues that the shift in power should be moderated to enhance the performance of MCOs, especially AMCOs, and that patient-centered orientation in medical management along with trust in the physician-patient relationship should be preserved. This can be accomplished by 1) requiring all MCOs, or at least AMCOs, to form a medical board elected by physicians participating in the MCO for the purpose of reviewing the plan's medical policy and other issues, and 2) facilitate through legislation the formation of MCOs and health care delivery networks controlled and/or operated by physicians.

10. *See* Jean Buckner, *The Managed Care Marketplace*, J. HEALTH CARE MARKETING, Mar. 1990, at 2, 5; Wanda J. Jones & John J. Mayerhofer, *Regional Health Care Systems: Implications for Health Care Reform*, MANAGED CARE Q., Winter 1994, at 31; VOGEL, *supra* note 5, at iv.

I. THE GROWTH OF MANAGED CARE

The health care industry is rapidly converting from the use of traditional indemnity health insurance plans to MCOs.[11] In 1991, only about 10 to 15 percent of Americans were beneficiaries of traditional health insurance plans. In contrast, 90 percent of Americans were part of traditional plans in the early 1970s.[12] The market share of advanced MCOs has grown dramatically during the last decade: approximately 15 percent of the United States' population is enrolled in HMOs,[13] which is triple the number enrolled in 1980,[14] and 19.5 percent of the population is enrolled in PPOs.[15]

The conversion to managed care is being driven by the cost crisis in health care.[16] In a traditional health care relationship, the health plan has no control over expenditures, and the patient and physician have no incentive to control costs. The physician's focus is solely on healing patients: any treatment the physician orders that is within the realm of acceptable medical practice is a covered expense. The result has been unmanageable increases in health care expenditures.[17]

The easiest way for the ultimate payers[18] for health care to control costs would be to substantially reduce or eliminate benefits. If most ultimate payers chose that tactic, there would be less money available to pay for health care and health plans, and the demand for both would decline. The resulting reduction in demand would force most health plans and providers to find ways to provide health care at lower costs or be forced out of

11. In a traditional indemnity insurance plan, the insurer agrees to pay for all reasonable and necessary medical services for the treatment of any illness or injury that is within the plan's defined scope of coverage. The insurer is obligated to pay claims incurred by the beneficiary regardless of whether the provider has a contractual relationship with the insurer. *See* BERTRAM HARNETT & IRVING I. LESNICK, THE LAW OF LIFE AND HEALTH INSURANCE § 6A (1992).

12. *See* VOGEL, *supra* note 5, at 9.

13. VOGEL, *supra* note 5, at 22; AMCRA, 1993-94 MANAGED CARE OVERVIEW 17 (1994). *See* Marsha R. Gold, *HMOs and Managed Care*, HEALTH AFF., Winter 1991, at 189, 190.

14. VOGEL, *supra* note 5, at 22; MICHELLE J. PORTER & RICHARD L. HAMER, 2 THE INTERSTUDY COMPETITIVE EDGE 4 (1993).

15. AMCRA, *supra* note 13, at 21.

16. For a summary of the cost crisis, see Susan M. Browning, *Forces for Reforming the U.S. Health Care System: A Review of the Cost and Access Issues*, 1 HEALTH ECON. 169 (1992).

17. *Id.* at 171.

18. The term "ultimate payers" in this article refers to employers, unions, professional associations, government entitlement programs, and other group purchasers of health care plans.

business. In reality, however, this will not happen because the moral imperatives associated with health care make solving this problem with significant cuts in benefits unacceptable.[19] Therefore, ultimate payers have had to find other ways to motivate health plans and providers to reduce costs while maintaining quality.

Managed care is an alternative ultimate payers are trying with regularity. MCOs attempt to reduce costs and maintain quality by focusing on the medical management of patients while containing provider payments. Medical management is achieved in a variety of methods, including: 1) eliminating unnecessary care, 2) providing needed care more efficiently, and 3) preventing the need for episodes of acute care. These methods of medical management tend to reinforce each other and blend together. The net result of medical management is to reduce the demand for medical services, but not to eliminate benefits. Providers, especially physicians, must ultimately employ these methods of medical management because they are the professionals that actually care for patients. Large-scale medical management will not work unless physicians and other providers alter their practice patterns or practice techniques. An important issue has been how best to motivate physicians to engage in medical management methods.

MCOs motivate physicians to change their practice methods by changing the way in which they are paid. Provider payment is contained by 1) discounts from usual charges or fees,[20] 2) fee-withhold arrangements, whereby a percentage of fees or charges is withheld and paid only if utilization goals are met,[21] and 3) capitation, whereby providers are paid a set amount per patient for a period of time, and are expected to provide all necessary services (as defined in the provider contract) to a specific patient population.[22]

While these methods may appear to save money, they will only reduce long-term health care expenditures when used in conjunction with methods of medical management. For example, while provider payment controls provide incentives for

19. John C. Gaffney et al., *Proposals to Reform the U.S. Health Care System: A Critical Review*, 1 HEALTH ECON. 181, 183-184 (1992).

20. Peter S. Kongstvedt, *Compensation of Primary Care Physicians in Open Panels*, *in* THE MANAGED HEALTH CARE HANDBOOK 55, 65 (Peter S. Kongstvedt ed., 1993).

21. *Id.* at 58.

22. *Id.* at 55.

providers to reduce costs, especially the volume and intensity[23] of medical services, actually reducing the volume and intensity of medical services provided constitutes medical management. Also, capitation fees encourage providers to find ways to conserve resources without compromising quality—another form of medical management.

Different kinds of MCOs combine the elements of medical management and payment arrangements in different ways. Some have been successful at reducing costs, while others actually cost more than traditional indemnity plans.[24] AMCOs, including PPOs and HMOs, are more effective than other managed care plans at reducing costs because they engage in the most comprehensive medical management of patients. The methods that they employ require a high degree of coordination between the practices of physicians and the practices of other providers. Most AMCOs have been group or staff-model HMOs.[25]

Who will be the individuals that control AMCOs and, therefore, control medical decision making within the AMCO? Will they be physicians or persons with other backgrounds? The answer lies in how the AMCOs evolve in a particular market. If present patterns continue into the future, insurance companies are likely to dominate, followed by hospitals, and then large group practices of physicians. Independent physicians with solo practices, a single partner, or in a small group practice will probably become part of the health care delivery network of an AMCO or health care delivery network organized by an AMCO, or they will stop practicing.

23. The term "intensity of services" refers to the degree of resources focused on a patient to resolve a medical problem. Cardiac bypass surgery has a high level of intensity for the resolution of heart disease, angioplasty has a lower level of intensity for the same problem, anticoagulant drugs a still lower level, and prevention of heart disease through screening and risk factor management the lowest of all.

24. *See generally* Donald W. Moran & Patrice R. Wolfe, *Can Managed Care Control Costs?*, HEALTH AFF., Winter 1991, at 120 (commenting on the range of successes within MCOs).

25. *See* Verdon S. Staines, *Potential Impact of Managed Care on National Health Spending*, HEALTH AFF., Supp. 1993, at 248 (outlining the cost savings generated by such plans).

II. CONTROL OF THE AMCOs

A. Market Dynamics

The way in which AMCOs evolve in regional markets tends to favor insurance companies, hospitals, and large groups, to the disadvantage of the independent physicians. Health care markets generally do not become dominated by AMCOs overnight. Instead, AMCOs evolve over a period of years because the establishment of an AMCO meets resistance primarily from beneficiaries but also from physicians. Patients are accustomed to selecting providers and having some control in making medical decisions. They resist health plans that will restrict their choice and control.[26] Since most individuals with health plans obtain them through their employers, and employees see the implementation of an AMCO as a reduction in their benefits, employers are often reluctant to implement a managed care program.[27] Providers on the other hand resent their loss of professional and economic autonomy. In addition, the widespread introduction of AMCOs may make solo and small group practice economically infeasible,[28] ending a way of life among physicians that is centuries old. Finally, health care delivery networks are complex to organize and efficiently operate, requiring provider experience of how to make it function well. The experience necessary takes time to obtain, resulting in a lack of networks needed for intensive medical management.

Because of these obstacles, managed care generally evolves in a market in steps, beginning with the least advanced managed care plans, then moving in sequence through the more advanced plans, and finally to AMCOs.

Phase One. The first phase of managed care is the implementation of utilization review techniques and case management by traditional indemnity plans. These techniques are initiated by insurance companies, which start to gain experience in medical management. Beneficiaries and providers are often disturbed by the use of these techniques, viewing them as an infringement on their control over medical decision making.

26. *See, e.g.*, Joseph L. Angeletti, *Clinton Plan Would Have Crippled Me*, WALL ST. J., Mar. 18, 1994, at A10 (author argues that under the Clinton plan, his rare disease would not have been treated).

27. *See, e.g., id.*

28. *See* Jeanne Kassler, *Managed Care—or Chaos: Profile of Health Maintenance Organizations*, N.Y. MAG., Aug. 23, 1993, at 44.

Also, small staff-model HMOs may be available in the market because employers are required to offer them under the Health Maintenance Organization Act of 1973. However, they generally do not have enough beneficiaries to justify employing more than a few primary care physicians and must contract with independent physician specialists and hospitals for care that their primary care physicians cannot handle. While these HMOs are usually priced at a low level, the savings is not enough to entice beneficiaries to switch given their concerns about loss of freedom of choice.

Independent provider association (IPA) model HMOs may also be available in the market, but they generally have a limited number of beneficiaries and, in practice, are structured much like a preferred provider organization (PPO). Patients must see IPA-member physicians as a condition of coverage. However, there might not be a gatekeeper physician, and since most physicians in the market will be IPA members, patients will have a wide choice of providers. The IPA members are paid on a fee-for-service basis, and savings are gained by attempting to reduce hospital charges and admissions. Because these HMOs offer a wide range of choice, they tend to gain market share more quickly than staff-model HMOs.

Phase Two. A second phase of managed care will come about when continued pressure to reduce costs causes employers and insurers to cooperate in the formation of PPOs. Employers will offer more complete subsidies to employees who choose the PPO over the indemnity plan traditionally offered by the employer. The PPO uses the volume obtained to negotiate fee discounts with the providers, and uses financial incentives to encourage patients to use the physicians in the PPO panel. A large percentage of physicians is recruited to become part of the approved panel from which beneficiaries can obtain care, reducing concerns over a loss of freedom of choice. This wide choice and lower price allows them to gain market share more quickly than the HMOs.

During this phase, the HMOs may make more aggressive use of financial incentives to reduce costs. They will ask physicians to agree to fee-withhold arrangements or capitation, and ask hospitals to accept a fixed rate per day regardless of the services used by the patient (per diems). In addition, HMOs become more aggressive about medical management, implementing gatekeeper systems and utilization review, and contracting more

selectively with providers. Although PPOs may grow more quickly than HMOs, the HMOs continue to gain market share.

Phase Three. The stage is now set for a third phase, with increased PPO market share, reduced hospital and physician charges, and rigorous use of utilization review techniques. To continue to reduce costs, PPOs begin to monitor the resource usage of the providers on their panels, and terminate physicians and hospitals who use more resources per patient than average, or who use more resources than a predetermined or predicted level.[29]

HMOs have become equally aggressive about reducing costs. Medical management in general starts to become more intense and large group practices become interested in contracting with HMOs. Experience with PPOs encourages more beneficiaries to switch to HMOs, providing the HMOs with the critical mass necessary to encompass enough providers to coordinate care on a larger scale.

At this point, insurers see the need to have health care delivery networks to remain competitive in the market, providers become less concerned about the incursions of managed care on their autonomy and more concerned about survival, and the PPOs' trademarks—provider deselection, lower fees, and increased medical management—encourage physicians and other providers to form their own health care delivery networks or MCOs. While insurers, hospitals, and large physician multispeciality practices are in a good position to form AMCOs,[30] independent physicians in solo practice or small groups must start from scratch to create a network.

Phase Four. During the fourth phase, with managed care beginning to dominate the market, price differentials between indemnity plans and HMOs and PPOs become significant, and beneficiaries become more comfortable with the restrictions of HMOs and PPOs. Most of the non-Medicare population join a PPO or HMO and most physicians and hospitals align themselves with HMOs, PPOs, or health care delivery networks capable of contracting with HMOs or PPOs.

29. The techniques for evaluating resource usage are generally crude in that they do not evaluate why the physicians used more or less resources than the average or the predicted amount. *Deselection Predilection*, MEDICAL STAFF AND PHYSICIAN ORGANIZATION LEGAL ADVISOR, Mar. 1994, at 1.

30. Some large physician multispecialty practices actually own or are organizationally affiliated with hospitals such as The Mayo Clinic in Minnesota, the Cleveland Clinic in Ohio, the Carle Clinic in Illinois, and the Scott & White Clinic in Texas.

In addition, as pressure on fee levels grows, providers become more interested in capitation arrangements or salaries as opposed to fee-for-service arrangements. This facilitates the formation of organized health care delivery systems capable of comprehensive medical management. While not many markets in the United States have reached this phase, some areas that have include the Los Angeles-Anaheim-Riverside-San Diego area in California, the San Francisco-Oakland-San Jose-Sacramento area in California, and the Minneapolis-St. Paul area.[31]

Phase Five. The final phase will occur when most of the non-Medicare population is in AMCOs. While this has not occurred in any market yet, the three markets mentioned above are approaching this phase. In the Los Angeles area market, forty-seven percent of the insured population is in an HMO, while in the San Francisco area it has reached fifty-six percent.[32]

While managed care has been evolving in some Phase Four markets over the course of decades, it is likely that early-stage markets will evolve into later stages at a much quicker pace. Organizers of managed care plans now have the benefit of the knowledge gained in the development of existing later-stage markets. In addition, pressures to reduce costs have become very intense. The evolution will accelerate if state or federal health care reform legislation is passed that facilitates the development of managed care.

B. Physician Control of a Minority of AMCOs and Networks

The market dynamics described above will leave a minority of AMCOs and health care delivery networks operated by physicians. Although large multispecialty physician group practices may be well positioned to enter the managed care market, only about one third of physicians are in group practice. Of this group, most are in small groups of less than 10 physicians. As of 1991, there were only 189 large group practices with more than 100 physicians, 67 groups with between 75 and 99 physicians, and 146 groups with between 50 and 75 physicians.[33] About one third of physicians are in solo practice or have a single partner, another third are in group practices, and the remaining third are

31. *See* Mike Mitka & Julie Johnsson, *Messing with Texas*, AM. MED. NEWS, Apr. 4, 1994, at 9.
32. *Id.*
33. PENNY L. HAVLICEK ET AL., MEDICAL GROUPS IN THE U.S.: A SURVEY OF PRACTICE CHARACTERISTICS (1993).

in other practice settings, such as medical school faculty, employees of HMOs, and employees of hospitals.

The structural and legal disadvantages that physicians in independent practice and small groups face constitute a formidable barrier to the development of physician-sponsored networks and health plans. Even if independent physicians succeed in organizing a network, it is likely to face stiff competition. To contract with an insurance company or self-insured employer, the network must be more competitive than networks that the insurers can organize themselves as well as hospital-organized entities or large group practices. Given that the competing organizations are probably already entrenched in the market, are more experienced and well organized, and have greater financial resources, the probability for success is low.

Thus, independent physicians often choose to work with a hospital to form a physician-hospital health care delivery network.[34] By doing so, physicians gain the benefit of the administrative infrastructure of the hospital and its financial resources, but must give up a substantial portion of control to the hospital. To create a fifty-fifty partnership with the hospital, physicians need to organize themselves in a separate structure that works with the hospital. Since the hospital or insurer often assumes the initiative as well as the organizational burdens, the independent physicians or small group practices are likely to forego the hard work and high risks of organizing their own network. Unless this trend changes, AMCOs and their health care delivery networks are likely to be controlled primarily by insurance companies, secondarily by hospitals, and then by large multispecialty group practices.

C. Implications of Nonphysician Control of AMCOs

As discussed above, control of AMCOs by nonphysicians gives nonphysician managers the ultimate authority over medical decision making, with at least three adverse effects: 1) less than optimal performance by AMCOs, where performance is measured by the value achieved, 2) loss of patient-centered values in the medical management of health plans, and 3) transformation of the patient-physician relationship from one of trust, with the physician as the advocate of the patient's well-being, into an arm's length business relationship.

34. William Madigan, Remarks at the American Medical Association Leadership Conference (Feb. 11, 1994) (on file with the author).

Less than optimal patient outcomes will result from the shift in power because the primary source of savings achieved by AMCOs comes from medical management.[35] The challenge faced by the health care industry is to determine ways to reduce costs while continuing to provide high-quality services, thereby increasing the *value* of health care. Historically, creative initiatives in advances in medical care have come primarily from physicians and other scientists, not administrators who have no medical training.[36] Physicians continue to be the best qualified to make medical decisions that maximize the value of health care services[37] and embrace and resolve the challenge of finding ways to reduce costs without sacrificing coverage or quality. If this challenge is taken away from physicians by having nonphysician managers direct them, the creative initiative of physicians will be muted.[38]

Second, the shift of power will result in the loss of patient-centered values in medical treatment. Nonphysician managers are remote from the patients and, more important, their job is to maintain the financial viability of the enterprise. The fiduciary duty of the nonphysician manager is to act in the best interest of the enterprise, which can conflict with patient needs. Their customs and values are oriented around that duty, and thus they will not focus on patient-centered ways to manage medical care to reduce costs. Historically, bars on the corporate practice of medicine prevented the orientation of corporate managers from affecting the needs of patients. While those bars are being eliminated in most states, no legal or ethical theory of the corpora-

35. David Blumenthal, *Commentary: The Vital Role of Professionalism in Health Care Reform*, HEALTH AFF., Spring (I) 1994, at 252, 253.

36. In fact, many of the individuals who pioneered the conceptual thought and research underlying the medical management in AMCOs were physicians. *See, e.g.*, Paul M. Ellwood et al., *The Jackson Hole Initiatives for a Twenty-First Century American Health Care System*, 1 HEALTH ECON. 149 (1992). Physicians also led the way in performing research that demonstrated that different incentives and better medical management could result in savings by reducing the amount of unnecessary care. *See* Richard Kronick et al., *The Marketplace in Health Care Reform: The Demographic Limitations of Managed Care*, 328 N. ENG. J. MED. 148, 149 (1993).

37. Joseph White, *Markets, Budgets, and Health Care Cost Control*, HEALTH AFF., Fall 1993, at 44, 53; Blumenthal, *supra* note 35, at 253.

38. This is not meant to degrade the very significant contributions made to the formation of successful AMCOs by nonphysician professionals. However, their chief contribution has been to establish economic incentives and organizational structures to motive health plans, physicians, and beneficiaries to maximize the value of health care services. Nonphysicians have also helped design administrative structures and information systems needed for AMCOs to function.

tion as the provider has emerged to guide the behavior of corporate managers of health plans.

Anecdotal incidents suggest that insurance company managers tend to rely on formulas or standards to determine whether medical care is needed or to evaluate the performance of providers. The goal of these formulas is often to scale back the amount of care given by the provider for a given condition. These formulas and standards are crude tools, applied without consideration of the unique circumstances of the patients being treated by the provider.[39]

For example, a Rhode Island insurer recently promulgated guidelines for hospitalization periods that it expects its participating physicians to follow, with the goal of reducing costs by cutting the number of days the patients spend in the hospital.[40] Also, some HMOs have stopped providing epidural anesthetics for births deemed to be healthy.[41] In Texas, an insurer is deselecting physicians based on whether they fall within cost levels predicted for them by a formula. If a physician exceeds the predicted cost, the physician is deselected without any inquiry into why the formula was exceeded.[42]

To the contrary, an example of a patient-centered way to reduce costs is to keep patients healthy (preventive care) so that they do not need expensive health care (aggressive treatment of a health care problem caused by inadequate preventive care).

Finally, it is inevitable that the shift in power will denigrate the patient's trust in the physician because the physician will no longer be economically independent. The physician will become the agent of the AMCO, economically dependent on the AMCO, and taking direction from the AMCO managers. There

39. Again, this is not meant to denigrate the contributions of nonphysician managers, nor does it seek to portray them as inhumane or unconcerned about patients. It simply points out the fundamental realities of the legal and practical constraints that these individuals are obligated to operate within, and the consequences those constraints are likely to have on their decisions: the manager owes a fiduciary responsibility to the corporation or the enterprise, while the physician owes a fiduciary obligation to the patient.

40. Greg Borzo, *R.I. Doctors Face 'Absurd' Inpatient Limits*, AM. MED. NEWS, Mar. 21, 1994, at 1.

41. Danielle Crittenden, *Don't Give Birth Up Here*, WALL ST. J., Mar. 31, 1994, at A14 (noting that just as a woman in Canada was unable to receive an epidural because it was not "her turn," some large HMOs refuse to pay for epidurals in California, the Midwest, and Florida).

42. In one case, a physician who was named the insurer's physician of the month was deselected due to this formula several months after being given the award. *Deselection Predilection*, *supra* note 29.

will be no independent patient-physician contract. Physicians will make treatment recommendations to patients based on the protocols and limitations established by the AMCO, regardless of whether the physician believes that the called-for protocol is the best alternative for the patient. A physician who is independent of such a health plan feels free to inform the patient of other alternatives and to advocate for those alternatives, while a physician controlled and directed by an AMCO will not feel this freedom.[43]

Numerous individuals, including medical ethicists, physicians, and legal scholars, have questioned the potentially damaging effects of the shift in power over medical decision making to managed care organizations. However, because the perceived savings from converting the health care industry to AMCOs are so great, most government and private-sector policymakers are preoccupied with facilitating the conversion, and have given little serious thought to these effects. In fact, the possibility of having a small number of AMCOs serving most of the patients in a market is viewed as positive because it could increase the competition between efficient competitors and spur them to find even more ways to reduce costs.

To the extent that the issue of control over medical decision making is raised, removing control from physicians tends to be viewed as positive or of no real concern for three reasons. First, one of the tools that is expected to be available to purchasers of managed care in the near future is information about the quality of care delivered by AMCOs. This information would be based on outcome data, and the outcomes of each plan could be compared against performance standards and the outcomes of other AMCOs. Policymakers expect that purchasers will then be able to select the plan that offers the best value (the best combination of cost and quality). The assumption is that regardless of who makes medical decisions, AMCOs will have to maintain a high level of quality in order to remain competitive.

The use of outcome data and increased levels of information will help assure high performance by the AMCOs, revealing abuses such as arbitrarily withholding health care in order to

43. Advocates of AMCOs recognize this problem but believe that it can be resolved by standardizing information about quality, requiring health plans to report that information, and enabling patients to use that information to select a health plan. Although such a process, if successfully achieved, will benefit patients, it will *not* replace patient concerns about individual encounters.

meet budgetary goals. Outcome data will also provide AMCOs with an incentive to improve their performance, and will enable them to monitor their own progress in achieving a better value. However, outcome data do not address the issue of how greater value is achieved; they simply show where matters stand. A professional group must evaluate the data and determine how outcomes can be improved while maintaining or reducing costs; nonphysicians are not capable of doing this as well as physicians, and well-motivated physicians must have responsibility and control over this process to assure the data and other medical information is used to attain higher levels of performance.

The second argument in favor of the shift in power over medical decision making is based on the view that physicians are the primary culprits of high health care costs.[44] Physicians are perceived as having a financial interest in providing high-cost care, and as being unwilling to adopt a lower-cost practice, even if that lower-cost style results in a higher quality of care.

While health care costs have been increasing at an unsustainable rate under a system of physician-directed health care decision making, cost increases are attributable to a number of causes beyond the scope of physician control.[45] Physicians' decisions contributed to the cost crisis largely because physicians operate with an ethical framework that emphasizes providing every beneficial mode of patient treatment, a malpractice environment that buttresses that ethic, and a financing system that provides no incentives to find ways to conserve resources while pursuing that ethic.

The current challenge is to maintain the ethic of making the health care needs of the individual patient the highest priority, while finding ways to accomplish that at a lower cost. The belief that physicians are incapable of meeting this challenge or too self-interested to care is cynical and simply wrong. Through the centuries, the medical profession has implemented significant changes and is capable of doing so today. In fact, the process is well under way, and is following a pattern that usually occurs when the profession transforms itself: the realization by some physicians that change is necessary and their proposed solutions. While change is usually controversial and humans often resist

44. *See* Joseph P. Newhouse, *An Iconoclastic View of Health Cost Containment*, HEALTH AFF., Supp. 1993, at 152; Walter A. Zelman, *The Rationale Behind the Clinton Health Reform Plan*, HEALTH AFF., Spring (I) 1994, at 9.

45. Browning, *supra* note 16, at 170-73.

changing the status quo, intense debate within medical societies, academia, and other forums reveal the merit of change, and the medical profession gradually embraces the concept that change is needed and then vigorously pursues a solution. Some of the major changes that were implemented according to this pattern are the nineteenth-century effort to distinguish scientifically based allopathic medicine from numerous other theories; the nineteenth-century effort to develop a system of physician licensure; the twentieth-century effort to establish accreditation standards for medical schools and graduate medical education; and the twentieth-century effort to develop specialties and methods for certifying physicians as specialists.

The need to control health care costs has caused physicians to take the lead in reassessing the value of medical care. Physicians performed the research that revealed that significant amounts of medical care provided to patients may not be yielding benefits. In addition, physician organizations are assessing various aspects of medical care and developing practice parameters to assist physicians in determining what care should be provided. At the present time, virtually every national medical specialty society is in the process of developing practice parameters. Although the current changes in medical practice are controversial, the medical profession will adopt them if they in fact prove to be more effective than current methods.

Finally, an argument for the shift in power is based on widespread agreement among health care economists that some arbitrary limits on the provision of health care are necessary and inevitable[46] because it is not economically feasible to provide all beneficial health care to all people, especially considering the advancement of technology. Many health care economists believe that even if every cause of medical inflation were resolved except the introduction of new technology, advances in medicine alone would continue to fuel unsustainable increases health care costs. This is so because health care is not a single product, but rather a cluster or portfolio of products constantly increasing as a result of new technology—products that can be purchased to help patients that could not be helped before. The logical extension of this belief is that some rationing of care, or

46. *See* William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief*, 257 JAMA 220 (1987); Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 SCIENCE 418 (1990).

at the very least some control of new technology, will be necessary in the future. From this perspective, concentration of power over medical decision making in the AMCO is an acceptable way of accomplishing rationing or limiting new technology, and gives the government a convenient tool for implementing a rationing program.

However, before rationing takes hold, every effort should be made to see if the patient-centered ethic of physicians and society can be preserved. Physicians should be given the responsibility and incentives to find ways to provide needed care. Even if rationing new technology or the coverage of medical services becomes necessary, it can be accomplished without taking medical decision making away from physicians.

III. The Solution to the Great Concentration of Power in AMCO Nonphysician Management

The problems caused by the concentration of power over medical decision making can be ameliorated in two ways. First, AMCOs could establish medical boards composed of physicians, at least fifty percent of whom participate in the AMCO. (At the present time there is no vehicle for physicians participating in an MCO to provide input into the plan about medical management and economic issues.) The medical board of each MCO would have the authority to periodically review the AMCO's medical coverage, quality assurance and efficiency, and credentialing operations. These boards could be established on a voluntary basis by AMCOs or could be required by legislation. Second, legislation could be passed that facilitates the development of physician-sponsored health care delivery networks and health plans by establishing structural criteria, changing legal regulations that interfere with their structure and operation, and providing tax preferences and other financial assistance.

A. Medical Boards

At first blush, the proposal that advanced HMOs form medical boards appears to be very radical. Fundamentally, however, this is not a new idea and not radical at all—historical precedent shows that this concept has been applied before in the development of new institutions that had the potential to exert tremendous control over medical decision making. To the contrary, the truly radical concept is the formation of AMCOs that may ob-

tain an extraordinary concentration of power over medical decision making without any formal structures for physician input.

The historical precedent is the development of the modern hospital. As recently as the nineteenth century, the hospital was not an important tool in medical practice. It functioned more as a nursing home for the poor and a resource for public health calamities, such as epidemics or large numbers of injuries caused by natural disasters or war. However, as medical technology and organization advanced, the hospital became an increasingly important place for treatment because it had the necessary facilities, equipment, and support personnel that even large groups of physicians could not afford to duplicate in their offices.[47]

Like AMCOs, hospitals developed a legal structure that had the potential to remove the ultimate power over medical decision making from patients and physicians and give it to nonphysicians, as most were organized as corporations with a management structure and a governing board controlled by philanthropists and other leading citizens. As the operation of hospitals became more complex, they were managed by nonphysician, professional administrators.

When the organizational structure of the modern hospital was developed in the early twentieth century, there were concerns over the control of medical decision making in the hospital. This concern was resolved by requiring hospitals to have a separate, organized medical staff responsible for medical management in the hospital. This requirement, established in 1919 by the founders of the hospital accreditation program,[48] is currently a part of the standards for hospital accreditation of the Joint Commission on Accreditation of Healthcare Organizations and of the statutory or regulatory conditions of hospital licensure in virtually every state.[49]

The hospital medical staff does not have complete control over the provision of care within the hospital as corporate law requires that the ultimate responsible for the quality of care pro-

47. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (discussing the historic development of hospitals and medical organizations).

48. Everett A. Johnson, *Ethical Considerations for Business Relationships of Hospitals and Physicians*, HEALTH CARE MGMT. REV., Summer 1991, at 7, 9.

49. In addition, most states have a common law or statutory bar on the corporate practice of medicine that is meant to prevent nonphysicians from exercising control over medical decision making. These laws have become dormant in most states, but are still enforced in California, Colorado, Iowa, Ohio, and Texas.

vided on hospital premises remain with the hospital governing board. However, the governing board delegates the responsibility for medical management to the medical staff, the very vehicle by which hospital physicians present their views to the hospital governing board.

If, as this article proposes, all AMCOs were required to have medical boards, their organization would be similar in nature to the hospital organization, but less elaborate. The medical board of each AMCO would be responsible for reviewing the operational areas of the health plan involving medical decision making and making recommendations to management and the governing board about what and how decisions should be made. While management and the governing board would not be obligated to accept or implement the medical board's recommendations, they would be required to consider them in good faith. The goal is to provide an organized vehicle that allows the physicians who actually care for plans' beneficiaries to have some input in medical management decisions. Physician input will help minimize the adverse effects of nonphysician managers' concentrated power over medical decision making.

Allowing physicians to have this voice is likely to increase the AMCOs' performance: participating physicians can become directly involved in evaluating and recommending ways to reduce costs while maintaining quality, thereby enhancing their level of commitment and motivation. Involvement also allows physicians to express patient-centered values during the process of reducing costs. By permitting physicians to continue in their traditional role as patient advocates, a valuable part of the physician-patient relationship is preserved.

B. Legislation to Facilitate the Development of Physician-Directed Health Care Delivery Networks and Health Plans

Another obvious solution to the problems caused by the concentration of power over medical decision making with nonphysicians is to enact legislation that facilitates the development of physician-controlled health care delivery networks and health plans. AMCO performance can be maximized by giving physicians the maximum incentive to embrace the challenge of finding ways to reduce costs while enhancing quality. Physicians will be most motivated if they own and operate the MCOs or the

health care delivery network and are responsible for managing the premium or capitation income.

This is not a new idea. Again, history supports resolving a health care crisis in America by passing legislation to facilitate the formation of provider-sponsored health plans and provider-sponsored health care delivery networks. Two legislative solutions proposed this century were very successful.

The first was state legislation promoting the development of Blue Cross and Blue Shield plans, which were to be sponsored by providers—Blue Cross plans by hospitals and Blue Shield plans by physicians. Before 1929, efforts to cover hospitalization expenses and/or provide for medical care were isolated, providing, at best, income replacement during illness.[50] In 1929, Baylor University offered the first hospital insurance coverage, guaranteeing twenty-one days of hospital care for six dollars per year. World War II brought additional pressures for health care coverage when wage freezes forced labor leaders to push for other benefits, including medical care.[51] Under the hospital coverage plans established in the early 1930s, beneficiaries contracted with a specific hospital for care; later, when attempts were made to offer a choice of hospitals within any given community, state insurance commissioners who viewed Baylor-type plans as group contracts wanted to subject free-choice plans, viewed as insurance, to state regulation.[52]

In response to this regulatory problem, states enacted specific legislation exempting hospitalization (Blue Cross) and medical services (Blue Shield) plans from state insurance regulations. These unique organizations solved the health care crisis existing at that time,[53] and were extraordinarily successful. In many states, the Blue Cross and Blue Shield organizations were sponsored by hospital associations and medical societies, respectively. Today, they are large, sophisticated organizations, in many states the largest operators of health plans and administra-

50. ROBERT D. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 9 (1963).

51. *Id.* at 19.

52. SYLVIA A. LAW, BLUE CROSS: WHAT WENT WRONG 7 (1974).

53. Blue Cross and Blue Shield plans differ from commercial insurance plans in several respects: 1) plans are nonprofit and include members of the public on the governing boards, 2) plans operate autonomously at the community level, and 3) rate or benefits changes must be approved in advance by state insurance regulators. BLUE CROSS BLUE SHIELD ASSOCIATION, FACT BOOK: ALL ABOUT THE BLUE CROSS AND BLUE SHIELD ORGANIZATION 3 (1994).

tive services for self-insured plans, and in many regions the carrier and intermediary for the Medicare program.

The second piece of legislation addressing a health care crisis was the federal Health Maintenance Organization Act of 1973 (HMO Act),[54] which specifically authorized the IPA-model HMO and generally facilitated the development of HMOs. Between 1960 and 1971, national health expenditures increased by 188 percent. A Senate Report noted: "There is substantial evidence which establishes that HMO enrollees receive high quality care at a lower cost—as much as one-fourth to one-third lower than traditional care in some parts of this country."[55] President Richard Nixon endorsed the concept of HMOs and federal involvement in their development in order to reduce health care costs, encourage preventive care, foster early treatment, and increase the number of physicians and outpatient facilities in the inner city and rural areas.[56]

The HMO Act preempts state law regarding formation and governance of these organizations. In particular, the HMO Act lists the services to be provided by HMOs to enrollees and requires employers with health benefit plans to offer HMOs to their employees if HMOs are available in the area.[57] The HMO Act was very successful: it provided a blueprint for the creation of HMOs, regulations for HMOs, and requirements and assistance that helped form them.

Legislation to facilitate the formation of physician-sponsored health care delivery networks and health plans could follow the same general pattern as the Blue Cross and Blue Shield statutes and the federal HMO Act, and be equally as successful.

First, the legislation should define and authorize the formation of networks and health plans sponsored by physicians and controlled by physicians that participate in the network, a health plan sponsored by physicians and controlled by participating physicians, and a joint venture health plan between a physician-sponsored network and an insurer, hospital, or other institution where the network physicians have substantial influence or control over the joint venture.

54. 42 U.S.C. §§ 300e to 300e-17 (1988).

55. S. REP. No. 129, 93d Cong., 1st Sess. (1973), *reprinted in* 1973 U.S.C.C.A.N. 3033, 3033-34.

56. *Id.* at 3034.

57. 42 U.S.C. § 300e-9.

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Second, the legislation must provide a separate regulatory structure for the networks and plans, preempting, for example, state insurance regulations, antitrust laws, and bars on self-referral. This structure must protect the public while not creating unreasonable barriers to the creation of these network or plans.

Finally, tax preferences and other financial and technical assistance must be provided: investment credits or deductions for funds invested in the components of these entities, such as computer hardware and software needed to provide the medical information necessary to support medical management, or amounts invested in required reserves; low-interest loan pools available for the formation of health plans; and reserve guaranty funds to assure purchasers that their health care would be financed.

Conclusion

These are extraordinary times for the health care industry. The traditional ways of doing business are being challenged as inadequate to meet the challenges of today. Ironically, the cost and access crises arise from the very success of traditional ways of doing business: health care is in such demand that our society is having difficulty finding ways to pay for it. In the process of reorganizing the health care industry to solve current problems, we should not forget the elements that have made American medicine so successful. In particular, any new ways of financing and delivering medicine should continue to foster the creativity and initiative of American physicians and should provide patients with the confidence that the recommendations of their physicians constitute the best professional judgement about what health care services will meet their unique needs. The proposals in this article will not interfere with efforts to provide high-quality health care at a lower cost and that will preserve the ingredients that have made American medicine the best in the world.