1998

The Evolution of Health Care Decision Making: The Political Paradigm and Beyond

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I. INTRODUCTION

Health care decisions in the United States traditionally have been made from the perspective of three distinct paradigms: the provider paradigm (influenced primarily by physicians), the free market paradigm, and the political paradigm.[1] The twentieth century has witnessed a dramatic

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1. Professor Einer Elhauge has identified four paradigms: moral, professional (what I have more broadly termed as the "provider" paradigm), market, and political. Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1452 (1994). Although I agree that all four paradigms theoretically exist, I do not believe that the moral paradigm identified by Professor Elhauge has ever played a dominant role in American health care decision-making. Under the moral paradigm, health care is provided any time it is morally imperative to do so, whether the moral "line" is drawn at absolutism or "adequate" health care, or somewhere in between. *Id.* at 1452-55. The moral paradigm has not played a

evolution in health care decision-making, with each paradigm continuously struggling for dominance. When one paradigm ultimately succeeds in gaining dominance, the others recede, but do not disappear. Inevitably, the weaknesses inherent in the dominant paradigm become obvious and unbearable, allowing another paradigm to emerge, at least temporarily, as dominant.

Traditionally, health care decisions in the United States were made according to the provider paradigm, in which providers—primarily physicians—held virtually unfettered authority to recommend and treat patients and were reimbursed on a fee-for-service basis.[2] The provider paradigm dominated health care decision-making for so long because market defects such as provider-induced demand, lack of quality or cost comparison information, and the ubiquity of indemnity insurance made it difficult, if not impossible, for consumers or other purchasers (such as employers) to rebut providers' treatment recommendations.[3]

Beginning in the 1970s, however, escalating health care costs forced Americans to look for alternatives to the provider paradigm. Specifically, because health care costs under the provider paradigm were virtually unrestrained, a market was created for alternative delivery systems that promised cost savings. Organizational structures and mechanisms designed to contain health care costs—most notably the health maintenance organization (HMO)[4]—became attractive alternatives for employers and other health

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dominant role in American health care decision-making because, in its absolutist form, it simply costs too much. In its watered-down form of mandating "adequate" or "basic" health care, the moral paradigm cannot dominate health care decision-making because moral agreement as to "basic" health care is realistically impossible. Indeed, to the extent that agreement may be had concerning the definition of "basic" health care, that agreement would most likely be the result of the dominance of the political paradigm, not the moral paradigm.

2. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE, BOOK ONE: A SOVEREIGN PROFESSION (1982); Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47 (1993).

"Fee-for-service" is the term used to describe a payment method whereby the provider establishes a fee for a given service and is reimbursed accordingly by the payer. Under a fee-for-service system, generally the only cost control mechanism available to the payer is the imposition of a "usual, customary and reasonable" limitation, in which the payer will pay only what similar physicians in a similar locality would charge for the service. *See* CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 1033 (1988).

3. *See* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 326-30 (1991).

4. The term "health maintenance organization" was first coined by Dr. Paul Ellwood, Jr., the founder of the Jackson Hole Group (a health reform discussion group) and the Foundation for Accountability (an organization dedicated to furthering quality improvement in managed care). Lisa Belkin, *The Ellwoods: But What About Quality?*, N.Y. TIMES, Dec. 8, 1996 (Magazine), at 68, 70. An HMO is generally defined as an organization that offers

care purchasers. The interest in and success of the HMO spawned a mind-numbing explosion of managed care hybrids which were armed and ready to do battle with unnecessary care: IPAs,[5] PPOs,[6] EPOs,[7] POSs,[8] and PHOs.[9] By 1996 approximately fifty-nine million Americans[10]—including three quarters of the working population with health care benefits[11]—were enrolled in managed care plans, and over eighty percent of doctors had signed contracts with managed care organizations (MCOs).[12] The era of the provider paradigm ended and was replaced by a market paradigm that ran virtually unchecked.

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comprehensive health benefits to members and pays for the provision of such benefits on a fixed per capita basis. BARRY R. FURROW ET AL., HEALTH LAW 309 (1995).

5. IPA is the acronym for Independent Practice Association, a managed care organization that contracts with individual physicians with independent practices. FURROW ET AL., *supra* note 4, at 309. Although the payment methodology varies from IPA to IPA, the chief characteristic of an IPA is the independence of the physicians, each of whom maintains his or her own private office. *See* Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678, 1678 (1995).

6. A PPO, or Preferred Provider Organization, is an organization wherein a selected network of health care providers offers its services to health care purchasers on a discounted fee-for-service basis. Jeffrey B. Schwartz, *The Preferred Provider Organization as an Alternate Delivery System*, 6 J. LEGAL MED. 149, 150 (1985). A PPO enrollee is allowed to obtain services from non-network physicians, but may be required to pay higher out-of-pocket costs and "make a copayment or pay a deductible," such as co-pays, coinsurance, or deductibles for out-of-network care. *Id.*

7. An EPO, or Exclusive Provider Organization, is a PPO in which the enrollee is not covered for care rendered by a non-network physician. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 799 (3d ed. 1997).

8. A POS, or Point of Service plan, is an HMO that permits enrollees to use non-network providers in exchange for increased enrollee cost sharing. *Id.*

9. A PHO, or Physician-Hospital Organization, is a joint venture in which one or more hospitals and one or more groups of physicians combine forces and market their services to MCOs and other payers, such as self-insured employers. *See* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 184 (1996); Carl H. Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 296 n.95 (1994).

10. *See* Julie A. Jacob, *Local Health Plans Could Top Big HMOs in '97*, AM. MED. NEWS, Jan. 20, 1997, at 3; *Nearly One Quarter of Americans Now Enrolled in HMO Plans*, MED. & HEALTH, Oct. 28, 1996, *available in* 1996 WL 7993740 [hereinafter *Nearly One Quarter*]; *see also* Janet Firshein, *Texas Malpractice Law Bites Managed Care-Plans*, LANCET, June 14, 1997, at 1753, 1753 (stating that 65 million Americans are enrolled in HMOs). The dominant managed care model is the IPA, which comprised 44 % of the total managed care population in 1996. *Nearly One Quarter*, *supra*.

11. Geri Aston, *HHS: Managed Care Applied Brakes to '95 Health Spending*, AM. MED. NEWS, Feb. 17, 1997, at 5.

12. *See id.* (reporting that, by 1995, 83% of physicians had signed managed care contracts).

Inevitably, perhaps, the freewheeling market paradigm created opportunities for abuse by managed care organizations more interested in the bottom line than patient care. By the mid-1990s, MCOs came under increasing attack by critics who claimed that the free market approach to health care decision-making was too impersonal, too inflexible, and too cost-conscious. Armed with a spate of horror stories of a free market gone awry, these critics began capturing the attention of state and federal legislators. Policymakers on both sides of the political aisle entered the fray, challenging the supremacy of the free market paradigm by introducing "anti-managed care" or "managed care reform" legislation designed to minimize perceived abuses.

The recent ascendancy of the political paradigm as the dominating influence in health care decision-making is a natural evolutionary reaction to the unrestrained market paradigm. And although a certain degree of political intrusion into the health care marketplace is both necessary and useful, it has the potential to unravel the efficiencies and progress achieved by managed care. It is essential, therefore, that health care policymakers recognize the limited utility of political intervention in the health care market and consciously strive to achieve a proper equilibrium between provider, patient, and payer. Overzealous political intervention in the name of "reform" may cause the health care decision-making pendulum to swing back to the provider paradigm, with its inherent tendency to escalate health care costs and diminish access.

One possible way to achieve decision-making equilibrium and end the cycling of extremist mono-paradigmatic dominance is to inject into the provider-patient-payer triad a neutral third party, a fiduciary whose duty is to guard the best interests of the patient, to stand as an informed agent between the financially self-interested provider and payer. This article will explore the recent ascendancy of the political paradigm, address its shortcomings, and offer suggestions for implementing a new health care decision-making process for the twenty-first century—the fiduciary paradigm.

II. THE RISE OF THE POLITICAL PARADIGM

A. Problems of the Market Paradigm

The market paradigm's dominance is approaching its nadir because its inherent incentive for underutilization poses a significant risk to patients when unchecked by regulatory limits. The anecdotal harms which have occurred thus far have received intense media attention. In a recent popular movie, actress Helen Hunt won an Oscar for her portrayal of a single mother who encounters difficulty seeking care from an HMO for her asthmatic son. In one scene, an enraged Hunt spews obscenities accusing

the HMO of being more interested in profit than her son's health. In many theatres, Hunt's rage draws applause from empathetic audience members.[13]

Hunt's fictitional frustration with managed care has real-life analogs. For example, in October 1996, in the case of *Grijalva v. Shalala*,[14] a U.S. district court judge granted summary judgment to a plaintiff class comprised of Medicare HMO beneficiaries who sought declaratory and injunctive relief against the Secretary of Health and Human Services for failing to enforce the statutory appeal rights of Medicare HMO enrollees.[15] Specifically, the plaintiffs asserted that the Medicare HMOs in which they were enrolled intentionally delayed the claims appeal process by failing to provide adequate notice of a coverage denial, leaving enrollees unable to pursue their appeal rights in a timely manner.[16] In granting summary judgment for the plaintiffs, the judge concluded that the HMOs' internal reconsideration processes

> approximate[d] a "rubber stamp" of the [HMOs'] initial denial . . . and . . . that existing reconsideration procedures followed by HMOs fail to secure minimum due process for Medicare beneficiaries. Notice and informal hearing requirements set forth by statute and regulations are all but ignored. The existing system fails to provide "a meaningful opportunity" to present the claim "at a meaningful time."[17]

Dilatory HMO appeal tactics were also the focus of a June 1997 decision by the California Supreme Court, which ruled that substantial evidence existed that Kaiser Permanente—the second largest MCO in the country[18]—committed fraud by intentionally dragging its heels in an internal arbitration dispute with an enrollee.[19] Specifically, the enrollee brought an arbitration claim against Kaiser after he was diagnosed with lung cancer, claiming his physician's five-year misdiagnosis had caused irreparable harm.[20] After filing the arbitration claim, however, Kaiser engaged in dilatory tactics, refusing to agree to the appointment of a neutral arbitrator for nearly five months, despite language in its enrollment contract which stated that all arbitrators "shall" be selected within sixty days of the demand for arbitration.[21] As a result of Kaiser's delay, the enrollee was

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13. Susan Brink, *HMOs Were the Right Rx*, U.S. NEWS & WORLD REP., Mar. 9, 1998, at 47.

14. 946 F. Supp. 747 (D. Ariz. 1996).

15. *Id.* at 749, 760-61.

16. *Id.* at 749-50.

17. *Id.* at 759.

18. *Nearly One Quarter*, *supra* note 10 (noting that as of January 1, 1996, the Blue Cross/Blue Shield System was ranked first with 10,134,592 members and Kaiser Foundation Health Plans was ranked second with 6,924,080 members).

19. Engalla v. Permanente Med. Group, Inc., 938 P.2d 903, 908 (Cal. 1997).

20. *Id.* at 908-09.

21. *Id.* at 910-11.

unable to resolve his dispute before he died.[22] The court viewed evidence of an independent analysis of Kaiser arbitration data which found that, despite contractual language promising selection of arbitrators within sixty days, it took Kaiser 674 days, on average, to appoint a neutral arbitrator to resolve coverage disputes.[23] The California Supreme Court concluded that the evidence of knowing misrepresentation was "plain,"[24] and that "there [was] evidence that Kaiser established a self-administered arbitration system in which delay for its own benefit and convenience was an inherent part, despite express and implied contractual representations to the contrary."[25] Thus, the court ruled that there was sufficient evidence to support the trial court's denial of Kaiser's motion to compel arbitration on grounds of fraudulent inducement.[26]

Moreover, in late April 1997, Kaiser Permanente paid a $1 million settlement with the Texas Department of Insurance, which had alleged that Kaiser had routinely retrospectively denied coverage for emergency room care and had faulty quality assurance mechanisms.[27] In July 1997, an arbitration judge in California awarded $1.1 million against a small HMO, Inter Valley Health Plan, for refusing to refer its enrollee, Joyce Ramey, to a kidney specialist, despite the recommendation of her primary care physician.[28] The willful refusal to refer Ramey, which caused permanent kidney failure, led the arbitration judge to take the unusual step of imposing $100,000 in punitive damages in addition to $1 million in compensatory damages.[29]

In yet another California case, parents have brought suit against the giant HMO PacifiCare, asserting an action for torture and alleging that the HMO denied home health care to their infant son, who suffered from a congenital heart defect.[30] Specifically, the complaint alleges that, in order to maximize profits, PacifiCare intentionally refused continued home health

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22. *Id.* at 912.

23. *Id.* at 913.

24. *Id.* at 917.

25. *Id.* at 918.

26. *Id.* at 921-22.

27. *See* David R. Olmos, *Texas Regulators Assail Kaiser on Physicians, Care*, L.A. TIMES, Apr. 24, 1997, at D1; Kathy Walt, *State Report Rips Health Care Giant; Kaiser Permanente's Refusal to Pay Cited*, HOUS. CHRON., Apr. 23, 1997, *available in* 1997 WL 6552759.

28. David R. Olmos, *Pomona HMO Found Liable in Malpractice Case*, L.A. TIMES, July 10, 1997, at D1. The suit was not barred by ERISA because the plaintiff was not enrolled in the HMO through an employer-sponsored health plan, but rather through Medicare. *Id.*

29. *Id.*

30. Jay Greene, *Family Sues HMO for Torture for Denying Care*, CHARLESTON GAZETTE, June 13, 1997, at 3C.

care for the infant, knowing its actions would cause imminent death.[31] Although the legal theory employed in this case (torture) is unusual,[32] it reflects the increasingly emotional tone of the backlash against MCO cost-containment practices and the growing creativity of plaintiffs' lawyers in devising causes of action.

These kinds of anecdotal cases have taken their toll on the public's perception of managed care. A November 1996 poll conducted by the Harvard School of Public Health and the Kaiser Family Foundation found that fifty-four percent of Americans believe that the "government needs to protect consumers from being treated unfairly and not getting the care they should from managed-care plans."[33] Moreover, a February 1997 poll conducted by Louis Harris and Associates found that thirty-eight percent of Americans believe MCOs "generally do a . . . bad job of serving their customers."[34] Even the "father" of managed care, Dr. Paul Ellwood Jr.,[35] has publicly admitted that "we are reaching the point where we need to have some sort of quality assurance mechanism that assures the public they are getting reasonably good care from HMOs."[36] Empirically, a study published in *The Journal of the American Medical Association* in October 1996[37] concluded that vulnerable subpopulations of Medicare HMO enrollees— such as the elderly, the poor, and those with chronic conditions or deteriorating health—had inferior health when compared with similar subpopulations enrolled in fee-for-service Medicare.[38]

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31. *Id.*

32. The lawyer for the family believes that an HMO had never before been sued under a California criminal torture statute. *Id.*

33. *See* David S. Hilzenrath, *Backlash Builds over Managed Care; Frustrated Consumers Push for Tougher Laws*, WASH. POST, June 30, 1997, at A1.

34. *See id.*

35. *See* Belkin, *supra* note 4, at 68.

36. *Should NCQA Become a Federal Agency?*, MED. & HEALTH, Dec. 16, 1996, at 3, 3.

37. John E. Ware et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 JAMA 1039 (1996).

38. *See id.* at 1039. *But see Statement of Medicare and Quality of Care for the American Association of Health Plans Before the Subcomm. on Labor, Health and Human Services and Educ. of the Senate Appropriations Comm.*, Nov. 13 1996, *available in* 1996 WL 667420 (statement of William A. MacBain) [hereinafter MacBain] (citing various studies indicating that seniors enrolled in Medicare HMOs are equally or more satisfied than their fee-for-service counterparts); *Statement on Safeguarding the Health Care of Senior Citizens Before the Subcomm. on Labor, Health and Human Services, and Educ. of the Senate Appropriations Comm.*, Nov. 13, 1996, *available in* 1996 WL 667417 (statement of Gail R. Wilensky, Chair of the Physician Payment Review Commission (PPRC)) (reporting results of the PPRC's survey of Medicare beneficiaries enrolled in HMOs which indicated high overall satisfaction levels).

B. Enter the Politicians

The high degree of negative attention on managed care has drawn intense political interest.[39] The natural political response to consumer and provider complaints about managed care has been to pass legislation mandating expanded benefits and increasing provider autonomy, a response which, if unrestrained, eventually will cause health care costs to rise and access to diminish, signaling a return to the dominance of the provider paradigm.

1. "Drive-Through" Deliveries

Perhaps the first evil targeted by lawmakers was the so-called "drive-through delivery," wherein some MCOs routinely required that new mothers be discharged from the hospital shortly after giving birth.[40] Media reports of mothers who were forced by MCOs to leave the hospital as early as six hours after delivery sparked public anger and captured the attention of lawmakers looking for a politically safe "'motherhood and apple pie'" issue.[41] In response, the majority of state legislatures quickly passed laws mandating that MCOs permit mothers to stay in the hospital for a minimum number of days.[42] In September 1996 President Clinton signed into law a bill, effective in 1998, requiring all ERISA[43] health plans to cover a

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39. *See generally Federal Legislation Relating to Health Care Quality: Hearing Before the Senate Labor and Human Resources Comm.*, 105th Cong. (1998).

40. Hilzenrath, *supra* note 33, at A6.

41. *See* Leigh Page, *State Legislators Spent Busy Year Trying to Manage Managed Care*, AM. MED. NEWS, Sept. 9, 1996, at 3 (quoting Geri Dallek, policy analyst for Families USA, an advocacy group for children and families).

42. *See, e.g.*, ALASKA STAT. § 21.42.347 (Michie 1996); ARIZ. REV. STAT. ANN. § 20-1057(s) (West Supp. 1997); ARK. CODE ANN. § 23-99-404 (Michie 1997); CONN. GEN. STAT. ANN. § 38a-503c(a) (West Supp. 1997); GA. CODE ANN. § 33-24-58.1 (1997); 215 ILL. COMP. STAT. ANN. 5/356s (West Supp. 1997); IOWA CODE ANN. § 514C.12 (West Supp. 1997); KY. REV. STAT. ANN. § 304.17A-145 (Michie 1996); MD. CODE ANN., INS. CODE § 490HH (1996); MINN. STAT. ANN. § 62A.0411 (West Supp. 1996); N.Y. INS. LAW § 3216 (McKinney Supp. 1997); TEX. INS. CODE ANN. 21-53F(4)(a) (West Supp. 1998); *see also* Christina Kent, *It's Unanimous: Senate Curbs "Drive-Through Deliveries,"* AM. MED. NEWS, Sept. 23, 1996, at 3 (stating that, at the time the Senate passed the federal law in September 1996, 28 states had passed laws mandating a minimum 48-hour hospital stay following delivery).

43. ERISA is the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C. & 29 U.S.C.). ERISA is a federal law that establishes standards for employer-sponsored pension and benefit plans, including health benefit plans. *See* FURROW ET AL., *supra* note 4, at 516.

minimum of two days' hospitalization after vaginal deliveries and a minimum of four days' hospitalization after caesarean delivery.[44]

2. "Drive-Through" Mastectomies

After the adoption of laws mandating minimum hospital stays for deliveries, consumer and provider groups turned their attention to a new cause: outpatient mastectomies—dubbed "drive-through mastectomies." State legislators again took the lead, successfully passing laws that required MCOs to cover inpatient mastectomies and corresponding minimum lengths of stay.[45] Federal legislators jumped on this bandwagon as well, introducing several bills to mandate inpatient mastectomy coverage and minimum lengths of stay.[46] In his State of the Union address in February 1997, President Clinton formally recognized Dr. Kristen Zarfos, a Connecticut surgeon vocally opposed to outpatient mastectomies, and joined the growing chorus of opposition:

> Just as we ended drive-through deliveries of babies last year, we must now end the dangerous and demeaning practice of forcing women home from the hospital only hours after a mastectomy. I ask your support for bipartisan legislation to guarantee that a woman can stay in the hospital for 48 hours after a mastectomy.[47]

Despite this political momentum, a recent study conducted by the Medstat Group of Ann Arbor, Michigan, for the American Association of Health Plans (AAHP)[48] indicated that the percentage of patients having outpatient breast cancer surgery in 1993 and 1994 was virtually identical for individuals enrolled in traditional fee-for-service insurance plans versus

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44. Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603(a)(5), 110 Stat. 2874, 2935-38 (codified at 29 U.S.C.A. § 1185 (a)(1)(A)(i)-(ii) (West Supp. 1997)).

45. As of April 1, 1997, 26 states had introduced bills regulating coverage of mastectomies. See, e.g., ARK. CODE ANN. § 23-99-405 (Michie Supp. 1997); N.M. STAT. ANN. § 59A-46.41.1 (Michie 1997); OKLA. STAT. ANN. tit. 36, § 6060.5(d) (West Supp. 1998); R.I. GEN. LAWS § 27-41-43:1 (Supp. 1997); TEX. INS. CODE ANN. § 21.52G(3)(a)(1) (West Supp. 1998); 1997 Conn. Acts 97-198 § (1)(a) (Reg. Sess.).

46. *See, e.g.*, H.R. 135, 105th Cong. (1997); S. 249, 105th Cong. (1997); S. 143, 105th Cong. (1997); *see also* H.R. 164, 105th Cong. (1997) (requiring health plans to pay for reconstructive breast surgery if they cover mastectomies).

47. *"We Must Be Shapers of Events, Not Observers"; "We Must Rise to a New Test of Leadership,"* WASH. POST, Feb. 5, 1997, at A19 (quoting President Clinton's February 1997 State of the Union address).

48. AAHP is a trade association located in Washington, D.C., which represents the interests and lobbies on behalf of approximately 1000 managed care organizations. MacBain, *supra* note 38.

managed care organizations.[49] Thus, as a matter of public policy, presently there is scant empirical evidence that managed care has created perverse incentives for the performance of outpatient mastectomies.

But empirical evidence is unlikely to dampen the zeal of managed care reformers. Anecdotal horror stories provide all the political fuel necessary to sustain a prolonged period of political success. Indeed, in February 1997, the Department of Health and Human Services, which contracts with MCOs under the Medicare program, notified all MCOs holding managed care contracts that, as a condition of contract renewal, the Department would forbid plans from imposing outpatient mastectomies on their enrollees.[50] Rather than imposing a minimum length of stay, the new HHS policy requires that the decision as to the location and subsequent length of stay for mastectomy surgery be left up to the patient, in consultation with her physician.[51]

The new HHS policy is clearly a reaction to political pressure from consumer and provider groups and may have a significant spillover effect into other contracts MCOs have with private payers, such as employers.[52] Perhaps in an attempt to ward off federal legislation applicable to all MCOs, the managed care industry's trade association announced an official policy in November 1996 that its member plans "'should not require outpatient care for removal of a breast.'"[53] Instead, in conformity with the new Medicare policy, member plans should allow physicians to make such decisions in consultation with their patients.[54]

3. "Gag" Clauses

The political paradigm also has focused on the so-called "gag clauses" contained in most early managed care contracts with providers. Gag clauses typically state that the provider "shall agree not to take any action or make

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49. Geri Aston, *Opposition to Outpatient Mastectomy Mounts*, AM. MED. NEWS, Mar. 3, 1997, at 1. Specifically, the Medstat Group study revealed that partial mastectomies were conducted on an outpatient basis for 19% of patients in indemnity plans as well as capitated plans. *Id.* Simple mastectomies were performed on an outpatient basis for 22% of enrollees in indemnity plans, versus 21% of enrollees in capitated health care plans. *Id.* Likewise, radical or modified radical mastectomies were performed on an outpatient basis for 7% of indemnity enrollees versus 8% of capitated enrollees. *Id.*

50. *Id.*

51. *Id.*

52. Medicare, the federal health care program for the elderly, pays for about one-third of all mastectomies performed in the United States. *Id.*

53. *Speedier Procedures Raise Regulatory Hackles*, MED. & HEALTH, Nov. 18, 1996, at 2, *available in* 1996 WL 7993717 (quoting the Board of the American Association of Health Plans); *see also* Leigh Page, *Managed Care Reforms Remain Focus of State Lawmakers*, AM. MED. NEWS, Jan. 27, 1997, at 3.

54. *Speedier Procedures Raise Regulatory Hackles*, *supra* note 53.

any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in [this MCO] or the quality of [this MCO's] coverage."[55] Many providers have interpreted these gag clauses as prohibiting them from informing their patients about the MCOs' provider reimbursement methodology or treatment options which are not covered by the MCO because such information could undermine the confidence of enrollees in the quality of the managed care organization's coverage.[56] Opponents of gag clauses view them as infringing upon the professional autonomy of physicians and as violative of the Hippocratic Oath, by which physicians pledge to act "for the benefit of the sick according to [their] ability and judgment."[57]

The backlash against gag clauses was so severe that *Time* magazine boldly printed a picture of a gagged physician on the cover of its January 8, 1996 issue.[58] By the end of June 1997, over thirty states had enacted legislative bans on gag clauses.[59] In late February 1997, the Clinton Administration announced that it will not allow MCOs contracting with Medicaid—the federal-state health care program for the poor—to include gag clauses in their provider contracts.[60] In announcing the policy, President Clinton proclaimed that "[f]amilies facing illness simply should not have to worry that the doctor they trust does not have the freedom to tell them what they need to know."[61] This regulation was explicitly codified in the 1997 budget bill,[62] which also imposed a similar ban upon MCOs contracting with the Medicare[63] program.[64]

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55. Paul Gray, *Gagging the Doctors*, TIME, Jan. 8, 1996, at 50, 50 (quoting a managed care contract between U.S. Healthcare and Dr. David Himmelstein, a vocal opponent of such gag clauses).

56. *Id.*

57. 5 ENCYCLOPEDIA OF BIOETHICS 2632 (Warren Thomas Reich ed., rev. ed. 1995).

58. TIME, Jan. 8, 1996.

59. Hilzenrath, *supra* note 33, at A1 (citing data compiled by Families USA).

60. Geri Aston, *Your Right to Talk to Patients*, AM. MED. NEWS, Mar. 10, 1997, at 1.

61. *Id.*

62. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4704(b)(3)(A), 111 Stat. 251, 496 (1997) (codified at 42 U.S.C.A. § 13966-2(b)(3)(a) (West Supp. 1997)).

63. Medicare is a federal program which provides health care to the elderly. Approximately 11% of Medicare beneficiaries are enrolled in HMOs. *Testimony Before the Subcomm. on Labor, Health and Human Services of the Senate Appropriations Comm.*, Nov. 13, 1996, at 2, *available in* 1996 WL 667419 (statement of Geraldine Dallek, Director of Health Policy, Families USA). However, enrollment in Medicare HMOs is growing at a rate of about 80,000 to 90,000 beneficiaries per month, or approximately 35% per year. MacBain, *supra* note 38.

64. Balanced Budget Act of 1997, § 4704, 111 Stat. at 295 (codified at 42 U.S.C.A. § 1395W-22(j)(3) (West Supp. 1997)). The new law states that an MCO with a Medicare contract

In an effort to curb the trend of legislatively imposed managed care mandates, many large MCOs voluntarily deleted gag clauses from their provider contracts.[65] Likewise, the managed care industry's trade association has announced a "Patients First" initiative which encourages MCOs to make publicly available all information regarding coverage decision methodology, including utilization review[66] and physician payment structure and incentives.[67] The industry's effort to derail legislative action is likely futile, since banning gag clauses is perceived as pro-consumer and pro-free speech, thus providing a big political payoff with relatively minimal adverse impact on the managed care industry.

4. Other Miscellaneous Piecemeal Reforms

Other piecemeal legislative reform efforts have succeeded at both the state and federal levels. At the federal level, for example, the Health Care Financing Administration (HCFA) has issued final HMO "sunshine" regulations, effective January 1, 1997, which require public disclosure of any physician payment incentives used by HMOs that contract with Medicare or Medicaid.[68] The regulation also requires Medicare or Medicaid HMOs to provide or otherwise ensure the existence of minimum levels of stop-loss insurance coverage for contracting physicians, who are

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shall not prohibit or otherwise restrict a covered health care professional . . . from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

Id. § 4001, 111 Stat. at 295. The budget bill was signed into law by President Clinton on Aug. 5, 1997. The inclusion of this Medicare gag clause prohibition should not have come as a surprise. A bipartisan bill, the "Patient Right to Know Act," introduced by Reps. Greg Ganske (R-IA) and Edward Markey (D-MA), had garnered over 280 cosponsors—more than a majority of the House—and was publicly supported by President Clinton. H.R. 586, 105th Cong. § 2(a)(1) (1997); *see* Aston, *supra* note 60, at 1.

65. Sharon McIlrath, *New Restrictions on HMOs?: Congress Looking at Gag Rules, 'Drive Through' Mastectomies*, AM. MED. NEWS, Dec. 2, 1996, at 1.

66. Utilization Review (UR) is a process of determining whether a claim for health care benefits should be paid (prospective UR) or whether a claim should have been paid (retrospective UR). *See* Andrew Ruskin, *Capitation: The Legal Implications of Using Capitation to Affect Physician Decision-Making Processes*, 13 J. CONTEMP. HEALTH L. & POL'Y 391, 409 n.108 (1997).

67. *Health Plans to Disclose Doctor Pay Methods, Utilization Management Criteria, Under Big New AAHP Campaign*, MED. & HEALTH, Dec. 16, 1996, at 1, 1; *see also Putting Patients First* (visited Aug. 12, 1997) <http://www.aahp.org/menus/index.cfm>.

68. 61 Fed. Reg. 69,034, 69,050 (1996) (to be codified at 42 C.F.R. § 417.479).

deemed to be at substantial financial risk.[69] These regulations were codified by Congress as part of the 1997 budget bill.[70]

Moreover, in late April 1997, in response to the decision in *Grijalva v. Shalala*,[71] the Health Care Financing Administration issued a final regulation to address the concern of Medicare HMO enrollees that their health plans were engaging in purposeful foot-dragging on appeals of coverage denials.[72] The new regulation requires all MCOs contracting with Medicare to decide appeals regarding urgently needed care within seventy-two hours.[73] Moreover, if the MCO denies the appeal, the Medicare beneficiary may appeal to an HCFA contractor, who then must review the MCO's decision within ten days.[74] Perhaps not wishing to forego political credit for this decision, Congress explicitly codified this final regulation in the 1997 budget bill.[75]

The 1997 budget bill included several additional important piecemeal reforms for both Medicare and Medicaid MCOs. Specifically, with regard to both Medicare and Medicaid MCOs, the budget bill required that emergency services be covered "without regard to prior authorization or the emergency care provider's contractual relationship with the organization."[76] This language thus prohibits the use of prior authorization for emergency services and mandates payment for such services without regard to whether the provider belongs to the MCO's network. More significantly, the Act defines an "emergency medical condition" as a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain)" according to the perspective of the "prudent layperson, who possesses an average knowledge of health and medicine, [and] could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."[77]

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69. *Id.* at 60,049.

70. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 296-97 (codified at 42 U.S.C.A. § 1395W-22 (West Supp. 1997)). The new law also prohibits Medicare MCOs from using indemnification clauses in their contracts with providers if the indemnification would result from a civil suit "brought for any damage caused to an enrollee . . . by the organization's denial of medically necessary care." *Id.* 1997 Conn. Acts 97-198 § (1)(a) (Reg. Sess.); § 4001, 111 Stat. at 297.

71. 946 F. Supp. 747 (D. Ariz. 1996); *see supra* notes 14-17 and accompanying text.

72. 62 Fed. Reg. 23,368 (1997) (to be codified at 42 C.F.R. pt. 417).

73. *Id.* at 23,375 (to be codified at 42 C.F.R. § 417.617). The regulation became effective June 30, 1997. *Id.* at 23,368 (to be codified at 42 C.F.R. pt. 417).

74. *Id.* The anticipated cost of the new regulation is approximately $60 million per year. *Id.* at 23,374.

75. Balanced Budget Act of 1997, § 4001, 111 Stat. at 294.

76. *Id.* § 4001, 111 Stat. at 290 (codified at 42 U.S.C.A. § 1395W-22 (West Supp. 1997)).

77. *Id.*

This reform was successful in large part due to pressure from consumer and provider organizations who complained that MCOs were routinely retrospectively denying reimbursement for emergency visits.[78] The common illustration of this problem is the patient who arrives at the emergency room, complaining of chest pains thought to indicate the onset of a heart attack, but who is determined to suffer only from a bad case of indigestion.[79] Under the new law, an MCO with a Medicare contract would have to reimburse such emergency room visits, so long as a prudent layperson would think that failure to seek emergency help would result in serious harm.[80]

Other significant reforms in the 1997 budget bill include a ban on all gag clauses in provider contracts with Medicare or Medicaid MCOs,[81] mandatory expedited appeals procedures for emergency care,[82] mandatory annual quality reviews of Medicare and Medicaid MCOs by independent, third-party reviewers,[83] and a requirement that Medicaid MCOs meet minimum state solvency requirements.[84] While these reforms help to palliate the most vocal concerns of managed care critics, they do not have to be applied to MCO enrollees who are not Medicare or Medicaid beneficiaries, such as those who purchase individual health policies or who receive health benefits through the workplace.[85]

State legislators have eagerly attempted to fill this regulatory void. As of April 1, 1997, some eight hundred managed care reform bills had been introduced,[86] most of which addressed narrowly defined abuses. Missouri, for example, passed a law in 1996 which established minimum standards for utilization review (UR) agencies, including a requirement that all coverage denial decisions be made by a licensed physician,[87] and that all UR

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78. Geri Aston, *Emergency Care Standards Seen as Step Forward, but Not Enough*, AM. MED. NEWS, Feb. 17, 1997, at 1.

79. *See id.*

80. *See* Balanced Budget Act of 1997, § 4001, 111 Stat. at 290.

81. *See supra* notes 60-64 and accompanying text.

82. *See supra* notes 72-75 and accompanying text.

83. Balanced Budget Act of 1997 § 4705, 111 Stat. at 498 (codified at 42 U.S.C.A. § 1396a-2 (West Supp. 1997)).

84. *Id.* § 4706, 111 Stat. at 501.

85. An estimated 10.4 million Americans receive health insurance through individual policies and 145.7 million Americans receive health insurance through the workplace. *See Statement of the Health Insurance Association of America on the Cost of Group-to-Individual Portability Before the Subcomm. on Health of the House Commerce Comm.*, Mar. 7, 1996, *available in* 1996 WL 134455 (statement of Thomas F. Wildsmith).

86. Leslie Werstein Hann, *Building New Walls Around Managed Care: Managed Care Legislation 1997*, BEST'S REV., May 1997, at 50, 50 (citing figures obtained from the Health Policy Tracking Service of the National Conference of State Legislatures, Washington, D.C.).

87. MO. ANN. STAT. § 374.510.3 (West 1996).

agencies provide an appeal mechanism which resolves all appeals within thirty days, or, in the case of an emergency, two business days.[88] The Connecticut legislature passed a virtually identical UR reform law in 1997.[89]

Several states have enacted so-called "any willing provider" statutes,[90] which require MCOs to contract with any provider who is willing to enter into a contract and who meets the MCOs standards for participation.[91] Access to cutting edge therapies is increasingly the focus of reformers, who complain that MCOs too often deny coverage to such therapies on grounds that they are "experimental."[92] A widely publicized lawsuit filed against Health Net by the family of an enrollee, Nelene Fox, captured the attention of California lawmakers.[93] Fox's estate claimed that the MCO wrongfully denied coverage for a bone marrow treatment for her breast cancer on grounds that it was experimental and thereby caused her death.[94] The Fox lawsuit ultimately resulted in an unprecedented $89 million verdict—including $77 million in punitive damages[95]—against Health Net, although the case was later settled out of court for a lesser sum.[96] A landmark California law passed in late 1996 attempts to ensure the Fox tragedy is not repeated by requiring that all MCOs and other health insurers permit enrollees to obtain independent, third-party review of any benefit claim denied as "experimental" treatment.[97] Such outside review for experimen-

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88. *Id.* § 374.510.1(3)(b)-(c).

89. CONN. GEN. STAT. ANN. § 38a-226c (West Supp. 1997). As of the time this article was written, Governor John Rowland was expected to sign H.B. 6883 into law. *See Texas, Connecticut, Florida, Arizona Laws Hit HMOs on Malpractice, External Review*, MANAGED CARE WK., June 2, 1997, *available in* 1997 WL 9048550.

90. *See, e.g.*, GA. CODE ANN. § 33-18-17(b) (Supp. 1996); IDAHO CODE § 41-3927.1 (1997); LA. REV. STAT. ANN. § 40:2202(c) (West 1992); MASS. GEN. LAWS ANN. ch. 176B, § 3 (West 1992 & Supp. 1997); MONT. CODE ANN. § 33-22-1704(3) (1995); N.M. STAT. ANN. § 59A-46-35 (Michie 1995); VA. CODE ANN. § 38.2-3407(B) (Michie 1994). Several other states are considering enacting such legislation. *See* Hann, *supra* note 86, at 50.

91. *See* WILLIAM J. CURRAN ET AL., HEALTH CARE LAW, FORENSIC SCIENCE, AND PUBLIC POLICY 880 (4th ed. 1990); Alice G. Gosfield, *Who Is Holding Whom Accountable for Quality?*, 16 HEALTH AFF. 26, 31 (1997).

92. *California Law to Expand Access to Experimental Care*, AM. MED. NEWS, Oct. 14, 1996, at 24 [hereinafter *California Law*].

93. Berkeley Rice, *Look Who's on the Malpractice Hot Seat Now: But Don't Think Doctors Are off the Hook*, MED. ECON., Aug. 12, 1996, at 192, 199.

94. *Id.*

95. *Id.*

96. *Id.*; *see also* Thomas William Malone & Deborah Haas Thaler, *Managed Health Care: A Plaintiff's Perspective*, 32 TORT & INS. L.J. 123, 140 (1996); Richard C. Reuben, *In Pursuit of Health*, 82 A.B.A. J. 54, 55 (1996); Jane Bryant Quinn, *Prognosis Is Poor on Suits Against HMOs*, WASH. POST, June 1, 1997, at H2.

97. *See California Law*, *supra* note 92, at 24.

tal treatments must be conducted by a panel of physicians, whose decision will be binding on the payer.[98]

C. Comprehensive Market Reform

1. State Efforts

While the "abuse of the month" approach to managed care reform is potentially minacious to the continued viability of managed care, the more serious long-term threat comes from emerging, broad-based reform efforts, particularly those efforts aimed at restricting the use of capitation[99] or closed provider panels.[100] As of April 1, 1997, twenty-six states had introduced comprehensive reform bills.[101] These comprehensive bills have met with mixed success. Anti-managed care ballot initiatives in both Oregon and California were narrowly defeated in November 1996.[102] Oregon Measure 35 would have banned the use of capitation to pay physicians.[103] California's defeated Propositions 214 and 216[104] would have, *inter alia*, outlawed the use of physician bonuses and withholds[105]

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98. *Id.*

99. In a 1994 survey of 108 managed care plans, 56% of IPAs and 34% of group-or staff-model HMOs used capitation as the primary payment method for primary care physicians. Gold et al., *supra* note 5, at 1681.

100. A recent survey found that 39% of MCOs admitted that physician utilization patterns had a moderate or large influence on their decision to enter into a contractual arrangement. *Id.* at 1680.

101. Hann, *supra* note 86, at 50.

102. *User-Friendly HMOs Could Stem Tide of Laws in West*, MED. & HEALTH, Nov. 18, 1996, *available in* 1996 WL 7993731. Proposition 214 was defeated by a 58-42% margin. *Id.* Proposition 216, which contained essentially the same reforms as Proposition 214, in addition to specifying certain taxes on the health care industry, was defeated by a larger margin, 61-39%. *Id.*

103. *See* David R. Olmos, *Election '96: Experts Foresee More Efforts to Reform HMO Regulation*, L.A. TIMES, Nov. 7, 1996, at D4; Joanne Wojcik, *Managed Care Survives Votes*, BUS. INS., Nov. 11, 1996, at 61. Measure 35 was supported by only 35% of Oregon voters. *Id.*

104. *See supra* note 102 and accompanying text.

105. *See* California Props. 214, 216 (1996), *available in* WESTLAW, Ca-Legis-Old Database; *see also* Robert Pear, *Stakes High As California Debates Ballot Issues to Rein In H.M.O.'s*, N.Y. TIMES, Oct. 3, 1996, at A1. A bonus is the payment of a certain sum of money at the end of a set period, often based upon the number of specialist referrals made by a particular physician or the overall profits of the MCO during that period. *See* MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST 140 (1993). Withholds, by contrast, are the mirror image of bonuses. They are a certain sum of money which is withheld from the physician as a reserve for referral or other expenses. *See* Lauren M. Walker, *Turn Capitation into a Moneymaker*, MED. ECON., Mar. 13, 1995, at 58, 68.

and mandated that MCOs and other insurers pay for health services recommended by a physician unless they obtained (and paid for) a contrary second opinion.[106] Likewise, in Missouri, a comprehensive MCO reform law was vetoed by the Governor due to fear of its potential adverse impact on health care costs.[107]

Despite these defeats, the momentum appears to be on the side of comprehensive reform, which is emerging as an attractive alternative to piecemeal legislation.[108] Several states have been successful in enacting comprehensive reform. For example, Texas recently made national headlines by passing a bill which, for the first time, provides an explicit, direct malpractice action against MCOs for injuries suffered as a result of denied coverage.[109] A successful companion bill imposed additional reforms, such as requiring all MCOs to obtain a certificate of authority from the State Department of Insurance;[110] banning gag clauses;[111] establishing mini-

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106. *See* Pear, *supra* note 105, at A1.

107. *See* Hann, *supra* note 86, at 50.

108. *See generally* Geri Aston, *Regulating Care: New Managed Care Bills Prompt Questions About Federal Oversight*, AM. MED. NEWS, Mar. 17, 1997, at 1.

109. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (West Supp. 1998). Governor George Bush allowed the Texas MCO liability law to take effect without his signature, due to concerns that the imposition of liability on MCOs might make managed care unaffordable for some Texans. Frank Bass, *HMOs in Texas to Be Made Liable for Malpractice*, WALL ST. J., May 23, 1997, at D3; Sam Howe Verhovek, *Texas Allowing Suits Against H.M.O.'s: State Will Be the First to Permit Consumer Claims for Malpractice*, N.Y. TIMES, June 5, 1997, at A16.

Similar bills are currently being considered by Congress. *See* H.R. 1719, 105th Cong. (1997); H.R. 1415, 105th Cong. (1997); H.R. 820, 105th Cong. § 2789 (1997); S. 644, 105th Cong. (1997); S. 373, 105th Cong. § 2789 (1997). Several state legislatures, including New York and California, are also considering similar bills. *See* Jay Greene, *California Bill Would Hold HMOs Liable for Denying Treatment*, ORANGE COUNTY REG., July 12, 1997, at C1 (stating that S.B. 977, sponsored by Sen. Steve Peace, would define HMO coverage decisions to be subjected to corporate liability); *HMOs to Face Malpractice Suits Under New Texas Law*, BESTWIRE, June 11, 1997, *available in* LEXIS, News Library, Curnws File (noting that the California Senate recently passed a bill sponsored by Sen. Herschel Rosenthal that would permit malpractice actions against MCOs under state law by revising the definition of "practice of medicine" under the state's corporate practice of medicine doctrine); Tom Precious, *Battle Under Way to Make State HMOs Liable on Care*, BUFFALO NEWS, July 27, 1997, at A1.

Aetna is currently challenging the Texas MCO liability law on the grounds that it is preempted by ERISA. Richard A. Oppel, Jr., *Aetna Challenges HMO Law in Suit: Statute Allows Malpractice Claims*, DALLAS MORNING NEWS, June 18, 1997, *available in* 1997 WL 7432491; Linda O. Prager, *Aetna Challenges Texas Law Lifting HMOs' ERISA Shield*, AM. MED. NEWS, July 21, 1997, at 1.

110. TEX. INS. CODE ANN. § 20A.04 (West Supp. 1998).

111. *Id.* § 7.

mum reserve requirements;[112] requiring mandatory internal quality assurance programs,[113] appeals procedures and expedited appeals for emergency care;[114] providing enrollee information regarding benefits and rights;[115] and setting forth certain termination rights for providers.[116]

In March 1997, Idaho also passed a broad reform law which, among other things, requires that MCOs reimburse care provided by physicians who are not members of the MCO's network.[117] Although an MCO is permitted under the new Idaho law to charge enrollees higher cost-sharing for care received out-of-network,[118] the imposition of a mandatory point-of-service option essentially bans the use of traditional, closed-panel HMOs, in which the enrollee is covered only for care provided by the HMO's physicians.[119] The Idaho law also bans gag clauses,[120] establishes minimum capital reserve requirements,[121] establishes enrollee complaint procedures,[122] and requires that MCOs allow obstetricians-gynecologists to be primary care gatekeepers.[123]

Missouri, which had passed a narrower UR reform measure in 1996,[124] passed a sweeping reform bill in 1997 which, *inter alia*, bans gag clauses;[125] requires MCOs to provide mandatory, point-of-service options and pay for emergency services[126] if a "prudent layperson" (rather than MCO administrator or physician) would believe care is immediately needed;[127]

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112. *Id.* § 13.
113. *Id.* § 28.
114. *Id.* § 11.
115. *Id.* § 8.
116. *Id.* § 19.
117. IDAHO CODE § 41-3905 (Supp. 1997); *see also* Julie A. Jacob, *New Idaho Law Includes Mandatory Point-of-Service Option*, AM. MED. NEWS, May 5, 1997, at 7. A similar bill was recently approved by the Health, Environment, Welfare, and Institutions Committee of the Colorado General Assembly by a vote of 10-1. Julie A. Jacob, *Colorado Bill Would Ease HMO Network Restrictions*, AM. MED. NEWS, Mar. 10, 1997, at 9. The Colorado bill, H.R. 1122, sponsored by State Rep. Marcy Morrison, also contains other reform measures, such as requiring MCOs to provide adequate access to specialists, COLO. REV. STAT. ANN. § 10-16-704(9)(a)(III) (West Supp. 1997), and providing consumer information regarding dispute resolution and appeals, *id.* § 10-16-704(9)(g)(I), and referral procedures, *id.* § 10-16-704(9)(b)(I)-(V).
118. IDAHO CODE § 41-3915 (Supp. 1997).
119. *Id.* § 41-3915(5).
120. *Id.* § 41-3927(4).
121. *Id.* § 41-3905(2).
122. *Id.* § 41-3918(1).
123. *Id.* § 41-3915(2)(e).
124. *See supra* notes 87-88 and accompanying text.
125. MO. ANN. STAT. § 354.442(2)(10) (West Supp. 1997).
126. *Id.* § 376.1367.
127. *Id.* § 354.600.

imposes binding, independent arbitration for coverage disputes;[128] and permits enrollees harmed by coverage denials to sue the MCO directly.[129] Governor Chiles of Florida recently signed into law a broad managed care reform law which bans gag clauses;[130] provides for expedited coverage dispute resolution;[131] and provides for the dissemination of consumer information relating to coverage, physician payment,[132] and appeal rights.[133]

2. Federal Efforts

Federal lawmakers could not be expected to sit idly on the sidelines of the reform debate. In March 1997, President Clinton appointed a thirty-two member Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which issued a report setting forth a health care consumers' "bill of rights."[134] The report sets forth seven broad rights for health care consumers:

(1) the right to receive accurate, easily understood information in making informed health care decisions;
(2) the right to a choice among health care providers that is sufficient to allow access to appropriate, high-quality health care;
(3) the right to access emergency health care when necessary (including a "prudent layperson" standard of when such emergency care is necessary);

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128. *Id.* § 376.1387.

129. *Id.* § 376.1378; *see also* David S. Hilzenrath, *Furor by Doctors, Patients Grows over Managed Care*, IDAHO STATESMAN, July 1, 1997, *available in* 1997 WL 12709781 (stating that Governor Carnahan signed the bill during the last week in June 1997); *Missouri Considers Ways to Regulate Managed Care*, AM. MED. NEWS, Mar. 3, 1997, at 24; *State Health Week: Missouri Moves to Restrict HMOs, Permit Malpractice Claims*, WASH. HEALTH WK., June 9, 1997, *available in* 1997 WL 9047987.

130. 1997 Fla. Laws ch. 159, § 2.

131. *Id.* § 8.

132. *Id.* § 9.

133. *Id.* § 10; *see also HMO Accountability Series*, ST. PETERSBURG TIMES, June 9, 1997, *available in* 1997 WL 6202441; *Texas, Connecticut, Florida, Arizona Laws Hit HMOs on Malpractice, External Review*, MANAGED CARE WK., June 2, 1997, *available in* 1997 WL 9048550. The 1997 Florida law, unlike the Missouri law, does not provide for an explicit direct cause of action against HMOs by enrollees damaged by coverage denials. Governor Chiles vetoed such a direct action law in 1996 on grounds that it would increase health care costs. *HMO Accountability Series*, *supra*.

134. *See generally* ADVISORY COMM'N ON CONSUMER PROTECTION & QUALITY IN THE HEALTH CARE INDUSTRY, CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES: REPORT TO THE PRESIDENT OF THE UNITED STATES (1997).

(4) the right to participate fully in one's own health care decisions;
(5) the right to considerate, respectful, and non-discriminatory care;
(6) the right to keep confidential all identifiable health care information (and the corollary right to view one's own medical records); and
(7) the right to a fair and efficient appeals process for resolving coverage disputes (including a system of external review).[135]

The Commission's recommendations were endorsed by President Clinton[136] and incorporated into legislation, the Patients' Bill of Rights Act, sponsored by Senate Minority Leader Tom Daschle and Representative John Dingell.[137] And while a recent poll indicates that seventy-four percent of Americans support the Commission's recommendations, their support drops off dramatically when told that the recommended changes may increase the cost of health insurance or cause some employers to drop health care coverage.[138]

Numerous other managed care reform bills have been introduced in the 105th Congress.[139] Perhaps the most significant comprehensive reform bills thus far are the Kennedy-Dingell bill,[140] and a Republican analog, the Patient Access to Responsible Care Act (PARCA), introduced by Senator Alfonse D'Amato and Representative Charles Norwood.[141] Both bills would prohibit prior authorization and require the use of a prudent layperson

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135. *Id.*

136. *See* Letter to Congressional Leaders on the "Patients' Bill of Rights Act of 1998," 34 WEEKLY COMP. PRES. DOC. 549 (Mar. 31, 1998).

137. *See* S. 1891, 105th Cong. (1998); S. 1890, 105th Cong. (1998); H.R. 3605, 105th Cong. (1998).

138. Kaiser/Harvard National Survey of Americans' Views on Consumer Protection inManaged(Jan.21,1998)<http://www.kff.org/kff/library.html?document_key=2059&data_type_key=301> [hereinafter National Survey]. Specifically, when told that the reforms might increase the cost of health insurance, support dropped to 33%; when told it might cause some employers to drop health coverage for workers, support dropped to 15%. *Id.*

139. *See, e.g.*, S. 701, 105th Cong. (1997); S. 386, 105th Cong. (1997); H.R. 1222, 105th Cong. (1997); H.R. 815, 105th Cong. (1997); H.R. 66, 105th Cong. (1997).

140. Health Insurance Bill of Rights Act of 1997, S. 373, 105th Cong. (1997) (introduced by Sen. Kennedy); Health Insurance Bill of Rights Act of 1997, H.R. 820, 105th Cong. (1997) (introduced by Rep. Dingell as the House version of S. 373).

141. Patient Access to Responsible Care Act, S. 644, 105th Cong. (1997) (introduced by Sen. D'Amato); Patient Access to Responsible Care Act, H.R. 1415, 105th Cong. (1997) (introduced by Rep. Norwood as the House version of S. 644). As of the time this article went to press, the House version of PARCA, H.R. 1415, had over 225 cosponsors—more than a majority of the House of Representatives.

standard for emergency care,[142] ensure direct access to certain specialists,[143] ban gag clauses,[144] and mandate internal quality assurance programs.[145] The bills would also amend the Employee Retirement Income Security Act (ERISA)[146] to permit MCO enrollees who are harmed by coverage denials to bring a direct malpractice suit against the MCO.[147] Several courts have held that such direct malpractice actions, even when available,[148] are preempted by ERISA on grounds that such suits "relate to" an employee benefit plan.[149] Thus, the leading federal bills would make it clear that statutes authorizing direct malpractice suits—such as the one recently passed in Texas[150]—would not be preempted by ERISA.

The combined force of piecemeal and comprehensive MCO reform legislation at both the federal and state levels will ineluctably erode the political paradigm's dominance. The expanded benefits and increased

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142. S. 373 § 2771; H.R. 820 § 2771; S. 644 § 2771; H.R. 1415 § 2771.

143. S. 373 § 2772; H.R. 820 § 2772; S. 644 § 2772; H.R. 1415 § 2772.

144. S. 373 § 2787; H.R. 820 § 2787; S. 644 § 2774; H.R. 1415 § 2774.

145. S. 373 § 2777; H.R. 820 § 2777; S. 644 § 2780; H.R. 1415 § 2780.

146. *See* 29 U.S.C. §§ 1001-1461 (1994).

147. S. 373 § 2789; H.R. 820 § 2789; *see also* H.R. 1749, 105th Cong. (1997) (creating a new federal cause of action under ERISA against MCOs). The Clinton Administration is on record as supporting amendment of ERISA to permit suits against MCOs. *See* Stuart Auerback, *Law Guarding HMOs from Suit Challenged; Patients Find Doctors Easier to Sue*, WASH. POST, Dec. 17, 1996, at Z8; Robert Pear, *H.M.O.'s Using Federal Law to Deflect Malpractice Suits*, N.Y. TIMES, Nov. 17, 1996, at A24.

148. A plaintiff wishing to sue an MCO may proceed under various theories, including respondeat superior, corporate negligence, breach of contract, and fraud. *See* Malone & Thaler, *supra* note 96, at 130-46. However, due to the existence of "corporate practice of medicine" statutes in some states, a plaintiff may not be able to sue the MCO for coverage denial decisions because such statutes effectively deem the MCO legally incapable of practicing medicine; therefore, any harm resulting from the decision to treat or deny treatment falls squarely on the shoulders of the treating physician, not the MCO. *See* Reuben, *supra* note 96, at 56; *see also* BARRY R. FURROW ET AL., LIABILITY AND QUALITY ISSUES IN HEALTH CARE 281-82 (1991).

149. *See* Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1490 (7th Cir. 1996); Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1329 (5th Cir. 1992); *see also* 29 U.S.C. § 1144(a) (1994). The Supreme Court has interpreted the "relates to" language and its corresponding preemption quite broadly, holding that a law relates to an employee benefit plan (and therefore is preempted) if "it has a connection with or reference to such a plan." Shaw v. Delta Air Lines, 463 U.S. 85, 97 (1983). The lower federal courts, however, are hopelessly split on the issue of the proper scope of ERISA preemption of various liability theories levied against MCOs. *See* Frank L. Coan, Jr., Note, *You Can't Get There from Here—Questioningthe Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1024 (1996); Laura H. Harshbarger, Note, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 191 (1996).

150. *See supra* notes 112-18 and accompanying text.

provider autonomy which are emerging from the political paradigm do not come free of charge. Rising health care costs will inevitably follow, and the question then becomes: how do we control health care costs in the long-run without reverting once again to the provider or market paradigms and their inherent abuses? This question will be explored extensively in the next section.

III. THE FIDUCIARY PARADIGM

Once the paradigm dominance phenomenon has been identified and accepted by policymakers, they will be in a position to rationally influence health care decision-making in a positive way. The question, of course, is: how?

One possible way to learn from the past and plan for a better future is to devise a new paradigm that would give health care consumers (patients) the power to fight for and receive quality health care when it is medically necessary. Health care consumers are in desperate need of assistance in understanding and fighting for their rights under increasingly complex laws, regulations, and insurance contracts. A new, consumer-oriented paradigm would provide a much-needed check on the power of payers and providers, who have inherent incentives to underutilize or overutilize care.[151] Health care consumer fiduciaries, in contrast to providers and payers, would act solely in the best interests of health care consumers.[152] A fiduciary

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151. Physicians, of course, are generally considered to have a fiduciary relationship with their patients. *See* Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 796 (1983); *see also* Moore v. Regents of Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990). Indeed, the Hippocratic Oath itself seems to establish such a fiduciary relationship. *See* 5 ENCYCLOPEDIA OF BIOETHICS, *supra* note 57, at 2632. However, cost-containment mechanisms used by MCOs—such as capitation and withholds and bonuses based on referral volume— undeniably interject a degree of financial self-interest which holds the potential to conflict with the physician's loyalty to the patient. *See* Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 339 (1996) ("The fates of patients cannot simply be entrusted to their physicians under the assumption that doctors have the incentives and discretion to provide satisfactory care."); *see also* Ruskin, *supra* note 66 (arguing that courts should engage in a financial risk analysis of capitation arrangements to determine if the MCO's payment methodology effectively controls the physician's clinical decision-making so as to justify the imposition of MCO liability). Thus, barring the highly unlikely action of completely abolishing such cost-containment mechanisms, physicians can no longer realistically be counted upon to act with unrestricted loyalty to their patients, necessitating the appointment of a fiduciary who does not face such conflicts. *See* Malinowski, *supra*, at 339.

152. *See* RESTATEMENT (SECOND) OF TRUSTS § 170(1) (1959). Section 170(1) establishes a duty of loyalty of trustees to "administer the trust solely in the interest of the beneficiaries." *Id.* Moreover, the principle established by § 170(1) is "applicable not only to trustees but to other fiduciaries." *Id.* cmt. a.

paradigm would provide a new system of checks and balances to stabilize and stop the dominance cycling of the provider, market, and political paradigms.

What would such a fiduciary look like? It could take any number of forms. Perhaps the first and most obvious form would be the establishment of a governmental entity to serve as fiduciary. In these times of shrinking budgets and correspondingly shrinking bureaucracies, however, the creation of a new governmental entity would be expensive and therefore politically unrealistic.[153]

Another, less expensive alternative would be for the government (state or federal) to contract with private organizations dedicated solely to assisting consumers with health care coverage disputes. Such private organizations could be empowered to make final determinations with regard to coverage issues (subject to limited judicial review) and would likely provide more expeditious determinations than a government bureaucracy. However, they, too, would not be cheap. One way of funding such private fiduciary organizations without raising taxes or reducing outlays in other governmental programs would be to require all insurers—whether traditional indemnity or MCOs—to contract directly with fiduciaries that are federally or state qualified. The process of state or federal qualification, not to mention explicit statutory language establishing consumers as their principal, would ensure that private fiduciaries are not beholden to insurers or MCOs. Although the cost of contracting with private fiduciary organizations may be passed along to health care consumers in the form of higher premiums, the existence of fiduciaries could, in the long-run, reduce health care costs by reducing the number of lawsuits filed for wrongful claim denials and improving the health of consumers who would be more likely to receive medically necessary care in a timely fashion.

A final alternative is to deem the MCO itself a fiduciary for its enrollees. Although this may seem strange given the inherent conflicting interests of the MCO, plaintiffs' lawyers are enjoying some success arguing that MCOs governed by ERISA are fiduciaries which breach their duty of loyalty by failing to reveal certain limitations or financial incentives placed on plan physicians.[154] For example, in *Shea v. Esensten*,[155] the Eighth

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153. Indeed, a poll conducted by the Kaiser Family Foundation and Harvard researcher Robert Blendon in early 1998 found that, when asked who should protect managed care consumers, only 23% of respondents said the primary responsibility should rest with the government. *See* National Survey, *supra* note 138. Interestingly, however, support for government responsibility rises to 51% when specific agencies, such as the Federal Aviation Administration or the Securities and Exchange Commission, are mentioned. *Id.*

154. *See* Eddy v. Colonial Life Ins. Co., 919 F.2d 747 (D.C. Cir. 1990). *Eddy* is the earliest case imposing a fiduciary duty upon a health insurer to affirmatively inform an enrollee of material information. *Id.* Although *Eddy* involved a traditional indemnity insurance defendant, its holding provided the basic analytical framework for later cases

Circuit held that a medical group which had contracted with the plaintiff's MCO was a fiduciary under ERISA and owed plan beneficiaries, such as the plaintiff, a common law duty of loyalty,[156] as well as the specific statutory obligation to discharge its duty solely in the interest of the participants and beneficiaries.[157] Thus, the medical group's failure to reveal to enrollees the existence of financial incentives to limit specialist referrals constituted a breach of its fiduciary duty of loyalty.[158] Specifically, the Eighth Circuit concluded:

> From the patient's point of view, a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self serving financial considerations created by the health insurance provider. . . . Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it "knows that silence might be harmful."[159]

Thus, under *Shea*, an MCO has a fiduciary duty to reveal any financial incentives which might discourage its physicians from providing needed care. This concept was followed by the district court in New Hampshire in *Drolet v. Healthsource, Inc.*,[160] a class action in which the plaintiff alleged that the managed care plan offered by her employer breached its fiduciary duty to enrollees by "egregiously misrepresent[ing] the nature of the relationship between the [MCO] . . . and its contracting physicians."[161] Specifically, the plaintiff argued that language in the "Group Subscriber Agreement" provided by the MCO did not reveal that physicians contracting with the MCO were given bonuses of up to thirty-three percent in additional income if they kept referrals, tests, and hospitalizations below a certain level.[162]

The MCO in *Drolet* moved to dismiss for failure to state a claim,[163] asserting that it owed no fiduciary duties to the plaintiffs because it was not a plan administrator within the meaning of ERISA.[164] The court rejected

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extending fiduciary duty principles to MCOs.

155. 107 F.3d 625 (8th Cir. 1997).

156. *Id.* at 628 (citing Varity Corp. v. Howe, 516 U.S. 489, 506-07 (1996)).

157. *Id.* (quoting 29 U.S.C. § 1104(a)(1)).

158. *Id.* at 629.

159. *Id.* at 628-29 (quoting Bixler v. Central Pa. Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993)).

160. 968 F. Supp. 757 (D.N.H. 1997).

161. *Id.* at 758.

162. *Id.*

163. *Id.*

164. *Id.* at 760.

this argument, finding that because the MCO admitted that it held the final authority to decide benefit appeals, it exercised the necessary authority or control over the plan to qualify as a plan administrator.[165] Thus, the court denied the MCO's motion to dismiss, concluding that it owed the plaintiff class a duty of loyalty, including a duty not to mislead and to disclose material facts potentially adverse to the enrollee's interests.[166]

More recently, in *Weiss v. CIGNA Healthcare, Inc.*,[167] a plaintiff brought a class action against her employer-sponsored HMO, alleging that the plan had violated its fiduciary duty under ERISA by, *inter alia*, imposing gag clauses on its physicians;[168] using capitation, withholds, and bonuses to pressure physicians to under treat patients;[169] and failing to disclose to enrollees its physician compensation methodology.[170] CIGNA moved to dismiss the suit for failure to state a claim,[171] and the district court granted the motion as to all of the plaintiff's claims except the claim relating to the gag clause.[172] In upholding the legal viability of the gag clause claim, the court concluded:

> CIGNA acts in a fiduciary capacity—and therefore comes under the obligations of loyalty imposed by ERISA—to the extent that it exercises discretionary control over the communication of medical information to Plan participants by their physicians. CIGNA's alleged policy of restricting the disclosure of non-covered treatment options would, if true, directly undermine the ability of plan participants to have unfettered access to all relevant information relating to their physical or mental condition and treatment options. Such a policy would thereby constitute a breach of CIGNA's duty under ERISA to manage the Plan "solely in the interest of the participants."[173]

Thus, although the court noted that the plaintiff had offered only "thin evidence" that such a gag policy actually existed, it acknowledged the

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165. *Id.* at 761; *see also* 29 U.S.C. § 1002(21)(A) (1994) (stating that a fiduciary duty is owed by any entity which "exercises any discretionary authority or discretionary control respecting management of such [a benefit] plan . . . or . . . has any discretionary authority or discretionary responsibility in the administration of such plan").

166. *Drolet*, 968 F. Supp. at 761-67.

167. 972 F. Supp. 748 (S.D.N.Y. 1997).

168. *Id.* at 751.

169. *Id.* at 752.

170. *Id.* at 753. The plaintiff in *Weiss* also alleged that CIGNA Healthplan's contractual provisions breached an implied covenant of good faith and fair dealing. *Id.* at 751. The district court dismissed these claims under Rule 12(b)(6) of the Federal Rules of Civil Procedure on grounds that such state tort claims were preempted by ERISA. *Id.* at 751-52.

171. *Id.* at 750 (moving under FED. R. CIV. P. 12(b)(6)).

172. *Id.* at 751-52.

173. *Id.* at 751 (footnote omitted).

viability of the breach of fiduciary duty claim as applied to gag clauses and left open the door for the plaintiff to prove the existence of such a policy after conducting additional discovery.[174] In so holding, the court sent a message that gag clauses may inherently violate the duty of loyalty imposed upon ERISA plans, a message which, if accepted by future courts, could essentially render moot state legislative reform efforts in this area.[175]

The *Weiss* decision is also notable for its rationale in dismissing the plaintiff's remaining claims regarding physician compensation methods. The gravamen of the plaintiff's claim was that, by paying its physicians via capitation combined with bonuses and withholds tied to referral patterns (and failing to disclose such payment methodology to enrollees), CIGNA violated its fiduciary duty to act solely in the interests of plan beneficiaries.[176] In dismissing these claims, the court found that the plaintiff had proffered no evidence that such payment methods actually coerced physicians to act out of financial self-interest at the expense of patients.[177] While the court acknowledged that capitation, bonuses, and withholds presented "dangers of abuse,"[178] it concluded that, "to the extent that a doctor takes advantage of financial incentives and withholds necessary care from his or her patients, that doctor's ethical breach is not attributable to CIGNA."[179] Such language seems reminiscent of the rationale behind corporate practice of medicine statutes[180] and is naive in regard to the actual role of MCO payment methods in modern health care decision-making. Perhaps the court's true motives for rejecting these claims lie not in such naive assumptions, but in its admission that acknowledging the legitimacy of the plaintiff's claims would be "tantamount to a claim that risk-sharing arrangements in managed care are inherently illegal,"[181] and its unwillingness to tackle an issue which is "best suited for resolution by branches of government other than the judiciary."[182]

The *Weiss* court explicitly refused to follow the holdings in *Shea* and *Drolet*,[183] reasoning that the fiduciary's duty to disclose material facts extended only so far as to require the fiduciary not to lie when asked

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174. *Id.* at 752.

175. *See supra* Part II.B.3.

176. *Weiss*, 972 F. Supp. at 752.

177. *Id.*

178. *Id.*

179. *Id.*

180. *See supra* note 148.

181. *Weiss*, 972 F. Supp. at 752.

182. *Id.*

183. *Id.* at 755 n.6; *cf.* Maltz v. Aetna Health Plans of N.Y., Inc., 114 F.3d 9, 12 (2d Cir. 1997) (holding that the district court did not abuse its discretion in denying issuance of a preliminary injunction against the MCO that had terminated a contract with pediatricians on grounds that such termination did not breach the ERISA plan's fiduciary duty of loyalty to the parent).

questions by enrollees.[184] Under this reasoning, a fiduciary must be truthful when questioned, but has no affirmative duty to disclose material information—such as physician incentive arrangements—on his or her own initiative.[185]

The *Weiss* court's parsimonious view of a fiduciary's duty to furnish information seems contrary to the common law. Under section 173 of the *Restatement (Second) of Trusts*, a "trustee is under a duty to the beneficiary to give him *upon his request* at reasonable times complete and accurate information."[186] However, comment d to section 173 makes it clear that a trustee is "under a duty to communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know for his protection in dealing with a third person with respect to his interest."[187] In its 1996 decision in *Varity Corp. v. Howe*,[188] the Supreme Court refused to decide whether an ERISA fiduciary ever has an affirmative duty to disclose material information absent a request from the enrollee.[189] Nonetheless, a fair reading of comment d would seem to support the conclusion of the *Shea* and *Drolet* courts that an MCO must inform its enrollees about a physician's financial incentives to withhold care, since an enrollee arguably "needs to know"[190] such information "for his protection in dealing with a third person"[191]—namely, the physician. Given the emerging split of opinion among the lower courts on this important issue, it seems likely that the Supreme Court will ultimately grant certiorari in a future case to resolve it. In the meantime, however, the law remains in flux.

Whatever the ultimate resolution of the scope of an ERISA fiduciary's duty, however, such resolution will come slowly and, when it comes, will only apply to ERISA plans, which cover only approximately sixty percent

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184. *Weiss*, 972 F. Supp. at 754.

185. *Id.*

186. RESTATEMENT (SECOND) OF TRUSTS, *supra* note 152, § 173 (emphasis added); *see id.* cmt. d ("Ordinarily the trustee is not under a duty to the beneficiary to furnish information to him in the absence of a request for such information."). The common law of trusts generally defines an ERISA fiduciary's obligations. *See* Central States, Southeast & Southwest Areas Pension Fund v. Central Transp., Inc., 472 U.S. 559, 570 (1985) ("[R]ather than explicitly enumerating *all* of the powers and duties of trustees and other fiduciaries, Congress [in ERISA] invoked the common law of trusts to define the general scope of their authority and responsibility."); H.R. REP. NO. 93-533, at 3-5, 11-13 (1973), *reprintedin* 1974 U.S.C.C.A.N. 935, 991-1019.

187. RESTATEMENT (SECOND) OF TRUSTS, *supra* note 152, § 173 cmt. d.

188. 516 U.S. 489 (1996).

189. *Id.* at 506 ("[W]e need not reach the question of whether ERISA fiduciaries have any fiduciary duty to disclose truthful information on their own initiative . . . .").

190. RESTATEMENT (SECOND) OF TRUSTS, *supra* note 152, § 173 cmt. d.

191. *Id.*

of the non-elderly population with health insurance.[192] Thus, any comprehensive, uniform policy regarding an MCO's fiduciary obligations will require broader legislative action. Health care policymakers should, therefore, consider establishing explicit statutory fiduciary obligations for all health insurers, ERISA-qualified or not, to serve as a balance against the inherent underutilization tendency of payers and the overutilization tendency of providers. If such a fiduciary paradigm were established, health care consumers would be more likely to receive medically necessary care, achieving a normatively desirable equilibrium in the provider-patient-payer triad.

IV. CONCLUSION

The era of the market paradigm has ended. In its place has emerged a political paradigm, as politicians at both the state and federal level have responded to consumer and provider complaints about the abuses of managed care. Ultimately, however, the political paradigm, like the provider and market paradigms before it, will go too far, expanding benefits and provider autonomy to the point where health care costs are, once again, out of control, potentially dismantling managed care as an effective cost-containment mechanism.

If policymakers wish to end this paradigmatic cycling, a new force must be interjected between the health care payor and the health care provider. One way to achieve balance between the payer and provider is to interject a fiduciary who acts on behalf of the patient, a neutral third party to determine whether care is medically necessary.

Although some courts have recently begun to capitalize on the fiduciary concept with regard to MCOs governed by ERISA, reliance on judicial establishment of a meaningful fiduciary paradigm is unrealistic. Courts are understandably loathe to expand MCO obligations absent legislative authorization. Thus, judicial reinterpretation or expansion of ERISA's fiduciary obligations in the name of protecting MCO enrollees—such as occurred in *Shea*[193] and *Drolet*[194]—will be slow and incremental at best.

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192. *See* Karen Davis et al., *Choice Matters: Enrollees' Views of Their Health Plans*, 14 HEALTH AFF. 99, 100 (1995) (stating that as of 1994, 63% of the non-elderly population received health insurance through an ERISA plan); *cf.* Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 58 (1993) ("[A]s much as sixty-five percent of the population is insured through an ERISA-qualified plan."). An estimated three-quarters of all MCOs are ERISA-qualified. Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 494 (1997).

193. *See supra* notes 155-59 and accompanying text.

194. *See supra* notes 160-66 and accompanying text.

Moreover, even if a majority of courts ultimately agree with *Shea* and *Drolet*, such precedents would equalize paradigm influence only for individuals enrolled in health plans governed by ERISA. If a fiduciary paradigm is going to be successfully implemented, it should be enacted via comprehensive legislation applicable to all health plans, not by piecemeal legislation or limited judicial precedents.