SHOULD THIRD PARTY PAYORS OF HEALTH CARE SERVICES DISCLOSE COST CONTROL MECHANISMS TO POTENTIAL BENEFICIARIES?*

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I. Introduction

During the past decade, third party payors[1] of medical services have struggled to control expenditures on health care for their beneficiaries. They have been motivated by dramatic increases in the cost of health care.[2] One of the alleged causes of increasing health care costs is the provision of substantial amounts of unnecessary or inappropriate care by physicians and hospitals.[3] Economists believe that the provision of unnecessary

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[1] Third party payor or payer is a term commonly used to describe persons who have a contractual or statutory obligation to pay for health care services needed by a patient. Payors include federal and state health benefit entitlement plans, such as Medicare, 42 U.S.C.A. §§ 1301-1320 (West 1983 & Supp. 1989) and Medicaid, 42 U.S.C.A § 1396 (West 1983 & Supp. 1989), private indemnity health insurance plans, and managed health care plans such as health maintenance organizations (HMO), preferred provider organizations (PPO), and others. See AMERICAN MEDICAL ASSOCIATION, PHYSICIANS' RESOURCE GUIDE TO HEALTH DELIVERY SYSTEMS (2d ed. 1989) [hereinafter AMERICAN MEDICAL ASSOCIATION], for a comprehensive description of managed care plans.

[2] From 1960 to 1987, national health care expenditures increased from 5.3% of the gross national product of the United States to an estimated 11.4%. Ginzburg, *A Hard Look at Cost Containment*, 316 NEW ENG. J. MED. 1151, 1151 (1987). The lowest annual rate of increase in the amount spent was 8.9% in 1985, the highest was 15.7% in 1981. *Id. See also* U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACTS OF THE UNITED STATES: 1989 at 89-95 (109th ed. 1989) [hereinafter U.S. BUREAU OF THE CENSUS].

[3] Studies conducted over the past two decades suggest that as much as twenty-five percent of acute care hospital use is unnecessary. Siu, Sonnenberg, Manning, Goldberg, Newhouse & Brook, *Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans*, 315 NEW ENG. J. MED. 1259, 1259 (1986) [hereinafter Siu]. For a theoretical explanation of when and why unnecessary care might be provided by physicians, see Enthoven, *Shattuck Lecture—Cutting Cost Without Cutting the Quality of Care*, 298 NEW ENG. J. MED. 1229, 1234-36 (1978); *see also* Relman, *Assessment and*

care has been facilitated by the incentives inherent in the payment mechanisms of traditional health benefit plans.[4]

As a result, payors have implemented a wide variety of techniques to reduce costs by eliminating expenditures for unnecessary or inappropriate medical services. These techniques include the use of financial incentives to encourage physicians and other providers to minimize the amount of care provided to payor beneficiaries.[5] Another widely used method is the monitoring of requests for payment to determine whether the care provided was necessary, and then denying payment for services found to have been unneeded.

Questions have been raised about the effect of cost control techniques upon the quality of care. Although these questions have been raised with respect to cost control mechanisms generally, the most serious concerns have been raised about financial incentives as opposed to other techniques.

Government officials and other persons have raised concerns

Accountability: The Third Revolution in Medical Care, 319 NEW ENG. J. MED. 1220 (1988); Roper, Winkenwerder, Hackbarth & Krakauer, *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197 (1988); Gleicher & Meyers, *A Successful Program to Lower Cesarean-Section Rates*, 319 NEW ENG. J. MED. 1511 (1988); Leape, Park, Solomon, Chassin, Kosecoff & Brook, *Relation Between Surgeons' Practice Volumes and Geographic Variation in the Rate of Carotid Endarterectomy*, 321 NEW ENG. J. MED. 653 (1989); Findlay, *Looking Over the Doctor's Shoulder*, U.S. NEWS & WORLD REP., Jan. 30, 1989, at 6. *But see* Ginzberg, *U.S. Health Policy—Expectations and Realities*, 260 JAMA 3647 (1988).

Other alleged causes of the increasing cost of health care include population growth, aging of the population, rising input prices, costs of malpractice insurance, and technologic innovation and diffusion. *See* Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies*, 257 JAMA 220 (1987).

[4] Enthoven suggests that there is a great deal of bias in favor of more care whether or not it helps the patient, and that this bias is due to the values of patients and physicians. Enthoven, *supra* note 3, at 1235. According to Enthoven, the patient and his family have every reason to seek whatever care that might do some good, and it is unnatural for the physician not to do all he can to cure disease and alleviate suffering. *Id.* This bias is reinforced by the physician's fear of malpractice litigation which causes the practice of defensive medicine. *Id.* Enthoven states that there is no check on this bias in traditional health plans, instead the traditional system of "fee for service for the physician, cost reimbursement for the hospital, and third party intermediaries to protect the consumer rewards providers for cost increasing behavior and leaves the insured consumer little or no incentive to consider the cost of care." *Id.* at 1229.

[5] For a description of financial incentives, see PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS, at 275-80 (1989) [hereinafter ANNUAL REPORT]. *See also infra* pp. 125-27.

that financial incentives to limit services may have an adverse impact on the quality of patient care.[6] These critics fear that incentives may induce providers to go beyond eliminating unnecessary care and cause them to withhold needed services. Currently available evidence about the effect of incentives on quality is equivocal.[7] There is anecdotal evidence of injuries caused by care being withheld,[8] but studies of payors that use cost control mechanisms have generally found that the quality of care provided under them is comparable to traditional plans. These studies, however, have involved payors that use a variety of cost control mechanisms, and they did not focus specifically on the effects of financial incentives. Therefore, no firm conclusions about the effects of financial incentives can be made. Furthermore, it does appear that the threat of malpractice liability, various quality assurance mechanisms, and the ethics of physicians may prevent widespread abuses from occurring.

Although the evidence about the impact of financial incentives is equivocal, there was sufficient concern about the use of financial incentives to limit care that Congress passed legislation which restricts, but does not eliminate, their use in the federal Medicare program.[9] Congress continues to study the issue, hold

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6 *See, e.g.*, ANNUAL REPORT, *supra* note 5, at 275-76, 280; U.S. GENERAL ACCOUNTING OFFICE, MEDICARE: PHYSICIAN PAYMENTS BY HOSPITALS COULD LEAD TO ABUSE, GAO/HRD at 86-103 (1986) [hereinafter PHYSICIAN PAYMENTS BY HOSPITALS]; U.S. GENERAL ACCOUNTING OFFICE, MEDICARE: PHYSICIANS INCENTIVE PAYMENTS BY PREPAID HEALTH PLANS COULD LOWER QUALITY OF CARE, GAO/HRD, at 89-129 (1988) [hereinafter PHYSICIAN PAYMENTS BY PREPAID PLANS]; COUNCIL ON MEDICAL SERVICE, AMERICAN MEDICAL ASSOCIATION, REPORT I, CONCEPT OF A GATEKEEPER, at 294 (1986); Veatch, *The HMO Physician's Duty to Cut Costs*, HASTINGS CENTER REP., Aug. 1985, at 13; Radwin, *Physicians' Conflicts of Interest*, 321 NEW ENG. J. MED. 1405 (1989); Hillman, *Financial Incentives for Physicians in HMOs, Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743 (1987).

7 *See, e.g.*, ANNUAL REPORT, *supra* note 5, at 284; PHYSICIAN PAYMENTS BY PREPAID PLANS, *supra* note 6, at 11-12. *But see* Shortell & Hughes, *The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients*, 318 NEW ENG. J. MED. 1100 (1988).

8 *See, e.g.*, Vance-Bryan, *Medicare's Prospective Payment System: Can Quality Care Survive?*, 69 IOWA L. REV. 1417 (1984) (description of incidents of abuse).

9 Section 9313 of the Omnibus Reconciliation Act of 1986 provides that civil penalties may be imposed on a hospital, or an HMO that has contracted with Medicare or Medicaid, if the hospital or HMO makes any payment to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. Omnibus Reconciliation Act of 1986, Pub. L. No. 99-509 § 9313, 100 Stat. 1874, 2002-005 (1986) (codified as amended at 42 U.S.C.A. § 1320a-7a(b) (West Supp. 1989)).

hearings, and is considering legislation about the use of incentives during 1989.[10]

There are few, if any, restrictions on the use of financial incentives to limit care by private payors. Use of the incentives is widespread, especially by health maintenance organizations (HMOs) and other managed health care plans.[11] Generally, payors who use financial incentives do not disclose them to actual or potential beneficiaries. There are virtually no legal requirements that the use of incentives be disclosed, and payors tend to regard the information as proprietary and confidential.

A federal government advisory commission has recommended that the use of financial incentives by payors be disclosed to beneficiaries.[12] The commission's rationale is that "[i]nformed and knowledgeable physicians and beneficiaries could facilitate the prevention or early identification of any inappropriate care that may result from financial incentives."[13]

This article reviews in depth the issue of whether payors should disclose to beneficiaries the use of financial incentives to limit care and other cost control mechanisms. It concludes that

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The law is effective as to hospitals, but the effective data was delayed for HMOs until April 1, 1989. Omnibus Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313, 100 Stat. 1874, 2003 (1986) (codified at 42 U.S.C.A. § 1320a-7a note (West Supp. 1989)). The effective date for HMOs was further delayed until April 1, 1990. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4016, 101 Stat. 1330, 1364 (1987) (codified at 42 U.S.C.A. § 1320a-7a note (West Supp. 1989)). The effective date was further delayed until April 1, 1991. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6207, 103 Stat. 2106, 2245 (1989).

[10] The Subcommittee of Health of the Committee on Ways and Means of the United States House of Representatives heard testimony on the use of financial incentives by HMOs to limit care in April of 1989. *Fiscal Year 1990 Budget Issues Relating to Physician Incentive Payments by Prepaid Health Plans: Hearings Before the Subcomm. on Health*, 101st Cong., 1st Sess. 2-56 [hereinafter *Hearings*]. On April 25, 1989, statements were presented by the United States General Accounting Office, the Physician Payment Review Commission, the Group Health Association of America, the American Medical Care and Review Association, and the Kaiser Permanente Medical Care Program. *Id.* Eventually Congress passed legislation concerning this issue in the Omnibus Budget Reconciliation Act of 1989, which is described *supra* note 9.

[11] *See, e.g.*, Hillman, *supra* note 6; PHYSICIAN PAYMENTS BY PREPAID PLANS, *supra* note 6.

[12] ANNUAL REPORT, *supra* note 5, at 276. *Hearings, supra* note 10, at 13-18. (statement of Karen Davis, Ph.D., Commissioner, Physician Payment Review Commission).

[13] *Hearings, supra* note 10, at 18.

disclosure of financial incentives which are closely linked to the treatment of individual patients, but which are not closely linked to objective medical criteria, should always be disclosed. These include payments based on utilization goals or risk sharing arrangements that involve a small number of patients for a short period, and which are not based on the actual medical needs of the patient. Under these arrangements, it is possible for a physician to be penalized for providing needed care. The incentives create an obvious conflict of interest between the patient and the physician, and government officials have concluded that the conflict is serious enough that it could adversely affect the quality of care.

This article also argues that cost control techniques which are not closely linked to the treatment of individual patients, but which are not closely linked to medically objective criteria either, should also be disclosed. The conflict of interest for the physician is not as great. The conflict, however, still exists, and it can result in the withholding of needed care. In addition, there are areas of medical uncertainty where it is not clear whether services should be provided.[14] The existence of financial incentives or other cost control techniques may influence the physician's decision about whether or not to provide treatment. The beneficiary is entitled to know what the bias of the physician will be when there is uncertainty. Some beneficiaries may prefer to be treated when there is doubt, others may prefer no treatment.

Finally, this article argues that disclosure is also appropriate when cost control techniques are used which have a tight link with individual treatment decisions and with medically objective criteria. The reasons for this argument concern the existence of payor imposed criteria. The patient is entitled to know that the criteria exist and that they will be the basis for treatment decisions. The patient should be aware of the criteria because of the influences which may shape the content of these criteria in the future.

There is now wide concern that the demand for health care may be greater than the resources available to provide it.[15] Pol-

[14] *See, e.g.*, Fortess & Kapp, *Medical Uncertainty, Diagnostic Testing and Legal Liability*, 13 L. MED. & HEALTH CARE 213 (1985).

[15] *See, e.g.*, Schwartz, *supra* note 3, at 223; Schwartz, *The Most Painful Prescription*, NEWSWEEK, Nov. 12, 1984, at 24 [hereinafter NEWSWEEK]; Morreim, *Fiscal Scarcity*

icy makers are debating about how health care should be financed and allocated. The possibility of rationing is discussed, as is changing the standard of care applicable in malpractice litigation to allow economic considerations to be included in the decision about the treatment of a given patient.[16]

There may come a time when economic factors, as well as medically objective criteria, are built into cost containment criteria. If the standard of care does change to allow consideration of economic factors, then it would not constitute malpractice to incorporate these factors into decisions about patient treatment, even if the decision results in an undesirable outcome. Patients are entitled to know about and understand whether economics are becoming part of accepted criteria for treatment decisions. Therefore, it is important to establish the principle of disclosure with respect to cost containment efforts. The public is entitled to know, understand, and debate the factors that are influencing the evolution of health care delivery.

The issues involved in the allocation of health care should be the subject of a wide societal debate. Decisions about the extent to which economics should be incorporated into treatment considerations should not be made by a small circle of persons and then implemented upon an uninformed public. Disclosure and debate should be the general rule.

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and the Inevitability of Bedside Budget Balancing, 149 ARCHIVES INTERN. MED. 1012 (1989).

16 Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 L. MED. & HEALTH CARE 347 (1989) (summary of the debate and its participants). See Morreim, *Cost Containment and the Standard of Medicare Care*, 75 CALIF. L. REV. 1719 (1987); Macaulay, *Health Care Cost Containment Medical Malpractice: On a Collision Course*, 21 SUFFOLK U.L. REV. 91, 103-07 (1987); Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004 (1985) for commentators who advocate a change in how the standard of care for assessing malpractice claims is evaluated to accommodate rationing. See Lairson, *Reexamining the Physician's Duty of Care in Response to Medicare's Prospective Payment System*, 62 WASH. L. REV. 791 (1987) for an argument against allowing the standard of care to be changed to accommodate economic decisions in how a patient should be treated. See Vance-Bryan, *supra* note 8, which argues that malpractice laws will not be sufficient to protect patients from adverse quality caused by economic considerations. See Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401 (1981); Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345 (1981); Schuck, *Malpractice Liability and the Rationing of Care*, 59 TEX. L. REV. 1421 (1981) for analyses of whether economic considerations will evolve into the standard of care as it is developed by the courts.

II. Background

A. *Traditional Plans and Increasing Costs*

Beginning in 1975, the primary nongovernmental means of financing health care was indemnity health insurance plans[17], also known as traditional plans. These plans were purchased by employers for employees, by associations for members, other groups, and by individuals.[18] The traditional plan covered all or most of the cost of reasonable and necessary health care purchased by the beneficiary, but normally did not cover preventive care such as physicals and vaccinations. Generally, the beneficiaries could use the hospital or physician of their choice. Insurers deferred to the decisions of the beneficiary's physician about the health care needed. Hospital services were reimbursed on the basis of the hospital's charges or its costs plus a percentage of costs.

Government health benefit entitlement programs, including Medicare and state Medicaid programs, followed the same pattern as traditional plans. Eligible beneficiaries could choose their own physicians and hospitals, and were reimbursed for most of the cost of reasonable and necessary medical services.[19] The programs usually deferred to the opinions of the beneficiary's physicians about the care necessary.[20] Hospital charges were re-

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17 U.S. BUREAU OF THE CENSUS, *supra* note 2, at 96.

18 Traditional plans are still available, but generally in a modified form. *See* Macaulay, *supra* note 16. Now they frequently require deductibles which must be met before coverage starts. *Id.* They often cover only a percentage of the beneficiary's health care costs up to a specified limit; beneficiaries may be required to obtain preauthorization from the insurer for hospital services, or a second opinion before undergoing surgery. *Id.* In addition, the insurer is more likely to review claims to see if the services were necessary. *Id.*

19 Medicare beneficiaries still have freedom of choice of providers with respect to most services. Hospitals must be qualified to treat Medicare beneficiaries, meaning that they must meet certain minimum standards of quality, but the vast majority of hospitals in the United States are qualified. *See* AMERICAN HOSPITAL ASSOCIATION, AHA GUIDE (1988). Any licensed physician may be used unless the physician has been excluded from the Medicare program for a transgression such as fraud or the provision of poor quality.

20 Medicare began to monitor whether services provided by physicians were necessary and appropriate when it organized Professional Standards Review Organizations (PSROs) in the mid-1970s. Social Security Amendments of 1972, Pub. L. No. 92-603 tit. II, § 249F(b), 86 Stat. 1329, 1429-30 (1972). PSROs were subsequently replaced by Peer Review Organizations, which actively monitor the necessity and

imbursed on the basis of the hospital's costs.[21] Physician fees were reimbursed at a rate based on the lower of the physician's actual fee, the physician's usual fee for the service, or the prevailing fee among physicians in the area.[22]

Under these financing mechanisms, beneficiaries and their providers had few incentives to limit the amount of care purchased. Providers decided what services were necessary for a beneficiary, the beneficiary did not have to worry about the cost of those services, and payors generally covered the costs without questioning the provider's judgment about the necessity of services.[23] Economists and other professionals believe that a number of factors, such as an increasing tendency of physicians to order more services to guard against malpractice litigation, costly advances in medical technology, population growth, wage and price inflation, and others caused upward pressure in the cost of health care.[24] It is believed that traditional plans did not have a means to counter this upward pressure and costs increased rapidly.[25]

B. *Changes in the Structure of Health Plans*

Substantial changes began to take place in the structure of health benefits plans when health care costs started to become a major factor in the budgets of the federal government, state governments, and private industry. In 1983, the federal government largely replaced its cost based system for reimbursing hospitals with a fixed fee schedule that applies regardless of a hospital's costs in treating a Medicare patient. The method is referred to as the prospective payment system (PPS), and the fees are based on the patient's diagnosis, as defined by a system of diagnosis re-

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quality of care provided to Medicare beneficiaries. 42 U.S.C.A. § 1320c (West 1983 & Supp. 1989).

21 *See* MEDICARE & MEDICAID GUIDE (CCH) ¶ 4500-5999 (description of the allowable cost method).

22 *See id.* at ¶ 3185-3400 (description of this method of evaluating physician reimbursement). This method will continue to be used until the physician payment reforms provided for in section 6102 of the Omnibus Budget Reconciliation Act of 1989 go into effect in 1992. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2169-89 (1989).

23 *See* Enthoven, *supra* note 3.

24 *See supra* notes 3 & 4; *see also* Reynolds, Rizzo & Gonzalez, *The Cost of Medical Professional Liability*, 257 JAMA 2776 (1987).

25 *See supra* note 2.

lated group (DRG) classifications.[26] Legislation was passed in 1989 that will alter Medicare reimbursement for physician's services in a similar fashion as of 1992.[27]

The PPS system gives a hospital an incentive to minimize the cost of treating a Medicare patient, as they are paid the same amount regardless of the true cost of treatment. If the cost of treatment is less than the PPS payment, the hospital profits on the patient; if the costs are greater than the PPS payment, the hospital loses money. Charges assigned to a given DRG are calculated on the basis of the average costs of all hospitals in the United States for providing the services involved. Hospitals which have lower average costs than all hospitals are rewarded by this system.[28]

In the private sector, the traditional plans have given way to HMOs,[29] preferred provider organizations (PPOs),[30] and other forms of managed health care plans.[31] HMOs have been particu-

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26 *See*, 42 U.S.C.A. § 1395ww(d)-(e) (West Supp. 1989). For a description of PPS and DRGs, see MEDICARE & MEDICAID GUIDE, *supra* note 21 at ¶ 4200-4296, 4395.

27 The current system, which allows for substantial variation among physicians, will be replaced by a fixed fee schedule called a Resource Based Relative Value Scale (RBRVS) that is applicable to all physicians. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2169-89 (1989).

28 Similarly, the RBRVS fees will be calculated on the basis of average costs, and will reward the physician who has lower costs than physicians as a whole. *Id.*

29 A health maintenance organization (HMO) is an organization system of health care delivery available to persons in an enrolled group who reside in a specific geographic area. The HMO provides a specific set of health care benefits to its members including the services of physicians and other health care professionals, as well as those of inpatient and outpatient facilities. The HMO member/enrollee pays a preset monthly fee, regardless of the actual services used.

AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 3. The federal government spurred the development of HMOs during the 1970's by subsidizing qualifying plans. *Id.*; *see also* 42 U.S.C.A. § 300e (West 1982 & Supp. 1989) (criteria necessary to qualify for assistance). States often have legislation which regulates HMOs. *See, e.g.*, N.J. STAT. ANN. §§ 17:48E-1 to -44 (West Supp. 1989).

30 A preferred provider organization (PPO) is an entity representing a group of physicians and/or hospitals that contracts with employers, insurance carriers, or third party administrators to provide comprehensive medical services on a fee-for-service basis to subscribers. The PPO contracts with physicians and hospitals to provide services at an established fee, generally at a discount from their usual charges.

AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 17.

31 "Managed care" is an imprecise term which generally refers to private health benefit plans that differ from traditional plans, in part because they are not indem-

larly successful. Between June, 1981 and March, 1988 the number of HMOs increased from 243 plans with an enrollment of 10 million members to over 660 plans with 31 million members.[32] PPOs have also proliferated. They have increased from thirty-four plans as of June, 1982 to 660 plans as of January, 1988.[33] It is estimated that 34 million Americans have the option of obtaining health care through a PPO.[34]

C. *Types of Cost Control Techniques*

Managed health care plans have been successful because they generally offer lower premiums or overall costs to beneficiaries than traditional plans, and they may offer more comprehensive coverage as well.[35] Managed health care plans can offer more coverage at a lower cost than traditional plans because they employ techniques to minimize their expenditures on medical services for their beneficiaries.

These techniques include monitoring the necessity and appropriateness of health care before, during, and after it is provided to the beneficiary;[36] requiring the use of providers which

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nity plans and in part because of the types of cost control techniques that they use. In recent years, traditional plans started to adopt some of the cost control techniques initiated by managed care plans, and the distinction between traditional plans and managed care is becoming less clear.

32 AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 5. *See also* U.S. BUREAU OF THE CENSUS, *supra* note 2, at 97.

33 AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 18.

34 *Id.*

35 HMOs were conceived, in part, to achieve cost savings by covering preventive care such as physicals and vaccinations, as well as necessary care. *See, e.g.*, 42 U.S.C.A. § 300e-1(1) (West 1982 & Supp. 1989).

36 Monitoring can occur before treatment is provided, in which case it is known as prospective review. When prospective review is used, beneficiaries are usually required to obtain authorization from the health plan before obtaining medical services as a condition of the receipt of benefits. If the health plan determines that the services are not necessary, then the beneficiary is notified that the plan will not pay for the services. Concurrent review takes place while a patient is receiving services, and is a means to determine whether continuing treatment is necessary. If the health plan decides that further treatment would be inappropriate, it notifies the beneficiary that further care will not be paid for. Retrospective review occurs after the service was rendered, and is for the purpose of determining whether the care was necessary and appropriate. If the health plan determines that the care was not necessary, it will not pay for the service. Prospective review, concurrent review, and retrospective review are all known as utilization review. *See generally* INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT (1989) [hereinafter INSTITUTE OF MEDICINE]; Smith, *In-*

have agreed to discount their fees and charges for the plan,[37] or by providing incentives to use such providers;[38] and by creating financial incentives for physicians and other providers to minimize the services provided to beneficiaries.

The financial incentives used to encourage physicians and providers to limit care are numerous.[39] These incentives vary in large part according to the base method used to compensate physicians under the plan. There are three basic methods of compensation: capitation, fee for service, and salary.

Under capitation,[40] providers are paid a predetermined fixed amount per beneficiary for a specific period of time, and are obligated to provide certain services to the beneficiaries. Capitation shifts some of the risk for funding care from the plan to the provider and gives the provider an incentive to minimize the services provided to a given beneficiary.

The extent of the risk shifted depends on the scope of the services that must be provided for the capitation and the capability of the provider. The least amount of risk is assumed when the capitation is for primary care and the provider accepting capitation is a physician or clinic capable of providing all of those serv-

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surance Carrier Liability as a Result of Pre-Admission Screening and Hospital Stay Guidelines, 12 OHIO N.U.L. REV. 189 (1985); Jesperson & Kendall, *Utilization Review: Avoiding Liability While Controlling Costs*, 4 HEALTHSPAN 3 (1987).

37 HMOs typically require their beneficiaries to use physicians and hospitals that have contracted with the plans to provide services to their beneficiaries, and they try to obtain discounts from these providers, or pay them a flat rate per beneficiary per year known as capitation. Some employ physicians on salary and operate their own clinics and hospitals. *See* AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 5-8 (description of different HMO arrangements with providers). Restricted choice of providers may or may not be a disadvantage for beneficiaries depending on the number of providers that have contracted with the HMO.

38 PPOs normally provide financial incentives to use providers with which the PPO has an advantageous contract. Normally the beneficiary is completely covered if a preferred provider is used, but must pay for a significant percentage of the fee if a non-preferred provider is used. AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 18-20.

39 A complete description of the types of financial incentives used to encourage providers to limit care is beyond the scope of this article. For general descriptions, see PHYSICIAN PAYMENTS BY HOSPITALS, *supra* note 6; PHYSICIAN PAYMENTS BY PREPAID PLANS, *supra* note 6, at 14-20; ANNUAL REPORT, *supra* note 5, at 227-83; AMERICAN MEDICAL ASSOCIATION, *supra* note 1, at 5-8.

40 A relatively recent survey showed that about forty-six percent of HMOs in operation during 1986 used capitation. Hillman, *supra* note 6.

ices.[41] The greatest amount of risk is assumed when the capitation is for overall health services and the provider may find it necessary to refer beneficiaries to other providers when it is not capable of providing a needed service. In the latter case, the provider accepting capitation must fund the charges of providers to whom referrals are made. The payor may withhold a portion of the capitation to create a pool of funds to pay for referrals, the balance of which may be distributed to contracting providers if the pool is not used up at the end of the capitation period.

Risk delimiters may be agreed upon to contain the risk assumed by providers accepting capitation. Delimiters include reinsurance to cover the cost of beneficiaries who are unusually expensive to care for.

Fee-for-service arrangements do not shift as much risk to the provider.[42] In order to create an incentive to limit care, the arrangement may call for a portion of each fee to be withheld to cover the cost of patient care that exceeds a predetermined budgeted figure. Funds in the withheld pool not spent are distributed to the contracting physicians at the end of the period. Alternatively, the plan may offer bonuses if budgeted targets are met.

Salary arrangements limit the risk of both the health plan and the physician provider.[43] Salaries may be combined with performance goals and bonuses to encourage physicians to limit care.

D. *Linkage of Cost Control Techniques to the Treatment of Individual Patients*

All cost control techniques are linked to the treatment of patients, meaning that physicians are evaluated, rewarded, or penalized according to how the payor's patients are treated. The

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41 When capitation is narrowly defined, such as for physician primary care services, the provider has an incentive to refer the patient to specialist physicians to minimize the provider's own input. ANNUAL REPORT, *supra* note 5, at 278. To discourage this incentive, the plan may withhold a portion of the capitation to cover referrals to specialists. *Id.* At the end of the capitation period, excess amounts left in the pool of withheld funds are distributed to the contracting physicians. *Id.*

42 In a relatively recent survey, about thirty-nine percent of HMOs had fee-for-service arrangements. Hillman, *supra* note 6.

43 About fifteen percent of HMOs surveyed in 1986 used salary arrangements. *Id.*

effort to influence physician behavior may be no more than to provide information to individual physicians about their practice patterns, or it can involve financial incentives and penalties, or even the threat of exclusion from treating payor's beneficiaries.

The link between rewards or penalties and medically objective criteria is widely variable among cost control techniques. In some, the link is very tight. For example, payment for treating a patient may depend upon whether the care provided was medically necessary. In other cost control techniques, the link is more remote. With capitation, whether or not a physician profits from an individual patient has as much to do with chance as with medically objective criteria. Capitation helps control cost through risk sharing as opposed to monitoring medical necessity.

The link between rewards or penalties and the treatment of individual patients is also variable. Financial incentives based on the performance of an individual physician for a small number of patients for a short period of time, such as a month, have a high degree of linkage with individual treatment decisions. The physician is aware that the care given any particular patient subject to the incentive will have a discernable impact on whether the incentive is achieved. In contrast, when incentives are based on the performance of a large group of physicians for a large number of patients over a long period, such as a year, the degree of linkage is lower. The care given any particular patient has a less discernable impact on the incentive.

Techniques, which involve monitoring the necessity and appropriateness of health care before, during, or after care is provided, usually have a tight link between the reward or penalty and medically objective criteria and they usually have a tight link with individual treatment decisions. Risk sharing mechanisms, fee withholds, and bonuses usually have a remote link with medically objective criteria, although they may be actuarially based on the expected medical needs of the beneficiaries. The link between these financial incentives and individual treatment decisions is highly variable.

E. *The Success of Cost Control Techniques*

There can be no question that cost control techniques have been successful in influencing the behavior of physicians and

other providers. The long-term success of cost control techniques in controlling health care costs, however, is in doubt.

The performance record of the cost control techniques introduced by third party payors shows that they have been successful at reducing operations costs. The prospective payment system introduced by Medicare is credited with reducing the average length of stay of Medicare patients in hospitals, thereby reducing the amount that Medicare has spent on hospital services.[44]

Studies have found that HMOs have a ten percent to forty percent lower cost than conventional insurance plans that deliver comprehensive care to comparable groups.[45] A substantial portion of the savings are realized by reductions in hospitalization in comparison to traditional plans,[46] in part because discretionary surgeries are avoided.[47] Studies have also found that savings are achieved by the selective omission of diagnostic tests, particularly high cost tests,[48] and by a decrease in the rate of referrals from less expensive primary care physicians to more expensive specialists.[49] It has been estimated that, as of 1984, if the United States

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44 Ginzburg, *supra* note 2, at 1152; Schramm & Gable, *Prospective Payment—Some Retrospective Observations*, 318 NEW ENG. J. MED. 1681 (1988).

45 Moore, *Cost Containment Through Risk-Sharing By Primary-Care Physicians*, 300 NEW ENG. J. MED. 1359 (1979); Luft, *How Do Health Maintenance Organizations Achieve Their "Savings?"*, 298 NEW ENG. J. MED. 1336 (1978); Enthoven, *supra* note 3.

46 Welch, *Health Care Utilization in HMOs, Results from Two National Samples*, 4 J. HEALTH ECON. 293 (1985); Manning, Leibowitz, Goldberg, Rogers & Newhouse, *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1550 (1984) [hereinafter Manning]; Stern, Juhn, Gertler & Epstein, *A Comparison of Length of Stay and Costs for Health Maintenance Organization and Fee-for-Service Patients*, 149 ARCHIVES INT. MED. 1185 (1989); Luft, *supra* note 45. *See also* Siu, *supra* note 3. Siu describes a study that examined hospitalization patterns under traditional plans and found that twenty-two percent of the hospital admissions and thirty-five percent of the hospital days were inappropriate.

47 Siu, Leibowitz, Brook, Goldman, Lurie & Newhouse, *Use of the Hospital in a Randomized Trial of Prepaid Care*, 259 JAMA 1343 (1988).

48 Clancy & Hillner, *Physicians as Gatekeepers, The Impact of Financial Incentives*, 149 ARCHIVES INT. MED. 917 (1989); Forstein, Begg & McNeil, *The Use of Ambulatory Testing in Prepaid and Fee for Service Group Practices*, 314 NEW ENG. J. MED. 1089 (1986); Manning, *supra* note 46; Hlatky, Lee, Botvinick & Brundage, *Diagnostic Test Use in Different Practice Settings*, 143 ARCHIVES INT. MED. 1886 (1983).

49 Schaffer & Holloman, *Consultation and Referral Between Physicians in New Medical Practice Environments*, 103 ANN. INT. MED. 600 (1985); Luke & Thomson, *Utilization of Within-Hospital Services, A Study of the Effects of Two Forms of Group Practice*, 18 MED. CARE 219 (1980).

converted to HMO care there would be 11 million fewer hospital admissions a year at an annual savings of fifteen to twenty billion dollars.[50]

Some commentators have suggested that some of the HMO savings may be illusory, as they may tend to be used by beneficiaries who want or need less care than beneficiaries who select traditional plans. One study found that of a group of individuals who were given the option of choosing an HMO plan or staying with a traditional plan, persons who chose the HMO had an average of fifty-three percent less inpatient days prior to joining the HMO than the individuals remaining in a traditional plan.[51] Operators of traditional indemnity plans often complain that HMOs are selected by younger healthier beneficiaries who prefer the coverage of preventive services, while older and less healthy individuals with more expensive illnesses select traditional plans.[52] Another commentator has suggested that traditional plan patients may have different expectations for health care, noting that their preferences for testing exceeds appropriate screening recommendations.[53]

Finally, other commentators have noted that Medicare's prospective payment system and the cost control techniques introduced by managed care entities have resulted in a one shot set of health care savings.[54] In their view, the cost savings have been achieved by removing "the fat" from the health care system, that is, services that did not need to be provided.[55] They believe, however, that the cost control techniques are not a permanent solution to the problem of increasing health care costs in the United States.[56] Studies performed show that costs are increasing at about the same rate, seven percent a year, for both man-

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50 *See* NEWSWEEK, *supra* note 15.

51 Jackson-Beeck & Kleinman, *Evidence for Self-Selection Among Health Maintenance Organization Enrollees*, 250 JAMA 2826 (1989). *Contra* Welch, *supra* note 46.

52 *See* Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield, 883 F.2d 1101 (1st Cir. 1989) (rationale for a traditional insurer's discrimination in rate setting against employers that also offered HMOs).

53 Clancy & Hillner, *supra* note 48.

54 *See* Schwartz, *supra* note 3.

55 *Id.*

56 *Id.*

aged care plans and traditional plans.[57]

If these commentators are correct, and underlying health care costs are still increasing at a rate significantly higher than the general rate of inflation after the use of cost control techniques, the struggle of payors to control those costs will only intensify in the future. In addition, there will be no more fat left to eliminate for the achievement of easy savings; harder choices will have to be made. Commentators suggest that economic considerations, such as cost benefit analyses, resource allocation, and other factors may have to be incorporated into treatment decisions.

III. Concerns Raised About Cost Control Mechanisms

Numerous commentators have raised concerns that the use of cost control mechanisms may adversely affect the quality of patient care. The most widespread concerns center on the use of financial incentives to limit care that are tightly linked to individual treatment decisions, but which are not tightly linked to medically objective criteria. It is believed that such incentives put too much pressure on physicians to withhold needed care. There is also concern that other cost control techniques create a conflict of interest between the physician and the patient. Some ethicists have expressed the view that application of any cost control techniques by the physician which balance societal needs against the individual patient is a departure from the well understood and accepted patient oriented role of the physician.

Physician ethicists have long argued that financial incentives to limit care create a conflict of interest between the patient and the physician. Traditional physician ethics provide that the physician should serve the patient unstintingly, and should not make treatment decisions based on considerations of personal gain.[58] According to the American Medical Association (AMA), physi-

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[57] *Id.*; *see also* Newhouse, Schwartz, Williams & Witsberger, *Are Fee-for-Service Costs Increasing Faster Than HMO Costs?*, 23 MED. CARE 960 (1985); Ginzberg, *supra* note 2.

[58] Economic incentives which may induce physicians to provide unneeded services to a patient are also considered to create a conflict of interest, and the provision of unnecessary services is considered to be unethical. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION, opinions 2.19, 4.04, 4.06, 8.03 (1989) [hereinafter CURRENT OPINIONS].

cians should be conscious of cost and not provide unnecessary services, but "social policy expects that concern for the care the patient receives will be the physician's first consideration,"[59] and "[it] is unethical to intentionally limit utilization of needed medical services to the detriment of a patient for the physician's own profit."[60]

The AMA has also stated that financial rewards to physicians for the purpose of limiting medical services can have, at the least, the appearance of impropriety, and that conflicts must always be resolved in favor of the patient.[61] According to the AMA, if the physician's own interests conflict so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient.[62] Other physician ethicists argue that physicians simply should not enter into arrangements that directly reward them for withholding services from the patient.[63]

Congress became concerned about incentive payments in 1985, when it learned that a hospital chain was paying bonuses to physicians who kept hospital costs for Medicare patients below DRG payments. The United States General Accounting Office (GAO) was ordered to study the issue, and it reported back to Congress in July of 1986.[64] The GAO's report did not discuss whether incentive payments had in fact caused harm to hospital patients. It concluded, however, that incentive payments could lead to patient abuse by inducing physicians to withhold needed care.[65] According to the report, the financial incentives most likely to compromise quality are those closely linked to the treatment of individual patients.[66]

Congress reacted to the report by passing legislation that, in

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59 *Id.*, opinion 2.09.

60 AMERICAN MEDICAL ASSOCIATION, REPORT A OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, PROCEEDINGS OF THE HOUSE OF DELEGATES, at 218, Interim-1986 [hereinafter REPORT A].

61 *Id.*

62 CURRENT OPINIONS, *supra* note 58, opinion 8.03.

63 Relman, *Practicing Medicine in the New Business Climate*, 316 NEW ENG. J. MED. 1150 (1987); Angell, *Medicine: The Endangered Patient-Centered Ethic*, HASTINGS CENTER REP., Feb. 1987, at 12; Hillman, *supra* note 6.

64 PHYSICIAN PAYMENTS BY HOSPITALS, *supra* note 6.

65 *Id.*

66 *Id.*

essence, prohibits hospitals from making any incentive payments to physicians based on the costs of treating Medicare patients.[67] The same prohibition was made applicable to HMOs that contract with Medicare or Medicaid[68] plans to finance the care of certain beneficiaries, but the effective date for HMOs was delayed until April 1, 1990 to allow the GAO to study the use of incentives by HMOs.[69]

A second GAO report was issued in December 1988, concerning HMO incentive payments.[70] The report noted that a number of studies had found the quality of care provided by HMOs to be comparable to care provided under traditional plans, but stated that these studies had not concerned HMOs which use a variety of cost control mechanisms and had not focused on the impact of financial incentives.[71] The conclusion of the report was similar to the earlier GAO report concerning hospitals, warning that incentive payments which are closely linked with individual patient treatment decisions may lead to abuse.[72]

The Health Subcommittee of the House of Ways and Means Committee heard testimony about HMO incentive payments and considered further legislation during 1989.[73] Most of the major interest groups that submitted testimony agreed that some types of financial incentive payments could lead to abuses, but also stated that other types of incentive arrangements are not a serious threat to quality and should be permitted.[74] The incentives

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67 *See supra* note 9.

68 As an alternative to the standard mechanisms for reimbursement of hospital and physician services under Medicare or Medicaid plans, eligible individuals may enroll in an HMO that has contracted with a Medicare or a Medicaid plan to finance the care of Medicare or Medicaid beneficiaries. *See* 42 U.S.C.A. §§ 1395mm, 1396b(m) (West 1983 & Supp. 1989). Medicare pays the HMOs at a rate ninety-five percent less than it would expect to spend on health care for beneficiaries in the area. The advantage to beneficiaries in joining an HMO is lower costs for deductibles and copayments that must be made under the alternative choice. It is estimated that about one million Medicare beneficiaries have elected to join HMOs. PHYSICIAN PAYMENTS BY PREPAID PLANS, *supra* note 6.

69 *See supra* note 9.

70 PHYSICIAN PAYMENTS BY PREPAID PLANS, *supra* note 6.

71 *Id.*

72 Vance-Bryan, *supra* note 8, at 1421.

73 *Hearings*, *supra* note 10.

74 *Id.* See the following statements made before the Subcommittee on Health, Committee on Ways and Means of the United States House of Representatives on April 25, 1989: Sarah F. Jaggar, Director of Operations, Human Resources Divi-

believed to be less threatening are those where there is not a close link between payments and individual treatment decisions, such as payments determined on the basis of the performance of a group of physicians with respect to a large number of patients.

The interest groups further stated that legislation should not ban all incentives, but should define those deemed to be threatening and restrict their use.[75] Other recommendations were also made, such as requiring Medicare HMOs to enhance quality assurance activities or disclose incentive arrangements to beneficiaries.[76] Congress did not finalize its consideration of this issue; it passed legislation extending the effective date of the restriction on incentive payments by Medicare HMOs until April 1, 1991.[77]

While the primary concerns about cost control mechanisms focus on incentive payments, especially those closely linked to individual patient treatment, other types of cost control techniques also affect physician behavior. There is less concern about these techniques because they are perceived as creating less pressure to withhold more than unnecessary medical service, especially when they are tightly linked to objective medical criteria. These mechanisms, however, do affect the treatment decisions of physicians.

When a payor retrospectively denies payment for care which it deems to be unnecessary, or retrospectively questions the practice pattern of a physician, it has an effect on the future decisions of a physician when treating the payor's beneficiaries. Physicians become aware that their decisions are under economic scrutiny, even if a given treatment decision will not have an immediate effect on compensation. Even when physicians are encouraged to minimize the amount of care provided on a less coercive basis, such as by voluntarily following medical objective criteria, it still affects their behavior.

The medical criteria which guides the physicians becomes

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sion, United States General Accounting Office; Karen Davis, Ph.D., Commissioner, Physician Payments Review Commission; Harris Berman, M.D., on behalf of Group Health Association of America, Inc.; Michael Stocker, M.D., on behalf of American Medical Care and Review Association; and Kaiser Permanente Medical Care Program. *Id.*

75 *Id.*

76 *Id.*

77 *See supra* note 9.

important in these situations. To the extent that economic considerations are built into these criteria, physician ethicists have reservations about their use by physicians.

IV. The Effect of Cost Control Techniques on the Quality of Care

The effect of cost control techniques on the quality of care is not yet well understood.[78] Most studies of HMOs have concluded that the quality of care provided under them is comparable, and sometimes better than the care provided under traditional plans.[79] There is a recent study, however, which has a somewhat contrary result,[80] and another study which raises the question of whether HMOs result in good quality care for certain subgroups but not others.[81] In addition, there are no studies which examine the effects of specific types of cost control techniques, especially financial incentives to limit care.[82]

Early studies about the effects of Medicare's prospective payment system showed that there were no material adverse affects on quality.[83] More recent studies, however, have questioned that

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78 *See, e.g.*, J. WARE, R. BROOK, W. ROGERS, E. KEELER, A. DAVIES, C. SHERBOURNE, G. GOLDBERG, P. CAMP & J. NEWHOUSE, HEALTH OUTCOMES FOR ADULTS IN PREPAID AND FEE-FOR-SERVICE SYSTEMS OF CARE—RESULTS FROM THE HEALTH INSURANCE EXPERIMENT at V (1987) [hereinafter WARE].

79 *See, e.g.*, Bates & Conners, *Assessing Process of Care Under Capitated and Fee-for-Service Medicare*, HEALTH CARE FINANCING REV., 1987 Annual Supplement, at 57-68; HAMMONS, BROOKS, & NEWHOUSE, EVOLUTION OF THE EFFECTS OF QUALITY OF CARE OF SELECTED PAYMENT ALTERNATIVES UNDER THE MEDICARE PROGRAM (1985); Ellwood & Paul, *But What About Quality?*, HEALTH AFFAIRS, Spring 1986, at 135; Yelin, Shearn & Epstein, *Health Outcomes for a Chronic Disease in Prepaid Group Practice and Fee-for-Service Settings—The Case of Rheumatoid Arthritis*, 24 MED. CARE 236 (1986); Scitovsky, *The Use of Medical Services Under Prepaid and Fee-for-Service Group Practice*, 15C SOC. SCI. MED. 107 (1981). *See also* ANNUAL REPORT, *supra* note 5, at 284.

80 *See, e.g.*, Shortell & Hughes, *supra* note 7.

81 *See* WARE, *supra* note 78; For a summary of the same study *see* Ware, Brook, Rogers, Keeler, Davies, Sherbourne, Goldberg, Camp & Newhouse, *Comparison of Health Outcomes at a Health Maintenance Organization With Those of Fee-for-Service Care*, 120 LANCET 1017 (1986). The study found that initially sick individuals from high income groups who joined an HMO had significant improvements in general health ratings in comparison with fee-for-service medicine. *Id.* However, initially sick individuals who came from low income backgrounds who joined an HMO reported worse general health ratings in comparison with fee-for-service medicine. *Id.*

82 *See* PHYSICIAN PAYMENTS BY PREPAID PLANS, *supra* note 6, at 11-12; ANNUAL REPORT, *supra* note 5, at 284.

83 *See, e.g.*, Schramm & Gabel, *supra* note 44.

conclusion.[84]

Although the precise effects of cost control techniques may not be certain, it is clear that they have not resulted in widespread discernable abuses. The focus is on whether they cause a deterioration in quality at the margins, where adverse effects are less obvious.

There may be several reasons why cost control techniques have not resulted in a widespread, discernable deterioration in care. These reasons include the threat of malpractice litigation if the withholding of needed care results in harm to a patient; the ethics of physicians, which emphasize fidelity to the patient; and the use of cost control techniques that do not place physicians under too great a conflict of interest.

Another reason may be that cost control techniques have been able to achieve savings by eliminating previously provided unnecessary care, and that there has been no reason to press against the boundaries of permissibility. This may change in the future after the easy cuts in health care costs are made. At that point, it is likely that the threat of medical malpractice litigation will still be a substantial deterrent to withholding needed care. Pressures may then arise to redefine what constitutes malpractice to allow economic considerations into the factors considered in patient treatment decisions.

V. The Role of Tort Law in Preventing Injuries that May Result From Cost Controls

One of the most important factors in preventing patient abuse caused by cost control mechanisms is the threat of malpractice litigation. Under principles of tort law, the physician owes the patient a duty to exercise the skill and knowledge commonly possessed by members of the profession in good standing during the course of treatment.[85] In addition, the physician must

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[84] *See, e.g.*, SEVENTH REPORT BY THE COMMITTEE ON GOVERNMENT OPERATIONS OF THE U.S. HOUSE OF REPRESENTATIVES, 101ST CONG., 1ST SESS., REPORT ON QUICKER AND SICKER: SUBSTANDARD TREATMENT OF MEDICARE PATIENTS (House Rep. 101-387, 1989); Fitzgerald, Moore & Dittus, *The Care of Elderly Patients With Hip Fracture, Changes Since Implementation of the Prospective Payment System*, 319 NEW ENG. J. MED. 1392 (1988); Vladeck, *Hospital Prospective Payments and the Quality of Care*, 319 NEW ENG. J. MED. 1411 (1988).

[85] *See generally* Note, *supra* note 16, at 1008.

obtain the patient's informed consent before providing a medical procedure,[86] and the physician must not abandon the patient once the physician-patient relationship is formed.[87]

If a physician intentionally or negligently withholds needed care from a patient, the duty owed to the patient is clearly breached.[88] If harm results, the patient may sue to recover any damages resulting from the breach of duty.[89] The existence of financial incentives to limit care or other cost control mechanisms is not a defense.

A duty of tort law is now developing which may impose a duty upon payors to exercise care in the implementation of cost control mechanisms.[90] The duty may require that the payor exercise some degree of care to prevent cost control mechanisms from causing needed care to be withheld from the payor's beneficiaries. The nature and scope of such a duty is not yet clear, and how the payor's duty may be affected by the physician's duty has not been established.

The duty is most likely to be found when a payor's actions can be closely linked with the withholding of needed care from a patient. The most significant reported case concerning the payor's duty involved a prospective denial of payment for continued hospitalization of a patient being cared for after major surgery.[91] As a result of the prospective denial of payment, the patient elected to be discharged from the hospital, and complications ensued which harmed the patient.[92] Ultimately the payor was found not liable because the patient's physician had not asked the payor to reconsider the denial.[93] The court did find

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86 *See* Morreim, *supra* note 16, at 1736.

87 *See* Lairson, *supra* note 16, at 793-94.

88 *Id.*

89 *See id.*

90 *See* INSTITUTE OF MEDICINE, *supra* note 36; Smith, *supra* note 36; Jesperson & Kendall, *supra* note 36; Byrnes, *Corporation's Institution of Health Care Utilization Review*, 33 MED. TRIAL TECH. Q. 478 (1987); Sloan & Bovberg, *Medical Malpractice; Crises Response and Effects*, RESEARCH BULLETIN, HEALTH INSURANCE ASSOCIATION OF AMERICA, 1989, at 6; Joffe, *Potential HMO and Physician Liability Arising from Physician Incentive Arrangements*, HEALTHSPAN, Dec. 1988, at 9.

91 Wickline v. State, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

92 *Id.* at 1634-41, 239 Cal. Rptr. at 812-17.

93 *Id.* at 1644-45, 239 Cal. Rptr. at 819.

that a payor has a duty to exercise care to prevent arbitrary prospective denials of payment for needed care.[94]

When the payor's actions are more remote from the individual treatment decision that gave rise to harm, it is less likely that a duty will be found, if for no other reason than it would be difficult to describe such a duty and place it within reasonable and predictable boundaries. Cases are currently being litigated, however, against payors where the causal link between cost control mechanisms and patient harm is indirect. One case alleges that a payor's financial incentives caused a physician to withhold needed diagnostic testing,[95] another alleges that a payor defrauded beneficiaries by failing to disclose its cost control mechanisms.[96]

Federal policy makers are aware of the effect of tort liability on physician behavior, and they rely on it to prevent abuses from being caused by Medicare's prospective payment system.[97] There are good grounds for this reliance. Unlike the operation of quality assurance mechanisms commonly used by payors, the possibility of malpractice litigation pervades every patient physician encounter.[98] The patient has a deep interest in detecting any malpractice, and has the legal right to bring suit for any breach of duty. The penalties for malpractice generally outweigh

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94 *Id.* at 1645, 239 Cal. Rptr. at 819.

> Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.

Id.

95 Bush v. Dake, No. 86-25767-NM (Mich. Cir. Ct., Saginaw Cty., Apr. 27, 1987).

96 Teti v. U.S. Healthcare, Inc., No. 88-9808, (E.D. Pa. Nov. 21, 1989). Recently, this case was dismissed at the district court level, and the plaintiffs' attorneys have said that they plan to appeal. Meyer, *MD Incentives Suit Against HMO Dismissed: Issue Lingers*, AMER. MED. NEWS, Jan. 12, 1989, at 1.

97 Vance-Bryan, *supra* note 8, at 1421.

98 Most quality assurance programs rely on some form of retrospective review of physician practice patterns. Generally payors do not have the resources to manually review the records concerning the treatment of all of their beneficiaries. Payors rely on screening or sampling techniques to segregate a subset of patient rewards to review. The initial review is normally not done by physicians, as that would be too expensive. Instead it is done by trained claims reviewers or nurses. *See* AMERICAN MEDICAL ASSOCIATION, MEDICARE CARRIER REVIEW (1988), (description of how Medicare carriers review claims submitted by physicians and Medicare beneficiaries).

the benefits to be gained by withholding needed care under a cost control arrangement.

The effect of potential malpractice liability has a profound affect on physician behavior. A much discussed phenomenon resulting from the awareness of potential liability is defensive medicine, which is the practice of providing tests and other services which might not be clearly indicated, but which the physician feels are necessary to protect against potential malpractice claims.[99]

Some commentators believe that potential malpractice liability is not a sufficient safeguard against the possibility that cost containment mechanisms may cause physicians to withhold needed care.[100] They believe that many patients, especially those who are economically disadvantaged, do not have the resources or sophistication necessary to access the judicial system. These commentators have proposed a number of solutions, including enhancing the physician's duty to the patient to include a duty of advocacy before the payor,[101] and administrative mechanisms to handle patient grievances.[102]

Other commentators have taken a contrary position, and argue that malpractice liability interferes with the effective implementation of cost control mechanisms.[103] These commentators believe, in essence, that the standard of care applied in malpractice litigation is too patient oriented, and that it is now necessary to balance patient interests against the societal need to reduce the cost of health care.[104] They would alter the standard of care to allow physicians to include economic considerations, such as cost-benefit analyses or the availability of resources for treatment, in deciding how the patient should be treated. Under such a standard, a poor patient outcome traceable to a decision to withhold care would not be malpractice if the decision was the result of societally approved economic considerations.

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99 *See* Reynolds, Rizzo & Gonzalez, *supra* note 24.

100 Vance-Bryan, *supra* note 8; Lairson, *supra* note 16.

101 Lairson, *supra* note 16, at 807.

102 Vance-Bryan, *supra* note 8, at 1447.

103 *See* Morreim, *supra* note 16; Macaulay, *supra* note 16; Note, *supra* note 16.

104 *See, e.g.*, Macaulay, *supra* note 16, at 106.

VI. The Limits of Tort Law in Previewing Injuries that May Result From Cost Controls

It is reasonable to assume that tort law provides an effective deterrent to widespread patient abuse that could arise from cost control mechanisms. There are limits, however, to the deterrent effects of tort law in preventing injuries that may be caused by the influence of cost controls on patient treatment decisions.

There is a grey area in medicine and tort law that emerges in situations where it is medically reasonable and defensible to provide care or, alternatively, not provide care for a patient's condition. In other words, given the information available when the treatment decision has to be made for the patient, it is not malpractice to provide medical services or, alternatively, to withhold treatment. In the absence of cost control mechanisms, the physician would be most likely to provide care, however, with cost controls, a decision is likely to be made to withhold treatment.

Withholding care from patients in the grey area is likely to cause injury to some individuals. These are patients who in fact do need treatment even though they do not display enough symptoms to make the need for care readily apparent. Physicians who have no considerations other than the patient's health will likely treat these patients as a matter of caution. Physicians influenced by cost control procedures will elect not to treat them. Since it is not malpractice to withhold care, tort law is not a deterrent to the injuries that will result.[105]

A notable example of an injury that was probably caused by cost control influences that tort law did not deter is the situation at issue in *Wickline v. State*.[106] The plaintiff in *Wickline* was a woman diagnosed with arteriosclerosis obliterans with occlusion of the abdominal aorta, otherwise known as Leriche's Syndrome.[107] On January 6, 1977, the plaintiff was admitted to the hospital for

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[105] It should be noted that some grey area patients do not need treatment, and it may in fact cause injury to provide care to patients who do not need it. The likely impact of a treatment, however, is probably well understood in these situations and can be effectively balanced against the possible consequences of failure to treat. Many forms of care, such as continued hospitalization, have very little risk of injury.

[106] Wickline v. State, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

[107] *Id.* at 1634, 239 Cal. Rptr. at 812.

what was categorized as " 'very major surgery.' "[108] After three surgeries and a stormy recovery with spasms, pain, and hallucinating episodes, the plaintiff was due to leave the hospital on January 17, 1977.[109] A specialist in peripheral vascular surgery and the chief decision maker for the plaintiff, felt that it would be in her best interest to remain hospitalized for an additional eight days.[110] The plaintiff's family physician and the Chief of Surgery at the hospital, who was also an assistant surgeon in the operations, were consulted and both concurred with the proposed recommendations.[111]

A formal request for an extension of hospitalization was made to Medi-Cal, the State of California's medical assistance program which was responsible for covering the plaintiff's care.[112] Rather than approving the additional eight days, Medi-Cal approved only four extra days of hospitalization.[113] Any of her physicians could have refiled for additional hospitalization, but because the plaintiff had not developed any new symptoms and her condition had not deteriorated, all three felt that it was medically reasonable to discharge the patient.[114]

Once at home, the plaintiff experienced complications and had to be readmitted to the hospital as an emergency patient.[115] As a result of these problems, the plaintiff's leg had to be amputated.[116] Subsequently, the plaintiff sued Medi-Cal for damages, believing that had she been hospitalized for the full eight days requested, the disastrous results would have been avoided.[117]

The court found in favor of Medi-Cal.[118] It recognized that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost control mecha-

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108 *Id.* at 1635, 239 Cal. Rptr. at 812.
109 *Id.* at 1635-36, 239 Cal. Rptr. at 812-13.
110 *Id.* at 1636, 239 Cal. Rptr. at 813.
111 *Id.*
112 *Id.*
113 *Id.* at 1638, 239 Cal. Rptr. at 814.
114 *Id.* at 1639, 239 Cal. Rptr. at 815.
115 *Id.* at 1640-41, 239 Cal. Rptr. at 816.
116 *Id.* at 1641, 239 Cal. Rptr. at 816.
117 *Id.* at 1633, 239 Cal. Rptr. at 811.
118 *Id.* at 1647, 239 Cal. Rptr. at 820.

nisms. . . ."[119] The court noted, however, that all of the medical experts who testified at trial agreed that it was medically defensible to discharge the plaintiff from the hospital and the decision to discharge did not constitute malpractice.[120] The court further noted that the plaintiff's physician did not appeal or protest the payor's decision to limit hospitalization.[121] The court believed that it would be unreasonable to hold Medi-Cal liable for a patient injury in which no malpractice was involved.[122] The court was not willing to hold the payor to a higher standard of care than the physicians who were responsible for the plaintiff's care.[123]

Had the plaintiff been under a plan which did not utilize cost control mechanisms, it is likely that she would have stayed in the hospital for the full eight days, thereby avoiding the complications which eventually claimed her leg. Due to financial considerations and the influence of a third party payor, the plaintiff was discharged against her physicians' better judgment. Tort law does not punish, and therefore does not deter, this type of incident.

Additional limits to tort law deterrence may emerge in the future. Some commentators believe that as health care cost containment becomes more important to society, it will become customary for physicians to consider economic criteria in patient treatment decisions. Since standards of care used in malpractice rely heavily on the customary practice of physicians,[124] it may be that economic considerations will be incorporated into standards of care over time.[125] This will prevent tort law from deterring decisions to withhold care when the decision is legitimized by ap-

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119 *Id.* at 1645, 239 Cal. Rptr. at 819.

120 *Id.* at 1646, 239 Cal. Rptr. at 819.

121 *Id.* at 1645-46, 239 Cal. Rptr. at 819.

122 *See id.*

123 *See id.*

124 *See generally* King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213 (1975). The courts, however, do not always follow accepted practice or customary practice of physicians in developing standards of care, on occasion the courts have found accepted practice to be inadequate. *See* Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974), *reaffirmed in* Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919 (1979); *see also* Comment, *Helling v. Carey: A Landmark of Exception in Medical Malpractice?*, 11 NEW ENG. L. REV. 301 (1975).

125 *See* Blumstein, *supra* note 16. For an analysis which argues that courts will not

proved economic criteria that are balanced against the perceived need for care.

Even if courts do not incorporate economic considerations into standards of care, legislatures may force the incorporation of economic criteria into standards. For example, title 42 section 1320c-6 of the United States Code immunizes physicians who, in the exercise of due care, follow medical criteria developed by a Peer Review Organization (PRO).[126] A PRO might develop criteria that include economic considerations, and physicians might follow the criteria to take advantage of the limited liability conferred by section 1320c-6. That would also prevent tort law from deterring decisions to withhold needed care based on economic criteria.

VII. Lack of Legally Required Disclosure of Cost Control Procedures

There are virtually no federal or state statutes which require payors to disclose the nature of any cost control mechanisms in their plans to actual or potential beneficiaries. Federal and state statutes that regulate prepaid health plans often have broad general disclosure requirements, but these requirements are directed at the disclosure of the financial stability of the payor and the extent of coverage offered under the payor's plans.[127] There appeared to be no statutes which specifically require cost control procedures to be disclosed.

State statutes often prohibit false advertising of prepaid health plans, but do not comment on whether cost control mechanisms should be disclosed in advertisements.[128] Federal and state consumer protection statutes prohibit fraudulent, unfair, and deceptive practices, but do not comment on disclosure of cost control mechanisms in prepaid health plans.[129] These stat-

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allow economic considerations to be incorporated into standards of care for malpractice, see Schuck, *supra* note 16.

126 Peer Review Organizations were implemented by Congress to monitor the quality and necessity of care provided to Medicare beneficiaries. *See* 42 U.S.C.A. § 1320c (West 1983 & Supp. 1989).

127 *See, e.g.*, 42 U.S.C.A. § 300e(c)(1)(B)(8) (West Supp. 1989); N.J. STAT. ANN. § 17B:30-3 (West 1985).

128 *See, e.g.*, N.J. STAT. ANN. § 17B:30-3 (West 1985).

129 *See, e.g.*, 15 U.S.C.A. § 45 (West 1973 & Supp. 1990); N.J. STAT. ANN. §§ 56:12-1 to -49 (West 1989 & Supp. 1989).

utes are written broadly enough that it might be argued that they require disclosure of cost control mechanisms, but it appears that no effort has been made by litigants to invoke them.

At least three states, Arkansas, Maine, and Maryland, have statutes that require prepaid health plans which engage in utilization review to make certain disclosures to state regulatory agencies.[130] Maryland and Arkansas require certain categories of prepaid health plans to submit descriptions of utilization review plans and obtain certification before conducting utilization review.[131] Maine requires plans that use prospective claim review to file annual reports which list statistics about prospective review decisions, including the number of denials, any litigation concerning the decisions, and other information.[132] This information is probably available to beneficiaries who contact the applicable state agencies, but payors are not required to disclose such information to beneficiaries who do not request it.

There are some lawsuits in which it has been alleged that failure to disclose cost control mechanisms violated state common law requirements of informed consent and other common law theories,[133] and, in one case, that the Racketeer Influenced and Corrupt Organizations Act[134] was violated.[135] It is too early to tell whether a pattern of cases will emerge that will require payors to disclose cost control mechanisms.

VIII. Commentators Who Argue that Cost Controls Should be Disclosed

Many authoritative commentators, including medical associations, physician ethicists, and government commissions have recommended that various types of cost control mecha-

130 Ark. H.R. 1569, 77th Gen. Ass. (1989); ME. REV. STAT. ANN. tit. 24, §§ 2302 (1)(A), 2341, tit. 24-A, § 2179 (Supp. 1989); MD. HEALTH GENERAL CODE ANN. §§ 19-1301 to -1313 (1990).

131 MD. HEALTH-GENERAL CODE ANN. §§ 19-1301 to -1313 (1990); Ark. H.B. 1569, 77 Gen. Assembly (1989).

132 ME. REV. STAT. ANN. tit. 24, §§ 2302(1)(A), 2341, tit. 24-A, § 2679 (Supp. 1989).

133 *See, e.g.*, Boyd v. Albert Einstein Medical Center, 377 Pa. Super. 609, 547 A.2d 1229 (Super. Ct. 1988); Bush v. Dake No. 86-25767-NM (Mich. Cir. Ct., Saginaw Cty., Apr. 27, 1989).

134 18 U.S.C.A. § 1961-1968 (West 1984).

135 Teti v. U.S. Health Care, Inc., No. 88-9809 (E.D. Pa. Nov. 21, 1989).

nisms be disclosed to potential beneficiaries. Most of these authorities believe that cost control mechanisms create a conflict of interest between the physician and the patient.

This conflict is analyzed similarly to other conflicts, such as situations where the physician may have an interest in providing unneeded or inappropriate care to a patient.[136] Sometimes conflicts are considered to be so great that physicians are advised not to treat patients when the conflict exists.[137] Physicians are advised that they may care for patients when a lesser conflict exists, but that the existence of the conflict should be disclosed to the patients.[138]

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136 A physician may be tempted to recommend unneeded care or inappropriate care when the physician is a passive investor in a medical facility to which the physician's patients may be referred. If the return on the physician's investment is calculated on the basis of the number of patients referred, the physician has a strong interest in referring patients to the facility that may conflict with the interests of a given patient. The American Medical Association has issued guidelines about how physicians should handle conflicts of interest that may arise when a physician is a passive investor in a medical facility. Disclosure of the conflict to the patient is an essential part of the guidelines. CURRENT OPINIONS, *supra* note 58, opinion 8.03. Certain states have passed statutes which require physicians to disclose to patients whether or not they have a passive investment in medical facilities to which the patient is being referred. *See, e.g.*, CAL. BUS. & PROF. CODE § 654.2 (West Supp. 1990); FLA. STAT. ANN. § 455.25 (West Supp. 1990). Recently, the federal government passed legislation which regulates the referral of patients by a physician to medical facilities in which the physician has an investment interest. Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, § 6207(a), 103 Stat. 2106, 2236-43 (1989).

Traditional plans are viewed by some authorities as creating a conflict of interest because the physician is always compensated for providing care, and therefore has an interest in providing services that the patient may not need. The American Medical Association has guidelines that address this issue. The guidelines suggest that physicians should not provide or prescribe unnecessary services, that treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice, and that physicians should not provide, prescribe, or seek compensation for services that are known to be unnecessary or worthless. *See* CURRENT OPINIONS, *supra* note 58, opinions 2.09, 2.19, 4.04.

137 *See, e.g.*, CURRENT OPINIONS, *supra* note 58, opinion 8.03. The opinion concerns conflicts created by a physician's passive investment in a medical facility. It further provides: "when a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient." *Id.*

138 *Id.* Opinion 8.03 states that "the physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization." *Id.*

Some commentators, however, argue that the conflict is so great that physicians should never refer patients to medical facilities in which they have a passive

Incentives to limit care created by cost control mechanisms are viewed as creating a conflict that is a departure from the traditional fiduciary relationship between a physician and a patient. "The traditional professional ethics of physicians—reflected in the Hippocratic Oath, the Declaration of Geneva, and elsewhere—is that the physician should always strive to do what he or she thinks will benefit the patient."[139] Some commentators view the conflict as resulting from the use of competition and the commercialization of health care as a cost containment policy, and that the intrusion of for-profit enterprises into medicine creates incentives that are incompatible with the traditional ethic. According to one commentator: "A physician cannot easily serve his patients as trusted counselor and agent when he has economic ties to profit seeking businesses that regard those patients as customers."[140]

Other commentators take a broader view that the conflict is an emerging tension between the health care needs of certain patients and the need of society to conserve and allocate scarce resources. It is being suggested that providing everyone with all

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investment interest. *See, e.g.*, Relman, *supra* note 63 at 1150. This commentator stated that "physicians should limit their practice incomes to fees or salaries earned from patient services personally provided or supervised." *Id.* The Institute for Medicine has taken a similar position. *See* Gray, *For-Profit Enterprise in Health Care*, WASHINGTON, D.C., NATIONAL ACADEMY OF SCIENCES PRESS (1986).

Authorities generally do not require that physicians disclose or discuss the conflict of interest that is created by traditional plans. That conflict, however, is generally created by the patient, via the patient's insurance coverage, as opposed to an arrangement between the insurer and the physician that the patient is not aware of. At least one authority has argued that patients understand and are prepared to guard against the conflict created by traditional plans, but do not yet understand or know how to guard against conflicts created by incentives to limit care. Berenson, *Capitation and Conflict of Interest*, HEALTH AFFAIRS, Spring 1986, at 141.

139 Veatch, *supra* note 6, at 13-15. *See also* CURRENT OPINIONS, *supra* note 58, opinion 2.09. ("[S]ocial policy expects that concern for the care the patient receives will be the physician's first consideration.") *See also* Report A, *supra* note 60.

140 Relman, *supra* note 63, at 1150. Relman goes on to say:

> After all, economic arrangements between physicians and for-profit corporations are designed to serve corporate ends, and therefore the financial interests of investors will have first priority. Patients' medical needs and corporate financial interests are not always congruent; indeed, they may be antithetical. Conflicts between the altruistic ideals of medicine and the financial imperatives of business will almost certainly be resolved in favor of the latter by corporate managers whose jobs and financial advancement are at stake.

Id.

the medical care that they want may be too expensive for society, and that physicians have a responsibility to limit care to reduce costs in appropriate circumstances. "Physicians are being told that a patient centered ethic may be too narrow, and they are already finding themselves party to a number of efforts to limit medical care to contain costs."[141]

The tension between needs and resources can be divided into three categories: (1) situations where the physician is encouraged to adopt the least expensive patient treatment strategy among a set of strategies that are likely to achieve the same benefit for the patient; (2) situations where the physician is encouraged to select a lower cost treatment strategy even though it is uncertain whether the strategy will be as effective for the patient as a more effective strategy; and (3) situations where the physician is asked to participate in the allocation or rationing of needed medical care.

Physician ethicists tend to argue that physicians should not deviate from the traditional patient centered ethic to participate in the rationing of needed care or to use lower cost treatment methods when their appropriateness for the patient is uncertain.[142] Ethicists do feel that it is appropriate for physicians to use the lowest cost method for treating a patient when that method meets the needs of the patient.[143] Further, it is considered unethical for physicians to provide unnecessary care.[144]

Cost control mechanisms are considered permissible as long as they do not tempt the physician to go beyond selecting the lowest cost treatment among equally effective treatment strategies and into the realm of rationing or withholding needed care.[145] Most commentators feel that some cost control mechanisms cause a substantial conflict of interest, and that physicians should not get involved in them. For example, one commentator

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141 Angell, *supra* note 63.

142 According to the American Medical Association: "To expect a physician when treating a patient to make rationing decisions based on governmental or other external priorities in the allocation of scarce health resources creates an undesirable conflict with the primary responsibility of the physician to his patient." CURRENT OPINIONS, *supra* note 58, opinion 2.03. *See also* Veatch, *supra* note 6.

143 "[P]hysicians should be conscious of costs and not provide unnecessary services or ancillary facilities . . . ." CURRENT OPINIONS, *supra* note 58, opinion 2.09.

144 *Id.*, opinions 2.09 2.19, 4.04.

145 REPORT A, *supra* note 60.

believes that, "physicians should not enter an arrangement with any organization (for-profit or not-for-profit) that directly rewards them for withholding services from their patients."[146]

It is recognized that cost control mechanisms which do not cause a substantial conflict of interest may still tempt physicians to withhold needed care in some circumstances. Physician ethicists argue that the best way to resolve the potential conflict of interest in those situations is through patient disclosure. The American Medical Association recommends that physicians disclose to patients the existence of conflicts of interest that may limit the provision of care needed by a patient. For example, the AMA recommends that physicians inform patients when an HMO or PPO does not permit referral to a medical specialist or diagnostic or treatment facility that the physician believes is needed by the patient.[147] The rationale for disclosure is twofold: (1) the physician should be a vigorous advocate for patients and the physician should not allow his or her judgment to be compromised by the needs of a third party payor, and (2) patients are entitled to know about conflicts and make their own judgments about how they want to proceed.

Other commentators have embellished on the concept that patients are entitled to full disclosure so that they can make their own judgments. One commentator has argued that (1) patients have a right to decide between the merits and drawbacks of HMOs and traditional plans which do not use cost control mechanisms; (2) that HMOs or other managed care plans that advertise the maximal benefits offered may mislead patients who are not told of specific rules and incentives designed to make it unlikely that maximal benefits will be offered, and; (3) patients are

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146 Relman, *supra* note 63, at 1151. Congress and various governmental advisory bodies agree. *See supra* notes 6, 9, 10. *See also* REPORT A, *supra* note 60, at 222-23. The report states:

> It is unethical to intentionally limit utilization of needed medical services to the detriment of a patient for the physician's own profit . . . The overriding principle is that conflicts between the physician's financial interest and the patient's medical interest must always be resolved to the benefit of the patient. Where the conflict is so great that the patient's interest is not served, the physician must cede the care of the patient to another qualified physician.

Id.

147 REPORT A, *supra* note 60, at 222-23.

entitled to disclosure of the emerging ethical dilemmas caused by incentives to withhold care because they are not as well understood and resolved as the ethical dilemmas caused by traditional plans.[148]

IX. The Rationale For Disclosure of Cost Control Mechanisms is Compelling

The law generally requires that fiduciaries avoid conflicts of interest or at least disclose them to those persons with whom they have fiduciary relationships.[149] For example, directors and officers of a corporation have a fiduciary or a quasi-fiduciary relationship with a corporation.[150] Before engaging in transactions in which they may have a conflict of interest with the corporation, directors and officers must disclose the conflict to the corporation and obtain the corporation's consent to proceed.[151] Principles of professional ethics applicable to attorneys also require that conflicts be disclosed.

These principles of disclosure of conflicts in fiduciary relationships have long histories. They are the judicial system's best answer to protecting the interests of the parties in a fiduciary relationship without prohibiting activities which may cause no harm. Persons to whom disclosure is made are left to judge whether the activity may harm them or not, and have the ability to curtail the activity if it is believed that harm may occur.

It seems reasonable to apply these principles to payors and physicians with respect to the use of cost control mechanisms. In particular, payors should disclose the cost control mechanisms that they use to potential beneficiaries. If the payor does not make disclosures when the beneficiary commits to a plan, and subsequently the physician makes disclosures, the beneficiary may have to choose between adhering to the recommendations of the plan's physician and obtaining coverage, or going elsewhere for treatment at the beneficiary's own expense. Reliance on the plan's physicians to make disclosures may not leave the beneficiary with a realistic choice. The beneficiary should have

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148 Levison, *Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans*, 317 NEW ENG. J. MED. 1729 (1987).

149 18B AM. JUR. 2D *Corporations* § 1716 (1985).

150 *Id.*

151 *Id.*

full information at a time when the choice is financially realistic, at the time when the beneficiary is selecting among plans.

The reasons why payors might not want to make disclosures are twofold. First, payors may be concerned that beneficiaries will overreact to the risk that a cost control mechanism will result in the withholding of needed care, and reject sound plans that make use of cost controls. Second, payors may be concerned about the cost of making disclosures.

These reasons, when balanced against the compelling reasons for disclosure, do not justify nondisclosure. It simply is not fair to withhold information from people that they may deem to be material on the grounds that they may overreact to it. People are entitled to make their own judgments about the risks they are willing to accept, especially with regard to a matter as intimate and personal as health care. While there will be a cost associated with disclosure, there is no evidence that it would be burdensome. It would be a matter of adding information to the brochures of materials that payors already issue to promote and explain their plans.

Disclosure should apply to all types of cost control mechanisms. The reasons for disclosing cost control mechanisms where financial incentives are closely linked to individual treatment decisions but are not linked to objective medical criteria, are well established. Congress has prohibited the use of such incentives by hospitals with respect to Medicare patients. Congress has set a deadline date for banning their use by Medicare HMOs, and the GAO has concluded that such incentives might reduce the quality of patient care.[152]

Cost control techniques where incentives are not closely linked to the treatment of individual patients, but which are not closely linked to medically objective criteria, should also be disclosed. Removing the close link to individual cases makes it less likely that clearly needed care will be withheld by a patient who may be seriously injured by the withholding. The techniques, however, are designed to influence physician behavior and to encourage physicians to opt for the least costly treatment strategy whenever possible. This can result in injuries in situations where there is some doubt as to whether a more expensive or a cheaper

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[152] *See supra* notes 9 & 10.

treatment strategy would be appropriate for the patient. The patient is entitled to know the economic criteria which will influence the physician in such a situation.

Techniques where there is a tight link between individual treatment decisions and medically objective criteria should be disclosed, as they can cause injury through the withholding of needed care. This is the technique that was used in *Wickline v. State*,[153] where the beneficiary appears to have lost a leg because she was discharged from the hospital sooner than her physicians would have preferred.[154] She was discharged because the payor, after evaluating a request for additional hospitalization, refused to cover it.[155] Some states have been concerned enough about the use of this technique in prospective coverage decisions that they have passed statutes prohibiting its use.

Finally, it is important that the principle of disclosure be established when economic considerations are used in deciding the medical care patients should receive. The need for cost reduction in health care has become an important issue for individuals, employers, unions, policymakers, and others. Current efforts are focused on the elimination of medical care that is unnecessary. Commentators predict, however, that costs will continue to increase and that we will soon have to decide whether to ration or allocate needed health care.

Policymakers may be tempted to use indirect or subtle mechanisms to allocate health care. Use of such methods may not be well understood, and could avoid controversy. However, health care is too important for decisions to be made about restricting its availability in a *de facto*, indirect fashion. Decisions about the availability of health care should be the subject of open and widespread debate. It is important that people be informed about and understand the cost control mechanisms now being used so that they will be well prepared to participate in the debate as it evolves.

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153 Wickline v. State, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

154 *See id.* at 1634-42, 239 Cal. Rptr. at 812-17.

155 *Id.* at 1638, 239 Cal. Rptr. at 814.