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# Releasing Managed Care's Chokehold on Healthcare Providers

*Kristin L. Jensen, J.D.\**

## I. INTRODUCTION

This discussion addresses the ways in which Managed Care Organizations (MCOs) wield power over physicians and how this power controls the content of treatment information provided to patients. MCOs' practices inflict financial and professional harm on physicians, and patients pay an unconscionable price because of these practices through reductions in patient autonomy and quality of care.

Section II of this article explores the nature of the doctrine of informed consent and its evolution in relation to how much and what kind of information physicians are obligated to disclose to patients. Section III covers the informed consent implications that have arisen with MCOs' practice of limiting communications between physicians and patients. Section IV highlights the ways that MCOs wield unfair bargaining power over physicians and addresses the ways that the legislative and judicial branches of government have failed to remedy this disparity at both the federal and state levels. Section V of this article highlights the power of the termination-without-cause clause and how MCOs strategically use it to coerce physicians into complying with unwritten policies to restrict the flow of information to patients. Finally, Section VI suggests methods to even out the massive imbalance of power between MCOs and physicians and to protect patients' rights to be fully informed of all treatment information. These methods include enacting a ban on termination-without-cause clauses, allowing physicians to bargain collectively, explicitly providing physicians with a private right of action, and creating an impartial appeals system to challenge terminations.

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## II. INFORMED CONSENT AND THE PHYSICIAN-PATIENT RELATIONSHIP

### *A. An Overview of the Doctrine of Informed Consent*

Approximately one hundred years ago, in Justice Benjamin Cardozo's New York courtroom, the concept of patient autonomy was born.<sup>1</sup> In the frequently cited case of *Schloendorff v. Society of New York Hospital*, Justice Cardozo announced that, "every human being of adult years and sound mind has a right to determine what shall be done with his own body."<sup>2</sup> Informed consent is the legal embodiment of the concept that each individual has the right to make decisions affecting his or her well-being.<sup>3</sup> This doctrine, first described by a California appellate court in *Salgo v. Leland Stanford Jr. University Board of Trustees*, states that a physician has an obligation to disclose facts that are necessary for a patient to assess his or her medical situation and to consent to treatment.<sup>4</sup> Although narrow exceptions exist, the general rule for informed consent is that a physician must obtain the patient's consent prior to treatment.<sup>5</sup>

However, merely obtaining consent to a treatment or procedure is not enough to fulfill a physician's obligation to a patient. In *Rizzo v. Schiller*, the plaintiff alleged that her physician failed to obtain informed consent to use forceps to deliver her baby, even though she signed an authorization form before the delivery.<sup>6</sup> The form did not apprise her specifically of any procedures that the physician intended to perform, nor did it inform her of any foreseeable risks or consequences of failing to perform any procedures.<sup>7</sup> This case illustrates the established principle that to obtain informed consent, the physician must provide the patient with a clear and honest explanation of all the factors that might affect the patient's treatment decision, and that consent that is not informed amounts to no consent at all.<sup>8</sup>

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1. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

2. *Id.*

3. Jon F. Merz, *An Empirical Analysis of the Medical Informed Consent Doctrine: Search for a "Standard" of Disclosure*, available at <http://www.piercelaw.edu/risk/vol2/winter/merz>. (last visited on Nov. 20, 2006).

4. 317 P.2d 170, 181 (Cal. Ct. App. 1957).

5. See 61 AM JUR. 2D *Physicians, Surgeons, and Other Healers* § 157 (2006) (noting that the theory of informed consent arises from a patient's right of self determination and the fiduciary relationship between the patient and the physician).

6. 445 S.E.2d 153, 154 (Va. 1994).

7. *Id.* at 155.

8. See *id.* at 155-56.

### B. *The Cause of Action*

Historically, the informed consent action was most often framed as an action for battery.<sup>9</sup> The actionable conduct in a cause of action for battery amounts to an “unconsented touching”; in that context, the patient does not have to prove that he would have consented to the procedure if the doctor had informed him properly.<sup>10</sup> Today, however, informed consent actions typically arise in conjunction with negligence in medical malpractice claims.<sup>11</sup> The grounds usually are that although the patient gives consent, the consent is inadequate because the physician did not disclose all the relevant factors pertinent to the patient’s decision.<sup>12</sup> However, lack of disclosure is not the same as misrepresentation. Healthcare providers who misrepresent the risks associated with treatments can be held liable to the patient on a theory of fraud or misrepresentation.<sup>13</sup>

To fulfill the duty of disclosure, a physician must explain to the patient all the risks and benefits of a particular course of treatment.<sup>14</sup> To determine what information a physician must disclose to his patients, jurisdictions use either an objective physician-based, objective patient-based, or subjective patient-based standard of disclosure.<sup>15</sup> A small majority of jurisdictions adhere to the objective physician-based standard, which requires that the physician disclose what a reasonably prudent physician would disclose under similar circumstances.<sup>16</sup> Under this standard, expert medical testimony is necessary to establish whether a physician has or has not complied with the standard of a reasonably prudent physician.<sup>17</sup> Other jurisdictions employ the objective patient-based standard, requiring that the physician disclose all risks that a reasonable patient would consider material in making a medical treatment decision.<sup>18</sup> An extreme minority of jurisdictions adheres to the subjective patient-based standard, which requires the physician to disclose

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9. MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 202 (6th ed. 2003).

10. *Id.*

11. *Id.*

12. *Id.*

13. *See, e.g.*, John P. Ludington, Annotation, *Medical Malpractice: Practice Liability Based on Misrepresentation of the Nature and Hazards of Treatment*, 42 A.L.R.4th 543 (2006).

14. HALL ET AL., *supra* note 9, at 200-01.

15. *Id.*

16. *Id.* at 201.

17. *Culbertson v. Mernitz*, 602 N.E.2d 98, 101 (Ind. 1992).

18. *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972).

all information that a particular patient would consider material in making a treatment decision.<sup>19</sup>

A patient may have a non-disclosure cause of action against a physician if: 1) the patient's treatment carried with it an undisclosed risk; 2) the physician's nondisclosure of that risk breached the applicable standard of care owed to the patient; 3) the undisclosed risk materialized; and 4) the physician's nondisclosure of the risk caused the patient's injury.<sup>20</sup> However, the patient must prove that his injuries were both physical and behavioral, and must demonstrate that he would have made a different treatment choice and avoided harm if he had proper disclosure.<sup>21</sup> For this element of causation, the courts use either an objective or a subjective test to determine whether a patient would have refused the treatment if the physician had made adequate disclosure.<sup>22</sup>

In some states, legislation controls. For example, the Texas Medical Liability and Insurance Improvement Act ("the Act") determines which risks and hazards related to medical care and surgical procedures that healthcare providers must disclose to their patients or patients' guardians.<sup>23</sup> The Act also establishes the general form and substance of disclosure.<sup>24</sup> The Texas Medical Disclosure Panel reviews medical treatments and surgical procedures and prepares separate lists of procedures and treatments that do and do not require disclosure.<sup>25</sup> The panel also establishes the required degree and form of disclosure.<sup>26</sup> If a physician adheres to what the panel advises, then the physician creates a rebuttable presumption that he has complied with the disclosure requirements; however, failure to disclose a listed risk creates a rebuttable presumption of a negligent failure to conform to the duty of disclosure.<sup>27</sup> Finally, if the panel's list does not provide instruction on a certain treatment, then the physician applies the objective patient-based standard discussed above.<sup>28</sup>

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19. HALL ET AL., *supra* note 9, at 201.
  20. *Id.* at 203.
  21. *Id.*
  22. *Id.* at 203-04.
  23. TEX CIV. PRAC. & REM. CODE ANN. § 74.102 (Vernon 2006).
  24. *Id.*
  25. *Id.* § 74.103 (Vernon 2006).
  26. *Id.*
  27. *Id.* § 74.106 (Vernon 2006).
  28. *Id.*

### C. *Exceptions to the Duty to Disclose*

Ordinarily, a physician is responsible for disclosing all risks associated with treating a patient's condition.<sup>29</sup> The law, however, recognizes some general exceptions to a physician's duty to obtain informed consent.<sup>30</sup> For example, a physician does not have to inform a patient of risks that are considered common knowledge.<sup>31</sup> Also, a patient cannot recover if a physician fails to disclose a risk already known to the patient.<sup>32</sup> Additionally, an emergency exception to informed consent exists when a patient is incapable of consenting, the potential harm from withholding treatment outweighs the potential danger, and no family member is available to consent.<sup>33</sup> In some instances, a physician also may withhold information if he feels that disclosing certain risks to a patient may present a serious threat of psychological detriment to the patient and may negatively affect his treatment.<sup>34</sup> Finally, patients may waive their right to a full disclosure by requesting that the physician not inform them of the risks of a treatment.<sup>35</sup>

### D. *Modern Issues Concerning the Duty to Disclose*

Today, the physician's duty to disclose information has broadened beyond the traditional requirements, encompassing a variety of modern issues. Recently, questions have arisen involving the physician's duty to disclose personal information that might impact the patient's decision to consent to treatment.

For example, courts have addressed questions of whether physicians are required to disclose to patients information regarding their own drug and alcohol use,<sup>36</sup> Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) status,<sup>37</sup> and their experience and

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29. *Cobbs v. Grant*, 502 P.2d 1, 9-10 (Cal. 1972).

30. *Canterbury v. Spence*, 464 F.2d 722, 789 (D.C. Cir. 1972).

31. HALL ET AL., *supra* note 9, at 207.

32. *Id.*

33. *Id.*; *but see Shine v. Vega*, 709 N.E.2d 58, 64 (Mass. 1999) (holding that the emergency exception does not override a competent patient's lack of consent).

34. *Canterbury*, 464 F.2d at 789.

35. *Cobbs*, 502 P.2d at 12.

36. *Compare Albany Urology Clinic, P.C. v. Cleveland*, 528 S.E.2d 777, 780-81 (Ga.2000) (holding no cause of action exists for a physician's failure to reveal drug use), *with Hidding v. Williams*, 578 So. 2d 1192, 1198 (La. Ct. App. 1991) (stating that a cause of action exists for a physician's failure to reveal his alcohol abuse).

37. *K.A.C. v. Benson*, 527 N.W.2d 553, 559 (Minn.1995) (holding that no claim

qualifications. In *Johnson v. Kokemoor*, the court found that a physician's experience regarding a procedure should be disclosed to the patient before obtaining consent because it is an element that will help apprise the patient of all the viable treatment options.<sup>38</sup> In this case, the plaintiff sued her physician after she suffered an aneurism and underwent surgery that left her an incomplete quadriplegic.<sup>39</sup> When the patient had questioned her physician about his experience, he responded that he had performed this surgery "dozens of times"; in fact, the physician only had performed six similar surgeries, and never one as large as the one the patient required.<sup>40</sup> The court held that along with his personal experience, the physician should have disclosed his risk statistics as compared to other surgeons who performed the same surgery, as well as the availability of other more capable medical care providers.<sup>41</sup> The plaintiff also was entitled to introduce expert testimony to show that the defendant should have referred the plaintiff to a care center with more extensive microsurgical facilities and more experienced surgeons.<sup>42</sup>

Another disclosure issue often brought before the courts is the physician's duty to disclose any financial interests he may have in a patient's care.<sup>43</sup> This highly debated issue has been the subject of national attention.<sup>44</sup> In *Moore v. Regents of the University of California*, the California Supreme Court held that a plaintiff stated a viable cause of action by alleging that his physicians failed to disclose their personal financial and research interests in his treatment.<sup>45</sup> In this case, the defendants, a surgeon and a genetics institute, used a leukemia patient's white blood cells to create and patent a cell line.<sup>46</sup> In addition, the surgeon and the institute retained the patient's spleen, other blood, and tissue for testing purposes.<sup>47</sup> The court held that although informed consent questions typically occur when a physician does not properly disclose all medical risks of a procedure, a cause of action for informed consent also exists in situations when a

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for negligent infliction of emotional distress exists when a patient seeks damages solely out of the fear of contracting AIDS but had no exposure to the virus).

38. 545 N.W.2d 495, 498 (Wis. 1996).

39. *Id.* at 499.

40. *Id.*

41. *Id.* at 498.

42. *Id.* at 509.

43. Mark A. Hall, *Is the Health Care Revolution Finished? The Theory and Practice of Disclosing HMO Physician Incentives*, 65 LAW & CONTEMP. PROBS. 207, 222 (2002).

44. *Id.*

45. 271 Cal. Rptr. 146, 147 (Cal. 1990).

46. *Id.* at 148-49.

47. *Id.*

physician fails to disclose all personal research or economic interests independent from the patient's health.<sup>48</sup>

In addition to financial interests in research, MCOs have created new financial cost containment incentives that many believe should be disclosed to patients prior to treatment.<sup>49</sup> To fully understand the importance of these obstacles to informed consent, the modern landscape of health care in the United States must first be understood.

### III. THE ERA OF MANAGED CARE: NEW OBSTACLES TO INFORMED CONSENT

Historically in the United States, patients paid physicians directly for services on a fee-for-service basis.<sup>50</sup> However, medical technology has become more sophisticated and expensive in the past thirty years, and annual costs of the fee-for-service system have skyrocketed.<sup>51</sup> As a result, payment for health care today is furnished largely through MCOs. In order for a physician to treat and receive payment for his services, he must enlist contractually with that patient's particular MCO.

MCOs are businesses characterized by different plans that consumers of health care may purchase. For example, in Health Maintenance Organizations (HMOs), "members are 'locked in' to the HMO provider panel, meaning that health services are covered only if HMO members receive care from the HMO's closed network of participating providers."<sup>52</sup> This "lock-in" feature distinguishes HMO models from Preferred Provider Organizations (PPOs) and HMO "Point of Service" (POS) plans.<sup>53</sup> PPO and POS plans do not restrict the delivery of care to a particular group of providers, but they do provide enrollees with financial incentives, such as reduced payment or increased benefit coverage, if they seek care from participating in-network providers.<sup>54</sup>

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48. *Id.* at 150.

49. Timothy S. Hall, *Bargaining With Hippocrates: Managed Care and the Doctor-Patient Relationship*, 54 S.C. L. REV. 689, 690 (2003) (citing Frank A. Chevenak et al., *Responding to the Ethical Challenges Posed by the Business Tools of Managed Care in the Practice of Obstetrics and Gynecology*, 175 AM. J. OBSTETRICS AND GYNECOLOGY 523 (1996)).

50. See Alexander Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 712 (1986).

51. Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 10 (1999).

52. HALL ET AL., *supra* note 9, at 932.

53. *Id.*

54. *Id.*



MCOs generally impose oversight on healthcare expenses to reduce the instance of costly, and sometimes unnecessary, medical interventions.<sup>55</sup> This “oversight includes external controls on physician spending per patient and internal financial incentives intended to bring the self-interest of individual physicians in line with the fiscal goals of the MCO.”<sup>56</sup> Some examples of these cost containment controls include: 1) forms of base pay from the MCO to the physician, including capitation, salary, and pay per episode; 2) additional incentives, such as bonuses, withholds, and risk pools; and 3) levels of incentives, for example, plan versus group versus individual.<sup>57</sup> As Professor Grant Morris explains, “under the fee-for-service system, the physician’s financial interest was to order additional, and perhaps unnecessary care, while under managed care, the physician’s financial interest is to order less, and perhaps deficient, care.”<sup>58</sup>

Following the lead of *Moore*, an argument has arisen that these additional cost-containment factors are relevant to treatment decisions and must be disclosed to patients so that they may make informed decisions regarding treatment. Professor Morris supports this position and argues that MCOs’ self-serving financial incentives conflict with the physician’s duty of loyalty to the patient.<sup>59</sup>

However, several commentators have argued that disclosing these topics to patients would be economically inefficient and would be both burdensome and counterproductive to the practice of medicine. For example, Professor Mark Hall argues that if an obligation to disclose financial incentives exists at all, disclosure should be satisfied when a patient first enrolls in a plan and periodically thereafter, regardless of pending treatment decisions.<sup>60</sup> Professor Hall argues that when patients enroll in managed care plans, they receive the benefit of their bargains, and concede their right to information in exchange for cheaper health care.<sup>61</sup> Although this approach seems economically feasible, the language of the *Canterbury* Court resonates loudly: “caveat emptor is not the norm for the consumer of medical services.”<sup>62</sup>

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55. Hall, *supra* note 49, at 690.

56. *Id.*

57. Hall, *supra* note 43, at 225. A discussion of the intricacies of these various types of cost containment mechanisms is beyond the scope of this paper.

58. Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 347 (2002).

59. *Id.* at 355.

60. Hall, *supra* note 43, at 213.

61. *See id.*

62. *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972).

Advocating for a different approach, commentator Susan Wolf argues that informed consent is no longer an issue only at the point of treatment; patients need disclosure at every step of the process.<sup>63</sup> Wolf asserts that physicians should disclose whether treatment exists and if the patient is eligible under the plan.<sup>64</sup>

Therefore, the problem with managed care is that while it cuts costs and increases the efficiency of health care, it also deprives healthcare consumers of autonomy and compromises informed consent. After all, fidelity to the patient's medical interest and restoring the patient's health should be placed above all other interests, including any personal or financial interest of the physician.<sup>65</sup> As briefly illustrated above, widespread disagreement has grown among commentators on the issue of if, when, and how this type of information should be disclosed to consumers. However, contractual terms that are designed by MCOs to prevent physicians from discussing treatment options with patients have directly violated the doctrine of informed consent and should be prohibited.

#### IV. OPPRESSIVE MANAGED CARE CONTRACTS

##### A. Onerous Contractual Terms

MCO-physician contracts are contracts of adhesion, written to enforce the cost-containment policies that ultimately reinforce the MCO's bottom line. Adhesion contracts are standardized, drafted by a party with superior bargaining power, and offered to an adhering party on a take-it-or-leave-it basis.<sup>66</sup> MCO-physician contracts are standard forms written by the MCO.<sup>67</sup> The MCO mandates all the contractual terms and the physician has no opportunity to strike clauses or make any other adjustments.<sup>68</sup> For example, when a group of anesthesiologists in New York attempted to negotiate the terms of a contract with an Aetna managed care plan, Aetna refused to negotiate the physician agreements and threatened to terminate all of its agreements with the group's hospital if they did not sign the contract in its original form.<sup>69</sup>

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63. Susan M. Wolf, *Toward a Systemic Theory of Informed Consent in Managed Care*, 35 HOUS. L. REV. 1631, 1639 (1999).

64. *See id.*

65. *See Capron, supra* note 50, at 710.

66. BLACK'S LAW DICTIONARY 40 (6th ed. 1990).

67. E. Douglass Baldrige, *Physicians Versus Managed Care: Is It Time for Physician Unions?*, 28 N. KY. L. REV. 65, 112 (2001).

68. *Id.*

69. *Ambroze v. Aetna Health Plans of N.Y., Inc.*, No. 95 CIV. 6631, 1996 WL 282069 at 3 (S.D.N.Y. May 28, 1996), *vacated by* 107 F.3d 2 (N.Y. 2nd Cir. Jan. 24, 1997),

These standard form contracts contain onerous terms, which include: 1) “hold-harmless” clauses used to decrease an MCO’s liability; 2) “unilateral amendment” clauses that allow MCOs to change contract terms by simply notifying the physician; and 3) “penalty clauses” that allow an MCO to refuse to reimburse a physician for providing an unauthorized treatment, even if a patient needed it.<sup>70</sup> MCOs also often include clauses that assign physicians an “independent contractor” status.<sup>71</sup>

MCOs have the power to “control the means and manner” of a physician’s work performance.<sup>72</sup> If an employer can “control and direct the work of an individual, not only as to the result to be achieved, but also as to the details by which that result is achieved,” then an employer-employee relationship exists.<sup>73</sup> Therefore, whether physicians consider themselves to be independent contractors or not, MCOs clearly treat them more like employees, but without the benefits. One method of controlling the manner of physicians’ work is through “gag clauses,” which MCOs have frequently included in these contracts.<sup>74</sup>

### B. Gag Clauses in Managed Care Contracts

The gag clause is the most well known example of how MCOs have challenged the flow of information from physician to patient. Traditionally, gag clauses were included in MCO-physician contracts to restrict the types of information physicians could provide to patients, including: 1) discussion of relevant medical interventions not covered under the plan because of cost; 2) information about potentially helpful specialists outside the approved provider; and 3) information about the economic incentives offered to physicians for performing or ordering fewer and less costly medical interventions.<sup>75</sup>

Although debate existed over whether MCO-physician contracts actually contained gag clauses,<sup>76</sup> MCOs justified the provisions on the grounds that they protect proprietary information and are necessary to protect trade

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*aff’d on reh’g*, 152 F.3d (N.Y. 2nd Cir. May 5, 1998).

70. Baldridge, *supra* note 67, at 113.

71. *Id.* at 128.

72. *Id.*

73. *Id.* (citing *Spirides v. Reinhardt*, 613 F.2d 826, 832 (D.C. Cir. 1979)).

74. *Id.* at 113.

75. Gisela M. Munoz, et al., *The Two Faces of Gag Provisions: Patients and Physicians in a Bind*, 17 YALE L. & POL’Y REV. 249, 250-51 (1998).

76. U.S. General Accounting Office, GAO/HEHS-97-175, *MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERNS REMAIN* (1997) [hereinafter GAO/HEHS-97-175]. In addition, the GAO found no reported court cases that provide guidance on what constitutes a gag clause.

secrets in a competitive managed care market.<sup>77</sup> However, gag clauses prevent physicians from making required disclosures to their patients or from referring patients to specialists.<sup>78</sup> Professor Joan Krause explains that these clauses allow MCOs to keep physicians quiet, and thereby keep costs low.<sup>79</sup>

The gag clause controversy centers on MCOs' explicit efforts to prevent physicians from apprising patients of treatment options that might not be covered or that are covered but discouraged because of high cost.<sup>80</sup> Specifically, these limitations include: 1) requiring non-disclosure of alternative treatment options; 2) bans on referring patients outside of network without authorization; 3) pre-approval limitations; 4) confidentiality clauses that prohibit physicians from disclosing proprietary information, such as the plan's payment rates; and 5) anti-disparagement clauses that prohibit physicians from "disparaging" the plan by making statements that "could undermine the patient, employer, union, or public confidence in the health plan" in any way.<sup>81</sup> In this respect, informing a patient that a potentially beneficial treatment exists but is unavailable because it was not covered by their health plan could "undermine the patient's confidence in the plan." Although not specifically designed to restrict physician's clinical recommendations, these provisions prevent physicians from discussing the merits of non-covered or expensive treatments.<sup>82</sup>

### C. Legislative Response

In the 1990s, due to nationwide negative media attention, a full-scale effort developed to prohibit gag clauses.<sup>83</sup> These endeavors were for good cause. With a gag clause in place, a physician cannot apprise a patient of all his treatment options. Additionally, patients may not seek second opinions and acquire withheld information because they would not be aware of the withheld information. By including gag clauses in provider contracts, MCOs not only control costs, but they also control the substantive practice of medicine by commanding what a physician can or cannot recommend to a patient.

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77. Munoz et al., *supra* note 75, at 252.

78. Joan H. Krause, *The Brief Life of the Gag Clause: Why Anti-Gag Legislation Isn't Enough*, 67 TENN. L. REV. 1, 10 (1999).

79. *Id.*

80. Julie A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J. L. & MED. 433-44 (1996).

81. *Id.* at 443-45.

82. *Id.* at 445-46.

83. *Id.* at 472-77.

In addition, beginning in 1996, Congress introduced a number of federal bills confronting the problem of gag clauses in MCO-physician contracts.<sup>84</sup> Unfortunately, none of the bills were enacted into law.<sup>85</sup> Some argue that, although the bills were well-intended, none of them effectively addressed the core issues of the debate: 1) the market's failure because of a lack of information available to consumers prior to enrollment in an MCO, and 2) the inability of patients to make informed healthcare decisions after enrollment.<sup>86</sup> In 1998, President Clinton banned the use of gag clauses by HMOs that serve Medicare and Medicaid patients, created an Advisory Commission on Consumer Protection and Quality in the Healthcare Industry charged with developing a "Consumer Bill of Rights and Responsibilities," and instructed his Cabinet to bring each Executive agency into compliance with the Commission's recommendations.<sup>87</sup>

The gag clause also became a highly popular issue at the state level. By the end of 1998, almost every state had at least one anti-gag law in place. For example, section 1301.067 of the Texas Insurance Code prohibits an insurer from interfering with a relationship between a patient and physician or other healthcare provider and limits these types of communications.<sup>88</sup>

#### V. THE TERMINATION-WITHOUT-CAUSE CLAUSE

Although the effort to outlaw gag clauses was laudable, it was an ineffective quick fix. The fact remains that adding a third-party payor to the equation introduces more complicated variables to the problem. Despite the legislative response, powerful implicit incentives such as termination-without-cause clauses still exist, and MCOs continue to control and restrict the dissemination of information to patients. In August 1997, the United States General Accounting Office (GAO) released a report acknowledging that "MCOs need not rely on written rules in their contracts to modify physician behavior, but might use guidelines, protocols, physician profiling, counseling, and other procedures."<sup>89</sup> Simply put, MCOs can maintain unwritten policies that restrict discussion of treatment options by enforcing the use of other less expensive treatments, denying coverage for some treatments, and disciplining physicians for inefficiency.<sup>90</sup>

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84. Munoz et al., *supra* note 75, at 271-77.

85. *Id.*

86. *Id.* at 272.

87. See ADVISORY COMM'N ON CONSUMER PROT. & QUALITY IN THE HEALTH CARE INDUS., CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES: REPORT TO THE PRESIDENT OF THE UNITED STATES (1997), available at <http://www.hcqualitycommission.gov/cboirt>.

88. TEX. INS. CODE ANN. § 1301.067 (Vernon 2006).

89. GAO/HEHS-97-175, *supra* note 76.

90. *Id.*

### A. *The Power of Termination-Without-Cause*

MCO-physician contracts contain non-renewal options and termination-without-cause clauses that unilaterally grant an MCO the power to terminate a physician prematurely and without cause.<sup>91</sup> MCOs “discipline” physicians by threatening to terminate them for not following the MCO’s profit-maximizing policies.<sup>92</sup> MCOs have terminated physicians for disclosing MCO policies to patients, for advocating for patients who’s MCOs have denied care, and for referring patients to specialists.<sup>93</sup> If the MCO has a large market share and has enrolled a significant percentage of a physician’s patient base, termination can be professionally and economically devastating.<sup>94</sup> The termination-without-cause clause is the most powerful weapon in the MCO arsenal because it aims directly at physicians’ wallets, inducing physicians to comply with MCO policies.<sup>95</sup> The logical course of action for physicians who disagree with these clauses would be either to negotiate for different terms or not to participate.<sup>96</sup> Negotiation, however, is often not an option, and non-participation means the physician cannot treat his patients enrolled with that particular MCO. Without another alternative, physicians must sign these contracts even though the standard terms are incompatible with their interests.

### B. *Harms of Physician Termination*

Physicians rely on MCO contracts for their patient base, income, and marketability. Accordingly, as physicians’ reliance increases, their incentive to consider cost in their practices also increases.<sup>97</sup> Cost consideration does not stem from a sense of duty to the MCOs, but from the fear of the personal and professional consequences of termination.<sup>98</sup> In particular, two significant harms that impinge on the physician-patient relationship emerge from termination.<sup>99</sup>

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91. Bryan A. Liang, *The Practical Utility of Gag Clause Legislation*, 13 J. GEN. INTERNAL MED. 419, 420 (1998).

92. John P. Little, Note, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1416 (1997).

93. *Id.* at 1417.

94. *Id.* at 1418.

95. *Id.*

96. RUSSELL KOROBKIN, *NEGOTIATION THEORY AND STRATEGY* 151 (Aspen Law & Business 2002).

97. Richard S. Liner, Note & Comment, *Physician Deselection: The Dynamics of a New Threat to the Physician-Patient Relationship*, 23 AM. J.L. & MED. 511, 513 (1997).

98. *Id.*

99. *Id.*

First, the ultimate financial threat to physicians is termination from an MCO. Believing that full disclosure of information may lead to termination from an MCO compromises physicians' abilities to make patient care their primary concern. Physicians' abilities to determine courses of treatment and make referral decisions based solely on their best medical judgment is jeopardized when they think they could be terminated from an MCO for economic reasons. The possibility of termination coerces physicians into compliance with an MCO's unwritten policies that restrict the dissemination of information to patients. This affects the quality of patient care and compromises principles of true informed consent.

In fact, physician participants in a GAO study stated that termination-without-cause clauses provide strong incentives to restrict patient communication, especially in regions where MCOs dominate the healthcare marketplace.<sup>100</sup> Professor Joan Krause explains that if MCOs structure financial incentives "correctly" from the MCOs' point of view, physicians will internalize the incentive structure and impose their own restrictions on interactions with patients.<sup>101</sup> These restrictions include providing less care or less expensive care and spending the minimum amount of time with patients.<sup>102</sup> Therefore, it is not difficult to see why and how MCO policies compromise patient information and autonomy. Limiting patient interaction by discussing fewer treatment options or making no referrals to out-of-network specialists serves the MCO's financial bottom line and may keep the physician from being terminated. An effect of the without-cause terminations is to coerce physicians to restrict care and terminate noncompliant physicians.<sup>103</sup>

Secondly, termination can produce results similar to patient abandonment.<sup>104</sup> Patients of terminated physicians may not be able to obtain a new physician in a timely manner.<sup>105</sup> If the patient is "expensive," has a terminal or chronic illness, or is elderly, then he or she is undesirable for a new physician because high acuity level patients will have an adverse effect on the physician's outcomes profile.<sup>106</sup> Additionally, new physicians and patients also accrue time and monetary costs associated with recounting the patient's past history, physical exams, previous testing, previous therapies and their results, and previous medications and their effects.<sup>107</sup>

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100. GAO/HEHS-97-175, *supra* note 76.

101. Krause, *supra* note 78, at 15.

102. *Id.*

103. Little, *supra* note 92, at 1443.

104. Liner, *supra* note 97, at 528.

105. Liang, *supra* note 91, at 419-20.

106. *Id.* at 420.

107. *Id.* at 419-20.

Additionally, the patient must now establish confidence and trust in the new physician and staff. Therefore, termination of a physician produces adverse effects that could prevent a patient from receiving adequate care and the patient may feel abandoned if obtaining a new physician proves to be difficult.

### C. Court Cases Evaluating Physician Termination

The courts have supplied limited recourse for terminated physicians. In some states, physicians may challenge termination on the grounds that it is contrary to public policy or that the termination denied the physician fair procedure.<sup>108</sup> In *Harper v. Healthsource New Hampshire, Inc.*, the New Hampshire Supreme Court allowed a physician to challenge termination on the ground that it violated public policy.<sup>109</sup> The Court reasoned that the relationship between physicians and HMOs affects patients' interests so substantially that public policy and fundamental fairness require that a decision to terminate a provider must "comport with the covenant of good faith and fair dealing inherent in all contracts, and may not be made for a reason that is contrary to public policy."<sup>110</sup>

In *Harper*, Dr. Harper was a participating physician for Healthsource for ten years, and thirty to forty percent of his patients were enrolled with Healthsource.<sup>111</sup> After he "realized Healthsource was . . . manipulating and skewing the records of treatment he had provided to several of his patients and that those inaccuracies adversely affected subsequent reports," he notified Healthsource about his concerns.<sup>112</sup> Healthsource responded by informing him that they were terminating his contract.<sup>113</sup> The court did not prohibit termination-without-cause clauses in provider contracts per se, but it held that in order to comply with public policy, HMOs must provide a terminated physician with a decisional review.<sup>114</sup> Relying on *American Jurisprudence*, the court declared that "an agreement is against public policy if it is injurious to the interests of the public, contravenes some established interest of society, violates some public statute, is against good morals, tends to interfere with the public welfare or safety, or, as it is sometimes put, if it is at war with the interests of society and is in conflict with the morals of the time."<sup>115</sup> However, the *Harper* decision provides

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108. *Id.* at 419.

109. 674 A.2d 962, 966 (N.H. 1996).

110. *Id.*

111. *Id.*

112. *Id.* at 963.

113. *Id.*

114. *Id.* at 966.

115. *Harper v. Healthsource N.H., Inc.*, 674 A.2d 962, 965 (N.H. 1996).



little guidance for the determination of what behavior will infringe on the public policy construction because the court never defined what circumstances surrounding a physician's termination would violate public policy or the covenants of good faith and fair dealing.

Similarly, in *Potvin v. Metropolitan Life Insurance Co.*, the Supreme Court of California ruled that even if a contract permits termination-without-cause, MCOs are required to afford physicians fair procedure, including notice and an opportunity to respond, and to ensure that the termination is not arbitrary or does not violate public policy.<sup>116</sup> The court held that a terminated physician has a common law right to fair procedure if the insurer possesses power substantial enough to impair the physician's ability to practice his specialty in a particular geographic area, thereby affecting an important economic interest.<sup>117</sup> This decision characterizes MCOs as powerful economic entities taking on a "quasi-public significance," requiring them to afford the same level of due process as other state actors. This was an important step in helping to adjust the massive imbalance of power between physicians and MCOs.<sup>118</sup>

Furthermore, a physician's conflict of whether to disclose other treatments for patients or to keep his job may present him with a lose-lose situation. A recent U.S. Supreme Court case, *Aetna Health Inc. v. Davila*, held that patients do not have the option to sue their health plans if they are injured because the plan denied coverage for care, increasing the risk that patients will sue their physicians if a recommended test or treatment is not offered.<sup>119</sup>

#### D. *The State of the Law in Texas*

Unfortunately, Texas has not followed the lead of either New Hampshire or California. Texas law fails to provide physicians with a private right of action against MCOs. In *Texas Medical Ass'n v. Aetna Life Insurance Co.*, the plaintiffs were a group of physicians whose PPO contracts were terminated without cause.<sup>120</sup> These physicians sought to have the termination-without-cause clauses in their contracts deemed as void and unenforceable. The plaintiffs claimed that the clauses violated Texas statutes because they were not granted due process upon termination, and the clauses required PPO contracts to be based solely on economic, quality, and

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116. 997 P.2d 1153, 1157 (Cal. 2000).

117. *Id.* at 1161.

118. Liner, *supra* note 97, at 521.

119. *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

120. 80 F.3d 153, 154 (5th Cir. Tex. 1996).

accessibility considerations.<sup>121</sup> The Fifth Circuit affirmed the district court's grant of summary judgment for the MCO because Texas statutes do not provide private rights of action for enforcement of PPO rules.<sup>122</sup> Despite the use of the term "any person" in the statute, Texas courts have limited those who may sue under the Insurance Code to either an insured or a beneficiary of a policy.<sup>123</sup> Thus, without reaching the merits of termination under these clauses, the court held that the aggrieved physicians had no cause of action and dismissed their suit.<sup>124</sup>

As a result of this litigation, the Texas legislature has enacted a series of piecemeal regulations designed to provide terminated physicians with procedural protections.<sup>125</sup> Although these laws require MCOs to allow a hearing by the advisory panel to review the termination, the decision of the advisory panel is not binding and the MCOs are not required to state why they did or did not accept the panel's recommendation.<sup>126</sup> Also, the terminated physician is not allowed to be present at the hearing or to have legal representation.<sup>127</sup> Consequently, physicians may be terminated without cause if they do not cooperate extensively with both the written and unwritten policies of MCOs.

Some might argue that since the gag clause controversy, the market has regulated itself because Texas MCOs must answer to the Texas Insurance Commissioner. However, consider the following hypothetical where the market does not regulate itself in the way that some believe it should: Dr. Jones, an orthopedic surgeon, is feeling the financial strain of the managed care revolution. Accordingly, he decides to take matters into his own hands and performs procedures on his PPO patients in an out-of-network ambulatory surgical center, rather than in a hospital setting. As long as the center is out-of-network, he will continue to operate on his HMO patients in a traditional hospital. In his center, Dr. Jones' patients receive comprehensive, efficient care in a sterile outpatient environment. This reduces the risk of hospital-based infection and the hassles of a hospital visit. In fact, a new report says that in 2004, in Pennsylvania alone, hospitals billed Medicare an extra \$1 billion to treat hospital-acquired

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121. *Id.* at 155, 157.

122. *Id.* at 160.

123. *Levinthal v. Kelsey Seybold Clinic, P.A.*, 1997 Tex. App. LEXIS 2824, at \*5 (Tex. App. Houston 1st Dist. May 29, 1997).

124. Bryan A. Liang, *Deselection Under Harper v. Healthsource: A Blow for Maintaining Patient-Physician Relationships in an Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 809 (1997).

125. 28 TEX. ADMIN. CODE ANN. §§ 3.3703, 3.3706, 11.1601 (West 2005).

126. 28 TEX. ADMIN. CODE ANN. § 3.3706(d)(3) (West 2005).

127. *Id.*

infections in 7,870 patients, and Medicaid was billed \$371.6 million more for 1,028 patients.<sup>128</sup> The advantage to Dr. Jones is that he can operate out-of-network and can regain some of his lost fees in a healthcare market where he is continuously being paid less and less for his services. Dr. Jones also can set his own surgical schedule instead of adhering to the hospital's very strict time slots. Although Dr. Jones' practice is legitimate, the MCO terminates Dr. Jones' contract under the without-cause clause because referring patients to the out-of-network ambulatory surgery center, instead of to an in-network hospital, costs the MCO more money.<sup>129</sup> Anti-gag rules and patient choice laws are supposed to protect against this kind of arbitrary termination, but they do not. To avoid termination, Dr. Jones likely would have to comply with the MCO's unwritten policies to save costs by not referring out-of-network, thus denying his patients information on all viable treatment options, as well the right to give informed consent.

Arguably, this MCO is engaged in a possible deceptive trade practice by selling a patient a premium policy that allows him to choose an out-of-network physician, and then terminating the physician who referred him out-of-network. Although situations similar to this are difficult to quantify, more and more aggrieved surgeons are coming forward with this type of problem.<sup>130</sup>

## VI. THE NEED FOR MORE EFFECTIVE SOLUTIONS

If we remain unwilling to surrender to Justice Cardozo's famous declaration that the right of autonomy belongs to the patient, something must be done to release managed care's chokehold on healthcare providers. Both administrative and judicial remedies should be provided. MCOs must be held responsible for their actions, and physicians need assurance that they will not be terminated for fully protecting their patients' interests and informing them of all viable treatment options.

1. One solution would be to lobby the legislature to enact a ban on termination-without-cause clauses in physician contracts on the grounds that they are unconscionable and against public policy. However, these contracts usually state that the relationship of the physician to the MCO is that of an independent contractor, and this recommendation might be met

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128. Pennsylvania Health Care Cost Containment Council, *Philadelphia Inquirer*, Nov. 17, 2005, available at <http://www.healthleaders.com/news/newspage74770.html?Contentid=74770>.

129. This hypothetical situation is intended to provide an example of a way in which MCOs arbitrarily terminate physician contracts.

130. Telephone Interview with Eric Gleichman, Vice President of Legal Services, Foundation Surgical Affiliates (Nov. 7, 2005).

with some resistance in states that are extremely supportive of the employment-at-will doctrine.

2. Alternatively, in accordance with anti-trust laws, physicians should be allowed to organize and form unions so that they may bargain collectively to ensure that insurers treat them equally and fairly. Enforcement of oppressive physician MCO contracts is unconscionable where the MCO has such superior strength in bargaining.<sup>131</sup> Restoring bargaining power to physicians via collective bargaining will allow physicians to renegotiate onerous contract terms that have heretofore been non-negotiable, and it may prevent some physicians from losing contracts with or being terminated by MCOs. Collective bargaining by physicians will also benefit patients. As we have seen, the interests of physicians and patients are aligned much more closely with each other than with the interests of MCOs. Furthermore, physician unions will cause MCOs to increase competition with one another. One significant obstacle to this approach is that physicians are often assigned an "independent contractor" status rather than "employee" status.<sup>132</sup>

Once physicians have some true bargaining power, MCOs will have to be more competitive with one another in order to negotiate physician contracts and to obtain the best quality and most efficient groups of healthcare providers. These qualities will appeal to consumers who want to pay the lowest premiums, but not sacrifice of quality of care.

3. Additionally, physicians should have a private right of action against MCOs. Inadequately informed patients have standing to pursue a cause of action against their physicians, but physicians have no right to sue MCOs for preventing full disclosure of information.<sup>133</sup> Problems with this approach are that litigation is costly, time-consuming, and diverts MCO resources away from patient care. In addition, a physician may not have standing to bring suit until he has been terminated for a time sufficient for damages to accrue. Also, if physicians are granted a private right of action, MCOs are likely to require an arbitration clause in their contracts. This may lead to another type of contract of adhesion and may not help resolve the underlying problem. However, in the presence of a neutral arbiter in any case, an illegally terminated physician would have access to fair procedure in the decision-making process.

4. State legislatures need to create an impartial appeals system for physicians facing termination from MCO networks. Once a physician receives notice of termination, a hearing should be held to resolve disputed

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131. Baldrige, *supra* note 67, at 111.

132. *Id.* at 128.

133. *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

terminations. An impartial panel with the power to issue binding decisions should conduct the hearing, and the panel must be agreeable to both the physician and the MCO. Also, physicians should be given the right to judicial review of unfavorable decisions. This will afford a physician a fair opportunity to obtain an injunction against the termination, as well as a court order addressing the practicality of onerous clauses in that particular provider's contract. Importantly, an impartial appeals process would provide a deterrent effect for arbitrary terminations, ensuring that MCOs only terminate physicians for valid reasons.

5. A final possibility for aggrieved physicians is to file a class action suit under the Racketeer Influenced and Corrupt Organizations Act (RICO). Following the lead of *In re Managed Care Litigation*, physicians may be able to band together to obtain recourse from unfair terminations.<sup>134</sup> The *Managed Care Litigation* class action suit began in 1999 when a physician sued Humana, CIGNA, and several other HMOs.<sup>135</sup> The physician alleged that health insurers used fraudulent marketing tactics and financial incentives to restrict patient care, thereby breaching their obligations under federal law to provide necessary medical care.<sup>136</sup> Within a year, a score of patients and physicians filed other suits making similar allegations.<sup>137</sup> CIGNA later settled with the physicians.<sup>138</sup> Although this is likely to be an increasingly attractive option to physicians who are fed up with unfair termination practices by MCOs, it primarily seeks to remedy the financial harm suffered by physicians as a result of arbitrary terminations. Until a class-action suit such as this is successful, patient information will remain compromised.

These remedies are important because termination not only causes physicians to lose patients and income, but termination also creates a decrease in professional autonomy. Other MCOs are less likely to have an interest in retaining a terminated physician, and they may eventually terminate that physician without cause as well. Physician reputation and marketability may further decrease if the termination is reported to the National Practitioner Data Bank.<sup>139</sup>

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134. 298 F.Supp. 2d 1259 (S.D. Fla. 2003).

135. Texas Medical Association Online, *TMA's Legal Action Against Managed Care Organizations*, published December 7, 2005, available at [www.texmed.org/Template.aspx?id=3537](http://www.texmed.org/Template.aspx?id=3537).

136. *Id.*

137. *Id.*

138. CIGNA HealthCare Agreement With Physicians Wins Approval in U.S. Federal Court PR NEWSWIRE, Feb. 2, 2004 available at <http://www.prnewswire.com/comp/165050.html> . . . [cigna.mediaroom.com/index.php?s=114&item=599](http://cigna.mediaroom.com/index.php?s=114&item=599).

139. Liner, *supra* note 97, at 517.

Some managed care proponents will likely argue that these proposals amount to “doctor protections” rather than “patient protections.” However, the legal and public policy questions associated with termination transcend a physician’s jeopardized income and reputation. By giving physicians recourse, it is not solely the physician that are being offered protection. Importantly, this recourse also substantially shields the physician-patient relationship and patients’ rights to full access of information from interference by MCOs.

## VII. CONCLUSION

For now, the dynamic evolution of managed care continues. It is clear that a healthcare crisis is currently unfolding in America and that cost-containment mechanisms are needed to prevent healthcare costs from spiraling upwards, especially in light of today’s aging population. However, as long as healthcare providers face the threat of termination-without-cause clauses, the incentives that anti-gag clause legislation sought to eliminate remain, the physician-patient relationship is compromised, and patients are denied truly informed consent to health care. Until legislative change occurs, physicians will continue to balance their traditional roles as patient advocates and their new roles as business managers who must control rising costs in order to avoid termination. This is precisely why state legislatures should allow physicians to bargain collectively, explicitly provide healthcare professionals with an impartial appeals system, and provide physicians with a private right of action to challenge MCOs that penalize them for engaging in patient advocacy. These are the only acceptable ways of ensuring that physicians can be heard and not have their profession derailed by unfair MCO tactics.