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Taking a Closer Look At The Managed Care Class Actions: Impact Litigation As An Assist to the Market

*Kathy L. Cerminara, J.D., L.L.M., J.S.D.**

The term “quality health care” implies many definitions. On an individual level, one may think of medical malpractice law when discussing the pursuit of quality health care. Systemically, concerns about quality health care almost certainly will lead to a discussion of the high rate of medical errors recently reported.¹ If one thinks in terms of structure, the term “quality health care” may trigger consideration of financing issues such as the impact of cost-conscious management of medical care on the type of care received by patients. This article will focus on the latter consideration — financing issues — not because the former lack importance, but because the latter necessitates a hard look at the interaction between individuals and the health care market.

One of the first subjects that comes to mind in terms of health care financing structures is the so-called “backlash against managed care.”² Along with media accounts of horror stories and calls for legislative action, the 1990s backlash against managed care brought a wave of class action lawsuits asserted by groups of covered individuals against insurance companies and other corporate entities engaged in the management of medical care (hereinafter referred to as the “managed care class actions”). While these lawsuits may not have come as a surprise,³ they

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1. See LINDA T. KOHN et al., eds., COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM (National Academy Press 2000).

2. For a thoughtful discussion of the backlash and its effect on consumers of health care services, see Marc A. Rodwin, *Promoting Accountable Managed Health Care: The Potential Role for Consumer Voice Persp.* (Oct. 2001), available at <http://www.indiana.edu/~speaweb/perspectives/vol5/notes.html> (last visited Feb. 25, 2002) [hereinafter Rodwin].

3. See William M. Sage, ‘Health Law 2000’: *The Legal System and the Changing Health Care Market*, HEALTH AFF. (Dec. 1996) (predicting that class actions may arise

caused much comment and made many headlines. Today, slightly more than ten years after the appearance of the initial managed care class actions,⁴ such lawsuits have proliferated.

This growth implicates concerns about the impact of managed care class actions on quality of care and prompts a series of thought-provoking questions. The issue arises as to whether litigation is an appropriate method to use in seeking to assure the provision of high-quality health care. Well-regarded policy-makers, academics and lawyers commenting on the medical malpractice system and tort reform differ on the validity of litigation as a device to ensure quality health care.⁵ The debate comparing litigation-prompted market regulation with free market competition as a means of securing quality health care will not be settled by anything said or written in any one lecture or article. Litigation is often expensive, and any money spent by insurance or managed care companies defending against lawsuits is arguably money that could be spent in providing health care services to covered individuals. Without accountability for quality of care, however, which is achieved classically through tort lawsuits, incentives to provide quality care are reduced. As Peter Hammer has said, “Those managed care advocates who invoke the virtues of employer choice, freedom of contract, and the efficiency of private markets need to be more attuned to the necessity of public accountability.”⁶

more frequently in health in this millennium; a look at how regulators and the courts may react to the rapidly changing healthcare landscape).

4. If not the earliest, *Teti v. U.S. Healthcare, Inc.*, No. 88-9808 (E. D. Pa. filed Dec. 27, 1988), and *Ehrlacher v. U.S. Healthcare, Inc.*, No. 88-9822 (E. D. Pa., filed Dec. 28, 1988) were among the earliest, having been filed in 1988. The next significant managed care class action lawsuits to surface seem to have been filed in 1993 and 1994 (*Grijalva v. Shalala*, No. 93-711 (D. Ariz. filed Feb. 10, 1993) and *Lynch v. Intergroup Healthcare Corp.*, No. 94-15694 (Ariz. Maricopa County filed Oct. 3, 1994). It was five years ago that attorneys filed the first two private-insurance (as opposed to Medicare-based) managed care class actions to make major headlines. They were *Weiss v. Cigna Healthcare, Inc.*, No. 96-1107 (S. D. N.Y. filed on Feb. 13, 1996) and *Drolet v. Healthsource, Inc.*, No. 96-166-B (D. N.H.) (Copies of complaints are on file with the Annals of Health Law) See generally Kathy L. Cerminara, *The Class Action Suit as a Method of Patient Empowerment in the Managed Care Setting*, 24 AM. J. L. & MED. 7 (1998) [hereinafter Cerminara].

5. See generally Peter J. Hammer, *Pegram v. Herdrich: On Peritonitis, Preemption, and the Elusive Goal of Managed Care Accountability*, 26 J. HEALTH POL., POL'Y & L. 767, 782 (2001) (discussing ERISA preemption, noting that “[m]aking health care policy through the ad hoc process of judicial decision making . . . has both severe limitations and modest strengths”); William M. Sage, *Principles, Pragmatism, and Medical Injury*, 286 J. AM. MED. ASS'N 226 (July 11, 2001) (commenting on the arguments for and against a fault-based tort system for medical malpractice).

6. Hammer, *supra* note 5, at 786.

Regardless of the questions about efficiency or efficacy of litigation, any person who feels aggrieved and has a legal basis upon which to claim relief for the grievance could engage in litigation. Recognizing the fact that litigation is one weapon in the arsenal of those seeking redress for injuries, the question with respect to the managed care class actions becomes whether class action litigation is more or less appropriate than other types of litigation in the quest for quality health care. Finally, the issue narrows to a consideration of whether the allegations of these particular class actions are likely to promote quality health care.

This article will first briefly illustrate why and how the class action is indeed an appropriate, even time-honored, approach to some types of litigation because of its ability to empower groups of people. In this setting, the groups consist of covered individuals, or the people who either are or will be patients requesting care of entities managing care. Thereafter, the article will examine the allegations of some of the current managed care class actions and will demonstrate that they are likely to promote quality health care, in both an empowerment and a free market competition sense. Therefore, although litigation is usually seen as an attempt to regulate the market, this type of litigation can assist in the functioning of the market.

I. THE IMPACT OF THE CLASS ACTION AS A PROCEDURAL DEVICE IN THE QUEST FOR QUALITY HEALTH CARE

In examining the validity and worth of the managed care class actions, it is important first to differentiate between the procedural and the substantive. Too often, observers decide that, because they believe its substantive allegations lack merit, the case should not be pursued as a class action. Such an approach, however, improperly conflates two distinct issues: whether the case itself should be pursued and whether class-wide treatment is appropriate. Rather than conflating the issues, or even approaching them in this order, courts considering class action cases must first determine in each case whether class-wide treatment is appropriate, and only thereafter examine the question of whether the substantive allegations of the claim have merit.⁷

Since this analysis is the method by which courts should pursue decision-making in class action cases, a similar approach will be used here in considering whether the current managed care

7. See FED. R. CIV. P. 23(c)(1) (requiring determination by the court whether suit will be maintained as a class action “[a]s soon as practicable” after commencement).

class actions are of value in the pursuit of quality health care. Because Rule 23⁸ instructs courts first to determine procedural propriety and then to examine substantive allegations, this article will first examine the worth of the managed care class actions as a procedural device in the pursuit of quality health care and then will discuss the substantive ways in which they can assist in that pursuit.

Procedurally, class action lawsuits can constitute a form of impact litigation aimed at achieving social justice.⁹ Indeed, they can be precisely this, rather than being aimed at the destruction of their opponents, in the managed care arena. They permit suits to be brought by “groups of people who individually would be without effective strength to bring their opponents into court at all,”¹⁰ thus empowering their plaintiff classes. If flaws exist in the system, the class action lawsuits enable the correction in one fell swoop of those flaws, which can affect vast numbers of people. Class actions also serve as clubs swung over the heads of their defendants, garnering attention and response in instances in which individual lawsuits would be treated summarily.

A. Power in Numbers

First, the class action is a way to make litigation a viable option for certain plaintiffs. Class action lawsuits enable the amassing of individuals whose claims are so small that, individually, they are not worth the cost of litigation.¹¹ For example, in many of the managed care class actions, damages are claimed to equal the difference between the type of health care coverage the plaintiffs expected based on certain contractual representations, and the type of health care coverage that the plaintiffs actually received.¹² Because covered individuals usually pay only a por-

8. See FED. R. CIV. P. 23(a), (b) which set forth the requirements a proposed class must meet to achieve class certification.

9. See Cerminara, *supra* note 4, at 9.

10. Benjamin Kaplan, Prefatory Note, *The Class Action: A Symposium*, 10 B.C. IND. & COM. L. REV. 497, 497 (1969).

11. For example, consumers of financial services have asserted class actions against banks imposing certain surcharges. See Leon E. Trakman, *David Meets Goliath: Consumers Unite Against Big Business*, 25 SETON HALL L. REV. 617, 620-21 (1994) (although criticizing a class action settlement, discussing a class action filed in a dispute over surcharges imposed for checks returned due to insufficient funds).

12. See, e.g., *Maio v. Aetna, Inc.*, 221 F.3d 472 (3d Cir. 2000); *In re Managed Care Litigation*, 150 F.Supp.2d 1330 (S.D. Fla. 2001).

tion of coverage premiums,¹³ this amount is not usually a huge sum for each plaintiff.¹⁴ Individual litigation to recover such a sum would be cost-prohibitive.

As a procedural device that allows plaintiffs to band together, the class action thus facilitates access to the courts for persons who would not normally be there. Using Marc Galanter's classic terminology, one can consider managed care organizations to be repeat players in the litigation world in that they have experienced, and expect to continue to experience, repeated litigation.¹⁵ Managed care organizations, for example, may be named as defendants in a number of substantially similar cases each year in various jurisdictions all across the country. In contrast, each person seeking to assert a claim against the managed care company is likely a "one-shooter" - "a person, business, or organizational entity that deals with the legal system infrequently."¹⁶

Class actions can help one-shooters voice their concerns. Joining together to litigate can give one-shooters the repeat players' advantage of aggregating litigation expenses. Because of the similarities among the cases in which they are defendants, repeat players can spread across multiple lawsuits the costs of crafting a strategy and engaging in discovery. Typically, one-shooters cannot do so because each stands alone, not necessarily knowing any of the other people filing individual suits against managed care entities. Banding together in one lawsuit, however, can permit many one-shooters to aggregate their expenses into those incurred in one, albeit large, suit. No single plaintiff must try to finance the costs of his or her own lawsuit.

In this regard, while there is a great deal of negative commentary regarding contingent fees and potential awards of attorneys' fees in class action cases,¹⁷ their availability helps open the

13. Some employers fund health care coverage entirely, in which cases their employees pay none of the coverage premiums. Others fund only a portion of their employees' health care coverage costs; in those instances, employees pay some amount per month toward their own coverage. See Cerminara, *supra* note 4, at 18.

14. Although "only taking a number" in general, the figures the court in *Maio* threw out for discussion during oral argument can be illustrative. The court discussed a premium of \$150 per month, which might be reduced to \$130 per month by the type of damage claimed by the plaintiffs. *Maio*, 221 F.3d at 484 n.10.

15. Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L. & SOCIETY REV. 95 (1974).

16. Joel B. Grossman, *Do the "Haves" Still Come Out Ahead?*, 33 L. & SOC. REV. 803, 803 (1999).

17. See, e.g., John C. Coffee, Jr., *The Regulation of Entrepreneurial Litigation: Balancing Fairness and Efficiency in the Large Class Action*, 54 U. CHI. L. REV. 877, 886 (1987).

courts to people who could not otherwise afford to be there. Certainly some attorneys will take a class action lawsuit because of a potential windfall in the form of a contingent fee in the event of a victory. But not all. Moreover, the attorney's motivation does not necessarily negate the pursuit of a valid claim. Rather, an attorney motivated by such financial interests merely gives the potential litigant access to the courthouse that the litigant otherwise would lack. By permitting the pooling of resources and financial risk into one large suit, with attorney representation facilitated by the possibility of a large payoff in return for the accompanying large gamble the attorney takes, the class action permits a number of one-shotters to assert claims on somewhat equal footing with the repeat players.

B. *Far-Ranging Impact*

In fact, despite the negative image that class action lawsuits have acquired in the mass tort and securities areas,¹⁸ they remain a valuable form of strategy aimed at changing policies.¹⁹ In *Grijalva v. Shalala*,²⁰ for example, a class consisting of patients in Medicare managed care plans called attention to due process problems inherent in rules regarding notification of their rights to appeal managed care entities' denials of care within the Medicare claims review system.²¹ A similar effort is under way in Connecticut to secure appropriate notice of adverse actions taken by a managed care organization on the claims of a class of Medicaid managed care enrollees for care and services.²² In *Metzler v. Kaiser Foundation Health Plan*, advocates representing a class of persons with disabilities using Kaiser Foundation and Kaiser Permanente facilities achieved a

18. See Cerminara, *supra* note 4, at 9 n.8, 39-44.

19. See Rodwin, *supra* note 2, at 34 (discussing *Grijalva v. Shalala*, see *infra* note 4, as an example of a strategic lawsuit changing policy).

20. *Grijalva v. Shalala*, 946 F. Supp. 747 (D. Ariz. 1996), *aff'd*, 152 F.3d 1115 (9th Cir. 1998), *vacated by*, 119 S. Ct. 1573 (1999), *remanded to* 185 F.3d 1075 (9th Cir. 1999).

21. For a discussion of due process rights in the managed care Medicare and Medicaid contexts, see Jennifer L. Wright, *Unconstitutional or Impossible: The Irreconcilable Gap Between Managed Care and Due Process in Medicaid and Medicare*, 17 J. CONTEMP. HEALTH L. & POL'Y 135 (2000).

22. *Hernandez v. Physicians Health Services, Inc.*, C.A. No. 399CV02244 (CFD), (D. Conn., Amended Complaint, filed October 26, 2000) (copy on file with the Annals of Health Law). See *Hernandez v. Physicians Health Serv.*, 202 F.R.D. 94, 2001 (D. Conn. 2001).

settlement guaranteeing persons with disabilities improved access to certain Kaiser facilities, very shortly after filing suit.²³

Most of the current managed care class actions do not have the warm, fuzzy appeal of cases brought to enforce due process rights of the old, the poor or the disabled. The lawyers who file them, including most notably those of big tobacco fame,²⁴ are not public interest lawyers. The lawsuits contain some claims — such as those arising under RICO²⁵ — that invite allegations of attorney greed as their primary motivation.²⁶ But that does not mean the lawsuits cannot have broad impact. A class action lawsuit will still have wide-ranging impact when claims contained within it assert rights on behalf of persons covered by multiple entities all using the same base coverage contract. The class action device thus can transform suits that repeat players might routinely treat with relative scorn, in part because they are asserted by one-shotters, into suits that cannot be ignored because they may have company-wide impact.

C. Corporate Responsiveness

A class action lawsuit by its very existence garners attention and respect, while an individual voice complaining, or an individual lawsuit, would not produce a response. The managed care backlash surfaced first through horror stories in the media and calls for legislative action. The public reaction to managed care, once covered individuals realized what managed care was, tended to reflect negativity, disappointment and anger. Such feelings lasted quite a while before the filing of most of today's managed care class actions. Yet, other than isolated legislative responses to individual, high-profile issues,²⁷ little happened to address the concerns of the people who were expressing that negativity, disappointment and anger.

23. Settlement Agreement in *Metzler v. Kaiser Foundation Health Plan, Inc.* (excerpted); *Metzler v. Kaiser Foundation Health Plan, Inc.*, Complaint for Violation of Civil Rights and Discrimination Against Persons With Disabilities, filed July 26, 2000 (copies of each on file the *Annals of Health Law*).

24. See Nancy McVicar, *Patients Fighting to Sue HMOs*, S. FLA. SUN-SENTINEL, at 1A (July 23, 2001).

25. The Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961 et seq. (West 1994 and West Supp. 2000), amended by Racketeer Influenced and Corrupt Organizations Act, Pub. L. No. 107-20, § 1961, 96 Stat. 17.

26. RICO claims, if proven, can result in treble damage awards. See 18 U.S.C. § 1964(c).

27. One example lies in the quick legislative reaction to news about managed care entities that required drive-through deliveries and 24-hour stays for mastectomies.

The absence of reaction is partially due to the lack of market-based incentive for managed care companies and insurance companies managing care to listen to their covered individuals.²⁸ This lack of incentive arises from the agency problems inherent in a system in which covered individuals are not the ones actually choosing, negotiating and purchasing the coverage in question.²⁹ The fact is that covered individuals, although nominally actors in the market, mostly are being acted upon, rather than acting in, the market for health care and health care coverage. The consumers of health care coverage are not its purchasers, and the purchasers may not be representing the consumers' precise interests in all cases.³⁰

Managed care companies also are not likely to listen to covered individuals because many lack both the power to exit their coverage arrangements and negotiating power. About fifty percent of covered employees have only one possible employer-provided source of health care coverage.³¹ In such a setting, the level of dissatisfaction among those who are covered may matter little to the company providing the coverage. Employers who do not adequately solicit and respond to expressions of dissatisfaction from their employees still will contract with that company for coverage. Covered individuals could pressure their employers to contract with other entities to provide coverage, but they hold little sway in approaching managed care companies. Thus, covered individuals effectively are unable to elicit change outside of the litigation setting, at least as long as employers choose and negotiate coverage contracts without either (1) soliciting significant and valued input from covered individuals or (2) making available coverage choices permitting individuals to drop coverage they dislike.

28. A possible exception to this statement exists to the extent entities managing care are rated by their covered individuals with "report cards" including questions about levels of consumer satisfaction.

29. See Clark Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 400 (noting that one "reason consumers feel disempowered in today's health care marketplace is that most receive health benefits through their employers rather than by purchasing a plan for themselves"). See also William M. Sage & Peter J. Hammer, *Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J.L. REFORM. 1069, 1092 (1999) (discussing agency issues).

30. Cf. Rodwin, *supra* note 2, at 10; Sage & Hammer, *supra* note 29, at 1092.

31. Sally Trude, *Who Has a Choice of Health Plans?*, Issue Brief No. 27, February 2000 at www.hschange.org/CONTENT/55/?topic=topic03 (last visited June 18, 2002). When one considers two-income households, the number of families offered a choice of plans rises to about 64 percent. *Id.*

Simply put, the opportunity for covered individuals to assert their voices is not present in the setting in which most health care coverage choices are made. Class actions provide a way for covered individuals to assert their voices,³² since many of these individuals can neither play a role in negotiating their coverage contracts nor exit their current coverage arrangements. Class actions permit a concerted assertion of concerns. They facilitate the expression of dissatisfaction that does not garner respect or response in the marketplace. Generally, individuals have been able neither to take an active role in health care coverage contract formation, nor to demonstrate sufficiently their disillusionment by dropping certain forms of coverage. In the class action setting, a group of covered individuals can approach a managed care company with possible negative consequences accompanying their approach. The assertion of disillusionment and anger is backed by power in the form of the potential for a damage award or an injunction, and it is that potential power which forces a response.

II. THE SUBSTANTIVE ALLEGATIONS OF THE CURRENT MANAGED CARE CLASS ACTIONS: WHAT DO THEY MEAN FOR QUALITY HEALTH CARE?

As a procedural device, the class action can be and often is a valuable tool, permitting plaintiffs such as those in the managed care class actions to band together, to achieve far-reaching results and garner attention and response in an economic setting in which they individually do not usually merit attention or response. Substantively, the current managed care class actions raise anew old questions about the interaction of health care coverage and the provision of health care in a managed care setting.

Specifically, the current managed care class actions highlight questions that have lurked beneath the surface of numerous legal issues since managed care first became widespread. Plaintiffs in managed care litigation who obtain health care coverage through their employers have become accustomed to seeing their chances for meaningful recovery rise or fall with court determinations of whether their cases concern coverage or quality of care. Determining whether coverage or quality of care is at the root of any particular managed care dispute is much more

32. Rodwin, *supra* note 2, at 34.

complex than it sounds. Managed care's virtual integration of financing arrangements and the provision of care, through either a single corporate entity or through intricate contractual arrangements, blurs the line between coverage and care. Similarly, the use of utilization control measures, such as preauthorization requirements imposed as part of coverage terms in the financing structure of a managed care plan, often means that decisions regarding coverage effectively result in a denial of care.

Most of the disputes about whether cases assert problems in coverage or in quality of care have arisen in the Employment Retirement Income Security Act ("ERISA") preemption context,³³ but the current managed care class actions seem to be raising such disputes in quite unrelated contexts. It is primarily useful to focus more precisely on the root concerns of the managed care class actions as part of the inquiry into whether they can indeed advance the pursuit of quality health care.

The current managed care class actions certainly are focused on health care coverage arrangements. Their plaintiffs are people covered by the defendant covering entities. The complaints quote provisions of the defendants' coverage contracts,³⁴ plan member handbooks, websites and provider directories.³⁵ The harm claimed revolves around the value of the coverage provided; the suits claim the provision of benefits of lesser value than the benefits represented to the plaintiffs.³⁶ The focus of their substantive allegations is that the insurer and managed care company defendants either failed to disclose the true nature of the coverage provided or affirmatively misrepresented the nature of the coverage provided.³⁷

These same cases are clearly concerned with the impact of allegedly undisclosed features of the plaintiffs' coverage arrangements on the quality of health care the plaintiffs might receive pursuant to those arrangements. In *Romero v. Prudential*

33. See generally Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (2000).

34. See, e.g., *Romero v. Prudential Insurance Co.*, C.A. No. 00-00-2592 at 13-16. (E. D. Pa. filed May 22, 2000) (Copy of complaint on file with the Annals of Health Law).

35. See, e.g., *Williamson v. Prudential Insurance Co. of America*, No. 2:99CV326 (S. D. Miss., Hattiesburg Division filed Nov. 22, 1999) (later consolidated in the S. D. Fla. at 29-34) (Copy on file with the Annals of Health Law).

36. See, e.g., *Price v. Humana, Inc.*, No. 99-8763 at 51 (S. D. Fla., Miami Division filed Oct. 4, 1999) (Copy of complaint on file with the Annals of Health Law).

37. See *infra* text accompanying notes 34-36.

*Insurance Co.*³⁸ for example, after quoting language aimed at covered individuals implying that “needed and appropriately provided” care will be covered,³⁹ the complaint alleges that the defendant’s “systemic policies adversely affect subscribers’ healthcare” and that the defendant “improperly utilizes inexperienced and inadequately trained personnel to make medical necessity determinations.”⁴⁰ Similarly, the complaint in *Williamson v. Prudential Insurance Co. of America*⁴¹ contains many paragraphs describing “strong reservations about the reliance by managed care companies” on certain guidelines in making utilization review decisions.⁴²

Whether the plaintiffs in those lawsuits ultimately are concerned about coverage provisions or about quality of care is of potential importance both substantively and as a matter of policy. Substantively, in addition to potential implications for claims asserted under ERISA,⁴³ whether plaintiffs appear to be most concerned about coverage or quality of care already has affected courts’ willingness to permit suits to proceed under the Racketeer Influenced and Corrupt Organizations Act (RICO).⁴⁴ As a matter of policy, the managed care class actions offer the most to improve the health care system if coverage value issues dominate plaintiffs’ concerns.

A. Managed Care Class Actions Alleging That Managed Care Is Necessarily Poor-Quality Care Neither Advance the Interests of Their Plaintiffs Nor Help Improve the Health Care System

The two most-publicized managed care class action decisions illustrate the conflicting conclusions courts might reach in attempting to determine the ultimate concerns of the plaintiffs in those cases.⁴⁵ In each case, the courts addressed questions of standing under RICO. One lawsuit, in which the court wanted to see a quality problem before it considered claims of diminished coverage to be more than speculative, was dismissed because the plaintiffs lacked RICO standing.⁴⁶ In the other

38. Romero, *supra* note 34.

39. *Id.* at 14.

40. *Id.* at 16.

41. Williamson, *supra* note 35; see *In re Managed Care Litigation*, 150 F. Supp.2d 1330 (Copy of complaint on file with the Annals of Health Law).

42. Williamson, *supra* note 35, at 40.

43. See generally 29 U.S.C. §§ 1001-1461 (2000).

44. See generally 18 U.S.C. §§1961-1964 (2000).

45. Maio, 221 F.3d 472; *In re Managed Care Litig.*, 150 F. Supp. 2d 1330.

46. Maio, 221 F.3d at 501.

lawsuit, the court accepted claims of diminished coverage value as conferring RICO standing upon the plaintiffs even absent allegations that poor-quality care resulted.⁴⁷

In *Maio v. Aetna, Inc.*,⁴⁸ the United States Court of Appeals for the Third Circuit ruled that the plaintiffs had failed to state RICO claims because they had failed to plead “injury to business or property.”⁴⁹ In *Maio*, the plaintiffs argued that they were injured in their “business or property” by defendants’ alleged misrepresentations in health care coverage documents and failure to disclose in those documents the use of various financial incentives and utilization control measures.⁵⁰ As economic harm, they claimed damages amounting to the sum that they overpaid, based on the representations, for the coverage they received.⁵¹ The plaintiffs also included in their complaint, however, a paragraph expressly stating that they were worried about the quality of healthcare they had received, in an apparent attempt to guard against potential pre-suit requirements and preemption of their state-law claims by ERISA.⁵²

The court seized upon that assertion, characterizing the plaintiffs’ allegedly injured property rights as “contractual rights to receive a certain level (quantity and quality) of benefits.”⁵³ It required the plaintiffs to show that they “suffered medical injuries, a denial or delay of medically necessary care, or the receipt of inferior or inadequate care” as a “necessary factual predicate for their argument that they suffered an injury to their property interests.”⁵⁴ Because the plaintiffs had not alleged any sort of personal injury in their complaint, the court ruled that they

47. *In re Managed Care Litig.*, 150 F.Supp.2d 1330.

48. *Maio*, 221 F.3d at 501.

49. 18 U.S.C. § 1964(c) accords a private cause of action to “any person injured in his business or property” under RICO.

50. *Maio*, 221 F.3d at 484 n.10.

51. *Id.*

52. The plaintiffs included in their complaint the following, somewhat internally contradictory, paragraph:

[T]his action does not seek to remedy claims of personal injury, contract, denial of benefits, medical malpractice and/or wrongful death against defendants. Moreover, this action seeks to remedy claims addressing the quality of healthcare services as set forth in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), and its progeny, and does not seek to recover benefits due under the terms of a plan, to enforce rights under the terms of a plan or to clarify rights to future benefits under the plan. *Maio*, 221 F.3d at 478-79.

53. *Id.* at 490.

54. *Id.* at 492.

lacked RICO standing and dismissed their RICO claims.⁵⁵ Because *Maio* asserted only RICO and state-law claims, the dismissal of the RICO claims resulted in dismissal of the entire lawsuit when the district court declined to exercise supplemental jurisdiction over the remaining state-law claims of fraud and violations of consumer protection acts.⁵⁶

Thus, the court in *Maio* sought evidence of a quality problem to support the plaintiffs' claims of diminished coverage value. This ruling stemmed from the court's apparent conviction that the plaintiffs ultimately were concerned about the assumed potential of managed care to reduce the quality of health care received by covered individuals.

The court, in fact, managed to stretch its interpretation of plaintiffs' claims so far that it viewed the claims as broadside attacks on managed care, similar to the claims asserted in the now-famous case of *Pegram v. Herdrich*.⁵⁷ Despite the *Maio* plaintiffs' assertions that they were concerned with misrepresentations made with regard to the plans at issue, rather than the structure of the plans themselves, the court viewed the case as requesting that it make "the social and medical judgment that the particular *structure* of [the defendant's health maintenance organization (HMO)] plan, by its very nature, places it in the category of a 'bad HMO' as opposed to a 'good HMO.'" ⁵⁸ The court thus presumed that the plaintiffs in *Maio* were blaming the defendant's financing structure for presumptive poor-quality care. Accordingly, the court admonished the plaintiffs, stating that the Supreme Court in *Pegram* had warned that federal courts were not in a position to judge the social value of one managed care structure over another.⁵⁹

In *Pegram*, the plaintiff asserted that the financial incentives built into her physician's managed care practice had prompted that physician to delay the administration of a needed ultrasound. (For ease of reference, the group of corporate entities comprising the physician's managed care practice collectively

55. *Id.* at 501.

56. *Id.* at 479-80.

57. 530 U.S. 211 (2000). *Pegram* was not a class action.

58. *Maio*, 221 F.3d at 499 (emphasis in the original). The court's conclusion apparently was based on the link between plaintiffs' two concerns: alleged coverage misrepresentations and quality of care.

59. *Id.* at 497.

will be referred to here as “Carle.”⁶⁰) After finding an inflamed mass in Cynthia Herdrich’s abdomen in early 1991, Ms. Herdrich’s physician decided that the condition did not constitute an emergency and scheduled her to receive an ultrasound at a facility operated by Carle fifty miles away, eight days later.⁶¹ During those eight days, Ms. Herdrich’s appendix ruptured, resulting in peritonitis.⁶² Thus, events obviously belied the physician’s determination that the inflamed mass could wait eight days for investigation and diagnosis.

In the resulting lawsuit, a portion of which reached the United States Supreme Court, Ms. Herdrich claimed in part that the financial incentives built into her physician’s practice – incentives designed effectively, in some cases, to deduct subscriber medical expenses from physician/owner end-of-year profit distributions – improperly motivated her physician to provide her with poor-quality health care. She fashioned this claim as one of ERISA breach of fiduciary duty.⁶³

The Court ruled that Ms. Herdrich had no breach of fiduciary claim because the physician’s determination was not of a fiduciary nature.⁶⁴ Writing for a unanimous Court, Justice Souter displayed concern about the role the Court was being asked to play in the case. Specifically, he ruled that “the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm.”⁶⁵ Just as the *Pegram* Court would not permit its sole plaintiff to use ERISA to attack an HMO structurally, the court

60. The entities were the Carle Clinic Association, P.C.; Health Alliance Medical Plans, Inc.; and Carle Health Insurance Management Co., Inc. (collectively “Carle”). Lori Pegram, the plaintiff’s doctor, was a Carle physician who both provided medical services to Carle subscribers and owned a portion of the for-profit managed care entity. *Pegram*, 530 U.S. at 215.

61. *Id.*

62. *Id.*

63. *Id.* at 216.

64. *Pegram*, 530 U.S. at 236.

65. *Id.* at 234. As other scholars have noted, in so ruling, the Court either assumed the existence of, or left many avenues open for, recovery for injury allegedly due to actions of a managed care entity at both the federal and state levels. See *Pegram*, 530 U.S. at 228 n.8 (implying that an allegation of failure to disclose could state a claim for fiduciary duty); see also *Pegram* 530 U.S. at 229 n.9 (noting that claims for ERISA benefits may be available). Comment on the case has been voluminous, including six articles published in the inaugural issue of *YALE J. OF HEALTH POL’Y L & ETHICS* (2001).

in *Maio*, after determining that the class action plaintiffs similarly attacked the structure of managed care, refused to permit those plaintiffs to use RICO in such an attack.

Contrast *Maio* with *In re Managed Care Litigation*, the lawsuit that resulted from consolidation in the Southern District of Florida of seven managed care class actions pursuant to order of the Judicial Panel on Multidistrict Litigation. In *Managed Care Litigation*, the court ruled that plaintiffs, alleging RICO, ERISA and common-law conspiracy claims which were factually substantially similar to those alleged in *Maio*, had sufficiently pleaded RICO standing.⁶⁶ The court analogized the plaintiffs' claims to those of fraudulent inducement because the plaintiffs asserted that the defendants allegedly misrepresented some facts, failed to disclose other facts about coverage arrangements and had improperly caused plaintiffs to purchase coverage with a market value less than what they had expected.⁶⁷ Rather than requiring plaintiffs to allege that the defendants had actually failed to provide quality care to validate their claims that they had overpaid for their coverage, the court ruled that allegations of overpayment alone sufficed to confer upon the plaintiffs RICO standing. According to the court, the evidence sufficiently demonstrated, at that stage of the case,⁶⁸ that plaintiffs had suffered an "injury to business or property."⁶⁹ The court did not read the plaintiffs' claims as presuming that cost-conscious management of health care would reduce the quality of that care. Instead, the court focused on the plaintiffs' allegations that they had been misled when signing up for their managed care coverage.⁷⁰

66. *In re Managed Care Litig.*, 150 F.Supp.2d 1330 (S.D. Fla. 2001). One possibly significant difference between *Maio* and the cases consolidated in *In re Managed Care Litigation* lies in the above-quoted paragraph, pursuant to which the plaintiffs raised the specter of quality of care. See *supra* note 52. That paragraph does not appear in any of the seven complaints consolidated in the Southern District of Florida.

67. *Id.* at 1338.

68. It seemed significant to the court that the case was at an early stage, when less certainty and precision are required of plaintiffs, who have not yet had the opportunity to engage in discovery. The *Maio* court also noted the stage of its case, which was the same, and the standard of review to be applied at that stage, but refused to "accept as true unsupported conclusions and unwarranted inferences." 221 F.3d at 500 (quoting *West Penn Power Co.*, 147 F.3d at 263 n.13).

69. *Id.* at 1337-38. In doing so, the court repudiated the distinction *Maio* court drew between property right in contracts and property rights in real property.

70. *Id.* at 1337. This court also, however, warned the plaintiffs that it would revisit the issue of injury at later stages of the case, noting that such an inquiry "might, for example, explore whether feasible alternatives to each managed care insurance company existed for the [p]laintiffs and whether the concept of 'overpayment' is an objec-

As *Maio* and *Managed Care Litigation* demonstrate, the courts examining the managed care class actions themselves engaged in contortions when they attempt to determine whether quality of care or coverage concerns are at the root of plaintiffs' cases. The court in *Maio*, probably too broadly, saw the case as alleging the provision of poor-quality care. The court in *Managed Care Litigation* recognized the plaintiffs' coverage-based allegations for what they were. The problem is that deciding whether certain treatments will be covered can result in poor-quality care. This is especially true when a treatment that is determined not to be covered will significantly benefit the patient and the patient cannot receive the treatment without coverage. As even the Supreme Court has stated, there is no clear distinction between coverage issues and quality of care in many situations,⁷¹ and to attempt to draw a bright line between the two may be to require overly fine-grained distinction.

Lawsuits, whether single-plaintiff or class-action, should not be aimed at invalidating management of care in the medical system. As the Supreme Court recognized, broadside claims attempting to invalidate a particular sort of health care financing structure are not properly asserted through litigation.⁷² Instead, one might turn to the legislature, as the Supreme Court envisioned. Alternatively, one might argue that the market should determine whether it is appropriate to manage care using financial incentives and how such financial incentives are best structured. Within the market setting, the debate could take place among a variety of parties, including physicians concerned about their ability to practice good medicine, corporate strategists concerned about cutting medical care costs and employers seeking to purchase health care coverage on behalf of their employees.

Allegations such as those at issue in *Pegram*, and those the court read *Maio* to assert, fall within a category tending to characterize the first wave of reaction to a new idea – a broadside attack against change. In the case of managed care, the claim is a broad one – that cost-consciousness in the provision of medical care automatically reduces the quality of health care provided. It is difficult to agree with this broadside attack, both

tive standard which can be verified by reference to a market for [managed care organization] services." *Id.* at 1339.

71. See *Pegram*, 530 U.S. at 228-29 (identifying eligibility decisions, treatment decisions and instances in which the "eligibility decision and the treatment decision [are] inextricably mixed").

72. See *Pegram*, 530 U.S. at 233-34.

because appropriate medical practice has always included considerations of cost-benefit tradeoffs and because, systemically, there is a need to contain health care costs. But even if one agrees with this attack, the allegations of bad intent and extremism contained within it do not belong in court. Therefore, these indictments of managed care as a whole are inappropriate subjects of either single-plaintiff or class-action litigation.⁷³

Simply stated, for managed care class actions, the implication is that plaintiffs must decide what it is they really want to argue about. Those who want to argue simply that managed care is necessarily poor-quality health care should not be making those arguments in court. To the extent that managed care class actions boil down to assertions that managed care is poor-quality health care, they do nothing more than interfere with the market forces attempting to provide quality health care at a reasonable cost.

B. Patient Empowerment Through the Managed Care Class Actions Can Assist in the Functioning of the Market if the Allegations Are More Precisely Focused

As demonstrated by *Managed Care Litigation*, however, not all managed care class actions presume automatically that managed care is poor-quality care. These class actions may presume that the use of certain financial incentives or utilization controls renders managed care coverage less valuable than other types of coverage. Such a presumption may require great effort to substantiate in actual numbers.⁷⁴ But such a presumption is also entirely consistent with the premise of managed care, since managed care is aimed precisely at reducing the amount of money covering entities pay for their clients' medical care. Setting aside potential benefits resulting from any accompanying increase in preventive care in the medical care setting, a covered individual choosing between two potential coverage contracts would expect to pay less for the contract that will provide less benefits. Some of the managed care class actions assert that certain covered individuals apparently thought they were receiving a level of coverage they were not actually receiving. To remedy

73. See *Maio*, 221 F.3d at 499.

74. See William M. Sage, *Therapeutic Coverage: Embedding Medical Professionalism in Health Insurance Contracts* 19 (June 2000) (unpublished manuscript, on file with the *Annals of Health Law*) (noting that "[t]here is little if any market for the unrestricted form of coverage that is the plaintiffs' benchmark").

such claims is not to interfere with the market, but is to help assure that those participating in the market understand its workings. Thus, to the extent that managed care class actions focus on the terms of the coverage bargain, and attempt to remedy informational asymmetries among covered individuals, they can help improve quality health care by ensuring that all participants in the market understand the terms of their coverage.

Continuing to pursue such claims in the managed care class actions is appropriate because “neither the Congress nor the Supreme Court in *Pegram* [has woven an] ‘all-encompassing cloak of immunity for the health care industry.’”⁷⁵ When the *Pegram* Court stated the debate about managed care belonged in the legislature and not the courts, it was not referring to the types of allegations that form the heart of many current managed care class actions. The current managed care class actions assert a need for correction of problems in the way managed care companies are dealing with those covered by their products. They argue, in essence, that managed care organizations are not playing by the rules, even if one assumes that the corporate structure in place is perfectly appropriate. They claim that managed care organizations must be more up-front about what they are doing when speaking to the individuals who are covered by their policies. As Clark Havighurst has noted, the current class actions, by raising such claims, actually could have a positive impact on the market for health care products.⁷⁶

Some of the managed care class actions, for example, are at least in part aimed at ensuring that the actors in the market, including covered individuals, know what is happening. Recall that, in the market for health care coverage, most covered individuals play a minor role in the process that leads up to their obtaining health care coverage. If they have choices, these covered individuals are still limited because they must choose a health care plan from among the choices offered to them by their employers. Covered individuals obtaining health care coverage through their employers do not negotiate; they do not make cost/benefit decisions, except in cases in which they can choose from among a few offered plans. Instead, especially when managed care first became popular, employees signed up for health care coverage based solely on the summarized infor-

75. *In re Managed Care Litigation*, 150 F. Supp. 2d at 1345.

76. Clark C. Havighurst, *Consumers Versus Managed Care: The New Class Actions*, 20 HEALTH AFF. 8, 14, 22-24 (July/August 2001).

mation provided to them after all details of the coverage contracts had already been negotiated.

Such summaries easily could have been defective in at least three ways. First, representations made in such summaries may not have adequately warned covered individuals that the contract that had been negotiated for them contained cost-containment measures.⁷⁷ Especially as managed care initially became popular, covered individuals, accustomed to fee-for-service coverage, may not have expected such measures. Second, marketing considerations, coupled with concerns that covered individuals would view managed care as intruding on the physician-patient relationship, may have encouraged the inclusion of affirmative misrepresentations in the summaries. The managed care class actions claim that in many instances, summaries and marketing material in fact contained language assuring covered individuals that physicians had the final word regarding their care.⁷⁸ They also claim that other language assured that no cost-containment measures would impact physician decision-making. Third, fear of adverse selection often prompts covering entities to be wary of disclosing too much information about coverage terms.⁷⁹ As a result, summaries may omit more information than covered individuals require to be truly informed.

Take for example the allegations contained within *Price v. Humana, Inc.* and *O'Neil v. Aetna, Inc.*, two of the managed care class action lawsuits that were consolidated as part of *In re Managed Care Litigation*.⁸⁰ In *Price*, the plaintiffs charged that defendant Humana engaged in "systematic and intentional concealment from members in its health plans of accurate information about when health care will be provided, when claims will be approved or disapproved, and what criteria and procedures are actually used to determine the extent and type of their coverage."⁸¹ In *O'Neil*, the plaintiffs alleged that member materials describing defendants' health plans represented that their "in-

77. That such cost containment measures were called for, maybe even necessary, may have been obvious to those involved in coverage contracting and to health care policy analysts. But it was not necessarily obvious to covered individuals, who do not take part in discussions at that level.

78. *Peterson v. Kaiser Foundation Health Plan, Inc.*, No C00-5370, First Amended Class Action Complaint, Western District of Washington, filed July, 2000 [hereinafter Peterson] (Copy of complaint on file with the Annals of Health Law).

79. See Havighurst, *supra* note 76, at 16; Rodwin, *supra* note 2, at 9.

80. See *In re Managed Care Litigation*, 150 F. Supp. 2d at 1334.

81. *Price*, *supra* note 36, at 2-3 (Copy of complaint on file with the Annals of Health Law).

centives [were] directed to reward better quality care and to guard against any potential to withhold care.”⁸²

Similarly, in *Peterson v. Kaiser Foundation Health Plan, Inc.*,⁸³ the plaintiff, seeking to represent a class, alleged a series of failures to disclose and affirmative misrepresentations. These allegations ranged from a characterization of the defendants’ documents as “uniformly represent[ing] or imply[ing] that coverage decisions will be based on the physician’s independent medical judgment as to whether medical services are medically necessary,” to the assertion that “Kaiser has . . . failed to disclose or accurately represent the nature, and in some cases, the existence of the criteria and procedures it actually uses to make decisions about coverage, including decisions about coverage requests and reimbursement of claims.”⁸⁴

Lawsuits seeking the provision of greater information to covered individuals aim to enhance understanding among those upon whom the system acts.⁸⁵ The provision of information about the way the system works – the acknowledgment that plans contain financial incentives designed to minimize medical care costs, for example – would help covered individuals feel more aware of the economic setting in which their medical care is administered. It also could improve agency relationships, enhance the performance of the system and, with more difficulty, conceivably assist in quality-based competition among health care coverage entities.⁸⁶

Although there has been a backlash in public opinion about managed care, covered individuals may very well support it once they have more information. Faced explicitly with information about the use of financial incentives to control excess utilization, and with the impact such utilization control can have on their health care costs, many covered individuals may well choose a managed care plan, even if they currently assert that they would not.⁸⁷ As Clark Havighurst has observed, “Most likely, people’s

82. See *O’Neil v. Aetna, Inc.*, No. 2:99CV284, Class Action Complaint, Southern District of Mississippi, Hattiesburg Division, filed October 7, 1999, at 40.

83. *Peterson*, *supra* note 78.

84. *Id.* at 2-3.

85. Havighurst, *supra* note 76, at 23; see also Havighurst, *supra* note 29, at 409-11.

86. See William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1701-02 (1999).

87. When covered individuals are given a choice of plan including one wide-access plan, they are likely to be more satisfied with their choice of plan. Alan C. Enthoven, Helen H. Schauffler & Sara McManamin, *Consumer Choice and the Managed Care Backlash*, 27 AM. J. L. MED. 1, 3 (2001). See also Jon R. Gabel et al., *Withering On*

fears [about managed care] reflect, more than anything else, a sense that they have had very little say in the process by which the old, reassuring health care system was replaced by something else.”⁸⁸

The statements appearing in the corporate literature cited in the managed care class actions do not exhibit respect for the consumers of the coverage in question. A statement in one plan’s marketing material assures covered individuals that the managed care entity “understands that health care decisions are best made between you and your doctors.”⁸⁹ Thus, it says, “we assist quietly, providing your doctors with information from case studies and treatment results, creating time-saving systems to reduce duplication of efforts and quickly approving a referral or an additional test. Our years of experience are working for you and your doctor.”⁹⁰ Such statements seem designed to assure covered individuals, somewhat falsely, that the system is still the same as the Marcus-Welby-type medical system some idealize. Irrespective of whether the system ever did operate that way, the truth is that now, with the advent of managed care, cost concerns figure into medical care decisions more than ever. To pretend otherwise, by asserting that a managed care entity merely assists the physician in quickly approving measures that the physician believes are necessary, is to treat the covered individual as someone who does not deserve to know the truth.

Alternatively, such assertions in marketing materials treat the covered individual as someone who could not understand⁹¹ or

the Vine: The Decline of Indemnity Health Insurance, 19 HEALTH AFF. 152 (2000) (study revealing that 62 percent of decline in indemnity enrollment is due to employee choice; 38 percent is due to employers’ no longer offering indemnity coverage) (discussed in *Decline in Indemnity Coverage Attributed to Employee Choice*, Reuters Medical News (2000)). Consumers, thus, may accept managed care when they are able to compare various plans and take part in their coverage process. The problem in the current system, however, is that less than 50 percent of families can choose between a health maintenance organization and plans with fewer restrictions. See Trude, *supra* note 31.

88. Havighurst, *supra* note 29, at 399.

89. *Hitsman v. PacificCare Health Systems, Inc.*, No. 2:99CV328 (S. D. Miss. filed Nov. 22, 1999 and later consolidated by the Judicial Panel on Multidistrict Litigation in the S. D. Fla., Miami Division. See *In re Managed Care Litigation*, 150 F. Supp. 2d at 1334 n.2. (Copy of complaint on file with the Annals of Health Law).

90. *Id.*

91. Kenneth Arrow, writing in a time of fee-for-service medicine, identified sources of market failure in the market for health care, including patients’ inability to understand information. Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 946 (1963). Arrow was speaking primarily of patients’ inability to understand medical information, but he also noted their inability

accept the truth if it were provided. The answer to any such potential lack of understanding, however, does not lie in refraining from providing the information; such a conclusion would be akin to stating that a patient need not be provided the information necessary to give informed consent. Health care professionals often insist that patients do not actually understand the information provided to them during the informed consent process. Yet the systemic response is not to give up on informed consent; rather, it is to urge health care professionals to help patients better understand the information provided during the informed consent process.

In a similar vein, the answer to concern about covered individuals' abilities to understand coverage information lies in providing assistance in understanding that information. Marc Rodwin has posited, for example, the use of learned intermediaries to help consumers understand.⁹² Such a solution raises its own agency concerns,⁹³ but, in fact, a managed care entity choosing to adopt such a solution⁹⁴ may learn that covered individuals can understand at least a portion of the information describing their coverage arrangements. More important, it likely will find that the covered individual no longer feels completely left out of the loop, as he or she feels when not provided any information at all. The information the managed care class actions seek, once understood, can help assuage the backlash that has arisen, and can enhance the level of public understanding, reducing calls for outright invalidation of the managed care system.

III. CONCLUSION

Ultimately, the managed care class actions are but one starting point in empowering covered individuals in the health care system. Empowerment could come about as a result of the dissemination of information in an understandable format, permit-

to understand and participation in health insurance contracting. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 226 (Basic Books 1982).

92. Rodwin, *supra* note 2, at 12.

93. See Sage, *supra* note 86.

94. An internal intermediary can provide assurance that the company can be trusted. See Rodwin, *supra* note 2, at 27; Mark A. Hall, *Trust, Law, and Medicine: Towards a Therapeutic Jurisprudence of Health Care Delivery*, manuscript at 44 (explaining that internally undertaken actions are more likely increase trust than externally imposed requirements). The implication may be that covering entities should heed calls for further information and provide intermediaries to enhance understanding rather than waiting for the courts to respond to complaints seeking such action.

ting the covered individual to understand the terms of his or her health care coverage. It also could come about simply by forcing the entities managing care to be more up-front with covered individuals, so that they do not feel as if the wool is being pulled over their eyes. The provision of information can thus help advance the public policy debate by reducing the covered individual's sense of resentment and distrust of managed care companies.⁹⁵ In a procedural justice sense, a covered individual's attitude toward the system might change significantly if he or she is treated with respect, and receives "process" in the form of a clear description of the financial incentives contained within his or her health care coverage arrangement.

The procedural justice aspect of the provision of information may in fact be the most important benefit of providing such information in the American health care system as it is constructed today. Procedural justice research reveals that people who have a sense of having been accorded process, or of having been dealt with fairly, feel positively about their experiences even if the experiences did not lead to satisfactory results.⁹⁶ A covered individual who has been dealt with fairly, who has been given appropriate levels of information and who may have been provided with access to someone who will help explain the information, could have a positive view of the managed care coverage, even if that coverage does not provide him or her with everything he or she wishes.⁹⁷

Such concerns relate to the importance of trust in the health care system, and one should not lose sight of that importance when speaking of possible benefits of the managed care class

95. Such a sense of resentment and distrust is implicit in studies indicating that people who believe they are in managed care plans or health maintenance organizations (HMOs) think poorly of their health insurers even if they are not actually in managed care plans or HMOs. See James D. Reschovsky & J. Lee Hargraves, *Health Care Perceptions and Experiences: It's Not Whether You Are In an HMO, It's Whether You Think You Are* (Center for Studying Health System Change September 2000), available at <http://www.hschange.com>.

96. See E. ALLAN LIND & TOM R. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE* 2, 3, 8 (Plenum Press 1988).

97. In fact, chances are the coverage will not change much under current market structure. To make a true, concrete difference in health care coverage contracts, information must trigger events in the marketplace. This is unlikely to occur from the provision of information explaining managed care to covered individuals, for informational asymmetry is only one of the dysfunctional features characterizing the market for health care and health care coverage. See Havighurst, *supra* note 76, at 15-17; Sage & Hammer, *supra* note 29, at 1090-96. When the purchaser of health care coverage is not the consumer, agency problems can confound straightforward market functioning.

actions. Trust is an important feature of the health care system. Certainly, trust in physicians is important, but also of great importance is the covered individual's trust in the system, trust that the system is not set up in a way designed to deceive the covered individual – the person who could be a patient.⁹⁸ The class actions are, to their worthy end, trying to rectify information asymmetry, which could help increase trust. Rightly or wrongly, justified or not, covered individuals have felt as if they have been sold a bill of goods with managed care. Class actions represent an attempt, perhaps draconian, perhaps heavy-handed, but nevertheless an attempt, by consumers to say forcefully, “Look at us. Tell us the truth.” Other avenues do not carry as much force, in part because of the structure of the health care market.

The current managed care class actions do not always question the place of managed care, with its system of controlling medical care costs through the use of financial incentives.⁹⁹ Some simply ask that all parties involved – those who are active participants in the market and those the market affects most but who cannot actively participate – be told the truth about managed care coverage. Knowledge about the cost/benefit tradeoffs inherent in managed care is not something from which the covered individual should be shielded; rather, it is something the covered individual should be told. This knowledge can then help the individual acquire a better understanding of the way the health care system is attempting to achieve high-quality care at a reasonable price.

98. See Hall, *supra* note 94, at 22 (describing both); *Id.* at 40 (“[o]nce . . . system trust is established, individual professionals do not have to earn their trust in each instance”). Trust in individual physicians, especially primary care physicians, apparently has not been harmed. See Anne G. Perreira & Steven D. Pearson, *Patient Attitudes Toward Physician Financial Incentives*, 161 ARCH. INT. MED. 1313 (2001).

99. See, e.g., Price complaint, *supra* note 36, at 3 (“This action does not challenge the legitimacy or wisdom of ‘managed care’ as a means of delivering health services in the United States.”).