'Health Law 2000': The Legal System And The Changing Health Care Market

A "big-picture" look at how regulators and the courts may react to the rapidly changing health care landscape.

by William M. Sage

PROLOGUE: As health care delivery and finance rapidly evolve from a system that featured solo physicians, community hospitals, and a not-for-profit culture to a new paradigm, the issues engaging medicine and the law have increased exponentially. However, the nation's judges and lawyers seem to be faring no better than government regulators in sorting out the new complexities that have been introduced by this transformation. In this insightful essay William Sage, an associate professor of law at Columbia University, discusses the likely impact of the law on this changing system, and vice versa. Sage regards himself as neither an advocate nor an opponent of managed care ("on the positive side of neutral" is how he characterizes his position), but rather as a lawyer whose job it is to identify and resolve conflict.

Sage is ideally suited to the task. He holds degrees in medicine and law from Stanford University. Since completion of his academic training, Sage has engaged in pursuits that reflect both professions, including residency training in anesthesiology at Johns Hopkins and the practice of law at the Los Angeles firm of O'Melveny and Myers. He also has demonstrated an abiding interest in public policy making. He was invited by the Clinton administration in early 1993 to participate in its crash effort to design a comprehensive health care reform plan. Sage was responsible for overseeing issues that touched on quality of care, medical information systems, professional liability, and the health care workforce, all of which contain numerous contentious legal issues.

ABSTRACT: The failure of national health reform confirmed in many ways the conservative nature of the American legal system. Legislatures, regulatory agencies, and courts usually find themselves in a reactive posture, responding to groups and individuals aggrieved by changing circumstances. The rapid transformation of the U.S. health care system through managed care presents an extreme example of this phenomenon, involving billions of dollars, millions of lives, and thousands of existing laws. Over the next few years the legal system will face a host of difficult issues deriving from the integration of health care financing and delivery, and the consolidation of fragmented providers into large corporations and contractual networks. What emerges may be neither logical nor consistent but no doubt will reflect the intricate interplay of societal and individual interests in health care.

TODAY'S RAPIDLY CHANGING health care marketplace continually generates new issues for lawyers, judges, and legislatures. In large part because of health care's long regulatory history and tradition of deference to professional judgment, the law is responding to the managed care revolution with difficulty. Guided as it is by past practice, law tends to be a deliberately conservative force. Parties aggrieved by health system change frequently come to courts as litigants and to legislatures as interest groups, while delays in fact-finding and dispute resolution make it hard for judicial decisions and regulatory structures to keep pace with the evolution of the health care industry.

The two most noteworthy trends in the U.S. health care system—horizontal consolidation of previously fragmented providers and vertical integration of service and payment functions—represent significant challenges for law and regulatory policy. On the one hand, legal norms governing health care financing and delivery are proving less adaptable than their marketplace equivalents. On the other hand, the current regulatory regime reflects a diffuse, professionally stratified health care system and consequently may be slow to address issues arising at the interstices of established structures. Both weaknesses are exacerbated by the state-to-state inconsistency and national/state redundancy typical of American federalism.

Traditionally part of the "police powers" ceded to states rather than to the national government, regulatory control in health care has been shared by the two sovereignties since at least World War II. Laws committing federal funds to health care, such as Hill-Burton, Medicare, and Medicaid, and laws creating national standards for commercial enterprises, such as the Employee Retirement Income Security Act of 1974 (ERISA), bear primary responsibility for this trend. States still regulate health insurance, but the federal government has exclusive authority over self-insured employers. Health care facilities and professionals are still subject to state licen-

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sure or certification, but their financial viability often depends on federal reimbursement policies.

This balance of authority is becoming unstable as independent providers combine to form larger organizations, insurance blends with health care delivery, and both government programs and private insurers replace fee-for-service reimbursement with prepaid coverage. In addition, regulatory agencies accustomed to distinct classes of insurers, hospitals, physicians, and health maintenance organizations (HMOs) are encountering a dizzying array of new, hybrid entities, requiring a detailed reassessment of traditional regulatory tools, creating gaps in oversight, and giving rise to battles over administrative "turf."

Moreover, the current managed care expansion is occurring on a much larger scale than previous market cycles in health care, suggesting that the legal system will have to climb a steeper "learning curve" to comprehend the changes that are occurring, that more will be at stake in lawsuits and lobbying battles, and that a new equilibrium will take longer to develop. In this paper I describe several noteworthy features of the managed care landscape and attempt to anticipate the likely responses of regulators and the courts.

Clash Of Cultures: Patients Or Populations?

Courts resolving private legal disputes are faring no better than regulators are at coping with the rapid transformation of the health care system. The paradigm shift of greatest importance to the judicial system is that health care costs that traditionally have been reimbursed on a fee-for-service basis are now being prepaid and delivered by risk-bearing entities, which blurs formerly distinct lines separating payers and providers. Managed care organizations serve patients in groups, not just as individuals. Physicians today are experiencing ethical tensions between patient advocacy and population-based health care management. Courts, which are constituted to vindicate rights in unique cases and controversies, are similarly ill equipped to craft social compromises.

■ **Managed care and ERISA.** Any discussion of managed care litigation must begin with ERISA. Although in its text "hospital" appears only once and "physician" not at all, ERISA may be the most important law affecting health care in the United States. Primarily designed to protect pension benefits by imposing fiduciary and

reporting requirements on employee benefit plans, ERISA also regulates welfare benefits such as health coverage.

ERISA broadly displaces, or "preempts," a variety of state laws without substituting a clear federal regulatory scheme, a phenomenon generally referred to as the "ERISA vacuum." ERISA plans are shielded from state laws that "relate to" employee benefit plans, other than laws regulating the business of insurance.[1] ERISA plans that are self-funded rather than commercially insured are exempt from state-mandated benefit laws and restrictions on specific policy exclusions. ERISA does not require employers to provide any substantive level of health coverage and allows them considerable discretion to vary benefits over time.[2]

Employers' flexibility to design cost-effective health benefit plans is arguably a major factor in the growth of managed care. At the same time, ERISA has curtailed the legal rights of individual beneficiaries. In addition to limiting states' regulatory authority, ERISA negates many state legal remedies, so that bad-faith breach-of-contract claims and emotional distress claims, sometimes available under state law, cannot be brought against ERISA plans or the managed care companies with which they contract.[3] All that remains to an ERISA plaintiff is an action to receive a wrongly denied benefit, plus legal fees in most cases. Punitive damages may not be awarded, and noneconomic compensatory damages ("pain and suffering") are probably unavailable as well.[4]

Courts have been able to temper the effect of the ERISA vacuum even without congressional action since the Supreme Court's 1995 decision in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company*.[5] The *Travelers* case, which upheld New York State's hospital surcharge program, opened the door not only to state funding strategies for the uninsured but also to judicial consideration of legal claims against managed care organizations.

■ **Convergence of coverage and care.** The inevitable convergence of coverage and care in integrated delivery systems is beginning to influence legal rights and remedies. For example, when a managed care enterprise promises to render comprehensive services for a prepaid premium, many bad health outcomes can be construed either as a denial of "medically necessary" benefits or as medical malpractice. Consider *Fox v. Health Net of California*, which yielded a staggering $89 million verdict against the defendant HMO.[6] The case was brought as a coverage suit because California permits claims of bad-faith breach of contract and because the insurance contract in question was an individual policy that was not covered by ERISA. Had *Fox* been brought as a medical malpractice suit, the plaintiff would have had to prove that the delay in receiving treat-

ment caused clinical injury, and any judgment would have been subject to the state's Medical Injury Compensation Reform Act (MICRA), which limits noneconomic damages to $250,000.

Recent decisions interpreting the preemptive scope of ERISA illustrate courts' struggles to understand the relationship between benefit design and care delivery. The critical subtext of many of these malpractice and coverage disputes is whether the legal standard of care should be different for managed care organizations (and the physicians who work within them) because they are responsible for organizing and financing care for groups of beneficiaries as well as for serving individual patients.

In *Dukes v. U.S. Healthcare*, a federal appeals court in Philadelphia suggested that an HMO would not be protected by ERISA against a state law medical malpractice claim involving a participating physician because only the "quality" of benefits was at issue, not their "quantity."[7] This reasoning, which is apparently being followed by other courts, fails to recognize that many aspects of benefit design that are clearly within the scope of ERISA preemption—such as selective physician networks, gatekeeper requirements, capitation arrangements, and provider-based utilization review—influence the quality of diagnosis and treatment.[8] Although the *Dukes* decision favored the injured plaintiff, it perpetuates rather than addresses the illogic of applying ERISA to managed care: The more intrusive a managed care organization is in dictating the practice of its affiliated providers, the less responsible it will be for negligent outcomes because of ERISA's limitations on liability and damages.

Although the long-predicted torrent of malpractice and related litigation against institutional defendants has yet to materialize, the logic of such claims remains irrefutable.[9] Current ERISA preemption doctrine, a political climate that is relatively unsympathetic to consumers and trial lawyers, instability in the composition of managed care networks, and a liability insurance market that is still geared to individual physicians are among the factors keeping the peace. Eventually, however, the legal system is likely to hold the organizations controlling clinical care—whether they be capitated medical groups, hospital-run networks, or insurance companies—accountable for negligent patient injury.

■ **Discrimination.** Both the insurance industry and the medical profession have traditionally distinguished among persons based on factors that tend to attract judicial scrutiny, such as race, sex, age, and health status. Although any bias is ethically problematic, the insurance industry has made these distinctions primarily to predict and reduce financial exposure, and the medical profession has done so largely based on its estimates of clinical risks and benefits. Dis-

criminatory behavior by integrated health care systems that confound categorization as "insurers" or "providers"—such as preferences in receiving high-cost therapies—will invite legal challenges on constitutional grounds and under statutes such as Title VII of the Civil Rights Act of 1964 and the Americans with Disabilities Act of 1990 (ADA). Because they are based on federal law, these legal claims are not precluded by ERISA, which adds to their attractiveness to plaintiffs in litigation involving employment-based insurance.

In *Henderson v. Bodine Aluminum*, a Missouri woman with breast cancer invoked the ADA to obtain a preliminary injunction from a federal appeals court compelling her employer to pay for high-dose chemotherapy requiring autologous bone marrow transplantation (HDC-ABMT).[10] The court reasoned that "if the evidence shows that a given treatment is non-experimental—that is, if it is widespread, safe, and a significant improvement on traditional therapies—and the plan provides the treatment for other conditions directly comparable to the one at issue, the denial of treatment arguably violates the ADA."[11] If sustained on appeal, this holding would seemingly outlaw specific exclusions in insurance contracts and cost/benefit determinations by employee health plans if those measures adversely affected patients with particular diagnoses.

■ **Information and privacy.** Concerns about discrimination are heightened because marketplace pressures, coupled with newly available technology, have finally catapulted health care into the information age. However, knowledge is power in managed care; it offers potential benefits in terms of improved practice, informed consumers, and reduced costs. Knowledge also raises significant issues concerning patients' rights and commercialization.

Collected systematically and stored in electronic form by integrated health care systems, patient-identifiable information, which traditionally was used only for diagnosis and treatment, is vulnerable to appropriation for medical underwriting, employment discrimination, and abusive marketing. In late 1994, for example, a federal judge in Pennsylvania upheld a jury award of $125,000 to an employee whose human immunodeficiency virus (HIV) status was disclosed to his employer through prescription drug benefit records, although the decision was later reversed on appeal for lack of proved injury.[12] Health care information statutes that attempt to balance individual privacy interests with reasonable commercial use are being debated and enacted in state legislatures and Congress.[13]

■ **Alternative dispute resolution.** A procedural consequence of the group focus of clinical care is the development of corporate forums in which to resolve disagreements. Contractual arrangements between enrollees and managed care organizations now gov-

ern most disputes and generally substitute nonjudicial proceedings for litigation. Alternative dispute resolution systems and other internal procedures for airing grievances are potentially advantageous to managed care organizations that wish to avoid the risk and expense of litigation and to patients whose needs must be addressed in a more timely manner than judicial review typically offers.

However, the easier accessibility and less adversarial nature of these health plan–based mechanisms may be offset by bias, duress, or, in public programs, denial of constitutional rights to judicial process. Even Kaiser Permanente's long-standing system of mandatory, binding arbitration has come under fire. Although one California appeals court rejected a broad attack on Kaiser's arbitration program, another district of the same court vacated an arbitration award on the ground that the neutral arbitrator had failed to disclose his past relations with Kaiser.[14]

Future managed care contracts may specify not only procedures for dispute resolution but also the legal standard of care and availability of damages. This would expressly allow judgments about cost-effectiveness to govern the provision of services. For example, by suggesting that a contractual standard of care would limit injured patients to suits under ERISA, the *Dukes* court offered health plans a strong incentive to include this type of provision in subscriber contracts.[15]

A Bigger Mousetrap: The Consolidating Health Care Industry

In today's health care system, size matters. Growth attracts capital, and capital allows further growth, which assures survival and dangles the carrot of "market power" in front of provider groups and managed care organizations. The transformation of health care from a fragmented, professionalized, and charitable endeavor to an industry dominated by large, profit-oriented corporate entities has altered the types of legal issues that arise and the way in which disputes are resolved by the courts. The current trend toward "virtual integration" adds to the mix of legal issues, as excess capacity in provider markets, time pressures, and improved information and communications technology lead many managed care organizations to "make-or-buy" decisions that favor nonexclusive, time-limited joint ventures and contractual arrangements over more permanent and capital-intensive forms of integration such as direct ownership.

■ **Antitrust.** One obvious legal consequence of consolidation is the potential for anticompetitive behavior that prompts public or private antitrust enforcement. Some managed care markets, such as Minneapolis, have been reduced to three or four large integrated

systems. Once available "covered lives" have been captured and excess provider capacity has been eliminated, prices will stabilize, which will channel competition into nonprice arenas and increase the danger of collusive behavior. Laws enacted to manage competition may be poorly equipped to police an oligopoly or administer a public utility; this raises additional concerns such as the risk of regulated entities' "capturing" their regulators.

Medical groups and physician-managed networks are retaining or acquiring dominant positions in many parts of the country, although in only a few (such as California) are they becoming the primary risk-bearing entities.[16] Through attrition of marginal provider groups or outright collusion, physician networks may capture large market shares for certain services or geographic areas.

The rapid pace of industry change increases antitrust risks in these situations because of the prevalence of partially integrated systems. For example, network-model organizations and other forms of virtual integration may raise antitrust concerns because providers that are collaborating for certain purposes remain competitors for others. The policy statements released by the Department of Justice and the Federal Trade Commission in fall 1994 include extensive discussions of the potential for "spillover collusion" of this kind, especially when a joint venture or other cooperative arrangement is not "economically integrated."[17]

At the same time, legislatures, courts, and antitrust enforcement agencies assessing the risks of anticompetitive behavior by physicians are accommodating societal concerns about a trade-off between high cost on the one hand and poor quality and "insurer dominance" on the other. Proposed amendments to federal antitrust law subject even outright price-fixing by physicians to an extended "rule-of-reason" analysis.[18] Some legislatures are granting physicians "certificates of competitive advantage" in the hope of permitting them to take collective action against managed care organizations under the "state action" exemption to the antitrust laws.

Judicial trends in private antitrust litigation are illustrated by *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*, in which the plaintiffs alleged that a physician-owned clinic excluded them from the HMO market in north central Wisconsin while using monopoly power (and colluding with other providers) to set above-market prices for indemnity patients. A jury verdict awarding $48.5 million to the plaintiff (reduced to $17 million by the trial judge) was overturned on appeal.[19] The appeals court concluded that the trial record was insufficient to demonstrate that HMOs are a separate market from health insurers in general for purposes of antitrust analysis or, with one minor exception, that the clinic's contractual

practices and influence over hospital privileges and physician coverage were anticompetitive.

■ **Fraud and abuse.** Hospitals, physicians, and other parties that do business under both fee-for-service and capitated arrangements during the transition to managed care may find themselves subject to unpredictable fraud and abuse laws. Federal antikickback laws and self-referral prohibitions were formulated to guard against creative billing practices, above-market pricing, and the performance of unnecessary services in a fragmented fee-for-service environment.[20] Contractual relationships that are common in managed care may appear suspect under these statutes as a technical matter, but large, prepaid health plans predispose less to traditional abuses than to improper denials of care or restrictions on services. Law enforcement authorities may have trouble adapting existing laws to these changing structures and incentives.[21]

■ **Class actions.** A procedural rather than a substantive effect of large-scale managed care on the judicial system is a probable increase in class-action litigation. Corporatization of private health care delivery makes previously idiosyncratic practices systematic, yet each case still arises in an emotionally charged environment. In visibility, contentiousness, and financial consequences, suits against managed care organizations may come to resemble current litigation over product liability involving today's "deep pockets:" pharmaceutical companies, medical device manufacturers, and government.

For example, in a case that has prompted similar suits and regulatory enforcement actions in other states, a federal district judge ruled that Blue Cross of Ohio overcharged subscribers for coinsurance by improperly concealing discounts it had obtained from hospitals.[22] Class-action suits in the future may be brought in situations in which (1) individual patients incur small costs that in the aggregate are economically important to health plans, such as miscalculation of copayments or failure to provide preventive services; (2) health care providers are dissatisfied with a managed care network's payment, certification, or review procedures; or (3) sympathetic plaintiffs are denied expensive services through blanket exclusions such as "experimental" treatment or "custodial" care.

Doctors, Inc.: The Corporation As Professional

Another consequence of managed care is that many responsibilities traditionally borne by individual professionals are being undertaken by corporations. However, the public and the legal system remain distrustful of "professional" judgment exercised by organizations rather than by individuals, a sentiment that the financial success of managed care has only encouraged.

Moreover, consumers and courts traditionally have taken for granted that physicians' clinical judgments were based on sound scientific evidence and were made in the best interests of patients. Managed care has changed that perception by revealing considerable variability in clinical practice and by generating cost savings through provider risk bearing and other financial incentives that reward crude reductions in service rather than measurable improvements in quality. Until the roles of health professionals as patients' advocates and as managers of corporate and community resources are reconciled, consumers' suspicions regarding providers' conflicts of interest will find sympathy among judges and regulators.

■ **Financial incentives and risk bearing.** As demonstrated by a California consumer group's reaction to relatively small physician performance bonuses contemplated by Kaiser Permanente of Southern California, the public is prepared to view certain payment methods as bribes to ration care.[23] The federal government recently promulgated but has yet to implement rules regarding compensation arrangements in Medicare and Medicaid managed care plans, and several states have considered or enacted laws limiting financial incentives to providers.[24]

Courts also are expressing concern over financial conflicts of interest. In a malpractice case that subsequently was settled, a Michigan court allowed a jury to decide whether an HMO's system of compensating a primary care physician caused him not to perform a Pap smear and led to the plaintiff's injury.[25] A federal judge evaluating testimony of a health plan's medical director in coverage litigation framed the question squarely by observing that the doctor's training "is not only in medicine but in 'cost containment.' In which of these disciplines she is better trained would be an interesting question [on which] to spend some time."[26]

An extreme form of economic incentive is "global capitation" of medical groups, placing them at financial risk not only for services within the scope of their licenses but also for the cost of inpatient and ancillary care provided by subcontractors. In addition to its potential effect on treatment decisions, global capitation raises concerns because of physicians' inexperience with managing insurance risk and their comparatively small financial reserves. In California globally capitated providers must meet licensure requirements for HMOs unless the legislature expressly approves regulating them indirectly through the HMOs or insurance companies with which they contract.[27] Other state regulators are facing similar pressures, and California is reconsidering its position.[28]

■ **Fiduciary duties.** The strain on the doctor/patient relationship produced by the perceived trade-off between cost and quality

in managed care is likely to intensify legal enforcement of physicians' special responsibilities (fiduciary duties) to individual patients.[29] *Wickline v. State of California* is the best-known decision recognizing a treating physician's "ultimate responsibility for his patient's care" in a managed care setting.[30] In response to *Wickline*, California enacted legislation that protects physicians who advocate for their patients from being terminated or otherwise penalized by managed care organizations.[31] Other states are following suit.

■ **Disclosure.** In managed care, information that influences patients' treatment decisions may be generated and distributed by corporate entities as well as by individual physicians, may have purposes other than the patient's best medical interests (such as cost containment or marketing), and may be provided at many different times, including the point of enrollment, the point of initial access, and the point of service. Recognizing these risks, states are likely to enact mandatory disclosure laws, independent verification requirements, and procedural safeguards that are designed to guarantee that patients receive accurate and complete information.

The judicial system also may expand the legal doctrine of informed consent, requiring disclosure by physicians in managed care systems of matters other than risks and benefits of therapy, especially if the facts suggest that the physician has a conflict of interest. In *Moore v. Regents of the University of California*, a case involving ownership of a cell line derived from the plaintiff's tissues, the Supreme Court of California held that "a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment."[32]

■ **Regulation of clinical care.** Perceived corporate influence over medical practice, the apparent decline of professional autonomy, and the overt presence of financial considerations also are reducing the reluctance of legislatures to undertake direct regulation of medical practice. Traditional "mandated benefit" laws required coverage of broad classes of services, usually in response to the concerns of health professionals such as chiropractors or podiatrists, or of public facilities such as mental hospitals. Although still usually framed in terms of payment for rather than provision of services, newly proposed or enacted legislation operates at a much narrower level, specifying matters such as administration of HDC-ABMT for breast cancer, length of postpartum hospitalization, and use of particular surgical techniques for abortion.[33] Legislative activism of this sort can be expected to increase as the allocation tradeoffs implicit in the design and operation of any private health care

system are brought into open political debate.

Courts are also questioning long-standing professional norms. Recent judicial decisions permitting physician-assisted suicide, while nominally increasing physicians' autonomy, also reflect concern that the profession's technological imperative has distorted traditional ethical obligations and that legal intervention is necessary to empower patients.[34] Surprisingly, the assisted-suicide rulings make no mention of the potential for "managed death" in a commercialized, resource-limited health care marketplace.

■ **Investor-driven health care.** The struggle for control between health care professionals and managers that characterized the first generation of managed care has given way to an entrepreneurial phase in which physicians are ceding ownership to corporate entities, and tax-exempt hospitals and HMOs are recasting themselves as profit-making enterprises in order to fund new ventures through public capital markets. Initial outrage over multimillion-dollar compensation of managed care executives and soaring profits for investors in previously charitable ventures will probably fade as growth slows and the market stabilizes. However, the central question—"Is more better?"—will remain. If managed care plans cannot maintain profitability by improving efficiency, resources traditionally reinvested in community services may be diverted to investors through allocation decisions that harm patients.[35]

The legal system is already beginning to focus on investor-owned corporations delivering health care. State regulators are attempting to protect public assets by closely scrutinizing conversions of charitable entities to for-profit status.[36] Laws have been proposed or enacted in several states to limit administrative costs and profits in managed care organizations.[37] A bill introduced in Massachusetts would go even further and ban many for-profit health care corporations from the state altogether.[38]

■ **Corporate ethics.** An additional challenge is that institutional health care providers, especially insurance-oriented managed care organizations, lack the ethical framework that has long reinforced regulation of individual professionals and maintained public confidence in "for-profit" physicians. Although managed care still will be delivered by physicians, nurses, and other trained health professionals who are subject to established codes of ethics, the whole of an organization may be less than the sum of its parts.

The hard lesson for the legal system may be that laws telling managed care plans what they must do will not necessarily translate into ethical commitments to what they should do. Various organizations are developing codes of ethical conduct for health care corporations, but those efforts are unlikely to be successful immediately.[39]

This Game Has Losers: The Costs Of 'Efficiency'

Managed care organizations profit primarily by reducing excess capacity among providers, capacity that came into existence in response to generous third-party payment, physician training subsidies, tax-exempt financing, and capital reimbursement for hospital construction. For example, management techniques such as precertification requirements, utilization review, and primary care gatekeeping exposed an oversupply of hospital and specialist physician services. Strategies to exploit this capacity, such as selective contracting, competitive bidding, and shifting of financial risk, have enabled managed care organizations to secure sizable price concessions in exchange for assurances of high patient volume.

Although this "squeezing-out" process is unlikely to lead to widespread physician unemployment, today's zero-sum game is a far cry from the "blank-check" days of fee-for-service medicine, when each new physician added an estimated $500,000 to annual health expenditures.[40] The fear of being left out in the cold is prompting legal and political activism to protect or restore the old regime and is dividing the medical profession against itself as never before.

■ **Anti-managed care laws.** Disenfranchised providers are the most vocal proponents of anti-managed care laws. Many states where managed care has not gained a secure foothold have enacted legislation requiring health plans to contract with "any willing provider" or guaranteeing patients "freedom of choice" with respect to physicians, pharmacies, or other providers. Some have even attempted to resurrect long moribund prohibitions on the corporate practice of medicine.[41] Even regions in which a significant subsection of the medical profession has seen the profit potential in managed care are experiencing a provider and consumer backlash favoring "patient protection" laws that regulate the contracting practices of managed care organizations.[42] As noted previously, the Supreme Court's *Travelers* decision will make it more difficult for managed care organizations to challenge these laws as preempted by ERISA.[43]

■ **"Deselection" and due process.** Even in the absence of statutory protection, physicians facing termination are bringing suit against networks alleging denial of due process. Although due process claims against private entities are more difficult to maintain than against public bodies, plaintiffs may successfully argue that large health care organizations are "tinged with a public purpose" or that their exclusion impaired a "fundamental economic interest."

Delta Dental Plan of California v. Banasky, a California appellate decision, held that judicial review of procedural fairness is available to

physicians and dentists who contract with managed care plans.[44] The ruling suggests that private entities may not arbitrarily exclude or expel providers if "important economic interests are at stake." In *Ambrosino v. Metropolitan Life Insurance Company,* a federal district court extended the *Banasky* decision, holding that providers have a common-law right to fair procedures, including the right not to be expelled from membership in provider networks for reasons that are arbitrary, capricious, and/or contrary to public policy.[45]

■ **Defensive litigation.** Litigation is often attractive to providers who are attempting to preserve their livelihoods and inflict retribution on their perceived injurers. Subject to defenses of ERISA preemption, one potential legal claim is tortious interference with business relationships, reflecting physicians' distress over the perception that long-standing professional relationships have been disrupted and that their patients are now "owned" by managed care companies.[46] Employment-related suits—ranging from wrongful termination claims to assertions of collective bargaining rights—also are increasingly common as more physicians and other previously independent health professionals join the majority of nurses as employees of provider institutions and managed care firms.[47]

Disgruntled physicians and hospitals that cannot compete in the managed care marketplace may bring antitrust litigation alleging behavior such as monopolization or boycotts as a last stand against industry consolidation. Although government antitrust enforcement actions have higher visibility, widespread private litigation, with its extensive discovery and threat of treble damages, may be more likely to influence the practices of managed care plans.

Law In The Postmodern Health Care System

Once unnecessary capacity has been eliminated, additional cost savings from managed care are possible only if demand for services is substantially reduced.[48] Countervailing pressures such as technology and aging make this appear unlikely. In addition, as became clear during the 1993–1994 health care reform debate, federal budgetary priorities constitute an important external constraint on health spending. The specific legal and regulatory problems that arise will vary based on contemporary perceptions of the principal sources of medical expense. The level of government intrusiveness—from limiting tax-favored treatment of health insurance up to and including the imposition of a nationally budgeted health care system—is likely to depend on the number of tax dollars at risk.

■ **Health planning.** The probable failure of cost containment efforts solely through managed care may prompt renewed interest in health planning, but in new ways not linked to traditional facility-

based "certificates-of-need." Because technologic advancement is commonly regarded as the primary challenge to cost containment in the managed care setting, policymakers may turn to technology assessment and other systems of regulating medical innovations that approach but do not offend public conceptions of "rationing."

Possible strategies include extending Food and Drug Administration (FDA)–like regulation to nonpharmaceutical treatments; requiring proof of cost-effectiveness in addition to safety and medical effectiveness; channeling new therapies into carefully circumscribed clinical investigations that slow dissemination; and regionalizing high-cost services to quasi-public referral centers where both price and quantity can be controlled. Demographic changes and the decreasing marginal benefit of restructuring acute care also will inevitably focus attention on managing chronic care. However, current managed care strategies of curtailing excess capacity and achieving economies of scale may prove ineffective, given current restrictions on funding for these services and long-standing patterns of facility-based, process-oriented regulation.

■ **Criminal prosecution.** Strict enforcement of civil and criminal laws against fraud and other "misbehavior" remains a politically popular form of health care cost control, one whose support will increase as large managed care systems grow in prominence (and as once-celebrated organizations encounter financial difficulties). As in the defense industry, sporadic but vigorous antifraud enforcement also is likely to accompany more general failures in cost containment, particularly if government is responsible for payment. This process is already being accelerated by "bounty-hunting" suits that can yield large recoveries to private plaintiffs.[49]

■ **Financial failure.** Managed care is no different from many other consolidating industries in that today's boom will not continue indefinitely, which eventually will lead to an increase in business failures and bankruptcies. Managed care shares with the airline industry rapid deregulation leading to savage price competition despite high fixed costs, and with the savings and loan industry inexperienced and previously sheltered competitors being encouraged to engage in speculative practices. For example, provider risk bearing, made possible by the current abundance of commercial reinsurance capacity, may increase the likelihood of failure if economic conditions change. The network structure of most managed care organizations will tend to magnify the effects of individual failures leading to disputes over performance of contractual obligations, ownership of funds and other property, and the continuing responsibilities of solvent affiliates.[50]

Maxicare's 1989 filing for federal bankruptcy protection, still the

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largest HMO failure to date, may foreshadow future events. The federal judge with jurisdiction over the case scrupulously safeguarded the interests of the reorganizing debtor to the detriment of other parties, requiring network physicians to maintain their affiliations with Maxicare and even prohibiting unaffiliated providers from balance-billing patients.[51] Other HMO failures have been handled in state insurance insolvency proceedings, protecting policyholders at the expense of the failed entity and its business creditors.[52] Which model of judicial involvement will be followed is anybody's guess and adds risk to managed care ventures.

Finally, an alarming possibility is that managed care is expanding too rapidly given the price inelasticity produced by a high level of direct and indirect public funding. Speculative business practices such as imprudent assumption of capitated risk by provider groups or leveraged acquisition by "mega-chains" may result in systematic financial failure, potentially threatening care for large populations. State guaranty funds and other protective mechanisms may prove inadequate in such a circumstance, raising the specter of a federal bailout reminiscent of the savings-and-loan debacle.

■ **Concluding remarks.** I have described developments in health law that may occur over the next decade, linking them to processes driving current changes in the health care system. Just as predictions of an oil glut and the collapse of communism during the late 1980s would have been ridiculed by observers a decade earlier, the future of health law will no doubt prove stranger than fiction, and the limits of our imagination will only be apparent with hindsight.[53]

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NOTES

1. 29 U.S. Code, sec. 1144.
2. *McGann v H&H Music Company,* 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom. Greenberg v H&H Music Company,* 506 U.S. 981 (1992).
3. M.A. Chirba-Martin and T.A. Brennan, "The Critical Role of ERISA in State Health Reform," *Health Affairs* (Spring II 1994): 142–156; D. Fox and D. Schaffer, "Health Policy and ERISA: Interest Groups and Semipreemption," *Journal of Health Politics, Policy and Law* (Summer 1989): 239–260; *Kuhl v Lincoln National Health Plan of Kansas City, Inc.,* 999 F.2d 298 (8th Cir. 1993), *cert. denied,* 510 U.S. 1045 (1994); and *Corcoran v United Healthcare, Inc.,* 965 F.2d 1321, 1338 (5th Cir.), *cert. denied,* 506 U.S. 1033 (1992).
4. *Pilot Life Insurance Company v Dedeaux,* 481 U.S. 41 (1987).
5. 115 S. Ct. 1671 (1995).
6. No. 219692 (Cal. Super. Ct., 28 December 1993).
7. 57 F.3d 350 (3d Cir.), *cert. denied,* 116 S. Ct. 564 (1995).
8. *Roessert v Health Net,* No. C-95-0604, 1996 U.S. Dist. LEXIS 2110 (N.D. Cal., 31 January 1996).
9. K. Abraham and P. Weiler, "Enterprise Medical Liability and the Evolution of the American Health Care System," *Harvard Law Review* 108, no. 2 (1994): 381–436; and W. Sage, K. Hastings, and R. Berenson, "Enterprise Liability for Medical Malpractice and Health Care Quality Improvement," *American Journal of Law and Medicine* 20, nos. 1 and 2 (1994): 1–28.
10. 70 F.3d 958 (8th Cir. 1995).
11. Ibid., at 960. The first version of the court's opinion omitted "arguably." No. 95-2469, 1995 U.S. App. LEXIS 27509, at *4 (8th Cir., 27 September 1995).
12. *Doe v Southeastern Pennsylvania Transportation Authority,* 886 F. Supp. 1186 (E.D. Pa. 1994), *rev'd,* 72 F.3d 1133 (3d Cir. 1995).
13. For example, *California Confidentiality of Medical Information Act,* Cal. Civ. Code, sec. 56 *et seq.*; and *Medical Records Confidentiality Act of 1995,* S. 1360, 104th Cong., 1st sess. (1995).
14. *Engalla v Permanente Medical Group,* 41 Cal. App. 4th 1698 (Cal. Ct. App.), *review granted,* 905 P.2d 416 (Cal. 1995); and *Kaiser Foundation Hospitals v Superior Court,* 19 Cal. App. 4th 513 (Cal. Ct. App. 1993).
15. It may well be that an employer and an HMO could agree that a quality standard articulated in their contract would replace the standards that otherwise would be supplied by the applicable state law of tort. 57 F.3d at 359.
16. J. Robinson and L. Casalino, "The Growth of Medical Groups Paid through Capitation in California," *The New England Journal of Medicine* 333, no. 25 (1995): 1684–1687.
17. U.S. Department of Justice and U.S. Federal Trade Commission, *Statements of Enforcement Policy and Analytical Principles relating to Health Care and Antitrust,* 27 September 1994, 66–106.
18. *Antitrust Health Care Advancement Act of 1996,* H.R. 2925, 104th Cong., 2d Sess. (1996).
19. 881 F. Supp. 1309 (W.D. Wis. 1994), *rev'd,* 65 F.3d 1406 (7th Cir. 1995), *cert. denied,* 116 S. Ct. 1288 (1996).
20. 42 U.S. Code, sec. 1320a-7b (kickbacks); and 42 U.S. Code, sec. 1395nn (self-referral).
21. U.S. Department of Health and Human Services, Office of Inspector General, "HHS IG Final Rule on Managed Care Safe Harbor Provisions for Medicare, State Health Plans," 61 *Federal Register* 2122, 25 January 1996.
22. *McConocha v Blue Cross and Blue Shield of Ohio,* 898 F. Supp. 545 (N.D. Ohio 1995).
23. "Group Accuses Kaiser Permanente of Plan to Link Bonuses to Rationing,"

BNA's Health Care Policy Report (9 October 1995): 1677.

24. *Federal Register* 61 (27 March 1996): 13430. Laws have been enacted in Minnesota and Georgia. Minn. Stat., sec. 72A, 20 Subdivision 33 (1995); and 1995 Ga. H.B. 1338. Current bills regulating financial incentives include 1995 Cal. S.B. 1478; 1995 Ill. H.B. 2967; and 1996 Md. S.B. 718. W. Krasner and T. Walsh, "The Regulation of Physician Incentives," in *Health Law Handbook*, 1995 ed., ed. A.G. Gosfield (Deerfield, Conn.: Clark Boardman Callaghan, 1995), 179–194.
25. *Bush v Dake*, No. 86-25767 (Saginaw County, Mich. 1989).
26. *Florence Nightingale Nursing Service, Inc., v Blue Cross and Blue Shield of Alabama*, 832 F. Supp. 1456 (N.D. Ala. 1993), *aff'd* 41 F.3d 1476 (11th Cir. 1995), *cert. denied*, 115 S. Ct. 2002 (1995).
27. A. Mickelson and B. McBride, "DOC's Global Capitation Announcement Sets Stage for Legislative Battle," *California Health Law Monitor* (February 1995): 2–4.
28. In March 1996 the California Department of Corporations granted Mullikin Medical Center a license to operate a full-risk integrated delivery system. Enabling legislation for provider organizations also has been proposed. 1996 Cal. A.B. 2493.
29. M. Rodwin, "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System," *American Journal of Law and Medicine* 21, nos. 2 and 3 (1995): 241–257.
30. 192 Cal. App. 3d 1630, 1645 (Cal. Ct. App. 1986). The decision is noteworthy for suggesting that third parties such as utilization review entities are legally accountable for their actions. See also *Wilson v Blue Cross of Southern California*, 222 Cal. App. 3d 660 (Cal. Ct. App. 1990).
31. 1993 Cal. S.B. 1832, Stats. 1994 c. 614.
32. 793 P.2d 479, 483 (Cal. 1990), *cert. denied*, 499 U.S. 936 (1991). But see *Abram v Children's Hospital of Buffalo*, 151 A.D.2d 972 (N.Y. App. Div. 1989) (disclosure of the qualifications of medical personnel not required by informed consent laws).
33. For HDC-ABMT legislation, see Minn. Stats., sec. 62A.307 (1995); Mo. Rev. Stat., sec. 376.1200 (1995); N.H. Rev. Stat. Ann., secs. 415:18-c, 419:5-c, 420:5-d, 420-A:7-e, and 420-B:8-e; 1995 Tenn. H.B. 1213; and Va. Code Ann., secs. 2.1-20.1, 38.2-3418.1:1. For postpartum hospitalization legislation, see 1995 Ga. S.B. 482; 1996 In. H.B. 1075; 1996 Ky. H.B. 186; 1995 Minn. H.B. 2008; N.C. Gen. Stat., sec. 58-3-170; 1994 N.J. A.B. 2224; and 1995 Kan. S.B. 573. Bills under consideration include *Newborns' and Mothers' Health Protection Act*, S. 969, 104th Cong., 1st sess. (1995). For legislation on use of particular surgical techniques for abortion, see *Partial-Birth Abortion Ban Act*, H.R. 1833, 104th Cong., 2d sess. (vetoed by President Clinton 10 April 1996).
34. *Compassion in Dying v Washington*, 79 F.3d 790 (9th Cir. 1996); and *Quill v Vacco*, 80 F. 3d 716 (2d Cir. 1996).
35. P. Nudelman and L. Andrews, "The 'Value Added' of Not-for-Profit Health Plans," *The New England Journal of Medicine* 334, no. 16 (1996): 1057–1059.
36. The story of California Commissioner of Corporations Gary Mendoza and the spin-off of WellPoint from Blue Cross of California is told in J. Garrison, "Health Care Hero: The Man Who Made Blue Cross Pay Its Dues," *California Lawyer* (December 1994): 32–35, 85–87. California has enacted a statute to address future conversions: 1995 Cal. S.B. 445, Stats. 1995, ch. 792.
37. California has authorized administrative cost limits, including net profits, in Medi-Cal managed care contracts: Cal. W&I Code, sec. 14464 (1995). Florida is considering a 20 percent cap for all HMOs in the state: 1996 Fla. S.B. 866.
38. 1995 Mass. H.B. 5910.
39. H. Engelhardt Jr. and M. Rie, "Morality for the Medical-Industrial Complex: A Code of Ethics for the Mass Marketing of Health Care," *The New England Journal*

of Medicine 319, no. 16 (1988): 1086–1089.

40. Josiah Macy, Jr. Foundation, *Annual Report, 1992* (New York: Macy, 1992).
41. *Berlin v Sarah Bush Lincoln Health Center,* 664 N.E. 2d 337 (Ill. App. 1996) (enforcing long-neglected prohibition on hospital employment of physicians).
42. For example, Texas Admin. Code tit. 28, sec. 3.3703, allows preferred provider networks to impose conditions in addition to the acceptance of a reduced fee, but contract terms must be "reasonable" and based "solely on economic, quality, and accessibility considerations;" all providers must be afforded a fair, reasonable, and equivalent opportunity to join networks; selection criteria must be disclosed to applicants; providers denied acceptance must be notified of the reasons for denial; and all such actions must be reviewed by a panel composed of at least three physicians.
43. But see *CIGNA Healthplan of Louisiana, Inc. v Louisiana ex rel. Ieyoub,* 82 F.3d 642 (5th Cir. 1996) ("any-willing-provider" law preempted by ERISA).
44. 27 Cal. App. 4th 1598 (Cal. Ct. App. 1994).
45. 899 F. Supp. 438 (N.D. Cal. 1995). See also *Harper v Healthsource New Hampshire, Inc.,* 674 A.2d 962 (N.H. 1996).
46. *Hollis v CIGNA HealthCare of Connecticut, Inc.,* Nos. 705357, 705358, 1994 Conn. Super. LEXIS 3394 (Conn. Super. Ct., 5 December 1994).
47. *Self v Children's Associated Medical Group,* No. 695870 (Cal. Sup. Ct., 29 December 1995) (suit by pediatric gastroenterologist claiming "termination in violation of public policy" for practicing at "a higher level of health care than his employer would tolerate").
48. W.B. Schwartz and D.N. Mendelson, "Eliminating Waste and Inefficiency Can Do Little to Contain Costs," *Health Affairs* (Spring I 1994): 224–238.
49. *United States ex rel. Pogue v American Healthcorp,* 914 F.Supp. 1507 (M.D. Tenn. 1996). In one Medicare fraud case involving clinical laboratory billings, a "whistleblower" who was a competitor of the defendants received more than $20 million of a $100 million settlement. J. Sheehan and R. Ward, "Civil False Claims Act: Impact on the Health Industry," *National Health Lawyers Association Health Law Update and Annual Meeting* (June 1995), 18.
50. S. Warren and W. Sage, "With Friends Like These . . . Protecting Participants in Integrated Delivery Systems from Bankruptcy and Insolvency Risks," in *Health Law Handbook,* 1995 ed., 115–151.
51. *Maxicare Health Plans, Inc. v Centinela Mammoth Hospital (In re Family Health Services, Inc.),* 105 B.R. 937 (Bankr. C.D. Cal. 1989).
52. *In re Estate of Medcare HMO,* 998 F.2d 436 (7th Cir. 1993).
53. These events were in fact "predicted" by a coffee-table book of the 1970s. T. Hendra, C. Cerf, and P. Elbling, eds., *The 80s: A Look Back at the Tumultuous Decade, 1980–1989* (New York: Workman, 1979).