William & Mary Law Review

Volume 48 (2006-2007)
Issue 2

Article 6

November 2006

Not Just a Minimum Income Policy for Physicians: The Need for Good Faith and Fair Dealing in Physician Deselection Disputes

Stephen D. Coppolo

NOTES

NOT JUST A MINIMUM INCOME POLICY FOR PHYSICIANS: THE NEED FOR GOOD FAITH AND FAIR DEALING IN PHYSICIAN DESELECTION DISPUTES

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INTRODUCTION

Physician deselection has been described as a "very complex issue that lacks a complex history."[1] Essentially, a standard contract term that gave no physician pause in the "good old days" now causes significant heartburn for doctors living in the world of managed care. The term "physician deselection" generally refers to the process by which a managed care organization (MCO) terminates its relationship with an affiliated physician in its network, whether with cause or without cause.[2] The problem of physician deselection is a product of the transition of the U.S. health care delivery system from a fee-for-service insurance model to a managed care model.

In the era of fee-for-service health insurance, insurers would pay for the medical bills of their insured essentially without regard to who was the treating physician.[3] During the MCO revolution of the 1980s and 1990s, physicians' role with respect to insurers suddenly changed from something akin to independent contractors to something much closer to being true employees. Physicians now need to worry not only about treating patients, but also about providing their services in a "managed care compatible" fashion.[4] In 1996, when the Supreme Court of New Hampshire issued its decision in *Harper v. Healthsource New Hampshire, Inc.*,[5] a state court of final jurisdiction for the first time held that deselections without cause and without the opportunity for review violate public policy.[6]

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1. Lowell C. Brown & Elizabeth Jagla, *Credentialing, Peer Review, and Provider Deselection in Managed Care: Providers in the Crossfire*, 20 WHITTIER L. REV 375, 375 (1998).

2. *See, e.g.*, Allen D. Allred & Don L. Daniel, *Upon Further Review:* Rush Prudential HMO, Inc. v. Moran *and a New Era of Managed Care Organization Liability*, 47 ST. LOUIS U. L.J. 309, 350-51 (2003); Bryan A. Liang, *Deselection Under* Harper v. Healthsource*: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 801 (1997).

3. *See* Brown & Jagla, *supra* note 1, at 375-76; Richard S. Liner, Note, *Physician Deselection: The Dynamics of a New Threat to the Physician-Patient Relationship*, 23 AM. J.L. & MED. 511, 516-17 (1997).

4. *See* Liner, *supra* note 3, at 514-16; *see also* N.J. Psychological Ass'n v. MCC Behavioral Care, Inc., No. 96-CV-3080, 1997 WL 33446538, at *1 (D.N.J. Sept. 17, 1997) (noting an MCO's use of the phrase "managed care compatible").

5. 674 A.2d 962 (N.H. 1996).

6. *Id.* at 964-67.

Though case law on physician deselection appears to have stagnated since the 2000 California Supreme Court decision in *Potvin v. Metropolitan Life Insurance Co.*,[7] legislators and courts need to continue working to prevent deselection abuses. This Note will examine recent judicial and legislative attempts to provide procedural protections to physicians facing deselection. This Note will also analyze the current state of health insurance markets to assess whether they have stabilized to the point where improper deselections will no longer be a significant problem. Evidence of continued consolidation among health insurers and increased competitive pressures will demonstrate the likelihood that insurers will continue to attempt to weed out physicians whose treatment costs are above average, whether due to legitimate aspects of the physicians' practice styles, patient advocacy, or other factors.

This Note will argue that the strongest method of protecting physician interests in the continually changing managed care environment is through the enactment of strong procedural protections for deselected physicians rather than through prohibitions against deselection on the basis of certain protected activities. While state legislative action is the preferred method of ensuring procedural protections for physicians,[8] *Potvin* and *Harper* demonstrate that existing common law doctrines are flexible enough to handle the implications of this emerging trend.

In the absence of state legislative action, courts can and should provide minimal procedural safeguards against abuses in physician deselection by reading the implied covenant of good faith and fair dealing into physician-MCO contracts. Using state and federal statutes as a basis for determining the current boundaries of public policy, courts should provide for the following: a notice period for physicians facing deselection; the opportunity for physicians who believe their termination is sought on improper bases to have an administrative review where they may challenge the termination; the ability for physicians to view evidence against them and have an attorney or other representative present at the review; the involvement of an unbiased physician at the review if the termination is

7. 997 P.2d 1153 (Cal. 2000).

8. *See infra* note 142.

made on medical grounds; and lastly, access to judicial review to ensure such procedures are followed.

Part I of this Note will examine physician deselection, how it is accomplished, and what effect it has on physicians and their patients. Part II will consider particular arguments for and against extending greater protections to physicians facing deselection. Part III will examine case law developments relating to physician deselection, including *Harper* and *Potvin*. Part IV will suggest and examine two hypotheses for the failure of the predicted trend of *Harper*- and *Potvin*-type decisions spreading to other jurisdictions across the country. This Part will examine the possibility that (1) state legislatures have already adequately dealt with MCO deselection abuses, and/or (2) health insurance markets have stabilized enough that where improper physician deselections are no longer a concern. Part IV will argue that neither state legislative developments nor conditions in health insurance markets eliminate the need for further judicial intervention in this area. Lastly, in Part V, this Note will suggest that courts adopt the *Harper* approach of employing the implied covenant of good faith and fair dealing to provide procedural protections to physicians facing deselection, and will consider the optimal shape of those protections.

I. THE PROBLEM OF PHYSICIAN DESELECTION

A. Deselection Defined

Physician deselection occurs when a managed care organization removes a physician from the group of providers authorized to receive reimbursement in return for treating the MCO's patients.[9]

9. *See* Liang, *supra* note 2, at 800-01 ("Deselection works through contract principles. Physicians who enter into agreements to serve as providers for MCOs must generally accept the standard 'termination without cause' clauses, which allow either party to terminate the contract with some specified time of notice for any or no reason at all.") (footnotes omitted). A broad definition of deselection is best, given the large variety of health insurance models existing in the United States today. This Note will use the term "managed care organization," or MCO, broadly to represent the full spectrum of health insurance models ranging from a loose preferred provider network to a highly regimented health maintenance organization. The only major form of health insurance specifically excluded from this definition of MCO are traditional, fee-for-service plans. For more information comparing the functional differences among the different types of health insurance plans, see America's Health Insurance Plans,

Although deselection is based on contract principles,[10] the significant power of MCOs in many geographical markets, and the negative consequences that can occur when physicians are deselected, raise concerns that transcend pure contract law. In fact, for the physicians who are being deselected, the economic effects can be equivalent to being fired.[11]

Deselection is typically accomplished through MCO use of provisions in their contracts allowing either "with cause" or "without cause" termination of physicians. Historically, without cause terminations have been the preferred method of removing a physician from an MCO's provider list.[12] Clauses allowing MCOs to terminate their affiliation with a physician "are almost universally present in physician/MCO provider agreements."[13] Without-cause termination clauses are also particularly susceptible to abuse by MCOs, because they can be used to mask a decision to terminate for reasons that violate public policy.[14] Indeed, the *Potvin* court found the use of a without-cause termination provision to be unenforceable when it conflicted with a physician's common law right to fair procedure.[15]

Because a physician's relationship with an MCO "is not an employer-employee relationship,"[16] and the physician is not "really an independent contractor for" the MCO,[17] a physician can be left

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Guide to Managed Care: What are My Health Plan Choices?, http://www.ahip.org/content/default.aspx?bc=41|329|353#choices (last visited Oct. 8, 2006).

10. *See* Liang, *supra* note 2, at 800 n.6 & 801.

11. Liner, *supra* note 3, at 516 ("Whether MCOs use the term 'deselection,' 'delistment,' or 'disenrollment,' the translation for the physician remains the same, termination."); *see also infra* notes 46-47 and accompanying text.

12. *See, e.g.*, Allred & Daniel, *supra* note 2, at 351 ("Provider deselection ... typically is accomplished through the use of 'termination without cause' provisions."); Liner, *supra* note 3, at 513 (stating that when an MCO's determination to sever a relationship with a physician is based on economic grounds, "MCOs can discretely accomplish this by invoking the termination-without-cause provision in the provider contract").

13. Allred & Daniel, *supra* note 2, at 351.

14. For a discussion of motivations to deselect physicians that violate public policy, see *infra* notes 28-36 and accompanying text.

15. Potvin v. Metro. Life Ins. Co., 997 P.2d 1153, 1162 (Cal. 2000).

16. Harper v. Healthsource N.H., Inc., 674 A.2d 962, 965 (N.H. 1996); *see* N.J. Psychological Ass'n v. MCC Behavioral Care, Inc., No. 96-CV-3080, 1997 WL 33446538, at *3 (D.N.J. Sept. 17, 1997).

17. *Harper*, 674 A.2d at 965.

without recognized legal recourse to challenge the basis for the termination.[18]

B. Common Bases for Physician Deselection

MCOs deselect physicians for a variety of reasons: some of which are recognized as permissible, and some not.[19] This Section will discuss some of the most common, but is not meant to be exhaustive.

An obvious, and clearly legitimate, basis for an MCO to seek to deselect a physician from its provider network is poor quality of care. Falling under this classification are "issues of board certification, pending disciplinary or malpractice actions, as well as sexual harassment or other improper conduct."[20] MCOs have a duty to their enrollees to ensure that network physicians will not cause them harm or behave inappropriately toward them.[21] As one commentator noted, "MCOs are increasingly taking on the role that hospitals had in an earlier era, in terms of credentialing and otherwise vouching for the quality of care provided by their physicians."[22] Given that MCOs are increasingly assuming the responsibility to ensure network physicians are competent, it is entirely appropriate that MCOs have procedures in place to remove potentially dangerous providers from access to their enrollees.

Legitimate business motives on the part of the MCO are also a valid reason for physician deselection. Like any business, MCOs must be able to reduce the size of their networks and their overhead costs should business conditions necessitate such action. Courts have traditionally been deferential to business decisions in the

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18. *See* Liang, *supra* note 2, at 804 ("Many physicians have been deselected under a termination without cause clause; the few who have challenged these terminations have generally been denied relief.").

19. Linda C. Fentiman, *Patient Advocacy and Termination from Managed Care Organizations. Do State Laws Protecting Health Care Professional Advocacy Make Any Difference?*, 82 NEB. L. REV. 508, 522 (2003).

20. *Id.*

21. *Id.* ("[M]ore and more courts are holding MCOs vicariously liable for the negligence of network [health care providers] ....").

22. *Id.* at 522 n.55.

sphere of traditional employment relationships.[23] Because MCO-physician contractual relationships are not employer-employee relationships,[24] MCOs ought to maintain at least as much control over their deselection decisions as they do over their employment decisions.

Included within legitimate business reasons for deselecting physicians are the winnowing down of large provider panels that MCOs tend to accumulate to attract enrollees when they first enter a new market[25] and the elimination of excess physician capacity following mergers and acquisitions between MCOs.[26] Further, the medical needs of a given geographic area will change over time, and MCOs should be able to assemble a provider panel that reflects those needs.[27] Unless MCO cost-controlling strategies become so onerous as to put patients at risk, MCOs should be entitled to deference in the area of financial and business determinations.

Deference to legitimate business rationale should not extend to any and all physician deselections based on raw economic criteria, however. The propriety of physician deselections based on highly

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23. *See, e.g.*, Rios v. Rossotti, 252 F.3d 375, 380 (5th Cir. 2001) ("This Court affords a high degree of deference to employers in their hiring and promotion decisions."); Hutson v. McDonnell Douglas Corp., 63 F.3d 771, 781 (8th Cir. 1995) ("It has become a commonplace for this court to observe ... that the employment-discrimination laws have not vested in the federal courts the authority to sit as super-personnel departments reviewing the wisdom or fairness of the business judgments made by employers, except to the extent that those judgments involve intentional discrimination."); Baez v. Yeshiva Univ., No. 99 CIV. 11644 (HB) 2000 WL 1897792, at *4 (S.D.N.Y. Dec. 29, 2000) ("This Court may not second-guess an employer's non-discriminatory business decisions, even if those decisions are illogical or unwise."). Though these cases arise in the employment discrimination context, the sentiments translate into the less-scrutinized area of business decisions concerning contractual relationships.

24. *See, e.g.*, Harper v. Healthsource N.H., Inc., 674 A.2d 962, 965 (N.H. 1996) ("Strictly speaking, [plaintiff's] relationship with [his MCO] is not an employer-employee relationship.").

25. For a description of how such a winnowing process typically is accomplished, see Stephen E. Roth, *Physician Deselection Under Attack: Will Without Cause Termination Soon Be a Thing of the Past?*, HEALTH LAW., Apr. 1999, at 1, 3.

26. For an example of the merger deselection scenario, see *Sammarco v. Anthem Ins. Cos.*, 723 N.E.2d 128 (Ohio Ct. App. 1998). The court in *Sammarco* held that the use of without-cause deselections following the merger of several MCOs did not violate public policy. *Id.* at 132-35.

27. *See* Fentiman, *supra* note 19, at 522 ("[B]road changes in national and local health care markets, such as the evolving medical needs of MCO enrollees and the need to reconfigure relationships with hospitals, can lead MCOs to deselect HCPs who no longer meet their needs.").

specific financial analyses of individual physicians' practice styles is an unsettled issue. Such analyses are known as "economic credentialing."[28] One commentator describes the rise of economic credentialing as an emerging "gray area" and defines the problem as "whether it is appropriate to deselect HCPs [Health Care Providers] due to their overutilization of diagnostic, specialist, and inpatient resources, particularly if these services are provided out of network."[29] MCOs, for the most part, are for-profit enterprises and thus have an inherent interest in maintaining lower cost physicians in their networks, while cutting ties with physicians whose practice costs are significantly above average.[30] Although numerous authors have discussed the financial incentives for MCOs to deselect physicians with higher-than-average treatment costs, there appears to be no consensus as to when such "economic credentialing" moves from being a legitimate business tool to being impermissible MCO interference with the ability of doctors to practice medicine. This lack of consensus underscores why it is important for courts to evaluate physician deselection litigation by focusing on procedural protections for physicians, rather than on bright line tests for economic credentialing in the absence of broad agreement.[31]

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28. The American Medical Association defines economic credentialing as "the application of economic criteria unrelated to quality of care or professional competence to decisions concerning appointment, reappointment, or delineation of staff privileges." Liner, *supra* note 3, at 513 n.8 (quoting John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM J.L. & MED. 173, 176 (1996)).

29. Fentiman, *supra* note 19, at 522.

30. Such "economic credentialing" is a widely used MCO cost containment tool: "Most MCOs operate as profit maximizing businesses by managing and underwriting health care. MCOs make economic comparisons among treatment choices and use these evaluations for credentialing purposes." Liner, *supra* note 3, at 517 (footnotes omitted); *see also* Allred & Daniel, *supra* note 2, at 350 ("The twin objectives of maximizing profit and controlling cost often force MCOs to terminate physician contracts in an effort to adjust their provider bases for efficient provision of care."); Liner, *supra* note 3, at 513 ("[E]conomically based factors ... have become prevalent in MCO credentialing. Sometimes, MCOs terminate providers for purely economic reasons."); Roth, *supra* note 25, at 1 (noting that "[n]othing is more fundamental to the effectiveness and profitability of ... MCOs [] than the doctors they select or employ. MCOs want to maximize their control over the composition of their panels of physicians: they want to retain the best and most profitable and cut their ties to the others with a minimum of fuss").

31. *See infra* notes 169 and 174 and accompanying text.

Whereas the propriety of economic credentialing is a subject of debate, there is a broad consensus among the medical community, policymakers, and the general public that MCO restraints on the ability of physicians to advocate for the needs of their patients are contrary to public policy.[32] One problematic MCO method of curtailing physician advocacy is the use of "gag clauses," which were reported on extensively during the 1990s.[33] And because some courts have found that physicians have a fiduciary duty to promote the best interests of their patients,[34] courts and legislatures should not tolerate deselections aimed at retaliating against such advocacy. The American Medical Association has placed patient advocacy among the most important ethical responsibilities of physicians.[35] In fact, "physicians are adjured to act as a patient advocate to challenge a denial of care that the physician believes will materially benefit the patient, and are even mandated to initiate appeals on behalf of their patients in certain circumstances."[36] Given the value

32. For a detailed discussion of physician deselection from a patient advocacy perspective, see generally Fentiman, *supra* note 19. For the purposes of this Note, the term "advocacy" will be used generally to describe any form of physician intervention with MCO policies or coverage determinations on behalf of one or more patients, whether within or outside of MCO appeal channels.

33. *See id.* at 510. According to the U.S. Government Accountability Office (formerly the General Accounting Office):

> A commonly understood definition of a gag clause is a contract provision that limits physicians' ability to advise patients of all medically appropriate treatment options.... Most agree that language that prevents physicians from giving patients complete information about their medical care choices or restricts the timing of such discussions is a gag clause.

GOVERNMENT ACCOUNTING OFFICE, MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERNS REMAIN 5 (1997), *available at* http://www.gao.gov/archive/1997/he97175.pdf. As the title of the report suggests, the agency found no explicit gag clauses in the 529 HMOs it surveyed. *Id.* at 3.

34. Fentiman, *supra* note 19, at 516-19 (discussing cases from California, New York, and Delaware).

35. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS OF THE CODE, E-8.13(1): Managed Care (2002), *available at* http://www.ama-assn.org/ama/pub/category/2498.html (follow "Current opinions" hyperlink) ("The duty of patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the system of health care delivery."); *see* Fentiman, *supra* note 19, at 514-16.

36. *Id.* at 515 (footnotes omitted). Other authors report that under the AMA guidelines, "abiding by certain gag rules could subject AMA physicians to sanctions." Mark A. Kadzielski, *Provider Deselection and Decapitation in a Changing Healthcare Environment*, 41 ST. LOUIS U. L.J. 891, 909 (1997).

that the medical community and the courts have placed on physician advocacy, reviewing courts should strongly discourage MCO deselections that are meant to punish such behavior.

II. PUBLIC POLICY ARGUMENTS FOR AND AGAINST LEGISLATIVE AND JUDICIAL RESPONSES TO PHYSICIAN DESELECTION ABUSES

A. Arguments Favoring Greater Legislative and Judicial Involvement

1. The Impact of Deselection on Physicians

When the majority of health insurance plans in the United States were fee-for-service plans, the implications for physicians of signing terminable-at-will insurer contracts were much less disastrous than they are today.[37] Because fee-for-service plans generally pay for medical services provided by any health care provider,[38] the health insurer traditionally did not play a significant mediating role in determining which patients saw which doctors.

In a modern MCO, the insurer becomes a significant, and perhaps the most significant, factor in creating and maintaining physician-patient relationships. Because MCOs operate by building relationships with a network of physicians and then only covering their insured's medical expenses incurred within the provider network, the financial incentives for patients to seek care from in-network physicians are enormous. As one commentator explained, "[i]n the fee for service era, patients could choose their doctors with virtually no limitations. However, that is no longer the case under managed care.... [T]he patient's control over the relationship is significantly lessened."[39] The financial incentives built into the "unique tripartite relationship among an insurance company, its insureds, and the physicians who participate in the preferred provider network,"[40] ensure that the MCO controls which physicians its insureds will

37. *See* Liang, *supra* note 2, at 801 ("Before managed care dominance, physicians were happy to sign contracts with such clauses.").

38. America's Health Insurance Plans, *supra* note 9.

39. Roth, *supra* note 25, at 5.

40. Potvin v. Metro. Life Ins. Co., 997 P.2d 1153, 1160 (Cal. 2000).

seek out.[41] If a physician loses her in-network status, she essentially loses access to the MCO's patients and the revenue they represent for her practice.

As MCOs have become the dominant player in group health insurance,[42] physicians have "come to rely on MCO contracts for their patient base, income, and marketability."[43] This reality has led physician professional associations to declare that "access to [MCO] provider panels [is] a 'practical prerequisite' to any effective practice as a health care provider."[44] Naturally, as physician reliance on MCO affiliation has grown, the consequences of deselection from an MCO's provider panel have increased correspondingly.[45]

Being deselected from an MCO provider network can bring consequences graver than simply losing access to the MCO's insureds, however. A deselection decision also carries

> enormous long-term consequences for the HCP's income, ego, and reputation. An MCO's action in ending its relationship with an HCP can often have a crippling economic domino effect. As the MCO's decision becomes known to state or federal regulatory bodies as well as other insurers or health plans, an HCP, particularly one who is a specialist, can quickly face a sharp fall-off in referrals from other HCPs. In other cases, an HCP's hospital staff privileges can be threatened.[46]

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41. *See id.* at 1159.

42. *See* Liner, *supra* note 3, at 514 (citing statistics that less than 10 percent of patients were insured through MCOs in 1970, compared with over 50 percent in 1996); MCOL, Managed Care National Statistics, http://www.mcareol.com/factshts/factnati.htm (last visited Oct. 8, 2006) (listing statistics that 142.8 million Americans, or 86.12 percent of all Americans with private (nongovernmental) health insurance are in a managed care model plan).

43. Liner, *supra* note 3, at 513 (footnotes omitted).

44. *Potvin*, 997 P.2d at 1160 (quoting joint amicus brief of the American Medical Association and the California Medical Association).

45. The importance of remaining on an MCO's provider panel is compounded in cases in which a single MCO dominates a geographic insurance market. The opinion in *Potvin* recognized that in some regions, because of a single MCO having dominant market share, "the insurer possesses power so substantial that the removal [from that insurer's network] significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty" in the area. *Id.* For physicians in these regions, the implication is that MCO affiliation is not only the *best* way for a physician to run a successful practice, it may be the *only* way. See *infra* Part IV.C for a discussion of several insurer-dominated markets.

46. Fentiman, *supra* note 19, at 572.

Because of such implications, deselection decisions cause as much disruption to physicians' careers as does termination for those in standard employer-employee relationships.[47]

As MCOs have attained the status of quasi-employers for physicians, they not only serve as a source of physicians' income, but also effectively serve as unofficial credentialing entities for physicians. As one commentator noted, "MCOs are increasingly taking on the role that hospitals had in an earlier era, in terms of credentialing and otherwise vouching for the quality of care provided by their physicians."[48] When one MCO terminates its relationship with a particular physician, nearby MCOs, physician groups, and hospitals that are aware of the deselection decision will be wary of adding that physician to their provider panels.[49]

The operation of the National Practitioner Data Bank (NPDB)[50] in physician deselection scenarios is also important in considering the economic impact that MCO terminations carry for physicians. The NPDB was established under the authority of the Health Care Quality Improvement Act of 1986[51] and serves as a nationwide clearinghouse for information on unethical or incompetent physicians, thus preventing physicians from being sanctioned in one state and then moving to a second to resume the practice of medicine.[52]

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47. In fact, it is easy to see why physician deselection carries with it more negative consequences than being terminated from most jobs. For example, when an administrative assistant in one part of a city is fired, whether he deserves it or not, he can likely find a new job across town without much additional difficulty due to the firing. This is because, in most jobs, there are simply no licensing and accreditation requirements analogous to those faced by physicians. Further, the community of physicians in a given metropolitan area is probably smaller and more interconnected than is the community of administrative assistants in the same city.

48. Fentiman, *supra* note 19, at 522 n.55.

49. Liner, *supra* note 3, at 517 ("A deselected physician loses more than patients and income. Other MCOs are less likely to have an interest in a deselected physician." (footnotes omitted)). In *Potvin*, the plaintiff alleged "that among the adverse effects of removal from MetLife's preferred provider lists were rejection by physician groups which were dependent upon credentialling by MetLife." *Potvin*, 997 P.2d at 1160-61 (internal quotation marks omitted).

50. 45 C.F.R. §§ 60.01-.14 (1994).

51. 42 U.S.C. §§ 11101-11152 (2000).

52. As Fentiman states,

> [The NPDB is] a national clearinghouse for information about incompetent HCPs, [that limits] these HCPs' ability to move from state to state and continue to practice their profession even after disciplinary action has been taken against them in another state. Actions that must be reported to the NPDB include state

The MCO deselection process can lead a physician to be reported to the NPDB,[53] thus further endangering the professional prospects of a deselected physician.

In these ways, deselection carries *at least* as many significant negative financial consequences as a termination. The effect of deselection on physicians provides a strong reason for extending some of the protections enjoyed by workers in standard employment relationships to physicians facing deselection.

2. Analogous Principles in the Employment Law Context

Although physician-MCO contractual relationships are not true employment relationships,[54] an examination of the principles applicable to employer-employee relationships is helpful in identifying how courts and legislatures can shape protections for physicians facing deselection. In American jurisdictions, there is a presumption that an employment relationship is "at will," meaning that either side can terminate the relationship for any reason, or for no reason at all.[55] Yet, the right of employers to fire at-will employees for any reason whatsoever has been drastically curtailed over the past sixty years.[56] As one commentator bluntly puts it, "the legal right to fire

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> disciplinary actions against physicians or dentists relating to that person's professional competence or conduct; adverse HCP clinical privileges decisions made by hospitals and other health care entities, including HMOs and professional societies; exclusions of HCPs from the Medicare and Medicaid programs; Drug Enforcement Administration (DEA) actions to revoke the registration of a HCP (i.e. the ability to write prescriptions), and; all medical malpractice awards paid by anyone other than the HCP himself (i.e., a malpractice insurer, medical group, or hospital).

Fentiman, *supra* note 19, at 525-26 n.69; *accord* Liang, *supra* note 2, at 804 n.19.

53. *See* Fentiman, *supra* note 19, at 525 n.69; Liang, *supra* note 2, at 804 n.19 ("[T]ermination which affects clinical and medical staff privileges must be reported to the [NPDB] ....").

54. *See supra* notes 16-18 and accompanying text.

55. MARK A. ROTHSTEIN ET AL., EMPLOYMENT LAW § 1.27 (3d ed. 2005) ("The American rule is that oral contracts of indefinite duration (the most common form of employment contract) are presumed to be 'at will' contracts."); *e.g.*, Bradshaw v. Brown Group, Inc., 258 F.3d 847, 849 (8th Cir. 2001); Wesson v. Huntsman Corp., 206 F.3d 1150, 1154 (11th Cir. 2000); Lytle v. Malady, 579 N.W.2d 906, 910 (Mich. 1998); County of Giles v. Wines, 546 S.E.2d 721, 723 (Va. 2001).

56. Cynthia L. Estlund, *Wrongful Discharge Protections in an At-Will World*, 74 TEX. L. REV. 1655, 1655 (1996). Only one state has abrogated the at-will employment doctrine by statute. *See* PETER O. HUGHES, LABOR AND EMPLOYMENT LAW § 259.04 (MB 2005), *available*

for bad reasons has been virtually decimated."[57] Recognized exceptions to the doctrine of at-will employment include federal and state statutory prohibitions,[58] collective bargaining agreements,[59] and considerations of public policy.[60] An employee who feels his termination is in violation of public policy can bring the common law tort claim of wrongful discharge.[61]

Most relevant to the current discussion are employment terminations that violate statutory prohibitions[62] or those that violate public policy. All fifty states and the federal government have enacted statutory exceptions to the doctrine of employment at will, with frequent examples including statutes barring termination on the basis of race, sex, religion, disability, or age.[63] Remedies for employees terminated in violation of a state or federal statute vary.[64] In some cases, the statutory right overcomes any common law wrongful termination claim that the employee might have had.[65] In others, the employee can bring an action on either basis.[66] Other statutes require the terminated employee to pursue an administrative, rather than judicial, remedy.[67]

Even if no statute explicitly proscribes the basis for an employee's termination, the employee may have a claim for wrongful discharge if the basis of the termination violates public policy. In general, for such a claim to succeed, the policy involved must be substantial and

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at LEXIS, LEXSTAT 10-259 (discussing a Montana statute).

57. Estlund, *supra* note 56, at 1655.

58. Examples of such statutes include the Federal Age Discrimination in Employment Act, 29 U.S.C. §§ 621-634 (2000), and the federal statute protecting against government civil rights violations, 42 U.S.C. § 1983 (2000).

59. ROTHSTEIN ET AL., *supra* note 55, § 9.1.

60. *Id.* § 9.9.

61. HUGHES, *supra* note 56, § 259.05.

62. Approximately thirty states have enacted some form of statutory limitations on the ability of MCOs to terminate contractual relations with physicians arbitrarily or on short notice. *See infra* Figure I.

63. HUGHES, *supra* note 56, § 259.04.

64. *See id.*

65. *Id.*

66. *Id.*

67. *Id.*

important,[68] and affect the rights of the public at large, not solely those of an individual.[69]

Closely tied to the concept of the public policy exception to at-will employment is the common law doctrine of good faith and fair dealing.[70] Under this doctrine, courts read into every contract an implied provision that neither party will act in a way to deprive the other party of "the fruits of the contract."[71] Some courts hold that because the employment relationship is contractual, it is subject to the implied duty of good faith and fair dealing as well.[72] Courts in a majority of jurisdictions, however, have refused to extend the implied covenant into the context of at-will employment relationships.[73]

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68. *See, e.g.*, Gantt v. Sentry Ins., 824 P.2d 680, 684 (Cal. 1992) ("[T]he [public] policy must be fundamental, substantial and well established at the time of the discharge." (quotations omitted)), *abrogated on other grounds by* Green v. Ralee Eng'g Co., 960 P.2d 1046, 1054 n.6 (Cal. 1998); Nelson v. Productive Alternatives, Inc., 715 N.W.2d 452, 454 (Minn. 2006) (stating that in Minnesota and other states, the common law public-policy exception to the at-will employment doctrine applies only when the policies at issue are "clear"); Berube v. Fashion Ctr., Ltd., 771 P.2d 1033, 1043 (Utah 1989) (holding that the court would recognize only those public policies that "are so substantial and fundamental that there can be virtually no question as to their importance for promotion of the public good.").

69. For example, one state court explained what it takes for a public policy to rise to the level of abrogating the at-will employment doctrine:

> [I]t can be said that public policy concerns what is right and just and what affects the citizens of the State collectively. It is to be found in the State's constitution and statutes and, when they are silent, in its judicial decisions. Although there is no precise line of demarcation dividing matters that are the subject of public policies from matters purely personal, a survey of cases in other States involving retaliatory discharges shows that a matter must strike at the heart of a citizen's social rights, duties, and responsibilities before the tort will be allowed.

Palmateer v. Int'l Harvester Co., 421 N.E.2d 876, 878-79 (Ill. 1981) (citation omitted).

70. *See* RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981) (adopting the doctrine).

71. Kirke La Shelle Co. v. Paul Armstrong Co., 188 N.E. 163 (N.Y. 1933). This phrase has been frequently used by courts.

72. *See* ROTHSTEIN ET AL., *supra* note 55, § 9.6 (stating that "[a] little more than one-fifth of the states permit the use of the implied-in-law covenant of good faith and fair dealing to challenge discharges").

73. The Rothstein treatise explains the uncomfortable place of the implied covenant in the law of wrongful discharge, noting that "most courts have rejected the application of the doctrine to employment contracts because of concerns that the doctrine is amorphous, too broad, and destructive of employer prerogatives." *Id.* Further, "[m]ost courts view the invocation of the implied covenant as the plaintiff's attempt to impose a just cause requirement on an employment relationship as a matter of law, where, as a matter of fact, the relationship is at will." *Id.*

Despite the limited acceptance of the implied covenant of good faith and fair dealing in the employment context, good reasons exist for courts to fully utilize the doctrine into the less-regulated area of MCO-physician contracting. The long history of case law in American jurisdictions upholding the presumption of at-will employment simply does not exist in the area of physician deselection. Because courts rejecting the doctrine in the employment context have viewed the implied covenant as an attempted end run around the policy of employment at will,[74] the lack of a strong body of case law regarding physician deselection disputes argues in favor of a broadly interpretation of the covenant in MCO-physician contracts.

The relationship between a physician and an MCO is not a perfect analogue to the relationship of an employer to an employee. Whereas under managed care, deselected physicians face economic consequences similar to those of terminated employees,[75] no analogous body of common law and statutory protections exists for physicians. The implied covenant of good faith and fair dealing is thus more appropriate in the less-regulated area of MCO-physician contracts than in the heavily regulated area of employment relationships. Paradoxically, it is the breadth and adaptability of the implied covenant—which has led courts to reject it in the employment context—that makes it well-suited for bringing employment-like protections to what has become an employment-like relationship.[76]

3. Physician Deselection Affects Patient Health

The financial relationship between MCO, physician, and patient ensures that a disruption in the physician-MCO relationship will affect the care received by the patient. Courts that have addressed the issue of physician deselection have recognized a public interest in the relationship between MCOs and their affiliated physicians.[77]

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74. *Id.*

75. *See supra* notes 46-53 and accompanying text.

76. *See infra* Part V.

77. *See* Potvin v. Metro. Life Ins. Co., 997 P.2d 1153, 1160 (Cal. 2000) ("[T]he relationship between insurers and their preferred provider physicians significantly affects the public interest ...."); Harper v. Healthsource N.H., Inc., 674 A.2d 962, 966 (N.H. 1996) ("The public

Further, a significant number of state legislatures have recognized the public's interest in stable physician-patient relationships and have passed statutes requiring that MCOs continue to reimburse patient visits to recently terminated physicians for a specified time period.[78] Lastly, a number of studies have concluded that stability in the patient-physician relationship contributes to a more positive experience for patients, makes patients more likely to follow suggested health regimens, lowers the number of hospitalizations and emergency room visits, and lowers the costs of care.[79]

Although physicians' derivation of income from MCO contracts has in many cases become sufficiently like an employment situation to justify procedural protections against unjustified deselections, the most important policy reason for scrutiny of deselection practices is the effect they have on patient care.[80] Essentially, "deselection can give rise to effects similar to patient abandonment."[81] For MCO enrollees, like all patients, the loss of a long-term physician-patient relationship can have adverse health consequences. As one report summarized,

> [t]he traditional practice of medicine was built on a long-term relationship with a single provider who knows the patient well and who acts on behalf of the patient in difficult situations. It takes time to develop such a relationship: some research

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has a substantial interest in the relationship between health maintenance organizations and their preferred provider physicians .... This relationship is perhaps the most important factor in linking a particular physician with a particular patient.").

78. *See, e.g.*, MD. CODE ANN., INS. § 15-112(b)(2) (LexisNexis 2002) (ninety-day period); VA. CODE ANN. § 38.2-3407.10(F) (2002) (same). States, however, generally make exceptions to such requirements in cases where the physician was terminated "for cause," *id.*, or for "fraud, patient abuse, incompetency, or loss of licensure status," MD. CODE ANN., INS. § 15-112(b)(2)(ii).

79. GERRY FAIRBROTHER & ARFANA HAIDERY, NEW AM. FOUND. HEALTH POLICY PROGRAM, HOW HEALTH INSURANCE STABILITY IMPACTS THE QUALITY OF HEALTH CARE 7 (2005), http://www.newamerica.net/files/archive/Doc_File_2470_1.pdf (last visited Oct. 8, 2006) (surveying research on the effects of a stable physician-patient relationship).

80. *See* Liner, *supra* note 3, at 513 ("Why, however, should the public, generally at risk for losing their own jobs, grieve for doctors just because the current deselection process jeopardizes their managed care contracts? The answer lies in the effect the physician's relationship with the MCO has on the physician-patient relationship. While deselected physicians may condemn the market and legal systems as betrayers of their economic security and professional autonomy, patient care must remain the focal point of any inquiry into the health care system.").

81. *Id.* at 528.

> suggests that it may take as many as five years or four to five visits in a single year for a physician to develop the knowledge base to treat optimally and for a patient to trust the physician. There are considerable advantages to building this level of knowledge.... Physicians are more likely to perform additional tests before prescribing when they do not have a sufficient knowledge base on the patient and also are less likely to take a "wait and see" approach in managing care. The physician's sense of responsibility increases more rapidly with close connection to their patient.[82]

By promoting stability in physician-patient relationships, legislatures and courts can thus promote higher-quality and lower-cost health care. Although there are legitimate and unavoidable reasons that physician-patient relationships must be severed, the impact of stable physician-patient relationships on public health is an important public policy reason to promote stability in those relationships when possible. A more vigilant legislative and judicial response to physician deselection abuses would be one such way to promote patient health.

B. Arguments Against Greater Legislative and Judicial Involvement

Two arguments give pause to legislatures and courts considering providing greater protections to physicians facing deselection. The first can be found in the sentiments of Justice Brown's dissent in *Potvin*, which began, "[w]ith its decision today, the majority, in effect, declares that it is the public policy of this state that physicians are entitled to a minimum income."[83] The argument is essentially that protection against deselection simply amounts to income protection for physicians, who by any measure are not generally the most impoverished class in our society. But to characterize concerns over abuses in physician deselection as simply an attempt to ensure adequate income for physicians fails to account for the devastating professional ramifications that a

82. FAIRBROTHER & HAIDERY, *supra* note 80, at 6.

83. Potvin v. Metro. Life Ins. Co., 997 P.2d 1153, 1162 (Cal. 2000) (Brown, J., dissenting).

deselection decision carries,[84] and also the negative impact on the patients of the deselected physician.[85]

The second argument is that providing greater procedural protections to physicians facing deselection from their MCO affiliation will further increase the already steep cost of health insurance. It is certainly true that the increasing cost of health insurance has long outpaced the rate of inflation.[86] Yet the cost impact of providing assistance to physicians facing deselection—specifically procedural protections ensuring notice and a meaningful hearing before the deselection becomes final—remains a matter of speculation. Although the initial cost impact of providing such protections on health insurance premiums may be measurable, it is conceivable that such an impact would be mitigated as MCOs become more familiar with the new procedural requirements, reduce the number of deselections they make for disfavored reasons,[87] and better document their deselection decisions. Further, any increased cost associated with protecting physicians from deselections that violate public policy would be offset to some extent by the lowered treatment costs and higher quality of care that result from a stable physician-patient relationship. Although courts and, to a greater extent, legislatures need to be mindful of the cost effects of their pronouncements, the above factors will likely mitigate any potential increase in the cost of health insurance from protecting physicians facing deselection.

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84. *See supra* Part II.A.1.

85. *See supra* Part II.A.3.

86. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 16 (2005), *available at* http://www.kff.org/insurance/7315/upload/7315.pdf (reporting a 9.2 percent increase in the cost of health insurance for a family of four in 2005, and a 73 percent increase in the cost of health insurance since 2000); National Coalition on Health Care, Health Insurance Cost, http://www.nchc.org/facts/cost.shtml (last visited Oct. 8, 2006).

87. Legislative or judicial requirements for increased procedural protections for physicians facing deselection will likely have the intended effect of forcing MCOs to treat physician deselection decisions with caution and not exercise such power arbitrarily. *See* Allred & Daniel, *supra* note 2, at 354-55 (discussing how MCOs should react to the *Harper* and *Potvin* decisions in order to reduce the likelihood of successful litigation against them from deselected physicians). Allred and Daniel recommend that MCOs rely on with-cause deselections when possible, and that when they must invoke a without-cause provision, they should be prepared to show that the deselection decision does not violate public policy and was made objectively, in good faith, and following a well-documented and consistently applied termination process. *Id.*

III. JUDICIAL RESPONSES TO PHYSICIAN DESELECTION

A. Harper v. Healthsource

In *Harper v. Healthsource New Hampshire, Inc.*,[88] defendant MCO Healthsource New Hampshire moved to terminate plaintiff Dr. Paul Harper after Harper reported concerns that Healthsource was manipulating his treatment records.[89] Harper made multiple requests for copies of documentation relied upon by the credentialing committee in making its determination, but was refused.[90] After two Healthsource internal review panels ruled against him (Harper did not attend the first review in protest of Healthsource's refusal to share its evidence against him), Harper filed suit alleging, among other things, that the termination without cause provision in his contract with the MCO should be void as against public policy.[91] The trial court granted Healthsource's motion to dismiss on all counts.[92]

The Supreme Court of New Hampshire stated that it would "not enforce a contract or contract term that violate[d] public policy," and pointed to the common law covenant of good faith and fair dealing as a vehicle for the application of public policy to private contracts.[93] Noting that "[t]he public has a substantial interest in the relationship between health maintenance organizations and their preferred provider physicians," the court determined that an MCO's deselection decisions "must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy."[94] Although refusing to hold that without-cause termination clauses in physician-MCO contracts

88. 674 A.2d 962 (N.H. 1996).

89. *Id.* at 963.

90. *Id.* at 963-64.

91. *Id.*

92. *Id.* at 963.

93. *Id.* at 965. The court also elaborated that the implied covenant of good faith and fair dealing "excludes a variety of types of conduct characterized as involving 'bad faith' because they violate community standards of decency, fairness or reasonableness." *Id.* at 965-66 (quoting RESTATEMENT (SECOND) OF CONTRACTS § 205 cmt. a (1981)).

94. *Id.* at 966.

were per se violations of public policy,[95] the court stated that "[i]f a physician's relationship [with an MCO] ... is terminated without cause and the physician believes that the decision to terminate was ... made in bad faith or based upon some factor that would render the decision contrary to public policy, then the physician is entitled to review of the decision."[96] Having found that such a right existed, the court ruled that Harper's claim could proceed on the merits.[97]

B. New Jersey Psychological Ass'n

In *New Jersey Psychological Ass'n v. MCC Behavioral Care, Inc.*,[98] the plaintiffs, a state professional organization and several of its members brought suit against the defendant MCO for the termination of the plaintiffs after the MCO deemed them "not managed care compatible."[99] The plaintiffs alleged that the MCO based its termination on the types of treatment regimens plaintiffs were recommending to their patients and then attempted to avoid added scrutiny by labeling the termination as without cause.[100]

The court stated that employees in New Jersey have a common law right to challenge both with- and without-cause terminations that violate public policy.[101] While noting that there was no employer-employee relationship between plaintiffs and MCC, the federal court nonetheless concluded that there was "sufficient suggestion ... under the facts alleged by plaintiffs" that the New Jersey Supreme Court "would countenance such a cause of action in this case."[102] The Court determined that two expressions of public policy precluded granting the defendant's motion to dismiss: (1) state case law that imposed a fair hearing before physician staff privileges with a hospital could be terminated, and (2) a newly

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95. *Id.* ("A terminated physician is entitled to review of the termination decision under this standard, whether the termination was for cause, or without cause. This rule does not eliminate a health maintenance organization's contractual right to terminate its relationship with a physician without cause.").

96. *Id.*

97. *Id.*

98. No. 96-CV-3080, 1997 WL 33446538 (D.N.J. Sept. 17, 1997).

99. *Id.* at *1.

100. *Id.*

101. *Id.* at *3.

102. *Id.*

adopted New Jersey statute requiring greater physician involvement in MCO utilization review decisions and policies.[103]

Following the trial court's decision in *New Jersey Psychological Ass'n*, the parties subsequently settled the suit in 2000.[104] The settlement agreement included an undisclosed financial settlement, as well as a pledge by CIGNA, the successor to MCC Behavioral Associates, to enact a number of procedural protections to psychologists facing deselection.[105]

C. Potvin v. Metropolitan Life Insurance Co.

Decided in 2000, *Potvin v. Metropolitan Life Insurance Co.*[106] is the most recent major court decision on physician deselection. Plaintiff Dr. Felix Potvin was a past president of the Orange County Medical Association and had served for nine years as Chairman of the Obstetrics and Gynecology Department at Mission Regional Hospital in Mission Viejo, Orange County, California.[107] Dr. Potvin entered into an affiliation with MetLife, the defendant MCO, in 1990.[108] Fewer than two years later, MetLife notified Potvin that it was terminating him without cause.[109] After Potvin pressed for an explanation, he was eventually informed that he did not meet MetLife's retention standards due to the history of malpractice claims against him.[110] Although Dr. Potvin had had four malpractice claims brought against him in his career—three dropped without recovery—each had been brought before Potvin's 1990 affiliation

103. *Id.* at **3-4. The only court that has cited the federal court opinion in *New Jersey Psychological Ass'n* is an Ohio appellate court, which held, in *Sammarco v. Anthem Insurance Co.*, that the implied doctrine of good faith and fair dealing does not apply to physician-MCO contracts. 723 N.E.2d 128, 135-36 (Ohio Ct. App. 1998).

104. Alan Nessman & Paul Herndon, *New Jersey Settlement Offers Strong Protections for Psychologists*, MONITOR ON PSYCHOL., Dec. 2000, *available at* http://www.apa.org/monitor/dec00/njlaw.html.

105. *See id.*

106. 997 P.2d 1153 (Cal. 2000).

107. *Id.* at 1155.

108. *Id.*

109. *Id.*

110. *Id.*

with MetLife.[111] MetLife did not respond to Potvin's requests for a hearing.[112]

The Supreme Court of California agreed with Potvin that MetLife's actions implicated California's common law right to fair procedure.[113] The court explained that the right to fair procedure applied to private entities that affect the public interest:

> [C]ertain institutions and enterprises are viewed by the courts as quasi-public in nature: The important products or services which these enterprises provide, their express or implied representations to the public concerning their products or services, their superior bargaining power, legislative recognition of their public aspect, or a combination of these factors, lead courts to impose on these enterprises obligations to the public and the individuals with whom they deal ... apart from and in some cases despite the existence of a contract.[114]

The court pointed out that following the MCO revolution, "patients are less free to choose their own doctors for they must obtain medical services from providers approved by their health plan."[115] Because health care delivery now occurs through a "unique tripartite relationship among an insurance company, its insureds, and the physicians who participate in the preferred provider network," the court concluded that "the relationship between insurers and their preferred provider physicians significantly affects the public interest."[116] The processes by which MCOs deselect physicians thus "must be both substantively rational and procedurally fair."[117]

Despite this logic, the court restricted the reach of its decision in a way that the *Harper* court did not. The *Potvin* court explicitly limited the applicability of the right to fair procedure to situations in which "the insurer possesses power so substantial that the

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111. *Id.* at 1155-56.

112. *Id.* at 1156.

113. *Id.* at 1161.

114. *Id.* at 1159 (quoting Matthew O. Tobriner & Joseph R. Grodin, *The Individual and the Public Service Enterprise in the New Industrial State*, 55 CAL. L. REV. 1247, 1253 (1967)).

115. *Id.*

116. *Id.* at 1160.

117. *Id.* at 1161 (quoting Pinsker v. Pac. Coast Soc'y of Orthodontists, 526 P.2d 253, 260 (Cal. 1974)).

removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest."[118] Thus, while both the *Harper* and *Potvin* courts found clauses in physician-MCO contracts that permitted without-cause terminations to be unenforceable so far as they violated important common law rights, the *Potvin* court restricted its holding to insurers holding large market shares.[119]

IV. WHY HAS THE *HARPER/POTVIN* TREND FAILED TO MATERIALIZE? AN ANALYSIS OF LEGISLATIVE AND MARKET DEVELOPMENT

A. Theories on the Failure of a Harper/Potvin *Trend To Materialize*

Despite predictions that *Harper* and *Potvin* represented a trend that other states would follow,[120] no other state has adopted common law procedural protections for physicians facing deselection in the five years since *Potvin*. Two possible reasons for this failure are (1) state legislatures have acted effectively to provide protections to physicians affiliated with MCOs and thus legal disputes regarding deselection have diminished, or (2) such activity is no longer necessary because market conditions are such that MCOs are unlikely to repeat past abuses of deselection procedures. This Section addresses each of these possibilities in turn.

B. Legislative Protections for Physicians Facing Deselection

The first theory, that state legislatures have already addressed the problem of physician deselection, is not borne out by the following survey of state legislative enactments. Only approximately one dozen states have enacted comprehensive statutory protections for physicians facing deselection.[121] Roughly twenty states have

118. *Id.* at 1160.

119. *See id.* at 1161-62; Harper v. Healthsource N.H., Inc., 674 A.2d 962, 964-66 (N.H. 1996).

120. Allred & Daniel, *supra* note 2, at 354; Roth, *supra* note 25, at 5.

121. *See infra* Figure I.

enacted no statutory protections at all.[122] Thus, while a minority of states have enacted serious statutory protections for physicians facing deselections, the argument that courts need not involve themselves with a matter adequately addressed by state legilatures cannot be sustained.

1. An Overview of State Statutes

As horror stories spread about patient abuses at the hands of MCO cost-cutting regimes,[123] state legislatures responded by passing legislation aimed at protecting physician advocacy and patients' rights.[124] State laws offering protection to physicians facing deselection, however, have come more slowly.[125] Currently, approximately thirty states have statutes offering some level of protection—however minimal—to physicians facing the deselection process.[126] Yet, some of these statutes provide only for a notice period before the termination becomes final.[127] Approximately one dozen states provide comprehensive statutory protection for deselected physicians, including provisions such as a requirement that MCOs inform physicians of the credentialing criteria they use to determine physician retention and deselection; a notice period

122. *See infra* Figure I.

123. *See, e.g.*, Larry Katzenstein, *Beyond the Horror Stories, Good News About Managed Care*, N.Y. TIMES, June 13, 1999, at WH6.

124. Fentiman, *supra* note 19, at 510-11 ("As horror stories circulated of risk-sharing arrangements that lead to denial of medically necessary care, Draconian utilization review, 'gagging' of physicians in their communications with patients, and as many patients began to have more impersonal and transient relationships with their doctors, there was an inevitable backlash against managed care's goals of cost containment and the more active and effective management of patient care.") (footnotes omitted)).

125. For a history of the development of state legislative responses to managed care abuses, see Alice A. Noble & Troyen A. Brennan, *The Stages of Managed Care Regulation: Developing Better Rules*, 24 J. HEALTH POL. POL'Y & L. 1275, 1280-96 (1999). Significant tension exists between state regulation of health insurance and the federal Employee Retirement Income Security Act ("ERISA"), which has a powerful preemptive effect on any matter "relating to" an employee benefits plan. ERISA's preemption provision is codified at 29 U.S.C. § 1144(a) (2000). *See generally* Fentiman, *supra* note 19, at 550-62 (discussing ERISA in detail and concluding that the Supreme Court would likely find that state statutes protecting advocacy are not preempted by ERISA). Despite the obvious importance of ERISA, it is outside the scope of this argument, and this Note will presume that any statutory or common law responses to physician deselection are not preempted by ERISA.

126. *See infra* Figure I.

127. *See infra* Figure I.

before a deselection becomes final, typically ninety days; a requirement that MCOs provide the reasons for the deselection to the physician; a review hearing at which the physician can challenge the deselection; and specific protections for patient advocacy.[128] Figure I below contains a state-by-state breakdown of statutory protections.

128. The information contained in the following paragraph and in Figure I is from the author's own research. Distinctions between "minimal" and "comprehensive" statutory protections are necessarily subjective.

Figure I

State	Statutory Protections	Applicable Statutes
Alabama	No statute	
Alaska	Statute requiring dispute resolution procedure; protecting open communication with and advocacy on behalf of patients	ALASKA STAT. § 21.07.010 (1962).
Arizona	No statute	
Arkansas	No statute	
California	Statutes protecting advocacy and requiring MCOs to provide economic review criteria to physicians	CA. BUS. & PROF. CODE § 510 (West 2003); *id.* § 2056; CAL. HEALTH & SAFETY CODE § 1367.02 (West 2000).
Colorado	Limited statutory protection requiring sixty days written notice before without-cause terminations; no review procedure requirements	COLO. REV. STAT. ANN. § 10-16-705 (2005).
Connecticut	Statutes requiring notice period, appeal procedures, protection for advocacy, and provision of economic criteria to physicians	CONN. GEN. STAT. ANN. § 38a-226c (West 2000); *id.* § 38a-478h (West 2006); *id.* § 38a-479aa (West 2006).
Delaware	Statute requiring notice period and mandating review procedure; protects advocacy	DEL. CODE ANN. tit. 18, § 3339 (1974).
District of Columbia	No statute	
Florida	Limited statutory protection requiring notice period and reason for termination; specifically creates no right of action based on reason provided	FLA. STAT. ANN. § 641.315 (West 2005).

Georgia	No statute	
Hawaii	No statute	
Idaho	Statute requiring notice of breach and a reasonable time to cure it prior to termination for "breach of contract"	IDAHO CODE ANN. § 41-3927 (2003).
Illinois	No statute	
Indiana	No statute	
Iowa	No statute	
Kansas	No statute	
Kentucky	Statute adopting the standards for professional review actions in health care settings set by 42 U.S.C. § 11112	KY. REV. STAT. ANN. § 304.17A-525 (LexisNexis 2001).
Louisiana	Statutory protection for advocacy only	LA. REV. STAT. ANN. § 40:2207 (2001).
Maine	Comprehensive statute requiring notice period, reasons for termination, mandatory review procedures, and protection for advocacy	ME. REV. STAT. ANN. tit. 24-A, § 4303 (1964).
Maryland	Statutory protection for advocacy; requires notice and establishment of review procedures; specifically creates no private right of action based on certain procedures related to participation in provider panels	MD. CODE ANN., INS. § 15-112 (LexisNexis 2005 Supp.).
Massachusetts	Comprehensive statute requiring notice period, reasons for termination, and review procedures	MASS. GEN. LAWS ANN. ch. 176B, § 7 (West 1998).
Michigan	Statute requiring notice and, upon physician's request, written reasons for termination	MICH. COMP. LAWS ANN. § 500.3531 (West 2002).
Minnesota	Statute requiring notice only	MINN. STAT. ANN. § 62D.123 (West 2005).
Mississippi	No statute	

Missouri	Comprehensive statute requiring notice period, reasons for termination, and specific review procedures	MO. ANN. STAT. § 354.609 (West 2001).
Montana	Statute requiring "just cause" for termination	MONT. CODE ANN. § 33-37-104 (2005).
Nebraska	Statute requiring sixty-day notice, but not reasons for termination	NEB. REV. STAT. § 44-7106 (2004).
Nevada	Statute protecting advocacy only	NEV. REV. STAT. ANN. § 616B.5285 (LexisNexis 2000).
New Hampshire	No statute	
New Jersey	Comprehensive statute requiring notice period, physician right to request reasons for termination, and review procedures	N.J. STAT. ANN. § 26:2S-8 (Supp. 2006).
New Mexico	No statute	
New York	Comprehensive statute requiring notice period, reasons for termination, review procedures, and protection for advocacy	N.Y. PUB. HEALTH LAW § 4406-d (Consol. 1997).
North Carolina	No statute	
North Dakota	Statute requiring notice, reasons for termination, six-month period to correct deficient conduct, and review	N.D. CENT. CODE § 26.1-36-41 (2002).
Ohio	Statute providing for reasons for termination, corrective period, and two hearings after which the decision "shall be final"	OHIO REV. CODE ANN. § 1753.09 (West Supp. 2006).
Oklahoma	Statute protecting patient communication and advocacy, providing for notice, and giving physicians right to request reasons for terminations	OKLA. STAT. ANN. tit. 36, § 6907 (West Supp. 2006).
Oregon	Statute protecting advocacy	OR. REV. STAT. ANN.

	and requiring notice and hearings prior to termination	§ 743.803 (West 2003).
Pennsylvania	Statute requiring hearings for quality of care or ethics inquiries; requiring approval of state department of health for terminations	40 PA. CONS. STAT. ANN. § 6324 (West, Westlaw through Act 2005-58).
Rhode Island	No statute	
South Carolina	No statute	
South Dakota	Statutes requiring notice period and protecting patient communication and advocacy	S.D. CODIFIED LAWS § 58-17C-14 (2004).
Tennessee	Statute protecting patient communication and advocacy; creating no private right of action	TENN. CODE ANN. § 56-32-230 (2000).
Texas	Statutes requiring notice period, reasons for termination, and hearing with review panel, which is not binding on MCO; whistleblower and advocacy protection	TEX. INS. CODE ANN. §§ 843.281, 843.306 (Vernon 2005).
Utah	Statute allowing termination with or without cause for the first two years of the contract; requiring notice period and reasons in for-cause terminations; providing for internal review process and mediation thereafter if both parties agree	UTAH CODE ANN. § 31A-22-617.1 (2005).
Vermont	No statute	
Virginia	Statute requiring notice period for termination with cause	VA. CODE ANN. § 38.2-5805 (2002).
Washington	No statute	
West Virginia	No statute	
Wisconsin	No statute	
Wyoming	No statute	

2. The New York Statute as a Model of a Comprehensive Protective Statute

Whereas legislatures in a majority of jurisdictions have not provided comprehensive statutory protection against wrongful deselections, approximately one dozen states have done so. Section 4406-d of the New York Public Health Law is an instructive example of a comprehensive deselection statute. Enacted in 1996, section 4406-d contains provisions addressing all the areas discussed above.[129] It epitomizes comprehensive deselection legislation. The New York law mandates that an MCO "shall not terminate a contract with a [physician] unless the health care plan provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing."[130] The statute requires that physicians be given at least thirty days in which to request a hearing before a review panel appointed by the MCO.[131] The law specifies that the MCO review panel shall be "appointed by the health care plan" and that "[a]t least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review."[132] The panel may consist of more than three persons, so long as one-third or more of the panel consists of members of the same or similar specialty as the physician.[133] In addition to choosing to reinstate or terminate the physician, the review panel may also provisionally reinstate the physician subject to conditions it finds appropriate.[134]

Regarding economic credentialing criteria, the MCO "shall develop and implement policies and procedures to ensure that health care professionals are regularly informed of information maintained by the health care plan to evaluate" physician perfor-

129. *See supra* notes 123-28 and accompanying text.

130. N.Y. PUB. HEALTH LAW § 4406-d(2)(a) (Consol. 1997).

131. *Id.* § 4406-d(2)(b)(ii)-(iii).

132. *Id.* § 4406-d(2)(c). Nothing in the statute requires any of the panel members to be unaffiliated with the MCO. Such an "in house" hearing panel is in line with what this Note proposes *infra* Part V.

133. *Id.*

134. *Id.* § 4406-d(2)(d).

mance.[135] MCOs are to consult with physicians in determining how "professional profiling data" is collected and assessed.[136] Lastly, the statute provides explicit protection for several types of patient advocacy, including advocating on behalf of an insured, filing a complaint against the MCO, and appealing a coverage decision by the MCO.[137] The protections in section 4406-d do not apply in deselections "involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a ... governmental agency that impairs the health care professional's ability to practice."[138]

The New York statute's protections are significant because they are available to physicians both before and during a deselection action. The physician facing deselection has access to both the general criteria used by the MCO to evaluate physician performance and also the reasons for which the insurer seeks to deselect him —information clearly important for a physician to make an effective defense against the proposed termination.[139] Physicians participate in drafting credentialing criteria and deselection reviews, but not to the exclusion of nonphysician MCO appointees.[140] The statute provides balance between the rights of the MCO and the physician during the deselection procedure. For instance, it provides explicit reasons for which MCOs can deselect without review proceedings as well as reasons for which MCOs can never deselect physicians.

Another reason that section 4406-d is a model example for statutory protection for physicians facing deselection is that a New York appellate court, in *Foong v. Empire Blue Cross*, found that the statute creates an implied right of action for physicians to seek enforcement of its terms.[141] That decision means that individual

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135. *Id.* § 4406-d(4). For a discussion of the somewhat controversial practice of "economic credentialing," see *supra* notes 28-31 and accompanying text.

136. N.Y. PUB. HEALTH LAW § 4406-d(4) (Consol. 1997).

137. *Id.* § 4406-d(5).

138. *Id.* § 4406-d(2)(a).

139. In *Harper v. Healthsource N.H., Inc.*, the defendant MCO repeatedly refused to give the plaintiff physician *any* documentation regarding the reasons it sought to deselect him. 674 A.2d 962, 963-64 (N.H. 1996). Not surprisingly, with no access to the evidence, the physician lost both internal MCO hearings. *See id.*

140. *See* N.Y. PUB. HEALTH LAW § 4406-d(2)(c) and (4). For a discussion of the importance of physician participation in deselection review procedures, see *infra* Part V.C.3.

141. 762 N.Y.S.2d 348, 349 (N.Y. App. Div. 2003).

plaintiffs can bring a tort suit to enforce the provisions of the statute, rather than, as in some states, being forced to rely on governmental enforcement. In jurisdictions with statutory protections for physicians facing deselection, courts could provide additional protection to those physicians by allowing them a private cause of action to enforce these statutorily guaranteed rights.

Were legislatures in states that have not yet addressed the issue of physician deselection to adopt legislation along the lines of the New York statute, physicians practicing in the age of managed care would be ensured a range of protections similar to those enjoyed by workers in traditional employer-employee relationships.[142] It would be unrealistic, however, to expect laws protecting physicians from improper deselection to sweep across the country.[143] Due to legislative inertia, courts in jurisdictions where the legislature has not yet spoken must be ready to assess the merits of using the common law to protect physicians, and their patients, from improper uses of deselection.

C. Market Forces Will Continue To Encourage MCOs To Deselect Physicians for Legitimate and Illegitimate Reasons

The second potential argument, that judicial and legislative intervention in MCO deselection procedures is no longer necessary given the intense public scrutiny of past MCO abuses,[144] can be tested by assessing the current dynamics of health insurance markets, especially in jurisdictions where no statutory protections have been enacted.

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142. Indeed, the imposition of detailed procedural requirements into MCO-physician contracts should ideally be handled by legislatures, not the courts. State legislatures have enacted detailed legislative schemes regulating health insurers within their jurisdiction. The task of creating a review process for physicians working within those regulatory schemes logically ought best to be handled by the democratically elected legislatures that fashioned those schemes in the first place. This Note argues that in jurisdictions where the legislature, the institution best suited to handle abuses in MCO-physician contracting, has not acted, it is incumbent upon state courts to do so.

143. *See supra* Figure I (demonstrating that a significant percentage of states have no protections or have incomplete protections). Given this fact, it seems unlikely that the remaining states will follow New York's policy.

144. *See* Fentiman, *supra* note 19, at 510-11 (discussing the abuses of early MCO practices and the resulting "counterattack on managed care").

Consolidation continues in the health insurance sector, boosting insurers' market share. For example, on July 7, 2005, UnitedHealth Group, Inc., the nation's second largest health insurer, announced plans to purchase PacifiCare, a California insurer with nearly 3.2 million health plan members.[145] In September 2005, WellPoint, Inc., the nation's largest health insurer, announced plans to merge with New York's WellChoice, Inc., the last independent, publicly traded Blue Cross/Blue Shield plan surviving in the United States.[146] After the acquisition, WellPoint's national enrollment increased to over thirty-three million members across fourteen states.[147] WellPoint became the nation's largest health insurer in 2004 through its combination with Anthem.[148] One commentator, writing in early October 2005, noted that "[s]ince January, at least a half-dozen health plans have been snapped up by larger rivals, while seven of the ten largest mergers in managed-care history have been struck or completed in the past two years alone."[149] The pace of mergers in the health insurance sector can be accurately described as brisk.

Despite the significance of MCO consolidation occurring on a national scale, the power of health insurers is best measured by their market shares in individual geographic regions.[150] The danger

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145. *See, e.g.*, Joe Duarte, Commentary, *Health-Care Merger May Have Broad Impact*, MARKETWATCH, July 7, 2005, *available at* LEXIS; David Phelps, *Prescription for Growth: Giant Health Insurers Such As UnitedHealth Are Buying up Smaller Ones Across the Country. What Will It Mean for Consumers?*, STAR TRIB. (Minneapolis, Minn.), Oct. 9, 2005, at 1D; Press Release, Merger with PacifiCare Health Systems Inc., http://www.unitedhealthcare.com/newsroom/newsreleases/pacificaremerger.htm (last visited Oct. 8, 2006).

146. Laura B. Benko, *Charting New HMO Territory: The Action Was in the Northeast Last Week, as WellPoint Moved on WellChoice, and HIP-Group Health Merger Announced*, MODERN HEALTHCARE, Oct. 3, 2005, at 6.

147. *Id.*; *see also* Daniel Lee, *WellPoint Profit Soars for Quarter and 2005; '04 Merger's Synergies Boost Income; Purchase of WellChoice Added 4.8 Million Members*, INDIANAPOLIS STAR, Jan. 26, 2006, at 3C; Victoria Colliver, *WellPoint Triples Its Profit; Largest Health Insurer Benefits from 2004 Merger*, S.F. CHRON., Jan. 26, 2006, at C1.

148. Milt Freudenheim, *California Backs Merger of 2 Giant Blue Cross Plans*, N.Y. TIMES, Nov. 10, 2004, at C1.

149. Benko, *supra* note 146.

150. Meg Green, *Big, Better, Best? Even as Some Insurers Gain National Size Through Mergers and Acquisitions, Competition Is Still a Local Battle*, BEST'S REV., Mar. 1, 2004, at 82-83 ("The issue isn't how big a certain company is, but how large its local market share is, said John Fitzgibbon, national industry director for managed care at accounting and tax firm KPMG .... 'You can't make global statements about health care,' Fitzgibbon said. 'It's a market-by-market business.'").

of insurers increasing their market strengths is apparent when one considers that the greater market share the MCO has in a geographic area, the greater the negotiating power that that insurer will have over physicians there. As the Supreme Court of California recognized in *Potvin*, the increasing consolidation of market share by California health insurers gives them an increasing amount of power both over physicians and patients.[151]

As of the early part of this decade, nearly half of urban health insurance markets faced near dominance by a single MCO:

> According to a 2002 study by the [American Medical Association], in 48% of highly concentrated HMO and PPO markets with populations more than 1 million, a single payer had a market share greater than 40%. In 24% of those markets, a single payer had a market share in excess of 50%.[152]

The greater the market share controlled by an MCO, the more unilateral control it will be able to exercise in physician contracting.[153] It follows that, in the absence of legislative or judicial directives, MCOs with such dominant market shares will not voluntarily cede their ability to terminate physicians without significant procedural protections.

This situation should legitimately concern physicians in jurisdictions without statutory deselection protections. In particular, many of the states with no statutory protection for physicians are also the states most dominated by a single insurer. According to various studies, Blue Cross and Blue Shield of Alabama maintains a market share of approximately eighty percent of the Alabama market.[154]

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151. Potvin v. Metro. Life Ins. Co., 997 P.2d 1153, 1160 (Cal. 2000).

152. Green, *supra* note 150, at 83.

153. *See, e.g.*, *id.* ("[I]n Pittsburgh, Highmark Blue Cross Blue Shield owns 61% of the HMO/PPO marketplace. 'Between Highmark and the government, it's pretty close to a single-payer system. There is no such thing as tough negotiations; it's almost like a budgeting process,' ... [said Dave Wilson, chief actuary of the Ventures Group, a consulting firm that deals in health care matters].").

154. DEBORAH CHOLLET ET AL., MAPPING STATE HEALTH INSURANCE MARKETS, 2001: STRUCTURE AND CHANGE 13 (2003), *available at* http://www.statecoverage.net/pdf/mapping2001.pdf (listing Blue Cross's share of the Alabama market at eighty-two percent); Sherri C. Goodman, *Blue Cross Names Pope New CEO*, BIRMINGHAM NEWS, Feb. 27, 2003, Business ("Blue Cross [Blue Shield of Alabama], the seventh largest Blue Cross plan in the country, covers 2.3 million Alabamians or about 75 percent to 80 percent of the private health

One study lists Alabama as second among state health insurance markets in terms of the market share of the largest health insurer, behind only North Dakota.[155] Alabama physicians have no protections via statute or case law against deselections that violate public policy.[156]

As in Alabama, the largest health insurer in Rhode Island is the state Blue Cross Blue Shield plan. Current figures place the market share held by Blue Cross Blue Shield of Rhode Island at between sixty-five and seventy percent.[157] Rhode Island is the fifth most dominated state health insurance market, in terms of the largest single insurer.[158] Like in Alabama, no statutory or case law protections exist for Rhode Island physicians facing deselection.[159]

On the West Coast, the health insurance market in Washington State also illustrates troubling market conditions in a state where physicians are without statutory or judicial protection against arbitrary deselections. The Washington State market is not dominated by a single insurer as completely as are Alabama's and Rhode Island's: Premera, the state's largest health insurer, controls only about thirty percent of the state market.[160] Yet, in the rural, eastern portion of the state, Premera "easily holds about seventy percent of the market."[161] Premera recently undertook a failed two-year bid to convert from a nonprofit to a publicly traded for-profit corporation, which the state insurance commission rejected "on grounds that it could expose policyholders to excessive premium increases, particularly in Premera's stronghold in Eastern Washington."[162] Even before the state denied Premera's bid to become a for-

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insurance market.").

155. CHOLLET ET AL., *supra* note 154, at 13.

156. *See supra* Figure I.

157. CHOLLET ET AL., *supra* note 154, at 13 (65 percent market share); Lynn Arditi, *Push Is On by UnitedHealth for Customers*, PROVIDENCE J., May 23, 2004, at A-1 (70 percent).

158. CHOLLET ET AL., *supra* note 154, at 13.

159. *See supra* Figure I.

160. *See, e.g.*, CHOLLET ET AL., *supra* note 154, at 13 (listing the share of the largest Washington insurer at 31 percent); Kyung M. Song, *State Rejects Premera Plan: For-Profit Request: Insurance Chief Rules After 2-year Battle To Shed Nonprofit Status*, SEATTLE TIMES, July 16, 2004, at B1 (describing Premera as "the state's largest health insurer").

161. Candace Heckman, *Premera Actions Worry Consumers: Insurer's Moves Could Limit Care Options, Groups Claim*, SEATTLE POST-INTELLIGENCER, Mar. 31, 2004, at B1.

162. Song, *supra* note 160.

profit insurer, Premera's contractual relations with physicians had been dangerously unstable in recent years.[163]

The concerns of the *Potvin* court, particularly its concerns with the power that a single MCO with dominant market share could exert over a physician's ability to practice medicine in its market, clearly apply to markets in Alabama, Rhode Island, and Washington State as well. As this brief survey shows, it cannot be contended that health insurance market conditions have become favorable enough for physicians that deselection abuses are no longer a legitimate concern. Because the legislatures in a significant number of states have not acted to protect the interests of their physicians and patients, courts should be prepared to intervene to protect the public interest.

V. PROPOSED GUIDELINES FOR COURTS FACING PHYSICIAN DESELECTION LITIGATION

A. Courts Should Use the Implied Covenant of Good Faith and Fair Dealing To Respond to Deselection Abuses

In states where no statutory protections have been provided for physicians,[164] courts should follow the *Harper* model and hold that, under the implied covenant of good faith and fair dealing, a physician facing deselection who believes that the action is based on improper grounds is entitled to an administrative review. At this review hearing, the physician should have the ability to challenge the termination, whether for cause or without cause, that he believes is being made for an improper reason.

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163. *See* Heckman, *supra* note 161 (noting that the company had recently stopped processing Medicare, Medicaid, and state-subsidized health plan claims, that it was under investigation for defrauding the Medicare program, and that two hospital groups had decided to terminate their contracts with Premera because the company was "unwilling to negotiate for fair reimbursements").

164. Courts in states where adequate statutory protections have already been afforded to physicians can reinforce such protections by holding that these statutes provide a private right of action should MCOs not abide by the statutory requirements. *Foong v. Empire Blue Cross*, 762 N.Y.S.2d 348 (N.Y. App. Div. 2003), provides a good example of a decision that does exactly this. *See supra* notes 141-43 and accompanying text.

While not going so far as to create a per se rule to hold that all without cause terminations violate public policy,[165] such a move would eliminate the ability of insurers to mask improper deselections as being without-cause terminations or terminations for legitimate business reasons. Barring any use of without-cause terminations in the physician deselection area might be problematic in that termination at will is still an important concept in employment law generally.[166] Maintaining this symmetry preserves the analogy of the physician-MCO relationship to a traditional employment relationship—an analogy that on the whole suggests greater procedural protections for physicians facing deselection.[167] To preserve the use of this analogy for future recognition of rights vis-à-vis insurer relations, physicians may not want to seek out rights that further distinguish their position from that of workers in employment relationships.

By using the doctrine of good faith and fair dealing, MCOs' good-faith business decisions would be protected from judicial second-guessing. There are, of course, valid reasons for which an MCO can deselect a physician from its provider network.[168] Judicial intervention in this area should strive to create as minimal an impact as possible on MCOs' ability to respond to changing business conditions and patient needs. The implied covenant of good faith and fair dealing allows courts to take such considerations into account on a case-by-case basis.

The implied covenant of good faith and fair dealing, therefore, should be the preferred method for courts to monitor physician deselections in which physicians have not had a fair review process at which to contest the termination. While attractive for its guarantee that termination procedures "must be both substantively rational and procedurally fair,"[169] the common law right to fair procedure, relied on by the *Potvin* court, is unique to California and

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165. Note that like the *Harper* court, the *Potvin* court also appears to have rejected such a per se rule. *See supra* notes 113-19 and accompanying text.

166. *See supra* note 55 and accompanying text.

167. *See supra* Part II.A.2.

168. *See supra* notes 20-25 and accompanying text.

169. Potvin v. Metro. Life Ins. Co., 997 P.2d 1153, 1161 (Cal. 2000) (internal quotation marks omitted).

thus cannot be easily imported into other jurisdictions.[170] Conversely, because the implied covenant of good faith and fair dealing is a fundamental principle of contract law,[171] the *Harper* model can be readily adopted by state courts.[172]

The use of the well-established good faith and fair dealing covenant would prevent the risk of judicial overreaching into the legislative sphere while at the same time allowing courts to set some basic principles that the good faith requirement imposes on provider-MCO contracts.[173]

The implied covenant of good faith and fair dealing opens the door for courts to consider the enactments of legislative bodies and physician groups such as the AMA as indicative of relevant public policy standards. The positions of groups representing health insurers ought to be consulted as well to ensure balance in making determinations of the prevailing procedural standards employed in our health care delivery system.

B. Courts Should Provide Procedural, Not Substantive, Protections to Physicians Facing Deselection

A focus on ensuring procedural fairness, rather than on compiling favored and disfavored bases for deselection, would prove a more adaptive response to a continually evolving health insurance environment.[174] Ensuring procedural protections would also provide

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170. Roth, *supra* note 25, at 5.

171. *See* RESTATEMENT (SECOND) OF TORTS § 205 (1981).

172. Given that *Harper* used the implied covenant of good faith and fair dealing to require the *procedural* protections for physicians facing deselection, the functional distinction between the right to fair procedure and the implied covenant of good faith and fair dealing does not appear to be significant. *See* Harper v. Healthsource N.H., Inc., 674 A.2d 962 (N.H. 1996).

173. The *Harper* court described these requirements as: "Good faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party; it excludes a variety of types of conduct characterized as involving 'bad faith' because they violate community standards of decency, fairness or reasonableness." *Id.* at 965-66 (quoting RESTATEMENT (SECOND) OF CONTRACTS § 205, cmt. a. (1981)).

174. The radical changes in the American health care delivery system since the advent of the managed care revolution illustrate the importance of not propounding substantive rules of law that are too heavily tied into the context of our current health care delivery system. It would be extremely difficult to hazard a guess at how Americans will pay for and receive their health care twenty-five or fifty years from now, other than to assume that it will not be the

an elegant and simple solution, again avoiding the potential for judges to invade the legislative sphere. In *Harper*, the only feature of good faith and fair dealing that the New Hampshire Supreme Court identified was the requirement of an administrative review, whether the termination was with cause or without cause.[175] This Note suggests that in applying the doctrine of good faith and fair dealing in provider-MCO contracts, courts could examine the broad features of statutory protections in other jurisdictions, as representative of public policy, and extrapolate some basic features. The most obvious of these are: a requirement of notice and a reasonable period of time before the termination becomes effective; some ability for physicians to examine the evidence against them; the ability for physicians to receive administrative hearings if they believe the contract was terminated for reasons that violate public policy; the ability of physicians to have attorneys or other representatives present for the review; the participation of unbiased doctors in the administrative review if the termination is based on the physician's medical decisions; and the ability of providers to seek redress in the courts should these standards not be met.[176] Holding MCOs to these broad requirements in contracting with providers should provide physicians with procedural protection from deselection on illegitimate grounds in the absence of legislative action.

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same way they do today.

175. *Harper*, 674 A.2d at 966.

176. While this Note does not argue forcefully that each and every one of the components described in this paragraph must be present for physician-MCO deselection disputes to comport with the implied duty of good faith and fair dealing, the absence of any one of these provisions could lead to significant abuse that transforms "good faith and fair dealing" into an illusion. *See infra* Part V.C.

Admittedly, none of these components could be classified as novel. Some have been discussed previously in the literature. *See, e.g.*, Brown & Jagla, *supra* note 1. That current proposals have followed this direction makes sense, given the strong connection between the contractual doctrine of good faith and fair dealing, traditional employment law, the shape and direction of current statutory enactments, and indeed the holdings of cases like *Harper* and *Potvin* themselves. Nonetheless, a detailed explanation of how and why these components are needed is of great utility to physicians and their proponents, especially when coupled with the demonstration that such protections are clearly needed across the country. *See supra* Parts IV.B.1 and IV.C.

C. Specific Procedural Components Courts Should Require Under Good Faith and Fair Dealing

1. Notice and a Reasonable Period of Time Prior to Termination Becoming Effective

Relevant statutes almost universally recognize the need for some sort of period under which the physician can assess her situation and decide whether to appeal the deselection.[177] Examples of such notice periods range from forty-five days[178] to sixty days[179] to ninety days.[180] Under a highly restrictive reading of *Harper*, an MCO could write into its provider contracts a provision that a physician may request an administrative review after receiving notice of intent to deselect, but then only give the physician ten days, for example, to request a hearing. Such a situation would effectively undercut any rights a physician would have to an administrative review if he would need to determine whether to contest the deselection, potentially locate an attorney or other representative, inspect any evidence against him, and prepare a defense, all in a span of a week-and-a-half. While not enunciated in *Harper*, the right to a reasonable notice period in which a physician can challenge notice of intent to deselect should be viewed as an integral part of the implied covenant of good faith and fair dealing; courts will likely view an administrative review structured so as to impair physicians' rights to participate fully in that hearing as violating both good faith and fair dealing.

2. Some Ability for the Physician To Inspect the Insurer's Evidence

In *Harper*, one of the most noticeable barriers to the plaintiff's ability to contest his deselection from Healthsource New Hampshire was the MCO's refusal to provide Dr. Harper with any documentation or evidence upon which it based its determination that he had

177. *See supra* Part IV.B.1.
178. MASS. GEN. LAWS ANN. ch. 176B, § 7 (West Supp. 2006).
179. *E.g.*, DEL. CODE ANN. tit. 18, § 3339(b) (1999).
180. N.J. STAT. ANN. § 26:2S-8(b) (West 2006).

not met its recredentialing criteria.[181] Clearly, "an appeals process serves no purpose, if the law denies the appellant access to the evidence necessary for discovering the true reason behind the termination."[182] Again, although the court in *Harper* did not explicitly require MCOs to provide physicians facing deselection with some level of access to the insurer's evidence as a part of the administrative review,[183] the facts of the case illustrate how any chance at meaningful process will be undercut if the insurer can withhold any and all evidence from the physician.

3. A Hearing at Which the Physician Can Be Represented and Present a Defense

For an administrative review to truly satisfy the implied covenant of good faith and fair dealing, the hearing must give the physician a fair opportunity to make her case against the deselection decision. To best make certain that such hearings are not merely rubber-stamp proceedings for the decisions of MCO management, the physician should be afforded the presence of an attorney or other representative who can lend experience and personal knowledge of such proceedings to ensure a fair playing field. This is perhaps even more important given that, by definition, such administrative review proceedings will occur within the institutional framework of the MCO rather than in a wholly separate tribunal.[184] Further, physicians are famously adverse to the legal and political spheres, thus further evincing the need for physicians to have the ability to be represented at administrative reviews.

If the decision involves questions of patient care, at least one independent physician should take part in the administrative review in order to ensure that the review panel is fully informed of

181. *See* Harper v. Healthsource N.H., Inc., 674 A.2d 962, 963 (N.H. 1996).

182. Liner, *supra* note 3, at 525.

183. In fact, Harper brought a separate statutory claim for damages due to Healthsource's failure to share the records it used in making the determination to terminate him from its network. The court dismissed this claim without prejudice as it was not raised at the trial court level. *Harper*, 674 A.2d at 967-68.

184. The protection of having an experienced representative present should not remove the obligation of insurers to establish a fair, if not wholly independent, panel of decision makers to determine the merits of the physician cases. Such panels should include at least one independent medical doctor if the deselection is based on the physician's medical judgment.

relevant medical information and the standard of care surrounding the treatment in question. The involvement of an independent physician, as opposed to a review panel comprised entirely of persons with insurance or management backgrounds, will help protect the interest of patients in receiving the most appropriate medical care. For instance, physician involvement in administrative reviews would ensure that variables such as the general health of the deselected physician's patient base are taken into account. Further, physician involvement on review panels will also help ensure that MCO officials do not overstep their bounds in "requiring" physicians to perform particular lower cost treatments in response to certain health conditions. The additional knowledge base that would accompany physician involvement would help panels recognize situations in which two or more medically appropriate treatments exist for a given medical condition and that in such cases physicians should be able to pursue their best medical judgment.

CONCLUSION

Though the apparent trend that commentators initially hoped for following the decisions in *Harper v. Healthsource New Hampshire* and *Potvin v. Metropolitan Life Insurance Co.* has not yet materialized, there is still an important need for courts in other jurisdictions to enact procedural protections for physicians facing deselection. Inertia in state legislatures, combined with a tightening health insurance market with significant merger and acquisition activity among MCOs, continues to create a difficult situation for physicians facing deselection. MCOs have the right to make legitimate business decisions to maintain a provider panel that meets the current needs of their insured. Yet, courts should ensure that physicians have the procedural protection necessary to challenge deselection decisions made without cause or for ostensibly financial reasons, if they believe unstated reasons that violate public policy played a role. Following the lead of *Harper*, courts can use the implied covenant of good faith and fair dealing to provide protection to physicians facing deselection while avoiding intrusion into medical or business decisions. Such decisions will ensure that MCOs respect the

important public interest entrusted to them in fostering the bond between physician and patient.

Stephen D. Coppolo[*]

* J.D. Candidate 2007, William and Mary School of Law; B.A. 2001, *summa cum laude*, Colgate University. Heartfelt thanks for years of support and encouragement go to my parents, Bernard and Stella, my brothers, Matthew and Andrew, and my fiancée, Dianna. Without all of you, I would not have reached the point of having a piece of legal scholarship published within these pages.