Regulating Managed Care Plans Under Current Law: A Radical Reversion to Established Doctrine

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INTRODUCTION

One popular response to the problem of increasing health care costs has been the introduction of programs of managed care. Self-insured employers and both private and governmental third-party payors frequently establish managed care programs for the purpose of monitoring the provision of health care services to covered individuals and, more specifically, intervening in and forestalling the provision of inefficient or unnecessary services. As these programs become more common, and some of their shortcomings become apparent, there is a growing recognition that the aggressive management of care might sometimes result in the denial of medically indicated care to individuals whose health care coverage involves a managed care program. While there are both regulatory and common law developments responding to this concern, to date there has been no attempt at comprehensive regulation of managed care programs. It is the thesis of this Article that there are, however, a number of established legal doctrines that could be, but by and large are not, used to ensure effectively that managed care programs do not hamper an individual’s access to necessary health services. In particular, this Article will explore the potential for regulating managed care programs by enforcement of the following doctrines: the prohibition against the corporate practice of medicine; the requirement that only licensed persons practice medicine; the prohibition against engaging in fee splitting; and the laws regulating the business of insurance. It will also explore the ways in which these doctrines can inform the development of new regulation of managed care plans.

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Until recently, plans offering access to pre-paid health care services were predominantly referred to and structured as health maintenance organizations ("HMOs"). As the name suggests, HMOs were initially intended to focus on the "maintenance" of the health of their individual subscribers. Through the prevention of morbidity, coupled with a system of incentives designed to reduce both consumer and provider demand for health care services, organizers hoped that HMOs could reduce the health care costs of their subscribers.

These same plans are now more generically referred to as "managed care plans" ("MCPs"). Part of the reason for the change in nomenclature is undoubtedly the emergence of a plethora of alternative mechanisms for the provision of prepaid services. The change in terminology is also an explicit recognition that the industry's primary means for achieving cost savings is not the maintenance of health through prevention, but, rather, the management of care.

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1. For example, the purposes of one early HMO, Sound Health Association, were described in its Bylaws as follows:

   The purpose of Sound Health Association is to promote the maintenance of optimal personal health by making available to the residents of the community comprehensive personal health care services and resources aimed at preventing and curing specific diseases, reducing debilitation and discomfort, and improving individual health behavior, in a manner . . . which reduces the impact of cost as a barrier to securing needed resources and services . . . . This Association shall place special emphasis on preventative medicine and health education programs . . . .

   Sound Health Ass'n v. Commissioner, 71 T.C. 158, 162 (1978).


3. HMOs are probably the most well known of the MCPs. However, there are a number of new entrants into the MCP market. Independent Practice Associations ("IPAs"), Preferred Provider Organizations ("PPOs") and Exclusive Provider Organizations ("EPOs") are just some examples of the mechanisms through which pre-paid health care services are now offered. See Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982) (involving and describing a PPO). Generally, members of these organizations receive services from a select group of providers who have entered into a variety of discounting and other cost-saving agreements (most notably, for purposes of this discussion, agreements relating to the management of care) with the payor. See Mark Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. Pa. L. Rev. 431, 437 n.18 (1988) (providing an extensive list of some of these mechanisms).

   While some indemnity plans use managed care programs, such plans are predominantly a feature of pre-paid plans that provide a service, rather than reimbursement, as their primary benefit; accordingly, this Article will focus on managed care in the context of the latter type of plan, although much of the criticism and analysis is equally applicable to a traditional indemnity plan.

4. Because MCPs typically provide services on a pre-paid basis, the amount of premium revenue that MCPs receive from subscribers will remain the same regardless of the volume of health care services consumed by the subscribers. Accordingly, MCPs must subsidize any excess in expenses for health care services over premium revenue. Conversely,
Throughout the industry, the predominant focus appears to be on controlling the services that are provided, rather than on providing preventative services.\(^5\)

This focus is at odds with the idealized vision of the MCP as an entity that will be compelled by the principles of economics, if not ethics, to ration care in a way that will prevent the occurrence of major (and expensive) morbidity. One commentator explained the economic incentives as follows:

\[\text{[B]ecause they must provide comprehensive care from an inelastic pool of resources, HMOs are well motivated to scrutinize the effectiveness of every risk-reducing measure they might take. Moreover, because their responsibility for care is comprehensive and because their organization usually allows them to provide more integrated services than most other providers, HMOs are well situated to compare each possible risk reduction with other uses of the available resources and to choose the most productive course of action.}\(^6\)

An MCP could be expected to view “health maintenance” (rather than service limitation) as the most productive course of action only if the MCP favors long-term over short-term profitability and anticipates that today’s enrollees will also be tomorrow’s enrollees. In a highly competitive market,\(^7\) where MCPs compete on price and routinely lose and acquire large groups of enrollees (as employers and physicians shift from plan to plan),\(^8\) goals are likely to be more short-term. The MCP will focus on reducing current costs, rather than on maximizing its enrollees’ long-term health.\(^9\) Even if an MCP believes that the maintenance of health will ultimately result in profit-

\(^5\) See infra text accompanying notes 6-14 and 30-39.


\(^7\) See Citizens League, Minn. HMO Rev. 1989, 3 (1990) (observing that the market was so competitive in Minnesota in 1987 that two HMOs became insolvent and three HMOs posted large losses).

\(^8\) See Barry D. Weiss & Janet H. Senf, Patient Satisfaction Survey Instrument for Use in Health Maintenance Organizations, 28 MED. CARE 434, 439 (1990) (observing that one study found 23% of the enrollees who left their MCP (“enrolled”) did so because they desired services from a physician who worked with another plan).

\(^9\) See FRECH & GINSBURG, supra note 2, at 48; Clark C. Havighurst & James F. Blumstein, Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs, 70 NW. U. L. REV. 6, 36 (1975).
ability, the ability to realize the goal of preventing costly illness is dependent upon the capacity of the MCP to identify those persons who are at risk for particular illnesses and to develop appropriate and efficacious responses. It is doubtful that most MCPs possess such a sophisticated ability. The economic pressures on MCPs to maximize short-term gain, coupled with the limitations on their capability to avoid illness, seems likely to result in policies that favor minimizing care, rather than preventing morbidity.

Even if the MCP is assumed both to have adopted the long-term view and to have the capacity to respond effectively to the risk of illness, the long-term maximization of the health of the enrollee population might not be in the economic best interests of the MCP. Whenever the cost of providing an additional unit of service to an enrollee outweighs the anticipated cost of the services that are avoided by its provision, the MCP has an economic incentive to withhold that unit of service. For example, an MCP might be expected to withhold an expensive test that identifies only a few treatable cases. While a judgment based on this principle unquestionably serves the interests of efficiency, an ethical analysis that is concerned with the welfare of individuals requires a weighing of the costs and benefits to the patient’s condition of providing a particular service, rather than the costs and benefits to the payor of providing the service.

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10. FRECH & GINSBURG, supra note 2, at 48.
11. Bovbjerg, supra note 6, at 1390.

Thus, there might be universal agreement that a certain test improves the accuracy of diagnosis from ninety to ninety-five percent in some moderately serious and generally treatable condition; a fee-for-service doctor would almost certainly perform such a test if it were readily available and covered by insurance, since no obvious benefit for his patient or himself could be achieved by foregoing the potential insurance payment. On the other hand, an HMO might decide that its subscribers’ resources were better spent, for example, on upgrading the staff of its emergency room than on the test.

Id. Compare Helling v. Carey, 519 P.2d 981, 982-83 (Wash. 1974) (holding a physician liable for negligence when he failed to administer a glaucoma test to a patient under forty, despite the extremely low incidence of glaucoma in that population) with David M. Eddy et al., The Value of Screening for Glaucoma With Tonometry, 28 SURVEY OF OPHTHALMOLOGY 194 (1983) (implying that the cost of performing the glaucoma test is not justified, as the test will identify very few cases of glaucoma and since nothing can be done to alter significantly the outcome even in those cases where glaucoma is found to exist).

Similarly, in cases where the adverse result that could be avoided by the additional unit of service is expected to be incurred at some point other than in the immediate future, one might expect the MCP to discount to present value the cost of the care that might be required in the future.

These incentives for short-term cost containment might explain why MCPs are increasingly concerned with the management of care, and why the management of care focuses on controlling access to services (which is the most direct and current way of avoiding costs). This focus is evident in the contracts entered into between the MCPs and the providers who perform services on behalf of the MCPs. These agreements typically incorporate provisions requiring the provider to comply with the plan’s pre-admission utilization review, referral, and case management policies and protocols. While these policies and protocols are designed to serve a variety of functions, they all operate to restrict or control the services that are provided.

One of the features that has distinguished MCPs from other systems of health care delivery is the provision of financial and other incentives for providers to utilize health care services efficiently. Indeed, as the foregoing discussion illustrates, much of the traditional support for MCPs stems largely from the belief that the financial structure of MCPs, as distinct from fee-for-service medicine, will rationalize the provision of medical care by eliminating financial incentives to over-utilize health care services. One commentator explained that MCPs “do not have mixed motives in imposing utilization control . . . . The key . . . may be imposing incentives on physicians . . . . Physicians who are good at control may obtain rewards, and those who are bad may be punished . . . .”

Providers have responded to these incentives by, among other things, attempting to reduce access to health care services. There is no novelty in the observation that these incentives may operate in opposition to the physician’s obligation to put his or her patients’ interests first. There is an inevitable tension between the provider’s desire to contain costs and the patient’s interest in receiving the best available (and all necessary) care. This is not to say that the tension must inevitably result in a conflict. There are situations in which patients’ best interests can be served efficiently. “The crucial ques-

13. See supra note 3.
14. See infra notes 61-80 and accompanying text.
16. See Bovbjerg, supra note 6, at 1376.
18. For example, where a costly diagnostic test has been replaced by a test that is both as accurate and less expensive, or where a painful and expensive procedure would not
tion is not whether financial incentives affect physicians' decisions, but whether some financial incentives distort physicians' judgment. . . . Do some HMO incentives influence doctors to conserve medical resources to excess—to the point where some patients do not receive the medical services they need?" The problem arises where the incentives to contain costs are so strong that conflict seems inevitable.

Because professional ethics and the specter of malpractice claims provide a strong incentive for physicians to provide necessary medical services, if incentives to economize are kept in check, physicians could be expected to make decisions which take into account, first and foremost, the particular patient's interests, rather than the interests of the provider or payor. Preservation of the physician's professional integrity and independence might be an effective way to temper the MCP's drive to conserve costs, but there has been remarkably little regulation directed at achieving this balance.

The concern that a physician's judgment might be influenced by economic incentives is most often voiced in the law in connection with the fear that some financial arrangements might create incentives for over-utilization of medical services. There is, however, a growing recognition that certain types of financial incentives might also result in under-utilization. The acknowledgment that efforts at cost containment might have resulted in a sacrifice in the quality of health care has resulted in a regulatory focus not only on cutting health care costs through containing utilization, but also on assuring that quality

enhance the patient's condition.

19. Alan L. Hillman, Health Maintenance Organizations, Financial Incentives, and Physicians' Judgments, 112 ANNALS INTERNAL MED. 891; see also Hall, supra note 3, at 444 n.44.


21. This Article does not seek to address the related and much debated question of whether the current system of malpractice liability creates inappropriate incentives to over-utilize services such as diagnostic tests. See generally Bovbjerg, supra note 6, and sources cited therein (discussing the incentives created by current malpractice law).

22. See, e.g., 42 U.S.C.S. § 1395nn (Supp. 1991) (barring Medicare or Medicaid referrals to laboratories in which the referor has a financial interest); id. § 1320a-7b(b) (1988) (barring the payment of remuneration for referral of Medicare or Medicaid patients).

23. See Id. § 1320a-7a(b) (1988) (prohibiting HMOs from offering incentives to under-utilize services and barring hospitals from offering inducements to limit or reduce services to Medicare or Medicaid programs). But cf. Pub. L. 99-509 § 9313(c)(2), 100 Stat. 1874, 2003 (codified at 42 U.S.C.A. § 1320a-7a note (West 1991)); 42 U.S.C. § 1320a-7a(c)(3) (1988) (imposing civil money penalties for giving false or misleading information that could influence a decision as to when to discharge a Medicare or Medicaid patient).
care is provided.\textsuperscript{24}

These attempts to ensure that cost containment is not realized at the expense of quality care are commendable. However, there are several long-standing bodies of law that could be utilized to achieve the same result. These include the prohibition against the corporate practice of medicine,\textsuperscript{25} the requirement that only licensed persons practice medicine,\textsuperscript{26} the prohibition against engaging in fee splitting,\textsuperscript{27} and laws regulating the business of insurance.\textsuperscript{28} The failure to apply these bodies of law to MCPs is a result of the historical support and legislative encouragement enjoyed by MCPs.\textsuperscript{29} This support grows primarily out of the perception that MCPs are effective vehicles for cost containment. As this Article will demonstrate, conduct that is fundamentally the same as that which is severely penalized in other contexts—the involvement of unlicensed persons in the provision of medical services, agreements to pay for referrals, and the assumption of significant risk by parties who are not licensed to engage in the business of insurance—is tolerated in the context of MCPs. If the established legal principles noted above were applied to MCPs, MCPs might be encouraged to operate in such a way as to alter the balance of interests in favor of quality care. At the same time, application of these principles should not preclude MCPs from using incentives to contain costs.

I. AN OVERVIEW OF INCENTIVES FOR COST CONTAINMENT

In order to understand how these legal principles are offended, it is first necessary to understand the methods used by MCPs to encourage cost containment. Perhaps the most common method of cost containment is the provision of financial incentives to the gate-keeper, most often the primary care physician, to limit his or her patients' access to health care services. The terms of a patient's coverage often

\begin{footnotes}
\footnote{24. See \textit{supra} note 23 and \textit{infra} notes 106-09 and accompanying text.}
\footnote{25. See \textit{infra} notes 45-82 and accompanying text.}
\footnote{26. See \textit{id.}}
\footnote{27. See \textit{infra} notes 120-37 and accompanying text.}
\footnote{28. See \textit{infra} notes 138-75 and accompanying text.}
\footnote{29. An example of the preferential treatment afforded HMOs is the fact that the federal HMO statute exempts HMOs from the operation of some state insurance laws. See, e.g., 42 U.S.C. § 300e-10(a)(1)(D) (1988). The HMO Act also requires that certain employers offer the option of obtaining HMO coverage to their employees. \textit{Id.} § 300e-9(a)(1). There is no similar requirement imposed on employers with regard to insurance or other types of health care coverage.}
\end{footnotes}
require that the patient obtain a referral from her primary care physician in order to gain access to other health services, be they tests, pharmaceuticals, in-patient care or specialty medical services. Even in the absence of such a requirement, the primary care physician, as the physician of first resort, and the physician from whom referrals for additional treatment or evaluation are typically made, is in a unique position to control access to care. If the primary care physician does not recommend products or services (e.g., a consultation with a specialist), the patient will receive these services only if she pursues them on her own; it seems likely that most patients would not.

The MCPs have developed a variety of mechanisms to persuade contracting physicians to restrict access to health care services. One of the most common mechanisms is the capitation system.\(^\text{30}\) Under this system, a medical clinic is paid a pre-agreed amount every month (the capitation payment) for each patient who has elected to use it as his or her provider of primary care. The capitation payments do not vary regardless of the value or cost of services that the patient requests.\(^\text{31}\) If the clinic has struck a poor bargain—for instance, if its pool of assigned patients includes an inordinate number of bad risks or if it manages utilization ineffectively—it will lose money in connection with the services that it has contracted to provide.

A portion of the capitation may be retained by the MCP to cover the cost of patient services provided by third parties. These services are often available only pursuant to the authorization or referral of the primary care physician. If, at the end of a specified period (generally a year), the cost of those services is less than the amount retained, all, or a portion, of the retained funds may be paid to the physician. Some plans go further and provide that if the costs are in excess of the retained amount, the provider may be compelled to pay part or all of the excess to the MCP. This type of arrangement makes the financial consequences of authorizing services very clear to the provider.

Typically, the physician stands to lose much more from authorizing outside services than he or she will lose from performing his or her own services. This is due primarily to the high cost of in-patient and specialty care relative to primary care. Other factors, such as the

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30. A 1987 survey found that 46% of the responding HMOs utilized capitation as a method of payment. Hillman, supra note 17, at 1745.

31. For a further discussion of some of the financial mechanisms used by MCPs, see Hillman, supra note 17; see also FRECH & GINSBURG, supra note 2, at 47.
ability to regulate in-house costs and the inability to contract effectively with specialty providers,\textsuperscript{32} might also affect the relative costs. The physician can decide to run his or her own practice more efficiently, but the only sure-fire way that he or she can control costs generated by third parties is to deny access.\textsuperscript{33} Another common arrangement utilizes a combination of a discounted fee-for-service schedule and a reserve. The provider is paid a fee for each service that he or she provides. This fee represents a discount from the provider’s customary charges. A percentage of each fee is retained as a reserve by the MCP, to be distributed to the provider only in the event that the reserve is not needed by the MCP to pay for subscriber services and other health plan costs. Distribution of the reserve is often made contingent on the physician’s per-patient costs comparing favorably to the average per-patient cost for the physician’s specialty.\textsuperscript{34}

MCPs might seek to control utilization by levying a financial penalty against a provider whose practice deviates from the norm. For example, the percentage of fees withheld might be more for “high” utilizers than it is for “low” utilizers. Providers whose utilization deviates from the norm significantly might even be excluded from participation in the MCP.\textsuperscript{35} Exclusion might mean the loss of all, or

\textsuperscript{32} Some larger primary care groups do enter into contracts with specialists, pursuant to which the specialists agree to provide services to MCP patients of the primary care group at a reduced rate; many small groups, however, cannot generate sufficient referrals to convince a specialty group to enter into a discounting relationship. This latter problem can be negated if the MCP, rather than the individual primary care providers, is able to enter into agreements with the specialty groups.

\textsuperscript{33} See Rev. Rul. 68-27, 1 C.B. 315 (explaining that a prepaid plan that involved the provision of services through plan-owned facilities and plan-employed staff was not insurance because an insurance contract must involve the element of shifting or assuming the risk of loss of the insured and must, therefore, be a contract under which the insurer is liable for a loss suffered by its insured. With respect to the preventive phase of the medical service contract . . . there is no hazard or peril insured against. With respect to the sick or disabled phase of the contract, although an element of risk exists, it is predominantly a normal business risk of an organization engaged in furnishing medical services on a fixed price basis, rather than an insurance risk. As a result of illness or disablement, the contracting organization generally does not incur any expense other than that which it incurs in providing the medical services through a salaried staff of physicians, nurses and technicians (emphasis added)).

\textsuperscript{34} See generally Hall, supra note 3, at 483-87; see also Hillman, supra note 17.

\textsuperscript{35} This mechanism raises questions of unlawful discrimination. If the norm is calculated without reference to the demographics of the physician’s patient base, a physician with sicker patients will be penalized, not because of utilization, but because of the make-up of his or
substantially all, of a physician's practice.

The MCP might also impose overt controls on a patient's access to health care services. Physicians might be required to seek prior authorization for certain referrals and in-patient services. The physician's contract with the MCP might put the physician financially at risk for the cost of services performed without the requisite consent, or might impose some other penalty on the physician, regardless of whether the services are ultimately proven to be medically necessary. Similarly, the MCP might require compliance with its care protocols, which might dictate, for example, permissible length-of-stay guidelines. One typical contract requires that the physician "comply with all ... protocols ... relating to the provision of the services ... including protocols related to hospital admissions and length-of-stays, referrals to physicians and other providers of health care ...."  

The MCP might control access in a more direct fashion. One program recently adopted by a large MCP requires that certain costly tests and procedures be pre-approved by the MCP. If a test or procedure is ordered by a physician, the MCP will contact the patient directly to ask a number of questions regarding his or her symptoms. On the basis of the data collected from the patient, along with data solicited from the physician, the MCP determines whether or not the care is medically indicated.  

MCPs undoubtedly have a legitimate interest in making determinations as to whether particular services and items are medically necessary and, therefore, covered under the MCP's contract with the

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36. See, e.g., Physicians Health Plan of Minnesota, 1983 Physician Participation Agreement. A brochure advertising a conference organized by a large organization representing managed care providers noted that "[t]he use of clinical practice guidelines has moved well beyond that of a 'passive aid' to practitioners. Today they are an integral part of clinical quality management efforts." Group Health Association of America, From Paradigm to Practice: Quality Management in the Clinical Environment (conference brochure). This statement illustrates the industry's acknowledgement of the impact that practice protocols are intended to have on practice decisions. It also requires that we acknowledge that practice protocols might, in many instances, be directed not only towards cost containment, but also towards enhancing the quality of care received by MCP beneficiaries.  
38. Blue Cross/Blue Shield of Minnesota, Value Health Services Program.  
39. Id.
subscriber. However, the controls used by MCPs are directed more often towards restricting access to care than towards denying payment after the care has been provided. This is, at least in part, because restriction of access is less likely to cause subscriber dissatisfaction than is denial of payment. The subscriber can be expected to be only vaguely aware, if at all, that care that his or her physician has suggested, or would have otherwise suggested, is being withheld, while she is likely to be acutely aware if payment is being denied; the provider would conventionally look to the subscriber for payment for such services. It is politically expedient for the MCP to obscure the gap between its perception of medical necessity and the physician’s perception of medical necessity.

II. INVOLVEMENT IN THE PRACTICE OF MEDICINE

There are two legal doctrines that have been used to preclude non-physicians from practicing medicine: the prohibition against the corporate practice of medicine; and the requirement that only licensed physicians engage in the practice of medicine. While these doctrines have been widely criticized as operating primarily to exclude competitors of physicians, they undoubtedly serve some legitimate objectives. Foremost among these is the protection of the public from the ministrations of unqualified people. The corporate practice doctrine also seeks to protect the autonomy of the physician to exercise his independent professional judgment, thereby seeking to assure patients the best that the physician can offer.

A. Overview of the Prohibition Against the Corporate Practice of Medicine and State Licensing Statutes

Although the corporate practice doctrine and the licensing statutes are concerned with similar problems, they are implicated by different conduct. The corporate practice doctrine holds that no layperson may interfere with the physician-patient relationship through a relationship that carries with it the possibility of control over, or

40. See infra notes 45-53 and accompanying text.
41. See infra notes 54-80 and accompanying text. For ease of reference, hereinafter all non-physicians shall be referred to as “laypersons.”
42. See, e.g., Hall, supra note 3, at 510-11.
43. See infra notes 54-60 and accompanying text.
44. See infra notes 56-79 and accompanying text.
influence of, the physician by the layperson.\textsuperscript{45} A non-physician may not hire a physician to perform diagnostic tests on third parties because “the law intends . . . that the patient shall be the patient of the licensed physician[,] not of a corporation or layman. The obligations and duties of the physician demand no less. There is no place for a middleman.”\textsuperscript{46} A corporation engaged in the practice of medicine may not allow non-professionals on its board of directors because:

[w]ithout licensed, professional doctors on Boards of Directors, who and what criteria govern the selection of medical and paramedical staff members? To whom does the doctor owe his first duty—the patient or corporation? Who is to preserve the confidential nature of the doctor-patient relationship? What is to prevent or who is to control a private corporation from engaging in mass media advertising in the exaggerated fashion so familiar to every American? Who is to dictate the medical and administrative procedures to be followed? Where do budget considerations end and patient care begin?\textsuperscript{47}

There is certainly the potential that some practices of MCPs could interfere with the professional autonomy of affiliated providers, and claims of such interference have occasionally reached the courts. For example, in \textit{Varol v. Blue Cross \\& Blue Shield of Michigan},\textsuperscript{48} the plaintiffs asserted that a pre-approval plan impermissibly interfered with the physician-patient relationship. The court reasoned that the plan was permissible because of the protection afforded by the treating physician’s autonomy, explaining that:

[w]hether or not the proposed treatment is approved, the physician retains the right and indeed the ethical and legal obligation to provide appropriate treatment to the patient. Thus, there is no direct interference with the physician-patient relationship nor in the treatment rendered . . . . Plaintiffs are saying in effect, “Since I am weak in my resolve to afford proper treatment . . ., [the preauthorization requirement] would induce me to breach my ethical

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\textsuperscript{45} See generally Hall, supra note 3, at 453-61. \\
\textsuperscript{46} Granger v. Adson, 250 N.W. 722, 723 (Minn. 1933). See generally J. Anthony Manger \\& Linda J. Cowell, \textit{The Corporate Practice Doctrine: Is it Still Viable?}, 6 \textit{Health Practice Span} 3 (1989) (explaining that many states have statutes that prohibit the practice of medicine through the corporate form, except where the corporation is organized as a professional corporation). \\
\textsuperscript{47} Garcia v. Texas State Bd. of Medical Examiners, 384 F. Supp. 434, 440 (W.D. Tex. 1974), \textit{on remand from} 492 F.2d 131 (5th Cir.), \textit{aff’d}, 421 U.S. 995 (1975). \\
\end{flushleft}
and legal duties, and the Court must protect me from my own weakness.”

The court declined to offer such protection to the plaintiff-physicians.

The court did not explore the question of whether the physicians did, in fact, retain autonomy. Because the contract between the physicians and the administrator of the plan required compliance “with the managed care requirements and procedures” of the plan, and because there were some minor adverse economic consequences of non-compliance, there was a question at least as to whether that autonomy existed. By guarding against the possibility that physicians and laypersons will enter into relationships that allow laypersons to exercise control or influence over physicians, the corporate practice doctrine seeks to remove possible impediments to the legal and ethical obligations cited by the court in Varol. A physician’s contractual duty to abide by the decisions, processes, or protocols of a managed care program, or her participation in an arrangement whereby she is offered financial incentives to limit access to health care services, at best, raises legitimate concerns about her ability to think only of her patient’s interests and, at worst, means that she has agreed to allow a third party to exercise control and direction over her professional judgment.

The prohibition against the unlicensed practice of medicine simply prohibits a layperson from engaging in activities that constitute the practice of medicine. A typical state law provides that a person is practicing medicine if he “offers or undertakes to prevent or diagnose, correct, or treat in any manner . . . any disease . . . of any person.” The danger against which these statutes are directed is obvious: patients should be protected from the harm that might follow from reliance on ill-informed advice. A patient might be damaged by his reliance on erroneous advice, either because he is incorrectly diagnosed or treated, or because he might fail to seek professional medi-

49. Id. at 833.
50. One wonders, however, if the court would have reached the same decision if the plaintiffs had been consumers of health care services, rather than physicians.
52. Id. In the plan at issue in Varol, the physicians would receive from the payor 80% of the fee for services for which they did not obtain pre-approval, and were free to bill the patients for the remaining 20%. Id. at 833.
53. See supra notes 45-52 and accompanying text.
cal help if he believes that he is receiving adequate care from the unlicensed healer.

Conduct that has been found to violate the licensing statutes usually involves a direct offer by a layperson, styling herself as a healer, to engage in one of the prohibited functions. While MCPs do not hold themselves out as qualified healers in the traditional sense, they often assert, in the context of both utilization review and pre-approval programs, the right and ability to determine whether particular diagnoses, treatments, or tests are medically appropriate. Some also promulgate protocols setting forth appropriate lengths of stay, testing and other guidelines relating to the practice of medicine. The cases endeavoring to impose tort liability on MCPs for the consequences of erroneous determinations as to the need for medical care illustrate the fact that MCPs are intimately involved in making medical care decisions. Increasingly, these activities involve direct contact with the patient or with the patient's family. Because this involvement carries with it the very real possibility of influencing the treatment that a patient receives, the same concerns that are raised with regard to unqualified healers are raised with regard to MCPs. The damage is done so long as the advice or determination could be expected directly and significantly to influence the course of treatment of the patient.

55. See, e.g., State ex rel. Shenk v. State Bd. of Examiners in the Basic Sciences, 250 N.W. 353 (Minn. 1933) (holding that a “naturopath” who, without a license to practice medicine, resorted to “natural” remedies in order to treat another person was unlawfully engaged in the practice of medicine); State v. Rolph, 167 N.W. 553 (Minn. 1918) (holding that the acts of a person who holds himself out as a doctor in caring for another person by examining, diagnosing, or suggesting treatment for the person, constitutes the practice of medicine, even though he neither prescribes a drug nor administers treatment); Op. Minn. Att’y Gen. 303c-2 (Mar. 10, 1975) (maintaining that acupuncture constitutes the practice of medicine).

56. See, e.g., Sarchett v. Blue Shield of Cal., 729 P.2d 267 (Cal. 1987). The “medical necessity” decision at issue in Sarchett was, in all but terminology, a retrospective utilization review decision.

57. See, e.g., Wilson v. Blue Cross of So. Cal., 271 Cal. Rptr. 876, 877 (Cal. Ct. App. 1990) (holding that a medical insurer that determined that a patient was not in need of further mental health treatment could be held liable for the patient’s suicide after discharge); Wickline v. State, 239 Cal. Rptr. 810, 812 (Cal. Ct. App. 1986) (holding that third-party payors of health care services can be held accountable for medically inappropriate decisions resulting from defects in their cost containment mechanisms).

58. For examples of the practical dynamics of this involvement, see infra notes 61-80 and accompanying discussion.

59. See, e.g., Wilson, 271 Cal. Rptr. 876; Wickline, 239 Cal. Rptr. 810.

60. For further discussion of this issue from a variety of perspectives see Furrow, supra note 12; Manger & Cowell, supra note 46; Hall, supra note 3; see also Bush v. Dake, No.
One physician described a situation in which an HMO tried to interfere with his treatment of a patient:

I have received requests from non-physician HMO staff members that newly admitted, acutely psychotic patients be transferred immediately to a hospital affiliated with a capitated specialty group. When I delayed the transfer to consult with the patient and family, the HMO contacted family members directly and instructed them to cooperate with the transfer, without mentioning the HMO’s appeals procedure.

Similarly, one of the pre-approval programs of which I am aware involves non-physician MCP staff contacting patients for whom certain procedures have been prescribed and gathering data relating to the patient’s symptoms. The MCP’s decision is communicated directly to the patient by the MCP.

The result of a pre-approval decision that a particular procedure is not medically indicated is likely to be that the patient does not receive the care. At least one court has recognized the significance of the prospective review process, noting that “[a]n erroneous decision [by an MCP] in a prospective review process . . . in practical consequences, results in the withholding of necessary care, potentially leading to a patient’s permanent disability or death.”

There are several reasons why the care might not be received:

86-2576-NM, Mich. Cir. Ct., Saginaw Cty., April 27, 1989. According to Paul Craig, Health Maintenance Organization Gatekeeping Policies: Potential Liability for Deferring Access to Emergency Medical Services, 23 J. HEALTH & HOSP. L. 135, 143 (1990), the Bush case was scheduled for trial in early 1990, and involved allegations that certain financial incentives to contain care offered by an MCP (the physician received a capitation payment) influenced the plaintiff’s physician both to refrain from ordering a pap smear and to refer the plaintiff to a specialist. As a result of these omissions, the plaintiff alleged, her cancer was not diagnosed in a timely fashion. The plaintiff alleged also that the MCP had failed to obtain her consent to the incentive relationship. Cf. Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392 (Cal. Ct. App. 1980).


62. Utilization review programs may require MCP approval during one of three phases of treatment: before (“pre-admission review”); during (“concurrent review”); or after (“retrospective review”) the treatment is contemplated. For a discussion of the evolution of these programs see Danny Ermann, Hospital Utilization Review: Past Experience, Future Directions, 13 J. HEALTH POL., POL’Y & L. 683 (1988).

63. Blue Cross/Blue Shield of Minnesota, Health Value Science Program.

64. Wickline, 239 Cal. Rptr. at 812. Along the same lines, one commentator has reported that there have been instances in which patients requiring immediate emergency attention have been directed by HMOs to proceed to emergency rooms at HMO-affiliated hospitals, even though other hospitals were closer to the patient. Craig, supra note 60, at 139.
(1) the patient might accept the decision and decline to seek the care in reliance upon the MCP's determination that the care is unnecessary; (2) the treating physician might choose to abide by the decision because he allows contractual obligations or financial incentives to sway his medical judgment; (3) the patient or the treating physician might disagree with the decision but abide by it because of the perceived futility (or time-consuming nature) of an appeal, or might simply be unaware that an appeal is available; or (4) the patient's treating physician might treat the determination as a valid and convincing second opinion.

The possibility that the patient might act in reliance on the MCP's judgment implicates the concerns that underlie the licensing statutes. Such reliance seems especially likely where the decision is conveyed directly to the patient by MCP staff, who might justify their position by explaining why the physician's judgment is in error. Pre-approval programs that involve the gathering of symptoms from a patient and communication of a diagnosis to the patient involve many of the features of the practice of medicine. In gathering data and reaching a conclusion as to the correct diagnosis, the MCP acts as a diagnostician. In issuing a statement as to the preferable therapy for a particular diagnosis, the MCP is engaging in treatment of the patient. To the extent that this information is gathered from and communicated directly to the patient, there might even be a physician-patient relationship between the MCP and the patient. When MCPs engage in behavior that constitutes the practice of medicine, they are in violation of the physician licensing statutes.

The MCP's decision might result in the denial of needed care because of the impact that the decision has on the treating physician's judgment. Two California cases—Wickline v. State and Wilson v. Blue Cross of So. Cal.—that involved MCP patients illustrate the potential that a physician's judgment could be influenced by the mere existence of a pre-approval requirement. Wickline involved the allega-
tion that a patient had been prematurely released from a hospital as a result of an MCP's determination that no further hospitalization was justified, and had consequently suffered complications. The court found that the treating physician believed that he was compelled to follow the MCP's directions regarding the appropriate length of stay. As a technical matter, the physician could have appealed the initial determination, and he could have simply refrained from discharging the patient. Believing the first course of action to be a fruitless endeavor, and apparently believing the second to be impractical (perhaps because he allowed the MCP's decision to sway his judgment as to the necessity of additional hospitalization), he chose instead to discharge the patient. It is notable in this case that the MCP's decision was made by a physician who served as a consultant to the MCP, and who disregarded the unanimous recommendation of the patient's attending physicians without either reviewing the patient's chart or examining the patient.

*Wilson* involved the allegation that a patient's suicide would not have occurred if he had not been prematurely discharged from the hospital. The patient's treating physician had recommended that the patient remain hospitalized for three to four weeks. The utilization review firm (acting as an agent of the MCP) determined that inpatient treatment was not medically necessary. The patient's treating physician discharged the patient and told his parents that the company had "terminated his [the decedent's] stay." The physician did not appeal the decision—in fact, it appears that no formal appeal procedure was available—and shortly after discharge, the patient committed suicide. The treating physician later testified that there was a "reasonable medical probability" that the decedent would have been alive if his hospital stay had not been prematurely terminated.

*Wilson* and *Wickline* are testimony to the fact that an MCP's...

70. *Id.*
72. *Id.* at 882.
73. Actually, the plaintiff was insured under a traditional indemnity type plan, which did not require pre-approval of in-patient care. It was alleged that the plan erroneously submitted the hospitalization request for review. *Id.* at 880-81.
74. *Id.* at 882.
75. *Id.*
76. *Id.* at 878.
77. *Id.* at 882.
decision is likely to influence the care offered to a patient, even in the absence of a relationship between the MCP and the physician. In neither case does it appear that the physician had incurred any contractual obligation to the MCP that might have influenced him to comply with the MCP's decision. Where a contractual relationship exists that either explicitly obligates the physician to comply with the MCP's decision or creates financial incentives for the physician to alter her practice patterns, the potential for cooption is greater. Those features of the relationship between providers and MCPs that give the MCP the ability to influence the care rendered to a patient offend the corporate practice doctrine. The existence of such a relationship is particularly troubling in a context where the physician's ability to exercise her independent judgment is crucial as a counter-weight to the determination of the MCP.

Regardless of the physician's recommendation, the MCP's decision to deny coverage might result in the patient's decision to forego the recommended medical procedure because the patient will now be responsible for out-of-pocket expenditures. In this situation, we are concerned only with the possibility that the MCP will make an erroneous decision. If, notwithstanding the licensing statutes, we assume that MCPs may make these determinations in some contexts, the best protection against that possibility is to protect the autonomy of the patient's treating physician, so that she will act as the patient's advocate in any appeal of an erroneous decision. If the treating physician's autonomy is compromised by the existence of a relationship that carries with it the possibility of control or influence, she is less likely to act as an advocate for the patient.

There is clearly a need to develop a principled analysis for determining what cost containment practices are acceptable under the licensing statutes and the corporate practice doctrine. With regard to the licensing statutes, one approach might be to focus on whether the MCP has created a situation that makes it likely that the patient will rely on, or the care will be determined by, the "advice" of the MCP. Where the program involves direct communication with a patient, and a decision is communicated as though it constituted a second opinion,

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78. See supra notes 15-20 and accompanying text.
79. See id.
80. In one case involving pre-admission review, a patient was persuaded to cancel what appears to have been medically necessary surgery after a claims adjuster implied, apparently without any legitimate basis, that the surgeon's opinion was questionable. Ronald J. Fadel, After the Carrier Scared My Patient Off, I Got Even, MED. ECON., Oct. 15, 1990, at 52.
such reliance seems likely. Similarly, where the communication is with the patient's physician, and the physician is bound by, or provided with an incentive to comply with, the decision, the decision seems likely to dictate the care.

The analysis might also take into account the existence of mitigating factors. For example, if the MCP has a policy that requires only appropriately qualified personnel make pre-approval decisions, and requires further that such decisions be made on the basis of a comprehensive review of the record, there is less likelihood of an erroneous decision. This seems especially true if the courts allow an MCP to be held responsible for erroneous decisions, even where the treating physician had the last clear chance to avoid the adverse outcome. 81 Similarly, where the treating physician is in a position to exercise his or her independent judgment—and likely to act as a patient advocate—the situation is less problematic.

Relationships that offend the corporate practice doctrine are particularly troublesome in a context in which the party in a position to exercise "control or influence" aggressively seeks to influence the physician's judgment. Physicians should not be permitted to enter into relationships with MCPs where they agree to abide by the MCP's patient care decision, or where they are provided with significant incentives to curtail utilization. 82 The autonomy of the physician's judgment is crucial to the preservation of a system of health care delivery that purports to provide all medically indicated care. The principles sought to be protected by both the licensing statutes and corporate practice doctrines—the quality of medical care and fiduciary nature of the physician-patient relationship—are compelling. The fact that MCPs continually apply pressure to the physician-patient relationship gives the doctrines particular relevance.

B. Possible Legal Grounds for an Exception from the Application of the Doctrines

1. Physician Involvement in Medical Decision-Making

When engaging in conduct that involves medical decision-making, many MCPs utilize physicians in an advisory capacity. (For purposes of clarity, these physicians shall hereinafter be referred to as "MCP consultants.") It could be argued that the involve-

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81. See, e.g., supra notes 47-54 and accompanying text.
82. See supra notes 15-19 and accompanying text. The parameters of acceptable incentives are discussed infra in the text accompanying notes 127-36 and 153-56.
ment of a physician in the process leads to the conclusion that MCP medical decision-making does not amount to the unlicensed practice of medicine. This reasoning was seemingly endorsed by the United States Supreme Court when it considered the question of whether the policy of a professional association of dentists to withhold dental x-rays from insurance companies violated the Sherman Act. The dentists argued, among other things, that the evaluation of x-rays by lay employees of the insurance companies constituted the unauthorized practice of dentistry. The Court rejected the argument as inapposite to the issue at hand, but noted in dictum that the association's concern was not compelling. The review system compelled lay evaluators to submit any recommendation that benefits should be denied, or that a less expensive course of treatment should be pursued, to a licensed dentist serving as a consultant to the payors. This fact led the Court to conclude that the practice was inoffensive. The Court noted that the consulting dentist made his decisions based on his professional judgment that the materials available to him—x-rays, claim forms and whatever further diagnostic aids he chooses to consult—are sufficient to indicate that the treating dentist's recommendation is not necessary to the health of the patient. There is little basis for concluding that, where a divergence of professional judgment exists, the treatment recommendation made by the patient's dentist should be assumed to be the one that in fact represents the best interests of the patient.

In essence, the Court appeared to concede that the insurance companies were engaged in the practice of dentistry, and to conclude that because the practice was conducted through a licensed dentist, the concerns of the association were baseless.

The Court did not see fit to explore several questions that ought to be raised with regard to the proposition that the patient's interests are protected by the involvement of a professional in the review process. First, many MCPs provide for comprehensive evaluation by a consulting physician only if the provider appeals the MCP's initial care decision. As a practical matter, the fact that the appeals pro-

84. Id.
85. Id. at 464.
86. Id. at 464 n.4.
87. FLA. STAT. ANN. § 395.0172(5)(b) (West 1991), which regulates the provision of
cess is often cumbersome and time-consuming might preclude the MCP consultant from involvement in many cases. Similarly, the physician might simply be unaware that the patient has a right to an appeal. The provider might often accept the MCP's decision without dispute (as did the physician in Wickline); the case might never reach the MCP consultant for review.

Even if the MCP consultant can truly be said to be making the decision with regard to a particular patient, so that she is practicing medicine, it is unlikely that she is exercising the appropriate standard of care. It seems unlikely that the diagnosis and treatment of a patient without a physical examination would normally meet the applicable standard of care, especially in contexts in which a physician who had examined the patient had recommended a contrary course of action. This is precisely what happened in Wickline, where the MCP physician made the decision regarding discharge without reviewing the chart and without seeing the patient. If the MCP can be said to be legitimately practicing medicine through its consultants, it will often be committing malpractice.

The Wickline court held, however, that the MCP consultant's erroneous decision to discharge the patient was not malpractice because the patient's physician, not the MCP, ultimately discharged the patient. The court opined that it was the physician's obligation to appeal the decision if it was erroneous, and that, accordingly, the fault was not with the MCP in making an erroneous decision, but with the physician in failing to oppose that decision. This approach
has merit only if the patient’s physician is free, both in theory and in practice, to exercise his independent professional judgment. If he is compelled by the MCP to follow the MCP’s decision, the MCP is dictating the decision, and the physician may properly be said to be an agent of the MCP. Accordingly, the MCP should not be able to escape responsibility.

Furthermore, if the consulting physician is practicing, he or she does so as an agent of the MCP and, accordingly, the corporate practice doctrine is implicated. The consulting physician could serve as a medical advisor to the MCP without offending this doctrine, but as soon as he or she undertakes to make medical care decisions for a particular patient in a context in which the decision is intended to dictate the care that the patient will receive, he or she is clearly practicing medicine and should be allowed to do so only within the constraints of the law.

2. The Nonprofit Exception

There is often one important exception to the prohibition against corporate practice: nonprofit corporations may engage in the practice of medicine. As many MCPs are organized as nonprofit corporations, this exception deserves attention. The authorities setting forth the exception contend that, in some contexts, the elimination of the profit motive negates the concern that the corporation will interfere with the delivery of medical care. These authorities also stress the fact that those nonprofits that are permitted to engage in the practice of medicine are committed to refraining from interfering with the physician-patient relationship. Organization as a nonprofit corporation

94. Indeed, the Wickline court contemplated that the payor could be held responsible for adverse outcomes resulting from the payor’s utilization review decisions where “medically inappropriate decisions result from defects in . . . cost containment mechanisms . . . .” Id.

95. See Sloan v. Metro Health Council, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987) (noting that if the court were to find that a staff model HMO was precluded from practicing medicine by the corporate practice doctrine, it would also have to find the operation of the HMO to be illegal).

It has been suggested that a consulting physician could be viewed as acting solely as an advisor to the plan, and not to the patient, and that, therefore, no physician-patient relationship would exist between the consulting physician and the patient. Craig, supra note 60, at 139 (citing Blum, supra note 66, at 219.). This characterization ignores the fact that the patient’s care is likely to be influenced by the consultant’s decision. See generally Craig, supra note 60, at 139-40.


does not in and of itself confer immunity from application of the
doctrine. The exception applies only to those entities that are not
motivated by a desire to profit from the provision of medical services
and that do not interfere with the provision of medical services.98

Many would argue that those MCPs that are organized as
nonprofits should be allowed to take advantage of the nonprofit ex-
ception. Upon closer scrutiny, however, it is clear that many of those
nonprofits are operated, for all practical purposes, with the same
profit motive as that of a for-profit corporation. Nonprofit MCPs are
often operated by for-profit management companies.99 Indeed, many
nonprofit MCPs are created by the entities that control the manage-
ment company.100 The compensation of the management company is
typically related to the profitability of the MCP. The management
company exercises a great deal of control over the day-to-day opera-
tions of the MCP and, most importantly, serves as the liaison between
the physicians and the MCP. The ability of a management company
to assert control over physicians was recognized by New Jersey’s
Commissioner of Health in the context of a relationship between an
outside management company and a group of physicians’ offices. She
explained that because “the management firm can exert [influence]
over the entire fabric of the operation, there is the definite possibility
that the firm can affect the physicians’ medical judgment.”101 The
MCP might be staffed entirely with management company employees
and serve as little more than a mail drop. In short, the MCP is typi-
cally dominated by the management company.

98. Id.
99. See, e.g., Hibbs, supra note 15.
100. For example, the two most recent additions to the Minnesota HMO market were
created at the same time as their respective management companies. Citizens League, Minn.
HMO Rev. 1989, 12 (1990). Because of the benefit reaped by the management companies,
these arrangements call into question the legitimacy of any tax exemption that a nonprofit
MCP might have. See generally Sound Health Ass’n v. Commissioner, 71 T.C. 158 (1978);
Rev. Rul. 69-54, 2 C.B. 117 (1969). Some nonprofit HMOs are converting to for-profit
status. Howard S. Levy, Note, Ronald J. Thompson v. Midwest Foundation Independent
Physicians’ Association (ChoiceCare): The Conversion of Nonprofit Health Maintenance
Organizations to For-Profit Status, 16 N. Ky. L. Rev. 361 (1988). This perhaps reflects an
acknowledgment of the true character of the HMO. As of 1988, two-thirds of the nation’s
HMOs were organized as for-profit plans. Id. at 361 (citing Meldin & Perkins, HMO Conver-
sions: How to Distribute the Charitable Assets?, NAT'L HEALTH L. PROGRAM, Oct. 1987, at
467).
1983); see also Flynn Bros., Inc. v. First Medical Ass’ns, 715 S.W.2d 782, 785 (Tex. Ct.
App. 1986).
To be sure, the nonprofit MCPs have boards of directors with members who may be, at least in part, persons who do not have an economic interest in the operation of the MCP. However, it is the management company that is making the day-to-day operational decisions and, because one of the dominant goals of the MCP is cost containment, it is unlikely that the board will be motivated to exert significant pressure to the contrary. In any event, the MCPs cannot be said to be refraining from involvement in medical decision-making, and this is a crucial distinction between MCPs and the nonprofits that have been allowed to take advantage of the nonprofit exception.

3. HMO Statutes

Various state HMO statutes acknowledge, either directly or indirectly, that HMOs will be involved in the provision of medical services. Consequently, it might also be argued that MCPs organized as HMOs are not subject to the corporate practice doctrine. It is unlikely that the domination of HMOs by for-profit management companies is contemplated by these statutes. Furthermore, these statutes do not specifically authorize HMO involvement in medical decision-making. So, while it might be possible to conclude that the HMO statutes protect the relationship between the professional medical care provider, acting as such (as either an employee or an independent contractor), and the HMO from scrutiny under the corporate practice doctrine, it is difficult to conclude that actual lay involvement in medical decision-making will be protected if it amounts to either a significant intrusion into the treating physician’s medical judgment or the unlicensed practice of medicine.

C. A Possible Solution: Transferring Responsibility for Medical Decision-Making to an Independent Third Party

It seems likely that MCP involvement in medical decisions will increase. There is a real need to develop principles that can be applied to each instance of possible involvement in order to distinguish legitimate from illegal practices. There are numerous activities direct-

102. See, e.g., ALA. CODE § 27-21A-23(a) (1986).
ed at cost containment that do not implicate either the corporate practice doctrine or the state licensing laws, and it is undoubtedly desirable to allow for the development of mechanisms whereby utilization can be contained appropriately and efficiencies encouraged.

The problem is that it is very difficult to identify the point at which legitimate behavior becomes illegitimate. MCPs might legitimately make coverage decisions that involve a determination of whether particular benefits are covered under their contracts with enrollees. MCPs are responsible only for payments for which they have contractually obligated themselves, and enrollees have an interest in knowing what services will be paid for, prior to incurring an obligation to pay for the services. But as soon as the coverage decision involves inquiry into whether a particular procedure is medically necessary, the possibility of involvement in medical decision-making arises. If the pre-approval process involves communication with and control over a treating physician, the corporate practice doctrine might be violated. If the process involves direct contact with a patient, the licensing statutes might be violated. MCPs may legitimately educate affiliated providers on the efficient practice of medicine. MCPs have a legitimate interest in containing costs, and the elimination of unnecessary care serves the enrollee's interest, both in cost containment and the avoidance of unnecessary tests and treatment. However, as soon as the MCP attempts to compel a provider to follow its treatment protocols, the MCP begins to undermine the physician-patient relationship and to jeopardize the independent exercise of the physician's medical judgment.

One approach would be to resolve the tension between cost containment and patients' rights by adopting a bright line rule barring MCPs from prospective coverage decisions to the extent that they involve determinations of medical necessity, and by further precluding MCPs from issuing statements relating in any way to standards of medical practice. In order to promote efficiency, MCPs could be permitted to affiliate with truly independent advisory organizations, which would take over these functions. These organizations would be responsible for studying utilization and recommending policies and protocols for avoiding over-utilization and promoting health. If these organizations were staffed by physicians, and if they were truly independent from the MCPs, they might better approximate the idealized notion of the MCP as an entity that has both the capacity and the incentive to prevent illness. One could expect professionalism to motivate these groups to develop appropriate, novel, and effective
methods of containing costs. In order to avoid any possible conflict of interest, it would be preferable for these groups to be paid in a manner that bears no relationship to the performance of the MCP.

A network of organizations that perform utilization review on behalf of third parties already exists. These organizations offer their services to private sector clients, such as self-insured plans maintained by employers, and to the public sector in connection with the Medicare program. In order for these organizations to avoid the problems with utilization review and the use of protocols, detailed above, the regulatory approach to utilization review will have to change significantly. Until recently, the activities of these reviewers have gone largely unregulated, at least to the extent that they have served the private sector. However, states are beginning to adopt laws regulating the activities of these private utilization review firms. These laws are concerned primarily with confidentiality, responsiveness and accountability, and the involvement of qualified personnel in coverage decisions.

While these first attempts at regulation are laudable, the statutes are deficient to the extent that they do not address the form in which the organization may be structured, the qualifications or rela-

104. While many MCPs manage care themselves, many contract with independent third parties to perform utilization review on their behalf. See, e.g., Wilson v. Blue Cross of So. Cal., 271 Cal. Rptr. 876, 833 (Cal. Ct. App. 1990). As a result, a substantial private industry has developed to assist MCPs in managing care.


109. See, e.g., FLA. STAT. § 395.0172(2)(c)8 (1991) (requiring, among other things, that a negative coverage determination must include the written evaluation and findings of a reviewing physician); MD. CODE ANN. § 19-1307(a) (1991) (requiring physician involvement in coverage decisions, but only in cases involving chemical dependency or mental health services).

110. It should be noted that the States' ability to regulate utilization review activities of self-insured plans may be constrained by the preemption provisions of ERISA, 29 U.S.C. § 1144(a) (1988).
tionship to the payor of those who control the organization, the scope of permissible activity, or the possibility that the reviewing organization might render its decision in a context in which the treating physician is obligated or encouraged to accept the decision without protest.\textsuperscript{111} They are also deficient in at least one other major respect: by and large, they completely fail to address the possibility that the physician, nurse, or other person performing the review might have a conflict of interest by virtue of either his relationship with his employer or the MCP's relationship with the reviewer's employer. The few statutes that acknowledge that the reviewer's judgment might be impeded by a conflict of interest do little to obviate the problem.\textsuperscript{112}

A better regulatory scheme could be modeled after the system used to regulate Peer Review Organizations ("PROs"). PROs are organizations used by the federal government to perform utilization review and quality assurance activities on behalf of the Medicare program.\textsuperscript{113} The primary function of PROs is to protect against over-utilization of Medicare and Medicaid services.\textsuperscript{114} PROs are nonprofit, physician-dominated organizations that are independent of the control of the providers whom they review.\textsuperscript{115} PROs routinely engage in pre- and post-procedure medical necessity decisions; they review services to establish whether the services are medically necessary, whether the quality of the services is sufficient, and whether inpatient services could have been provided more economically on an outpatient basis.\textsuperscript{116} The PROs establish norms of care, diagnosis, and treatment, including designations of the most economical type of health care facility considered medically appropriate for the particular diagnosis.\textsuperscript{117} PROs operate pursuant to a complex statutory scheme

\textsuperscript{111} For an interesting discussion of what types of protocols carry with them a degree of coercion, see Hall, \textit{supra} note 3, at 454-60.

\textsuperscript{112} \textit{See}, e.g., FLA. STAT. § 395.0172(5) (1991) (requiring disclosure of payment arrangements providing an incentive to deny services); MD. CODE ANN. § 19-1305.1(a) (1990) (precluding a physician who is involved in the review of chemical dependency or mental health services from being compensated in a manner that rewards a denial or reduction of coverage).

Because of the deficiencies in the statutes noted above, they cannot properly be read as condoning any particular activity engaged in by the utilization review firm. The corporate practice doctrine and licensing statutes can be read to apply to the utilization review process without conflicting with these regulatory schemes.


\textsuperscript{115} 42 U.S.C. § 1320c-3(b) (1988).

\textsuperscript{116} \textit{Id.} § 1320c-5.

\textsuperscript{117} \textit{Id.} § 1320c-3(a) (1988 & Supp. 1989).
designed to ensure that neither over-utilization nor under-utilization occurs.\textsuperscript{118}

One could envision the current network of PROs expanding to serve the MCP industry. Indeed, many PROs already perform some review services for private organizations,\textsuperscript{119} and there are numerous private utilization review organizations that perform utilization review, primarily for employer-sponsored self-insurance plans. Concentration of utilization control functions on PROs could be expected to give PROs access to significant epidemiological data. PROs are likely to have the sophistication to use that data. Moreover, so long as their compensation was not linked to the performance of the MCPs on whose behalf they provide advice, PROs could be expected to take the long view. With PROs, or other similar organizations, taking over utilization control, MCPs might be more effective in their efforts to cut costs through prevention.

In summary, in order to address the concerns discussed thus far, regulation of utilization review should embody, at a minimum, the following requirements:

1. In order to insulate the utilization review decision-maker from financial and institutional incentives to deny needed care, prospective utilization review decisions (and perhaps all utilization review decisions, since all are directed towards influencing, and probably do influence, practice patterns) should be made by third parties who are not controlled by, or otherwise related to, the MCP, and whose compensation is not contingent on the performance of the MCP.

2. In order to encourage professionalism, to ensure that decisions are made by qualified personnel, and to curtail lay involvement in the practice of medicine, the independent utilization review organization should be controlled and directed by physicians.

\textsuperscript{118} Id. § 1320c.

\textsuperscript{119} Ermann, supra note 62, at 689 (citing data from a 1983 survey conducted by the American Peer Review Association, which found that eighty-nine of one hundred eleven responding PROs were conducting utilization review for private payors).
3. In order to minimize erroneous decisions, and in recognition of the significant impact that denial decisions can have on the care received by patients, denial decisions should be made only by a physician, after the review of such information that would normally be required by a physician rendering a second opinion in consultation with a primary care physician.

4. In order to encourage the treating physician to appeal denials that she feels to be inappropriate, appeal procedures should be standardized, rationalized and publicized.

5. In order to encourage MCPs to engage in programs of prevention, the organization should be required to collect specified data and to participate in a program of epidemiological study on the efficacy of various modalities of diagnosis.

6. In order to protect the patient from misplaced reliance, and in recognition that the MCP is not assuming the role of the treating physician (because of its inherent conflict of interest, and because it is unlikely to be exercising the standard of care that is required of a treating physician), the MCP should be required to gather diagnostic information from the treating physician (if the accuracy of the information is at issue, a second opinion could be required) rather than from the patient, and should be required to communicate any diagnostic information through the treating physician.

While these proposals are radically at odds with the current practice of the industry, with the exception of the proposal outlined at point five, all of them are firmly grounded in the doctrine and policy that produced the prohibition against the corporate practice of medicine and the requirement that only licensed physicians practice medicine.

III. Fee-Splitting

Restrictions on referrals vary from plan to plan. A provider is
often required to make all referrals to participating providers unless certain limited conditions exist and unless the provider complies with designated procedures. The latter restriction is often so onerous that it effectively precludes out-of-system referrals. While the patient might be aware that comprehensive coverage is available from the MCP only if she uses participating providers, she is unlikely to know that her physician's freedom to refer to other providers is restricted. If the physician abides by the restrictions, the patient might not be given the option of electing to receive care outside of the plan.

A. The Referral Relationship

Restrictions limiting referrals to participating providers serve at least two purposes. The most obvious purpose is cost containment. Participating providers have typically agreed to provide services at a discount from their customary fee schedule. A second significant purpose is that the restrictions give the MCP something to offer—increased volume—as an inducement to referral providers to become participating providers. A specialist or hospital enters into a provider agreement and gives a discount in return for inclusion in the network of providers to whom referrals may be made.

The referral relationship is also valuable to the primary care physician. Where MCPs put the primary care physician at risk for the cost of health care services, the discount offered by the specialist inures directly to the primary physician's benefit, as it serves to reduce the cost of the referral services. Even if the primary care physician is not at risk, there are incentives to refer patients to participating providers. MCPs often make it a condition of participation in the MCP that the physician conform her referral patterns to the MCP's requirements. The physician might have access to the MCP's patients only if she agrees to the restrictions on referrals.

B. Legal and Ethical Prohibitions Against Payments for Referrals

There are both legal and ethical prohibitions against a physician offering something of value in exchange for a referral. At the state level, these types of arrangements are generally referred to as fee-

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splitting. For example, a typical anti-fee-splitting law provides that "paying [or] . . . receiving . . . a . . . rebate, or remuneration, directly or indirectly, primarily for the referral of patients . . . , [consti-
tutes] grounds for disciplinary action . . . ." Federal law makes it a felony to give or receive anything of value in exchange for a referral of a Medicare or Medicaid patient. A physician who owns an interest in a home health agency may not certify the necessity of that care to Medicare, and recent legislation extends this principle to prohibit a physician from referring to clinical laboratories in which he has a financial interest. The medical profession's ethical standards also counsel physicians to avoid financial relationships that might influence their medical judgment.

These prohibitions against fee-splitting are concerned primarily with the possibility that a physician who stands to gain financially from the use of health services will over-utilize these services. The underlying assumption is that financial incentives will interfere with the physician's medical judgment, and that she might consequently use services that are not medically indicated. There is also a concern about quality, inasmuch as financial incentives might sway a provider to choose services that are less than optimal. The use of financial incentives to contain costs should lead to an equal concern that physicians might under-utilize services. That a physician might be inclined to withhold medically indicated treatment, or to refer a patient to a provider who is the physician's second choice, seems at least as problematic from the patient's point of view as the possibility that financial incentives will lead the physician to over-treat the patient. Incentives to over-utilize and incentives to under-utilize deserve at least equal attention.

C. Do Incentives to Contain Utilization Violate Prohibitions Against Payments for Referrals?

When a specialist agrees to give an MCP a discount from her

121. MINN. STAT. § 147.091, subd. 1, ¶ (1) (1990).
125. See, e.g., American College of Physicians Ad Hoc Committee on Medical Ethics, Standard Regarding Commercialization of Medicine and Other Conflicts of Interest, in ETHICS MANUAL (1990).
regular fee schedule, she has clearly given the MCP something of value. As has been discussed, the quid pro quo for the discount is the opportunity for the specialist to have MCP patients referred to her. A specialist who gives a discount in exchange for the right to see patients can thus be viewed as giving remuneration in order to induce referrals. If the discount were given directly to a primary care physician, and if the primary care physician were able to bill either the patient or a third party for the specialist’s services at a price that is greater than the price at which she purchased the service, the discount would have the same economic effect as a cash payment in the amount of such overage made to the primary care physician by the specialist. This practice would clearly run afoul of the prohibitions against fee-splitting, and both the primary care physician as the recipient and the specialist as the inducer would be subject to scrutiny.

Where the primary care physician is at risk for the cost of the referral care, she likewise stands to benefit financially from the reduction of any fees for referral care and, thus, it is difficult to see why the fact that the discount is given in the context of an MCP provider agreement context should distinguish the exchange from impermissible fee-splitting. The potential for distortion of the primary care physician’s judgment remains the same.

Even if the primary care physician is not directly at risk, and does not otherwise stand to benefit directly from the discount, the arrangement is suspect. The primary care physician has agreed to make the referrals in exchange for something of value: the opportunity to participate in the MCP. So long as the specialist agrees to give

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127. See supra notes 120-26 and accompanying text.

128. If the discount is passed directly through to the physician’s patient, however, the primary care physician would not profit by the discount, and his or her judgment would not be expected to be influenced. See 42 U.S.C. § 1320a-7(b)(3)(A) (1988 & Supp. 1989), which contains an exception for such discounts.

129. The Office of the Inspector General (“OIG”), HHS, recently promulgated regulations setting forth “safe harbors.” See 42 C.F.R. 1001-1001.109, pursuant to the Medicare and Medicaid Fraud and Abuse Law, 42 U.S.C. § 1320a-7(b), which contain a limited safe harbor for personal service contracts. In the preamble to the new regulations, the OIG explained the limited scope of the safe harbor as reflecting the concern that the Fraud and Abuse Law might be implicated by arrangements between health care providers where the payment might vary with the volume of referrals. 54 Fed. Reg. 3088 (1991). But cf. 42 C.F.R. Part 1001 (54 Fed. Reg. 3088, preamble, at 50), in which the OIG indicates that it is “expecting to publish a rule that will protect many of these [discounting relationships from scrutiny under the Medicare and Medicaid Fraud and Abuse Law] . . . where certain standards are met . . . .” Just what these standards will be remains to be seen.

130. See supra page 103.
a discount in exchange for an opportunity to participate, she is paying for referrals.

D. A Potential Solution: Point of Purchase
Disclosure of Coverage Restrictions

Patients do benefit from the existence of these discounting relationships to the extent that the discount operates to reduce premiums for MCP coverage. If the discount is applied to lessen the primary care physician’s risk, rather than passed on to the consumer, the benefit is tenuous. Where the physician is not at risk, and if patients make an informed decision to restrict their choice of provider to participating providers, the prohibition against fee splitting should not be implicated. In that context, the discount can be viewed as an inducement to the patient to choose a participating provider, and the patient is, in fact, directing the physician to choose from the restricted group. In such a situation, the interests of the patient and the physician are not in conflict: it is the patient’s direction, and not the prospect of receiving something of value, that ultimately determines the physician’s judgment. If adequate disclosure were made, the MCPs could continue to arrange with a network of providers to offer discounts without offending this doctrine.\textsuperscript{131}

It is unlikely that MCPs will voluntarily provide adequate disclosure. Full and effective disclosure is likely to create political problems for the MCPs as enrollees realize that their options are being limited in ways that are unacceptable. Accordingly, the disclosure might properly be the subject of legislation. Legislation requiring disclosure of certain subscriber rights is already a feature of insurance and HMO statutes,\textsuperscript{132} but the disclosure required by the statutes might not be adequate either as to the scope or the method of disclosure, and some forms of MCPs are not regulated at all.\textsuperscript{133}

A typical statute will require the MCP, for instance an HMO, to disclose the fact that there are limitations on coverage.\textsuperscript{134} These statutes do not compel disclosure of the fact that participating provid-

\textsuperscript{131} See Levinson, supra note 61.
\textsuperscript{132} See, e.g., MINN. STAT. § 62D.07(3)(b) (1990).
\textsuperscript{133} For example, an MCP may be organized as a preferred provider organization, with the MCP acting as, a broker between the employer-purchasers of care and the physician-providers of care. Because the MCP does not take risk or offer health services, it may escape regulation under the insurance, health service plan, and health maintenance organization statutes. The regulation of PPOs, as such, is in its infancy.
\textsuperscript{134} See, e.g., MINN. STAT. § 62D.09(1)(b) (1990).
ers have agreed to refer only to other participating providers. At a minimum, the patient should be put on notice that her physician is not necessarily selecting his first choice of provider, since a non-participating provider might be the physician’s first choice. The patient must be sufficiently informed so that she may elect to use a non-participating provider, and either forego coverage or compel the MCP to cover the out-of-network referral.\textsuperscript{135}

Since it is unlikely that most subscribers read and understand their policy documents, merely requiring that the restrictions be detailed in the policy document probably will not result in better informed patients. The most effective method of disclosure would be to require the physician to inform the patient at the time that the referral is made. The physician should be required to disclose the restriction on referrals and indicate whether, absent these restrictions, she would refer elsewhere. As a corollary to the disclosure requirements, the physician’s contractual obligation to the MCP should be restated to require only that she always provide an option of a referral to a participating provider. Under these circumstances, physicians who are not directly at risk are likely to be forthright, thereby arming the patient with the knowledge that he needs in order to make an informed choice; however, depending on the ability of the MCP to exclude the physician from participation, and the degree of reliance that the physician has on the MCP as a source of patients, there might still be compelling financial incentives to satisfy the MCP.

Physicians who are directly at risk, however, seem less likely to make effective disclosure. As discussed at length below, the financial risk-sharing arrangement creates a high potential that the physician’s judgment will be distorted.\textsuperscript{136} This writer feels that the risk of distortion is so high that point of purchase disclosure is unlikely to

\begin{footnotesize}
\textsuperscript{135} This scheme is consistent with state fee-splitting laws that permit fee-splitting in certain circumstances so long as the arrangement is adequately disclosed to the patient. \textit{See}, \textit{e.g.}, \textsc{Minn. Stat.} § 147.091, subd. 1, ¶ (4) (1990) (requiring that the physician disclose the existence of the relationship and the fact that the patient is free to choose another health care provider). Ethical canons also require disclosure of financial relationships that carry with them the possibility of influencing a physician’s judgment. \textit{See}, \textit{e.g.}, Council on Ethical and Judicial Affairs of the AMA, Current Opinions § 8.13 (1989) (requiring that the physician disclose the existence of the restriction on referrals when “the patient’s condition requires” a referral to a non-participating provider). The report goes on to require that “[i]f a third party limits a patient’s access to necessary medical services . . . the physician should so inform the patient and protest the limitation.” \textit{Id.}

\textsuperscript{136} \textit{See infra} notes 138-75 and accompanying text.
\end{footnotesize}
satisfy the goals of the anti-fee splitting legislation.  

IV. UNLICENSED INSURER

MCPs generally undertake to provide subscribers with unlimited access to certain specified services in exchange for a pre-agreed payment. This arrangement is indistinguishable from traditional insurance relationships, except that MCPs covenant to provide services, whereas traditional health insurers typically contract to pay or reimburse costs incurred as a result of the receipt of those same services. The result is the same—both types of relationships shift the risk for the cost of services from the patient to the payor.

Traditional insurers typically pass off some or all of this risk onto reinsurers. MCPs may also purchase reinsurance. For example, many HMOs purchase “stop-loss” insurance on in-patient hospital costs. MCPs may also enter into relationships with providers pursuant to which they pass off some portion of the risk to the providers. These relationships serve the dual purposes of minimizing the MCP’s exposure and, by putting the physician at risk for all or part of the cost of providing health care services to MCP patients, creating an incentive for physicians to contain costs.

Risk-shifting arrangements might involve one or more of a variety of mechanisms. For example, some of these arrangements put the provider at risk for the cost of her own services. This serves primarily to shift the risk for the provision of primary care services from the MCP to the physician. Since the most significant cost of providing services to patients is the provider’s overhead, and since the provider is unlikely to be able to control access to his or her own services effectively (except, perhaps, by delegating tasks to ancillary personnel), this mechanism is unlikely to result in a significant curtailment of access to medical care.

Another risk-shifting mechanism is to return reserves withheld by the MCP only if the costs incurred in providing all covered services to the providers’ patients are kept below a particular level. Since this mechanism gives the provider a positive incentive to contain costs, it might be expected to result in some degree of restraint on the patient’s access to care. If the return is based on plan-wide per-

137. See id.
138. For further discussion of these issues, see infra notes 142-53 and accompanying text.
139. See supra note 34 and accompanying text.
formance, the incentive for individual providers to constrain access could be expected to be minimal. Even if the return is based on individual performance, the fact that the return is contingent and not a sum certain dilutes its motivational strength.

Yet another mechanism is to put the provider directly at risk for some of the cost of the provision of care to the provider’s patients. Of all the methods of providing an incentive to contain costs, putting a physician directly at risk seems most likely to persuade the physician to favor cost containment over the provision of appropriate medical care. I am aware of several instances where this type of a risk-shifting arrangement resulted in a three- to seven-physician primary care provider incurring an annual liability to an MCP of between $30,000 and $70,000. The cost to the provider of authorizing referral or in-patient care is direct, certain and current, whereas the financial benefit to the provider of providing appropriate preventative and corrective care is far more likely to be indirect, uncertain and remote.

A. The Provider as Insurer

When the provider agrees to reimburse the MCP for certain costs incurred in the provision of services to MCP patients, the provider’s role is indistinguishable from that of an insurer. The provider not only agrees to provide services, but in essence she also agrees to indemnify the MCP against the risk that the cost of care will exceed the amounts reserved to pay for the care. A typical statutory definition of insurance provides that insurance is “[a]ny agreement whereby one party, for a consideration, undertakes to indemnify another to a specified amount against loss or damage from specified causes, or to do some act of value to the assured in case of such loss or damage.”

The general rule is that no one may engage in the business of insurance without complying with a complex regulatory scheme and obtaining a license.

140. See supra notes 30-33 and accompanying text.
141. Even though the provider will typically be entitled to participate in savings that might result from efficient utilization, the factors discussed supra notes 35-39 and accompanying text operate to make the provider more concerned with short-term profitability than with long-term performance.
142. MINN. STAT. § 60A.02, subd. 3 (1990).
143. Id. § 60A.07, subd. 4 (providing that “[n]o insurance company or association . . . not specifically exempted therefrom by law, shall transact the business of insurance in this
The Supreme Court has determined that, for federal tax purposes, a contract of insurance exists when there is an element of risk-shifting or risk-distribution. Similarly, for purposes of an exception from the antitrust laws, the business of insurance is a practice that: (1) has the effect of transferring or spreading a policyholder's risk; (2) is an integral part of the policy relationship; and (3) is engaged in only by entities in the insurance business. In holding that a provider that had contracted to provide eye examinations and necessary eyewear to union members in exchange for a capitation payment was engaged in the business of insurance, an Illinois court explained that

\[\text{[I]ke the insurance ... arrangement it attempts to distinguish, [the plaintiff's] operation is essentially of a risk bearing nature: actuarial data is used to calculate estimated use of services and [the plaintiff] sets its rates accordingly; once payment is made by an employer [the plaintiff] bears the burden of providing these services as needed, even if actual use is in excess of what was anticipated ...} \]

The rate of capitation paid to primary care clinics is calculated using actuarial data. Once the clinic has entered into the capitation relationship, it bears the burden of providing the services even if actual use is in excess of what was anticipated. The MCP has thus shifted the risk of loss to the provider. In fact, a recent Maryland Attorney General's Opinion concluded that providers who were at risk for the provision of their own services (pursuant to a capitation arrangement), and for the services of others (pursuant to an agreement to indemnify the payor against certain costs incurred for the provision

144. See Helvering v. LeGierse, 312 U.S. 531 (1941).
147. In a letter dated May 15, 1987 to the Physicians Health Plan ("PHP"), a Minnesota HMO, the Minnesota Commissioner of Commerce took the position that, while PHP was free to enter into an agreement with a hospital whereby the hospital assumed financial risk for its services to PHP subscribers, it could not enter into an agreement whereby the hospital assumed financial risk for services rendered to PHP subscribers by third parties over which it has no control. For hospitals to assume the risk for services delivered by third parties would render the hospitals insurers.
of referral and in-patient care), were engaged in the business of insurance and were, accordingly, subject to regulation as insurers.\textsuperscript{148} Similarly, a recent General Counsel Memorandum explained that an HMO would be considered to be engaged in the business of insurance, for purposes of section 501(m) of the Internal Revenue Code, where it did not provide the health care services itself but, rather, contracted with providers on an indemnity basis. This arrangement meant that the HMO incurred an insurance risk "in that [its] expenses were not limited to the physicians' salaries, to the cost of operating health facilities, or to the actual amount of the premium collected. [The HMO] incurred the risk that the charges [that it] had contracted to pay might exceed the premiums collected."\textsuperscript{149}

Consequently, it is possible to characterize both arrangements under which providers take risk for their own services, and arrangements under which providers take risk for the services of others, as insurance. With regard to the first type of arrangement, there are both precedents that support,\textsuperscript{150} and precedents that detract from, such a characterization.\textsuperscript{151} However, for the purposes of this analysis, the point will not be belabored. To the extent that MCPs are qualified as HMOs or nonprofit health service plans, generally the state statutes explicitly contemplate that providers will take risk for the cost of their own services.\textsuperscript{152} Even if these arrangements exist in the absence of such legislation, the harm that can follow from these types of relationships is minimal. The risk to which the physician is exposed is limited\textsuperscript{153} and, therefore, this exposure is unlikely to unduly sway his or her judgment. In contrast, where a physician is at risk for the services of others, she will lose money every time she authorizes a referral service. Accordingly, the focus of concern should be on relationships in which the physician agrees to take risk for the services of others.

\textsuperscript{151} See, e.g., Gen. Couns. Mem. 39,829 (August 24, 1990) and cases cited therein.
\textsuperscript{152} See, e.g., MINN. STAT. § 62D.05, subd. 3 (1990).
\textsuperscript{153} See supra discussion accompanying notes 138-41.
B. The Risks Obviated by the Regulation of the Business of Insurance

Insurance licensing statutes typically cover three primary areas: provisions intended to assure the financial strength of the company; provisions intended to assure fair benefit determinations; and mandatory benefit provisions. In other words, the primary purpose of the licensing statutes is to assure that the insurer provides the benefits that it has promised to provide and that it has the financial ability to provide these benefits.

Risk-sharing capitation relationships implicate the same concerns as traditional insurance relationships. Like traditional insurers, providers can minimize their costs by denying legitimate claims. However, unlike traditional insurers, providers are capable of controlling whether many of the claims are generated; by denying access to care for which the provider is at risk, the cost is avoided. The physician acts as a check on the traditional insurer because he will at least alert the patient to the fact that the care is indicated. However, if the physician does not recommend the care, the patient will never know that the care might be indicated. Since traditional indemnity insurers typically make coverage decisions after the fact, the physician, not the insurance company, determines what care will be received. The greatest harm that can follow from the failure of an insurer to provide coverage is purely economic, while the harm that can result from the decision of a physician to forego treatment can be much more significant.

156. See, e.g., MINN. STAT. § 62A.01 (1990).
157. See California Physicians' Serv. v. Garrison, 172 P.2d 4, 17 (Cal. 1946) (explaining that "[t]he extensive insurance regulations primarily are designed to protect the insured, or the public, from the insurer.").
158. A recent government study found that the use by the Medicaid program of fixed payments to HMOs encourages HMOs to restrict care rendered to Medicaid recipients. GENERAL ACCOUNTING OFFICE, MEDICAID: OVERSIGHT OF HEALTH MAINTENANCE ORGANIZATIONS IN THE CHICAGO AREA 2 (1990 Report to Rep. Cardiss Collins) [hereinafter GAO REPORT].
159. Perhaps in recognition of this problem, the federal HMO law requires that if an HMO provides services through a "medical group," that group must "establish an arrangement whereby a member's enrollment status is not known to the health professional who provides health services to the member." 42 U.S.C. § 300e-1(4)(C)(v) (1988).
160. "A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death." Wickline v. State, 239
Licensed insurers are generally subject to rigorous regulation designed to ensure their financial ability to honor claims. These regulations usually involve, among other things, the maintenance of significant reserves.\textsuperscript{161} It has been suggested that the primary public policy served by the reserve requirements is to ensure that the subscribers do not fear the risk of personal liability for the cost of medical services.\textsuperscript{162} This particular risk is obviated, in the case of HMOs, by state HMO acts that specifically compel affiliated providers to waive any right that they might have to secure payment from patients, and to continue, for a specified period of time, to provide care in the event that the HMO defaults.\textsuperscript{163} However, because of the ability—even the tendency—of some MCPs to dominate the practice of affiliated providers, the financial collapse of an MCP might result in the disruption of care.\textsuperscript{164} These providers are not required to, and in fact rarely do, maintain reserves, and their continuing care obligations in the face of the MCP's collapse can cause immediate financial ruin. It is difficult to believe that patients will not be adversely affected. If an insurance company fails, some claims will not be paid, but in most instances patient care should not be disrupted. Providers are unlikely to be dependent on a single insurer for a large portion of their practice, while they are often wedded to an MCP.

Those risk-shifting arrangements that require the provider to reimburse the MCP could jeopardize the financial health of large networks of providers. These arrangements generally provide that a portion of the "premium" revenue be set aside for funding referral and specialty care. The provider becomes liable for out-of-pocket payments to the MCP only after the set-aside has been expended. If premiums are set too low (which is a very real possibility in a competitive market), many of the providers will, despite their best efforts at cost containment, become liable to the MCP. Since the potential liability is so onerous, these providers might become insolvent.

Wholly apart from any concern for the well-being of the provid-

\textsuperscript{161} See, e.g., \textsc{Minn. Stat.} \textsection{60A.07, subd. 5a} (1990).
\textsuperscript{162} \textit{People ex rel. Roddis v. California Mut. Ass'n}, 441 P.2d 97, 100 (Cal. 1968).
\textsuperscript{163} See, e.g., \textsc{Minn. Stat.} \textsection{62D.121} (1950).
\textsuperscript{164} The GAO raised these same concerns with regard to capitated HMOs when it recently recommended that HMOs participating in the Medicaid program be required to prove financial solvency, develop a plan for coping with insolvency, or enroll a specific percentage on non-Medicare/Medicaid patients in order to ensure an adequate base for spreading risk. \textit{See GAO Report, supra} note 158.
ers, this prospect is alarming. Financial instability could lead to the disruption of the health care delivery system. Many physicians would likely terminate their relationship with affected clinics, and affected clinics would be unlikely to renew their relationships with the MCP. A significant exodus of physicians from an MCP’s network could jeopardize the health of the MCP in two ways. The MCP might find itself without sufficient physicians to serve its patients and, if the providers are unable to make good on their financial obligations to the MCP, the MCP might also find itself facing insolvency.

C. Do HMO Statutes Exempt MCP Risk-Sharing Arrangements from Regulation Under the Insurance Statutes?

Most of these risk-sharing arrangements are operated by HMOs. MCPs that qualify as HMOs under either federal or state law are typically exempt from regulation as insurance companies, even though the risk assumed by the HMOs is not readily distinguishable from the risk assumed by insurers. It is doubtful that the exemption can also be construed to exempt affiliated providers from regulation. The federal statute specifically authorizes federally qualified HMOs to obtain insurance or to make other arrangements for passing off certain specified risks. With regard to providers, the statute specifically authorizes the HMO to “make arrangements with physicians or other health professionals, [or] health care institutions . . . to assume all or part of the financial risk on a prospective basis for the provision of basic health services by physicians or other professionals or through the institutions.” It is unclear whether this provision should be interpreted to permit the HMO to contract with one type of provider (a physician, for example) to take risk for the provision of health care services by the other types of providers, or whether the statute contemplates that the HMO may contract with a physician only to take financial risk for his own services. In any event, this statutory provision only describes the type of entity that is eligible for federal qualification. The statute has absolutely no bearing on HMOs that are not federally qualified, and many are not. Even if the HMO is federally qualified, the limits of the HMO’s authority to contract to pass off risk to providers, and the restrictions on the legality of providers

166. An HMO qualifying as a federal HMO is exempt under state insurance statutes with respect to initial capitalization and reserve requirements. Id. § 300e-10(a)(1)(D) (1989).
167. Id. § 300e(c)(2) (1991).
taking risk, are matters of state law.\textsuperscript{168}

Most state statutes explicitly contemplate that some risk will be assumed by the provider. Some statutes, such as New York’s, could be read to contemplate that providers will assume risk not only for the provision of their own services, but also for the cost of services provided by third parties. New York’s statute provides, in pertinent part, that the HMO may “require providers to share financial risk under the terms of their agreements.”\textsuperscript{169} Some other state laws do not clearly contemplate such an arrangement. For example, Minnesota’s HMO statute provides that HMOs may “[c]ontract with providers of health care services to render the services the health maintenance organization has promised to provide . . . [and] contract with insurance companies . . . for insurance, indemnity or reimbursement of its cost.”\textsuperscript{170}

Absent a specific statement that physicians may take risk for the cost of services provided by others, public policy and traditional rules of statutory construction favor a strict construction of the state HMO statutes. As discussed above, the interests of the public are jeopardized by these types of risk relationships.\textsuperscript{171} Moreover, no state statute that I have found explicitly exempts the physician (rather than the HMO) from regulation under the insurance laws. Thus, even HMO laws that specifically acknowledge that risk can be assumed by a physician can be made entirely consistent with the insurance laws only by finding that physicians who participate in such relationships must first obtain a license to engage in the business of insurance.

\textbf{D. The Impact of the Elimination of Risk-Sharing Relationships.}

The practical result of the application of the insurance laws to physicians\textsuperscript{172} is that, with the possible exception of large

\textsuperscript{168} \textit{But see id.} § 300e-10(a)(1)(E) (1989) (exempting federally qualified HMOs from state regulations that impose requirements that “prohibit the entity from complying with the requirements of this subchapter.”). It is not clear that state law requirements that prohibit providers from taking financial risk for the services of others would be construed as violative of subsection (1)(E) inasmuch as the federal law arguably permits, but certainly does not require, that HMOs enter into such relationships.

\textsuperscript{169} \textit{N.Y. PUB. HEALTH LAW} § 4402(c) (McKinney 1985).

\textsuperscript{170} \textit{MINN. STAT.} § 62D.05, subd: 3 (1990).

\textsuperscript{171} \textit{See supra} notes 158-64 and accompanying text.

\textsuperscript{172} A recent example of a law that specifically addresses the question of whether providers may engage in risk-sharing arrangements is \textit{MINN. STAT.} § 62D.12, subd. 9b (1990), which prohibits hospitals from assuming risk for services provided by “facilities or providers not owned, operated, or otherwise subject to the control of the hospital assuming
multi-specialty clinics, they will no longer participate in those risk-sharing arrangements that put them at risk for the cost of the services of others. Thus, a powerful incentive for cost containment will no longer be available to MCPs. MCPs will still, however, have available to them a panoply of financial incentives and structural methods for encouraging cost containment.

CONCLUSION

It has not been the aim of this Article to suggest that MCPs should be abolished, as they undoubtedly serve a legitimate competitive function. Rather, it has been to point out that accepted MCP practice is moving further from legal and ethical norms governing the practice of medicine. It seems unlikely that the beneficial effects of MCPs are so great as to justify the complete disregard of these norms. The suggestions set forth in this Article would go a long way toward forcing MCPs to operate in an acceptable manner without, I believe, significantly impairing their ability to recognize efficiencies. Perhaps this Article will initiate a discussion regarding the appropriate regulation of MCPs. There is simply too much at stake to continue to ignore the control that MCPs exercise over the delivery of health care, not to mention the influence that they exert on physicians in the exercise of their professional judgment and the fulfillment of their moral and ethical obligations.

173. Another consequence might be that many MCPs will find it difficult to avoid taxation under I.R.C. section 501(m). See, e.g., supra note 149.

174. See, e.g., supra text accompanying notes 30-40 for a description of the financial incentives.

175. See, e.g., supra text accompanying notes 25-29 and 36-39 for a description of the structural methods.