



# THE PERILS OF MANAGED CARE II<sup>1</sup>

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Managed care is at the center of a revolution in health care in this country, with far-reaching effects for patients, health care providers, and attorneys. This paper will outline the basic principles of managed care, and the problems and conflicts which it presents to our clients.

## What is Managed Care?

The AMA defines managed care as “a system or techniques that affect access to and control payments for, health care services.”<sup>2</sup>

Managed care is not a new idea. The Kaiser plan in California pioneered the idea in the 1930s that patients would receive care through a single “seamless” system as they moved from wellness to illness and back to wellness again. Continuity of care, prevention, and early intervention are stressed.<sup>3</sup>

Unlike the “one stop shopping” approach of the early Kaiser system, there are many hybrid models today, the most common of which are:

1. Under a **Capitated Payment System**, hospitals, physicians and other providers negotiate set payment rates for the services they provide, or for the number of patients for whom they are responsible. Unlike traditional indemnity plans, in which

the insurance company bears the financial risk and burden of patients requiring more complex and costly care, capitation places the risk and burden on the health care provider. When patients require care that is more costly than the negotiated amount, the burden of the extra cost is borne by the contracting health care provider. The financial incentive, therefore, is to provide preventive care as well as only those services which are thought necessary.

2. **HMO’s** are the most tightly structured form of managed care. They require patients to use designated physicians for all but emergent care. The physicians can be in a multi-specialty group practice which contracts with the HMO, or they can be employees of the HMO.

3. An **Independent Practice Assoc. (IPA)** is a group of physicians who form a legal entity for the purposes of contracting with payors to provide health care services, but who maintain their separate offices and individual corporate identities.

4. **Preferred Provider Organizations (PPO’s)** are entities through which employer group health plans or other insurance payors contract to purchase discounted health care services.

Today, managed care is growing at an impressive rate; 75% of physicians in the U.S. practice in the context of managed care in some form.<sup>4</sup> In 1991, 47% of U.S. patients belonged to

a managed care plan. By 1994, that number had increased to 65% and by 2000 it is expected to reach 95%.<sup>5</sup>

## How Do Managed Care Entities Hold Down Costs?

Such systems manage or control the physician’s and patient’s behavior through financial and administrative restrictions including: the use of case managers to coordinate medical care in expensive cases; offering monetary rewards (or penalties) to encourage physicians to “conserve resources;” excluding some services from the benefits package; and requiring primary care physicians to serve as “gatekeepers” to control access to specialty care, tests and technology.

Managed care as a cost containment strategy has been effective at least on a short-term basis, although no one knows whether the same will hold true in the long run. There is at present no reliable evidence that health care costs and expenditures are significantly lower in an area with long-term utilization of managed care.<sup>6</sup>

The use of a primary care provider who acts as a gatekeeper, limiting access to more expensive specialists, tests and technologies, definitely saves money on a short-term basis. Many studies confirm that primary care physicians can effectively manage 55% of the problems of their patients, and they do so for 25% of the cost of a hospital setting in the short-term.<sup>7</sup> Another study shows that internists

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order 23% to 47% fewer tests than their specialist colleagues on admitted patients.<sup>8</sup>

Although the trend of using gatekeepers with financial incentives to hold down costs may be penny-wise, it is possible that over the long run it will prove to be pound-foolish. I hear horror stories each week from specialists who receive referrals only when the patient's condition has markedly deteriorated after every less-expensive treatment modality has failed. The patients then require more expensive care, and have worse outcomes as a result of the delay in making the referral. These observations were echoed in a recent study by researchers at Duke University, which concluded that elderly heart attack patients who were immediately treated by a cardiologist were 15 percent less likely to die than patients whose initial treatment was provided by a family practitioner.<sup>9</sup>

In many systems, managed care has also changed the fundamental roles of the insurance company and the health care provider. Financial risk of expensive care was traditionally borne by the insurer. Managed care entities have learned how to shift the risk of cost overruns to the providers: mainly physicians, hospitals and commercial laboratories. This has resulted in enormous profits for some managed care entities; and a financial disincentive for those bearing the risks to provide costly treatment when such therapy may be required.

Contrast Kaiser Permanente's "Medical Loss Ratio" of 95% (meaning 95% of every premium dollar is spent on medical services for members) with

U.S. Healthcare's rate of 68.9%. This difference is what allowed U.S. Healthcare (one of the largest managed care entities with 1.7 million members) to earn a net profit of \$105 million in a recent quarter.<sup>10</sup>

If we project those profit margins throughout the remainder of the market, there is a potential \$60 billion profit in managed care annually. Thus, it should come as no surprise that patients are increasingly referred to as "clients".

Of course, the group calling the shots, the large insurance coverage purchaser, is happy: The cost of employer-sponsored health benefits, which was rising an average of 17.1% in 1990, declined an average of 1/1% in 1995. Some health plans offered to cut large employers' rates by as much as 10% in 1996.<sup>11</sup> Employers may be happy, but patients and their families are suffering.

**A Typical Example**

Some months ago, you probably read about Long Island Jewish Medical Center in the New York Times. There were three anesthesia-related deaths of otherwise healthy patients in less than three months at that hospital, an incident which is fortunately unusual. Investigators concluded that the deaths were the indirect result of the impact of managed care. Rather than continue to contract with the experienced private group of anesthesiologists earning \$350,000 annually, the hospital terminated their contract and hired salaried employees at the rate of \$100,000 to \$200,000 per year, attracting graduates fresh from residency and foreign-trained physicians. This move, to increase operating room profits, has cost at

least three healthy people their lives.<sup>12</sup> Similar horror stories have appeared in many publications of late.

**The Toll on Health Care Providers**

The health care community is a wash in turmoil, uncertainty, and anxiety. Health care providers are having great difficulty concentrating on patients when they are facing layoffs, mergers, affiliations, loss of autonomy and power, and pressure to contain costs. The overwhelming concern at every interface is the profit margin, so institutions are re-configuring themselves to increase profits.

Hospitals are eliminating large numbers of nursing jobs, despite the fact that American hospitals already use 20 percent fewer nurses than their foreign counterparts.<sup>13</sup> Nonprofessionals technicians, also known as unlicensed assistive personnel, or "care partners," are being hired and trained to provide bedside nursing care. Some of these employees are high school graduates with four to six weeks of training. There is no consensus about minimum requirements for these positions, and the duties and responsibilities differ from institution to institution. The result is fragmented care and a missed opportunity for patient assessment and intervention.

These economic forces are also a deleterious effect on the physician-patient relationship. Managed care can result in:

- *Decreased patient choice in selecting providers;*
- *Decreased incentive for competence at the expense of productivity;*
- *Decreased communication due to productivity pressures;*



- *Decreased compassion (who has the time?);*
- *Decreased continuity of care as employers shift from one plan to another; and*
- *Increased opportunity for conflict of interest between physician and patient because of economic incentives for the physician NOT to use medical services, and because of the need for the physician to balance the needs of other patients competing for the same limited resources.*<sup>14, 15</sup>

HMO's frequently withhold 15-30% of physicians' or hospitals' fees until the end of the year, and pay those fees only if the physician meets a set of resource utilization goals.<sup>16</sup> Payments may be made in inverse proportion to a physician's average patient cost: the more costly the care, the less they will be paid per unit of service as a disincentive to provide "costly" care.

Some HMO's or PPO's even allow a primary care physician to keep all funds budgeted for the care of his or her patients left unspent by the end of the year. Others offer incentive payments to physicians based upon medical outcomes and cost performance.

Needless to say, patients are not informed of these secret deals. They believe that physicians are recommending a course of care which is in the patient's best interest, not the physician's best interest. Patients are at a disadvantage when it comes to detecting withheld care because they usually have no idea that certain treatment options even exist.

Physicians I have recently encountered are demoralized by being forced to consult an insurance company staff

member who sometimes has little relevant education or background to seek authorization to provide care which they believe is medically necessary.

### **The Eroding Standard of Care in the Managed Care Environment**

The critical issue for hospitals is no longer whether care is reasonable and appropriate, but whether it is time-limited and cost-effective. The source for this determination is not practice parameters, but a utilization review study called the Milliman & Robertson Healthcare Management Guidelines, generated by a Seattle actuarial consulting firm. It prescribes what are represented to be reasonable lengths of hospital stays for various conditions, and outlines necessary services. Milliman executives assert that health plans' medical bills can be lowered by 15% when guidelines are followed. Among others, Prudential, U.S. Healthcare, and some Blue Cross and Blue Shield plans currently use the Milliman guidelines when making coverage decisions. Many hospitals use the guidelines as an information source; physicians are expected to discharge their patients within those guidelines or they will be held accountable.

The American Medical Association asserts that the guidelines are unreasonable because they are based on a minority of patients who have the shortest length of stay, and also assume that home health services are available to the patient.<sup>17</sup> Physicians individually feel that their professional judgment has largely been supplanted by fiscal policy, and as a result patient well-being is potentially at risk. The guidelines have been attacked in a class action lawsuit filed December 27, 1996

in the United States District Court for the Eastern District of New York in *Nancy T. Vogel v. The Prudential Insurance Company of America and The Prudential Health Care Plan of NY, Inc.* The complaint charges, among other allegations, that the Milliman & Robertson guidelines interfere with a physician's exercise of medical judgment and conflict with generally accepted medical standards.<sup>18</sup>

In an effort to maintain quality of care while reducing costs, professional associations are developing clinical practice guidelines.<sup>19</sup> Potential hazards include making the guideline overly broad to be useful in clinical decision-making, or overly narrow to allow for modification in individual complex cases. Some local physicians fear that the end result of guideline proliferation may be "cookbook medicine" delivered by ancillary health care providers and overseen by physician administrators. They see this as yet another step in supplanting their professional judgment and depersonalizing medical practice.

### **Emerging Liability Theories**

As utilization of managed care increases, various theories of liability have been asserted, some with success. Due to space constraints these emerging theories can only be outlined, but the references cited can provide a starting point for further research.

One issue causing confusion and conflict among health care providers is how to weigh the patient's right to know the full scope of treatment alternatives, versus only those treatments a managed care entity is willing to fund. When does an insurer determine the range of choices the patient is allowed to evaluate and consider? In a

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case involving whether a managed care entity should fund bone marrow transplantation in a patient with advanced breast cancer, an oncologist queried “If you know that someone’s a Health Net patient, do you talk to them differently than if they’re somebody else?”<sup>20</sup>

A health care provider’s duty to secure an informed consent from the patient includes the recognized possible alternative forms of treatment. Failure to inform a patient of available treatment alternatives because they would not be approved by the patient’s insurer violates the basic trust foundation of the physician-patient relationship, as well as the doctrine of informed consent.

The doctrine of informed consent may expand to compel disclosure of facts which suggest that the physician has a potential conflict of interest. In *Moore v. Regents of the University of California*, the Supreme Court of California held that “a physician who is seeking a patient’s consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient’s informed consent, disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect his medical judgment.”<sup>21</sup>

A physician-patient relationship has long been a necessary precedent to imposing liability for physician negligence. Recently, a new paradigm for the physician-patient relationship has evolved, thus expanding physician liability. In *Hand v. Tavera and Humana Hospital*, 864 S.W.2d 678 (Tex. App. 1993), telephone contact between an emergency room physician seeking

authorization for hospital admission for a managed care plan insured and a managed care plan physician responsible for authorizing such admissions, was sufficient to establish a physician-patient relationship, and thus a duty of care, between the plan physician and the insured.

As patient choices are limited in managed care, the vicarious liability of managed care entities will expand. The extent of liability will depend to some extent on the architecture of the managed care entity; some are merely administrative conduits while others exercise control of the patient care provided.

The most direct approach to establish liability against a managed care entity is the theory of respondent superior. One may overcome the independent contractor defense by showing that the managed care entity exercises a right to control the health care provider. For example, IPAs and PPOs customarily require pre-authorization for hospital admissions, and concurrent reviews of lengths of stay and fees for both inpatients and outpatients. Failure to abide by these regulations may result in a provider being removed from the panel of approved health care providers. These factors may be sufficient evidence of control to constitute an employer-employee or principal-agent relationship. Additional factors to consider include how and by whom fees are set, and how the provider is paid.<sup>22</sup>

Under the theory of ostensible agency, an entity can be held liable for the acts or omissions of an independent contractor if, considering all of the

facts and circumstances, a patient reasonably believes that the physician is an employee of the entity, the belief is generated by some act of the entity, and the patient justifiably relies on the appearance and representation of authority.<sup>23, 24, 25</sup>

Factors to consider as possible evidence of ostensible agency include the degree of choice a patient may exercise in selecting a physician, how the relationship between the entity and the physician is described in the entity’s promotional materials, and whether the entity’s name appears on the building, office, name tag, stationery, reports or bills of the physician.

Just as in hospitals, under the doctrine of corporate negligence, owe an independent duty to their patients to exercise reasonable care in selecting, retaining, and supervising the performance of their medical staff<sup>26</sup>, so also may managed care entities.<sup>27, 28</sup> The basis of liability is the hospital’s duty of reasonable care to protect its patients from harm. Given the managed care entity’s selection of health care providers, and the restriction of the patient’s choice of health care providers under managed care, it seems probable that the doctrine of corporate negligence will be extended to managed care entities.

Finally, a number of cases have been brought against managed care entities for underutilization: liability for unreasonable cost-containment efforts causing patient harm. These efforts are part of the process of utilization review in which the managed care entity reviews medical care for medical necessity, and attempts to ensure that care is rendered by health



care providers within the managed care system. Cases have most frequently involved the issue of patient injury resulting from the denial of coverage for requested services, typically either allegedly experimental treatment or extension of a previously approved length of hospital stay.

Managed care entities have argued that they are merely denying payment, not treatment, but this approach may not insulate them from liability. For many people, denial of payment is equivalent to denial of treatment given their limited economic resources. Liability will be determined in part by weighing the societal benefit of cost-containment against the risk of harm caused by the denial of benefits, and the reasonableness of the patient care rendered.<sup>29,30,31,32</sup>

### The Erosion of the ERISA Defense

Whether a claimant has been successful in an action against a managed care entity for tortious conduct has depended in part upon the nature of the claimant's health care plan. Managed care entities, contracting with employee benefit plans to administer health care, have been successful to varying degrees, depending upon the jurisdiction, in avoiding liability for violations of state statutory and common law. In many of those cases, courts have held that state law is pre-empted by the federal law, commonly referred to as ERISA, even though that law was not designed to provide an alternative code for compensating injured persons for such tortious conduct.

ERISA is the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

It comprehensively regulates the administration of employee pension and welfare plans which provide employee "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident disability [or] death." It does not regulate the substantive content of such plans. It does, however, contain a broad pre-emption provision declaring that the statute shall "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Section 514(a). On the other hand, it contains an "insurance savings clause" at § 514(b)(2)(A) which, with one exception provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." The one exception is if the employer self insurers. A self-insured employer may contract with a managed care entity to serve as its agent to administer its plan so long as the risk of loss is on the employer rather than on the insurance company, and still avoid regulation by state insurance laws.

There are hundreds of decisions, many of which are inconsistent, interpreting the scope of the ERISA pre-emption. Nevertheless, one can draw some generalities as to the types of claims against employee pension and welfare plans which courts have usually found to be pre-empted by ERISA, and those which are usually found to avoid pre-emption.

The broad pre-emption language in ERISA has been successfully used by managed care entities to defend claims based upon laws which regulate the type of benefits or terms of the plan; which create reporting, disclosure,

funding or vesting requirements; which provide rules for the calculation of the amount of benefits to be paid under the plan; and which provide remedies for misconduct growing out of the administration of the plan itself. *National Elev. Indus., Inc. v. Calhoun*, 957 F.2d 1555 (10th Cir. 1992) cert. denied, 506 U.S. 953, 113 S.Ct. 406, 121 L.Ed.2d 331 (1992). In this regard, claims for breach of contract, and liability for the managed care entity refusing to pay for certain equipment under the benefits plan have been deemed pre-empted by ERISA. *Elsesser v. Hospital of Philadelphia College*, 802 F.Supp. 1286 (E.D. Pa. 1992).

Also deemed pre-empted have been claims against managed care entities for denying certain benefits to participants. See, e.g. *Corcoran v. United HealthCare, Inc.* 965 F.2d 1321 (5th Cir. 1992); *Kuhl v. Lincoln Health Plan of Kansas*, 999 F.2d 298 (8th Cir. 1993).

On the other hand, the ERISA pre-emption has generally not been extended to claims concerned solely with the quality of the benefits provided, or of medical negligence against a managed care entity for substandard care, particularly where such claims are based upon a theory of vicarious liability for the acts of physicians acting as ostensible agents of the managed care entity. *Chaghervand v. Healthcare Corporation of the Mid-Atlantic, Inc.*, 909 F. Supp. 304 (D.Md. 1995); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Prihoda v. Shpritz*, 914 F. Supp. 113, 118 (D. Maryland 1996); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994); *Dukes v. U.S.*



Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) cert. denied, U.S. , 116 S.Ct. 564, 133 L.Ed.2d 489 (1995). (But see Nealy v. U.S. Healthcare HMO, 844 F. Supp. 966 (S.D.N.Y. 1994) in which the court held that claims, including those for medical negligence against an HMO and its medical director “relate to” the administration of the plan and were therefore subject to pre-emption.)

In *Dukes*, Mr. Dukes was a member of an HMO through an employer-sponsored health care program. He underwent surgery on his ears and was given a prescription by his physician to have blood tests. The hospital refused to do the tests. Although the tests were eventually done, Mr. Dukes’ condition had deteriorated in the meantime, and he subsequently died as a result of the delay. The Third Circuit held that this was not a claim to recover benefits due, but was a claim about the quality of a benefit received and was therefore not pre-empted by ERISA.

Inconsistencies between the rights of patients covered under ERISA plans and those who are not, and inconsistencies in the application of the pre-emption language by the courts have led a number of federal lawmakers to consider offering amendments to ERISA. Representative Charles Norwood (R-GA) has just offered a bill entitled The Patient Access to Responsible Care Act of 1997 which would, among other things, clarify that individuals are not prevented from bringing liability claims against the agents of self-insured plans for wrongful death or personal injury suffered by the medical decision-making policies of the plan.

## CONCLUSION

Absent legislation prohibiting monetary incentives (or penalties) between managed care entities and physicians (including physicians employed by that entity), and recourse enabling physicians and patients to challenge such abuses, horror stories will multiply. The fault lies not with the physician, but with a system which shamelessly promotes a conflict of interest between the managed care entity, the doctor, and the patient.

Applying marketplace economic theory to health care is fraught with peril: the health care system is not about cost containment, it is about the interface between science and caring. Once that essential moral content is eradicated from the system, it is replaced by a corporate system ruled by money; and the Hippocratic oath to “first, do no harm,” becomes an anachronism.

*Ms. Greenstreet limits her practice to representing plaintiffs in medical negligence actions.*

## FOOTNOTES

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