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MOVE OVER MARCUS WELBY, M.D. AND MAKE WAY FOR MANAGED CARE: THE IMPLICATIONS OF CAPITATION, GAG CLAUSES, AND ECONOMIC CREDENTIALING

I. INTRODUCTION—SAY GOODBYE TO THE GOOD OL' DAYS

Imagine you are awakened one morning by severe abdominal pain. As the day progresses, the pain does not go away; in fact, the pain gets worse and you begin experiencing rectal bleeding. You have health insurance through a health maintenance organization (HMO) so you contact your primary-care physician, Dr. Wong, and arrange an examination. Dr. Wong examines you and runs a battery of tests to attempt to diagnose your condition. Dr. Wong preliminarily determines that you have rectal cancer. She wants an oncologist, a cancer specialist, to examine you and confirm the diagnosis. However, Dr. Wong receives $35 per month from your insurer for all of the primary care that you require. If she refers you to a specialist, Dr. Wong must pay the specialist's fees herself, since your $35 capitated fee will not cover the specialist's fees. After considering the economic impact of her decision, Dr. Wong decides not to refer you to a specialist.

Dr. Wong though, is torn between her economic self-interest and your best interests. She struggles to reconcile her decision with the ethical precepts of the medical profession. She recalls the oath she took upon joining the medical profession, "First do no harm." The guilt tears at her conscience and Dr. Wong asks you to come in to see her. She informs you of her diagnosis and confesses that her economic self-interest got in the way of her ethical obligations. She describes to you a process she calls "capitation," which is the method your HMO uses to compensate her a fixed amount per patient, regardless of the amount of care she provides.

Although you empathize with the precarious position in which Dr. Wong finds herself, you can no longer trust her. Consequently, you change to another HMO and select Dr. Lopez as your primary-care physician. Dr. Lopez believes that he can confirm your diagnosis through a particular test and thus would not have to refer you to an oncologist. However, your new HMO does not cover that test. Dr. Lopez wants to tell you about the test; in fact, he knows he has an ethical and maybe even a legal obligation to tell you about this option. However, Dr. Lopez knows that if he tells you about the non-covered treatment, your HMO could prevent him from participating in the plan by using the "gag clause" that the HMO included in his contract. After much reflection, Dr. Lopez decides not to tell you

about the test and instead uses a less accurate test which is covered by your HMO.

Even though Dr. Lopez keeps quiet, your HMO terminates him anyway. The HMO decides that Dr. Lopez orders too many tests and refers too many patients to specialists and those practices affect the HMO's bottom line. Your HMO terminates Dr. Lopez because it concludes that Dr. Lopez is economically inefficient, even though the HMO acknowledges that the quality of Dr. Lopez' care is unquestionably good. He just costs the HMO too much money.

Capitation, gag clauses, and economic credentialing present just three of the dilemmas that doctors face in a managed care environment. The days of practicing medicine like Marcus Welby, the television character of another era, are gone. Consider the following description of the physician-patient relationship in the 1950s:

> It's up to every doctor to learn to give his patient something besides a pill. If the patient is not too ill, and especially when he is convalescent, sit and talk with him a while about some subject that interests him. Tell him a new joke if you have one on tap; make him smile before you leave if possible.[1]

The relationship that physicians and patients enjoyed in the 1950s is considerably different from the relationship of today, especially after the advent of managed care. Managed care, which has come under considerable attack by both patients and physicians, has shifted many of the traditional health care paradigms. For example, capitation has replaced the traditional fee-for-service model.[2] In addition, patients formerly believed that they should have access to the latest medical technology and any available medical treatments, regardless of the costs or benefits.[3] In fact, it was not unusual for patients to believe that the more services that a physician provided, the better the care.[4] Managed care replaces that paradigm in favor of health care rationing.

Managed care is defined as "[a]ny type of intervention in the delivery and financing of health care that is intended to eliminate unnecessary and

1. Laurel Shackelford, *The Patient or 'the Plan': For Doctors, Who is Boss?*, COURIER-JOURNAL (Louisville), Nov. 3, 1996, at 1D (quoting Dr. Edwin A. Davis).

2. *See infra* notes 23-25 and accompanying text for a brief discussion of the fee-for-service model.

3. *See* Erik Larson, *The Soul of an HMO: Managed Care is Certainly Bringing Down America's Medical Costs, But it is also Raising the Question of Whether Patients, Especially Those with Severe Illnesses, Can Still Trust Their Doctors*, TIME, Jan. 22, 1996, at 44, 45.

4. *See* Carol Gentry, *Doctors as Double Agents*, ST. PETERSBURG TIMES, Jan. 1, 1995, at 1D.

inappropriate care and to reduce costs."[5] Generally, managed care is a health care system that manages the financing and delivery of health care services so that health care is provided more effectively and for less money.[6] Managed care evolved as a means to put the brakes on out-of-control health care costs caused primarily by the third-party payment system.[7] The third-party payment system offers no incentive to contain health care costs because the people buying health care services are not the consumers.[8] Rather, physicians sell health care services to patients through insurers.[9] Thus, the patient receives services, but a third party, not the patient, pays for those services.[10] The injection of managed care into the third-party payment system has helped arrest the rise in health care premiums, from double-digit inflation in previous years to just a two percent increase in 1995.[11]

Managed care troubles patients because it involves the rationing of health care, which some would argue is antithetical to the health care system in the United States.[12] Physicians resent the changes that accompany managed care because they have always resisted efforts by outsiders to change the medical profession.[13] In addition, managed care intrudes upon the unquestioned autonomy that physicians enjoyed before the arrival of managed care.[14]

Despite these concerns, today, many physicians and other health care professionals provide health care through a web of managed-care organizations (MCOs).[15] Over fifty million Americans,[16] three million of whom are Texans, are enrolled in some sort of managed-care plan.[17] Currently, about twenty percent of Texans are enrolled in HMOs and about forty percent are enrolled in preferred provider organizations (PPOs).[18] Without

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5. Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?*, 83 GEO. L.J. 1821, 1825 (1995) (quoting KATHRYN LANGWELL, CONGRESSIONAL BUDGET OFFICE, THE EFFECTS OF MANAGED CARE ON USE AND COSTS OF HEALTH SERVICES 22 (1992)).

6. *See* John K. Iglehart, *The American Health Care System: Managed Care*, 327 NEW ENG. J. MED. 742, 742 (1992).

7. *See* M. Stanton Evans et al., *The Trouble With HMOs*, CONSUMERS' RES., July 1995, at 10, 11.

8. *See id.*

9. *See id.*

10. *See id.*

11. *See 40 States Trying to Bandage HMO Ills*, COLUMBUS DISPATCH, Mar. 15, 1996, at 1A.

12. *See* MICHAEL E. CAFFERKY, MANAGED CARE & YOU: THE CONSUMER GUIDE TO MANAGING YOUR HEALTH CARE 89 (1995).

13. *See* Richard H. Egdahl & Cynthia H. Taft, *Financial Incentives to Physicians*, 315 NEW ENG. J. MED. 59, 59 (1986).

14. *See* Iglehart, *supra* note 6, at 742-43.

15. *See id.* at 743.

16. *See* CAFFERKY, *supra* note 12, at 12.

17. *See id.* at 3.

18. *See* Terrence Stutz, *Senate Bills May Expand HMO Patients' Rights, Protections*, DALLAS

question, managed care has altered the face of health care delivery in the United States. Some contend that not all of the changes brought about by managed care are wise.

The purpose of this Comment is to examine three foundational, yet controversial, areas of managed care: financial incentives to physicians, gag orders in physician contracts, and economic credentialing. Part II introduces managed care by examining its history and the types of MCOs that have developed over the years. Part III analyzes physician financial incentives, gag orders, and economic credentialing to determine whether, in fact, these managed-care mechanisms truly raise a Hobson's choice for physicians or whether they provide workable solutions to the health care crisis.

II. EBBS AND FLOWS OF HEALTH CARE SYSTEMS IN THE UNITED STATES

Contrary to public opinion, managed care is not a new philosophy.[19] Originally developed to entice immigrants into certain parts of the country,[20] managed care is at least partially responsible for holding health care costs steady.[21] In the process of containing costs, MCOs have taken on a life of their own by transforming from the traditional HMO into other kinds of business structures.[22]

A. Historical Perspective of Managed Care—The Early Years

The fee-for-service model is the traditional form of health care where indemnity insurers reimburse doctors and hospitals for all of the care that they provide.[23] Under the fee-for-service system, a patient's insurance company pays physicians and other health care professionals for each particular service they provide to the insured patient, rather than paying the physician a fixed payment per patient or a salary.[24] The fee-for-service model encourages doctors and hospitals to overtreat patients because they accumulate revenues for each and every procedure they perform.[25] The

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MORNING NEWS, Jan. 31, 1997, at 23A.

19. *See* Robert Kuttner, *Mutant HMOs*, WASH. POST, Jan. 1, 1997, at A19.

20. *See* Emily Friedman, *Capitation, Integration, and Managed Care: Lessons From Early Experiments*, 275 JAMA 957, 957-59 (1996).

21. *See 40 States Trying to Bandage HMO Ills*, COLUMBUS DISPATCH, Mar. 15, 1996, at 1A.

22. *See infra* notes 48-62 and accompanying text.

23. *See* Pamela Gaynor, *Some Definitions Can Make Sense of Managed Care*, PITTSBURGH POST-GAZETTE, Dec. 8, 1996, at C4.

24. *See* THE SIGNET MOSBY MEDICAL ENCYCLOPEDIA 314 (Walter D. Glanze et al. eds., rev. ed. 1996).

25. *See* Carolyn M. Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?*, 273 JAMA

notion of overtreating patients is significant, not only because the end result is the overcharging of patients, but also because providing unnecessary services increases the patient's odds of iatrogenic injury, which is injury caused by doctors and health care institutions through treatment or diagnosis.[26]

The influx of immigrants into the United States during the 1800s ignited the development of managed-care organizations in the United States because employers often included health care as part of an immigrant's compensation or used health care benefits to induce immigrants to work in remote areas of the country.[27] At least one health care plan, which resembled today's HMO, existed as early as 1849.[28] Dr. Michael Shadid, a United States immigrant, created the first capitated physician-hospital organization (PHO) in 1931.[29]

The early managed-care plans resembled the Kaiser-Permanente Health Plan, which was created in the 1940s and continues to exist today.[30] Kaiser-Permanente's medical group employed physicians who practiced in facilities owned by the health plan and who provided medical care for a fixed monthly premium.[31] The early managed-care plans were not highly successful, however, because they were unpopular among the medical establishment and they competed against the more traditional fee-for-service model of health care delivery.[32]

President Richard Nixon transformed the managed-care plans of the 1930s and 1940s into what is known today as an HMO by, among other things, signing into law the Health Maintenance Organization Act of 1973 (Act).[33] Congress expected that the Act would slow escalating health care expenditures by increasing the number of HMOs, thereby stimulating competition.[34] The federal government's belief in managed care was so strong that it provided subsidies to help HMOs get started.[35] Although the Nixon Administration failed to meet its goal of creating 1,700 HMOs, it

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338, 338 (1995).

26. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 24 (2d ed. West Publishing 1991); *Doctors Sue to Fight Economic Credentialing*, 48 MED. & HEALTH, Oct. 3, 1994, at 1.

27. *See* Friedman, *supra* note 20, at 957-58.

28. *See id.* at 957 (referring to La Société Française de Bienfaisance Mutuelle founded in San Francisco, California).

29. *See id.* at 959 (referring to the Community Cooperative Hospital of Elk City, Oklahoma).

30. *See* Iglehart, *supra* note 6, at 743.

31. *See id.*

32. *See id.* at 743-44; *see also supra* notes 23-25 and accompanying text for a discussion of the fee-for-service model.

33. Health Maintenance Organization Act of Dec. 29, 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified at 42 U.S.C. § 300e (1994 & Supp. I 1995)).

34. *See* Iglehart, *supra* note 6, at 744.

35. *See id.*

nevertheless set the foundation for major changes, the effects of which continue to exist today.[36] First, the popularity of HMOs surged during the 1980s.[37] Second, the 1980s saw countless nonprofit health care entities convert into for-profit enterprises.[38]

B. *The 1990s—Mergers and Acquisitions are Booming in Health Care*

In the 1990s, mergers and acquisitions epitomize the trend in the health-care industry as hospitals merge to gain market share and realize economies of scale.[39] Merger and acquisition activity in the Texas health care industry is booming. In fact, Texas led the country in hospital closures in 1996, principally as a consequence of MCOs' cost-cutting measures.[40] Recent examples of hospital mergers in Texas include Parkland Memorial Hospital of Dallas' proposed merger with Children's Medical Center, Zale Lipshy University Hospital and Texas Southwestern Medical Center at Dallas,[41] and Tenet Healthcare's bid for the Baylor Health Care System.[42] Mergers, though, are not limited to hospitals; 1996 marked the first acquisition of an HMO, U.S. Healthcare, by an insurance company, Aetna Life and Casualty Company.[43] Plans are also under way for Columbia/HCA Healthcare Corporation to acquire Blue-Cross & Blue-Shield of Ohio for $299.5 million.[44]

One report estimated that fifteen percent of all private hospitals were involved in a merger, acquisition, or joint venture in 1996.[45] Two MCOs clearly dominate the industry as a result of merger and acquisition activity: (1) Columbia/HCA, with 300-plus hospitals; and (2) Tenet Healthcare Corporation and Ornda HealthCorporation which, after a planned merger, will hold 126 hospitals.[46] As an illustration of their market dominance,

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36. *See id.*

37. *See id.* Enrollment in HMOs increased by almost 29 million during the 1980s. *See id.*

38. *See* Kuttner, *supra* note 19, at A19.

39. *See Hospital Merger: Parkland's Commitment to Poor Hasn't Changed*, DALLAS MORNING NEWS, Nov. 17, 1996, at 2J.

40. *See* Frank Bass, *Texas Led U.S. In Hospitals Shutting Down*, WALL ST. J., Jan. 15, 1997, at T1.

41. *See* Bill Deener, *Girding for an Attack: 3 Hospitals, Medical School Doctors Plan Merger to Fight Networks*, DALLAS MORNING NEWS, Sept. 1, 1996, at 1H.

42. *See* Bill Deener, *Tenet Interested in Baylor Hospital: Chain is 2nd-largest Health Facility in U.S.*, DALLAS MORNING NEWS, Jan. 25, 1997, at 1A.

43. *See Aetna and U.S. Healthcare: Yet More of the Same Medicine*, ECONOMIST, Apr. 6, 1996, at 67.

44. *See* Diane Solov & Mark Tatge, *Playing the Blues: Trio Brought Ohio's Largest Health Insurer Success, Power But Now Face Criticism as They Pursue a Controversial Merger*, PLAIN DEALER (Cleveland), Jan. 19, 1997, at 1A.

45. *See 15% of Hospitals Involved in Mergers*, CHI. SUN-TIMES, Dec. 23, 1996, at 16.

46. *See id.*

Columbia/HCA and Tenet Healthcare own all of the major private hospitals in El Paso.[47]

C. ABCs of Managed Care—Types of Managed Care Organizations

Almost 140 million Americans use some sort of MCO to meet their health care needs.[48] MCOs, which are beginning to dominate the health care industry, represent a sort of alphabet soup with acronyms like HMO, POS, IPA, and PPO to name a few.

1. Health Maintenance Organization

The most commonly recognized MCO structure is the Health Maintenance Organization (HMO).[49] Under this structure, an HMO provides a certain set of services in exchange for prepaid premiums.[50] A staff-model HMO directly employs physicians, while a group-model HMO contracts with physicians who deliver the health care services.[51] An HMO may not pay for services unless patients receive their medical care from a health care provider who is part of "the network," meaning an employee or contractor of the HMO.[52] A customer selects a physician from an authorized list of physicians to serve as the customer's primary-care physician.[53] The primary-care physician, in turn, either provides routine services for the patient or, alternatively, refers the patient to a specialist if

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47. *See* Rex Dalton, *El Paso on Health Care Frontier*, SAN DIEGO UNION-TRIBUNE, July 21, 1996, at A1. Health care mergers have antitrust implications. *See generally* Robert J. Enders & Thomas A. Papageorge, *Managed Care and Antitrust: The Divergent Views of Government and Providers*, 18 WHITTIER L. REV. 121, 122 (1996) (discussing the issuance by the Federal Trade Commission of the "Antitrust Enforcement Policy Statements in the Health Care Area"); Mark L. Glassman, *Can HMOs Wield Market Power? Assessing Antitrust Liability in the Imperfect Market for Health Care Financing*, 46 AM. U. L. REV. 91, 107 (1996) (discussing possible antitrust ramifications as "health care market matures"); Nancy L. Sander, Note, *Health Care Alliances: Good Medicine For An Ailing Health Care Industry, or Antitrust Illnesses to Fence In?*, 27 U. TOL. L. REV. 687, 696 (1996) (stating that "health care providers face the same liability and can assert the same defenses as other types of businesses in antitrust actions"). Antitrust issues are beyond the scope of this article.

48. *See* Families USA, *HMO Consumers at Risk: States to the Rescue* (visited Jan. 17, 1997) <http://epn.org/families/farisk.html>.

49. *See* Seema R. Shah, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to* PacifiCare of Oklahoma v. Burrage, 80 MINN. L. REV. 1545, 1459 (1996).

50. *See* TERRY O. TOTTENHAM ET AL., FULBRIGHT & JAWORSKI, L.L.P., TEXAS MEDICAL JURISPRUDENCE 288 (11th ed. 1996).

51. *See* CAFFERKY, *supra* note 12, at 19-20. A network model exists when the HMO contracts with two or more medical groups. *See id.* at 20. The staff-model HMO is not used in Texas because Texas prohibits corporations from practicing medicine or directly employing physicians to practice medicine. *See* TOTTENHAM ET AL., *supra* note 50, at 288.

52. *See* TOTTENHAM, ET AL., *supra* note 50, at 288.

53. *See* CAFFERKY, *supra* note 12, at 57-58.

the HMO concurs with the physician that a referral is appropriate.[54] The point of service plan (POS) is a variation of the HMO.[55] The POS enables customers to pay more to see physicians and other health care providers outside of the HMO network.[56]

2. *Independent Practice Association*

An Independent Practice Association (IPA) is similar to an HMO except that the physicians contract with the IPA which in turn, contracts with HMOs.[57] Consequently, the IPA, rather than the HMO, compensates the physicians and it is the IPA, not the HMO, which makes treatment decisions.[58] The IPA serves as an intermediary between a panel of physicians and the insurer.[59]

3. *Preferred Provider Organization*

A Preferred Provider Organization (PPO) is an arrangement whereby physicians and hospitals contract with the PPO to provide medical care at discounted rates.[60] A PPO patient can go outside of the PPO network if the patient pays more.[61] In addition, a patient can use any provider on the PPO list, without obtaining a referral from a primary-care physician.[62]

III. THE DIAGNOSIS—MANAGED CARE DILEMMAS

Regardless of the form the MCO takes, all managed-care entities share some similar characteristics in their quest to contain health care costs. First, MCOs may provide financial incentives, such as capitated payments and bonus/withhold arrangements to their providers.[63] These financial incentives attempt to make providers fiscally accountable by tethering providers' level of compensation to the amount of care that they deliver.[64] Second, MCOs may insert gag clauses in their providers' contracts to

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54. *See id.* at 28.
55. *See id.* at 21-22.
56. *See id.* at 21.
57. *See id.*
58. *See id.*
59. *See id.*
60. *See id.* at 23.
61. *See* Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 297 (1995).
62. *See* Gaynor, *supra* note 23, at C4.
63. *See* McGraw, *supra* note 5, at 1827-28.
64. *See* DAVID W. LEE, AMERICAN MEDICAL ASSOCIATION, CAPITATION: THE PHYSICIAN'S GUIDE 54 (Mark J. Segal et al. eds., 1995).

protect proprietary information.[65] The reality is that many MCOs are for-profit enterprises that compete with one another, so the need to protect proprietary information is clear.[66] However, gag clauses may prevent physicians from making all required disclosures to their patients or from referring patients to specialists.[67] Third, MCOs perform utilization reviews, which involve an evaluation of patients' treatment, either before or after the fact, to determine the "necessity and appropriateness (and sometimes the quality) of medical care."[68] A form of utilization review involves the concept of economic credentialing, whereby the MCO examines a provider's economic efficiency to determine whether to extend or renew a provider's staff privileges.[69] The use of financial incentives, gag clauses, and economic credentialing creates dilemmas for the physician, which must be weighed against the success of managed care to contain health care costs.

A. *Financial Incentives—The Carrot and the Stick Approach*

MCOs use financial incentives, including capitation and bonus/withhold arrangements, to make physicians and other health care providers accountable for the care they provide.[70] Financial incentives are more than payment mechanisms, however.[71] In fact, financial incentives are designed to motivate physicians to consider more carefully the necessity and appropriateness of their patients' medical care.[72] When treatment is necessary, financial incentives should steer physicians towards the most cost-effective care, which would lead to a more efficient health care system.[73] In addition, financial incentives are designed to encourage doctors to keep their patients healthy because a healthy patient will require less medical care and thus will incur lower health care costs than a sickly patient.[74]

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65. *See* Robert Pear, *Doctors Say H.M.O.s Limit What They Can Tell Patients*, N.Y. TIMES, Dec. 21, 1995, at A1.

66. *See id.*

67. *See infra* notes 143-215 and accompanying text for a discussion of gag clauses.

68. BARRY R. FURROW, ET AL., HEALTH LAW 321-22 (West Publishing 1995).

69. *See infra* notes 230-93 and accompanying text for a discussion of economic credentialing.

70. *See* LEE, *supra* note 64, at 1-2.

71. *See* McGraw, *supra* note 5, at 1827.

72. *See id.*

73. *See id.*

74. *See* LEE, *supra* note 64, at 2.

1. The Nuts and Bolts of Capitation and Bonus/Withhold Arrangements

Capitation and bonus/withhold arrangements are two common financial incentives that MCOs use to control health care costs. Capitation, literally meaning "by the head,"[75] refers to a method of paying physicians, usually on a monthly basis at a fixed rate per patient regardless of the level of services the physician provides.[76] MCOs pay most primary-care physicians and almost one-half of specialty-care physicians by capitation, at least in markets with a heavy concentration of MCOs.[77]

Capitation shifts the burden of loss from MCOs to physicians, who must bear the costs of treating patients when the costs of treatment exceed the monthly capitated amounts.[78] The capitated fee is an actuarially determined amount that is derived through a risk rating process, which takes into account certain factors in the patient pool.[79] Factors actuaries take into account when rating risk include demographic factors such as age and sex, as well as other factors such as family history, income, and education level.[80] Theoretically, the capitated amount reflects the patient pool so that if any one patient's costs exceed the capitated amount, those costs would be offset by payments made for a patient with costs below the capitated amount.[81]

An MCO may also create financial incentives for physicians through bonus/withhold arrangements.[82] An MCO could use a bonus arrangement to reward a physician who controls referrals to specialists, limits patients' hospital stays, or patients' emergency room visits.[83] Withhold arrangements are similar to bonuses, except that the MCO actually withholds part of a physician's payments to pay for certain services that a physician

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75. *See* Thomas S. Bodenheimer & Kevin Grumbach, *Capitation or Decapitation: Keeping Your Head in Changing Times*, 276 JAMA 1025, 1025 (1996).

76. *See* McGraw, *supra* note 5, at 1827; *see also* LEE, *supra* note 64, at 25-26 (stating that the insurer bases the capitated amount on actuarial assumptions).

77. *See* Bodenheimer & Grumbach, *supra* note 75, at 1025.

78. *See* Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 338 (1996).

79. *See* LEE, *supra* note 64, at 25-28.

80. *See id.* at 26-27. Income and education positively correlate with health care utilization because the higher the level of income or education, the more health care services the consumer demands. *See id.* at 27.

81. *See* Frances H. Miller, *Forward: The Promise and Problems of Capitation*, 22 AM. J.L. & MED. 167, 167-68 (1996).

82. *See* Paul Gray, *Gagging the Doctors: Critics Charge that Some HMOs Require Physicians to Withhold Vital Information From Their Patients*, TIME, Jan. 8, 1996, at 50, 50 (interviewing Dr. David Himmelstein, former provider with U.S. Healthcare).

83. *See id.*

provides over a specified period of time.[84] The MCO then distributes any remaining funds to the physician.[85]

2. *Balancing the Good and the Bad*

Physicians, scholars, ethicists, and others have levied strong and constant criticism against MCOs for their use of financial incentives.[86] At the outset, it is noteworthy that physicians have always been motivated by financial incentives.[87] Under the fee-for-service model, physicians made more money by overtreating patients.[88] On the other hand, salaried physicians may have had an incentive to undertreat.[89] Critics of managed care attack the effect of financial incentives on everything from the physician-patient relationship to the quality of patient care.[90]

Capitation and bonus/withhold arrangements create a dilemma for physicians because they create a conflict between the patient's interests and the physician's financial interests.[91] However, it is illogical to conclude that physicians would necessarily sacrifice patient care to make more money. Clearly, "physicians are motivated by financial concerns."[92] However, that motivation does not necessarily translate into a threat to the quality of care that physicians provide.[93] In fact, physicians are "strongly devoted to . . . enhancing the health of their patients."[94] The Hippocratic Oath, to which all physicians ascribe, requires no less.[95]

Some courts have suffered little distress over the notion of financial incentives. The plaintiffs in *Pulvers v. Kaiser Foundation Health Plan* sued the plan for the wrongful death of a plan enrollee who suffered from

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84. *See* LEE, *supra* note 64, at 1.

85. *See id.*

86. *See, e.g.*, *id.* at 10 (stating that most physicians "do not accept capitation"); McGraw, *supra* note 5, at 1830-31 (stating that financial incentives "inject a conflict of interest into the physician-patient relationship").

87. *See* Egdahl & Taft, *supra* note 13, at 59.

88. *See id.*

89. *See id.*

90. *See, e.g.*, David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1694 (1996) (discussing that payment mechanisms may undermine patients' trust of their physicians); Ronald Kotulak & Peter Gorner, *Just Who is Managed Care Taking Care Of? While Anecdotal Evidence is Emerging of Patients Abused Under Managed Care, There's Little Agreement About Statistics*, NEWS TRIB. (Tacoma, Wa.), Oct. 13, 1996, at G2 (stating that financial incentives, particularly capitation, can encourage doctors to "skimp" on medical treatment).

91. *See* McGraw, *supra* note 5, at 1830-31.

92. David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 159 (1995).

93. *See id.*

94. *Id.*

95. *See* THE SIGNET MOSBY MEDICAL ENCYCLOPEDIA at 387 (Walter D. Glanze et al. eds., rev. ed. 1996).

Bowen's disease.[96] The basis of the plaintiffs' complaint was that the physicians delayed a biopsy on the decedent because the physicians were motivated by financial incentives offered by the plan.[97] The court relied on the fact that professional organizations recommend the use of financial incentives and that Congress requires HMOs to use incentives and concluded that financial incentives do not cause physicians to "refrain from recommending [necessary] diagnostic procedures or treatments."[98]

The court in *Madsen v. Park Nicollett Medical Center* reached a similar conclusion.[99] In *Madsen*, the plaintiff alleged that the physician was negligent when he did not hospitalize her when she began experiencing complications during her pregnancy.[100] The plaintiff contended that the physician's negligence caused her child's illnesses, which included blindness and brain damage.[101] A jury found in favor of the defendants by concluding that the physicians were not negligent in caring and treating the plaintiff.[102] On appeal, the plaintiff argued that the trial court abused its discretion by excluding evidence that the patient was an HMO member and that the physician's profits would be negatively impacted if the physician hospitalized the patient.[103] The appellate court held that the trial court properly excluded the evidence because that information was only "marginally relevant" and could be highly prejudicial against the physicians.[104]

3. *Mitigating Capitation Risk*

In reality, capitation and bonus/withhold arrangements do not raise the evil specter that their critics espouse. First, although financial incentives transfer the risk of insuring patients from the MCO to the physician, stop-loss insurance is available, either from the MCO or through a third party.[105] Stop-loss insurance limits the amount of risk that a physician accepts because the MCO or the third-party insurer covers costs that exceed some agreed upon amount.[106] For example, if the stop-loss amount is

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96. 160 Cal. Rptr. 392, 393 (Cal. Ct. App. 1979). The enrollee was the original plaintiff. *See id.* However, the enrollee died during the pleading stage of the malpractice action and thus, the widow and the decedent's children continued the case. *See id.*

97. *See id.* at 393-94.

98. *Id.* at 394.

99. 419 N.W.2d 511 (Minn. Ct. App.), *rev'd on other grounds*, 431 N.W.2d 855 (Minn. 1988).

100. *See id.* at 513-14.

101. *See id.* at 513.

102. *See id.* at 514.

103. *See id.* at 515.

104. *See id.*

105. *See* LEE, *supra* note 64, at 44.

106. *See id.*

$5,000, the physician must cover all costs for a patient up to the threshold amount of $5,000; once the costs exceed $5,000, the MCO or third-party insurer would cover the additional costs.[107] The Health Care Financing Administration (HCFA), the division of the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs,[108] recently adopted rules that prohibit MCOs from requiring Medicare and Medicaid providers to accept more than twenty-five percent of the risk, without ensuring that providers have stop-loss protection.[109]

Another method of mitigating the risk, that a physician will sustain a loss by extending treatment to a patient beyond the capitated amount, is to pool large numbers of patients.[110] The larger the patient pool, the greater the ability to spread the risk across patients and physicians.[111] In addition, by combining pools of doctors and patients, one doctor's decision is not linked too closely to any particular patient and likewise, a particular patient's treatment is not tied too closely to just one physician's financial situation.[112]

MCOs provide "carve-outs" as an additional way to minimize the risk physicians accept as a result of financial incentives.[113] Carve-outs are certain services or procedures that MCOs will pay for separately, rather than as part of the capitated payment.[114] MCOs generally carve out "high-cost, low-volume services" so that if a physician must use an expensive test, for example, the physician would be paid separately for the test.[115] Carve-outs eliminate a physician's precarious dilemma of having to choose between the risk of losing money and not providing a particular treatment, because the MCO, not the physician, pays for the carve-outs from non-capitated funds.[116] MCOs may also carve-out certain preventative procedures, such as immunizations, "PAP smears," and "well-baby care," to encourage physicians to keep their patients healthy without affecting their capitated funds.[117] Stop-loss insurance, large patient pools,

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107. *See id.* at 20.

108. *See* Health Care Financing Administration, *About HCFA* (visited Mar. 28, 1997) <http://www.hcfa.gov/about.htm#whatis>.

109. *See* 42 C.F.R. § 417.479 (1996) (setting forth HCFA's regulations regarding physician incentive plans).

110. *See* Michele Conklin, *Two Faces of Medicine: Painful Choices Loom for Doctors Paid for Not Treating Patients*, ROCKY MTN. NEWS, Dec. 1, 1996, at 1B.

111. *See id.*

112. *See* Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1230 (1996).

113. *See* LEE, *supra* note 64, at 16.

114. *See* Bodenheimer & Grumbach, *supra* note 75, at 1027-28.

115. LEE, *supra* note 64, at 44.

116. *See id.*

117. *Id.*

and carve-outs help diffuse the conflict that financial incentives present for physicians.

Patients complain that financial incentives force primary-care physicians to diagnose or perform procedures that are beyond the scope of their training and skill because bonus/withhold arrangements discourage primary-care physicians from referring their patients for necessary specialty care.[118] However, as more specialists participate in capitated models, primary-care physicians will have more incentive to refer their patients to specialists, knowing that the specialists' fees are also capitated.[119] Specialists likewise will have an incentive to control costs because their fees are capitated as well.[120]

The necessity of MCOs developing and implementing quality assurance measures that will help offset the potential negative effects of financial incentives is apparent.[121] In response to this need, members of the Texas Senate Interim Committee on Managed Care and Consumer Protections have introduced legislation in the current legislative session that would require MCOs to establish quality assurance programs and make that information available to the commissioner of insurance.[122] Another proposed bill would require that the Office of Public Insurance develop consumer report cards that rate the performance of MCOs.[123]

4. Capitation Benefits Physicians

Financial incentives provide several benefits for physicians. First, financial incentives increase physician autonomy because they decrease MCOs' interest in reviewing, pre-certifying, and second-guessing every decision that providers make because MCOs are no longer at risk for excessive care.[124] Further, physicians can benefit from financial incentives because the incentives can increase physicians' income.[125] Specifically, physicians receive the capitated payments regardless of whether they treat any patients, whereas under the traditional fee-for-service model, MCOs would only compensate physicians when they provided treatment.[126] A capitated system, on the other hand, allows physicians to earn income without providing unnecessary treatment.[127] Critics assert that

118. *See* Orentlicher, *supra* note 92, at 158.
119. *See* Bodenheimer & Grumbach, *supra* note 75, at 1028-29.
120. *See id.* at 1029.
121. *See* Egdahl & Taft, *supra* note 13, at 61.
122. *See* Tex. S.B. 385, 75th Leg., R.S. (1997).
123. *See* Tex. S.B. 387, 75th Leg., R.S. (1997).
124. *See* LEE, *supra* note 64, at 11.
125. *See id.*
126. *See id.*
127. *See* Miller, *supra* note 81, at 167.

financial incentives encourage physicians to withhold necessary treatment.[128] However, physicians have a strong countervailing incentive to keep their patients healthy.[129] Otherwise, physicians will face higher health-care costs in the future when their patients develop more serious complications, which are more expensive to treat.[130] In addition, the threat of litigation deters physicians from undertreating and provides incentives for MCOs to monitor the quality of health care that physicians provide.[131]

5. *Financial Incentives Should Not Be a Secret*

Little empirical evidence suggesting that the conflict of interest created as a result of financial incentives jeopardizes the quality of patient care exists.[132] In fact, the data "consistently shows that costs are lower in managed-care systems, with quality equal to or better than that in fee-for-service care."[133] Admittedly, the mere appearance of a conflict of interest could undermine a patient's trust in her doctor.[134] However, efforts are underway in the health-care industry to help ensure that the physician and patient can maintain a relationship of trust in a managed-care environment. The American Association of Health Plans, a trade group that represents 1,000 HMOs, recently asked its members to disclose financial incentive arrangements to their patients.[135] HCFA has also adopted rules that require HMOs to disclose physician financial incentives to HCFA and to make that information available to Medicare patients.[136] HCFA's rules also prohibit HMOs from making specific payments to a physician to induce the physician "to reduce or limit medically necessary services to a patient."[137] Texas Representative Smithee introduced a bill into the current Texas legislative session that would require MCOs to

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128. *See e.g.*, McGraw, *supra* note 5, at 1828, 1830; Malinowski, *supra* note 78, at 350-51.

129. *See* Kotulak & Gorner, *supra* note 90, at G2.

130. *See* Massachusetts Association of HMOs, *Setting the Record Straight: Rebutting Some Common Myths About HMOs* (visited Mar. 28, 1997) <http://www.mahmo.org/hmomyths.html>.

131. *See* Orentlicher, *supra* note 92, at 159; *see also* David Azevedo, *Did an HMO Doctor's Greed Kill Joyce Ching?*, 73 MED. ECON. 43, 56 (Feb. 26, 1996) (quoting a physician's defense attorney as saying that "financing doesn't drive medical decisions . . . [a]nd if a doctor doesn't live up to the standard of care for any reason . . . the law has a provision to find him negligent").

132. *See* McGraw, *supra* note 5, at 1828, 1832; Malinowski, *supra* note 78, at 348-49.

133. Berwick, *supra* note 112, at 1228.

134. *See* Mechanic & Schlesinger, *supra* note 90, at 1694.

135. *See* Spencer Rich, *HMO Industry Moves to Allay Patient Worry on Care Quality: Guidelines Aimed at Ensuring Consumers Get Data*, WASH. POST, Dec. 18, 1996, at A2.

136. *See U.S. to Curb Doctors' Awards: Rules Aim to Ensure HMO Cost-Cutting Won't Cut Needed Care*, BALTIMORE SUN, Dec. 26, 1996, at 1A [hereinafter *Doctors' Awards*]; *see also* 42 C.F.R. § 417.479(h) (1996) (outlining disclosure requirements).

137. *Doctors' Awards*, *supra* note 136, at 1A; *see also* 42 C.F.R. § 417.479(d) (1996) (discussing prohibited physician payments).

disclose the "general types of financial arrangements [that] exist between providers and the plan."[138] Another bill would prohibit an MCO from using financial incentives that directly or indirectly induce physicians to limit medically necessary services.[139]

The central aim of financial incentives is to make physicians accountable for their conduct by connecting the physicians' conduct to their pocketbooks.[140] Evidence suggests that merely educating physicians regarding the need to strive toward more efficient health care is not enough.[141] Financial incentives, however, are changing physicians' behavior without any empirical evidence that the quality of health care is being compromised.[142]

B. *MCOs Stopped Suffocating Doctors, But Doctors Are Still Gagging*

Individual physicians and the American Medical Association (AMA), among others, have criticized MCOs for including gag clauses in physicians' contracts.[143] Kaiser-Permanente used an overt gag clause in its provider contracts until the MCO rescinded the clause in 1995.[144] The clause prohibited physicians from discussing treatment options with patients until the option was approved or from discussing the authorization procedures with patients.[145] A less conspicuous gag order used by U.S. Healthcare stated that:

> Physicians shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in [the HMO] or the quality of [the HMO's] coverage . . . . Physicians shall keep the Proprietary Information [payment rates, utilization review procedures, etc.] and this Agreement strictly confidential.[146]

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138. Tex. H.B. 893, 75th Leg., R.S. (1997).
139. *See* Tex. S.B. 385 § 10, 75th Leg., R.S. (1997).
140. *See* LEE, *supra* note 64, at 54-55.
141. *See* Egdahl & Taft, *supra* note 13, at 59.
142. *See* Malinowski, *supra* note 78, at 348-49.
143. *See* Gray, *supra* note 82, at 50.
144. *See* Robert Pear, *H.M.O. Contracts: The Tricky Business of Keeping Doctors Quiet*, N.Y. TIMES, Sept. 22, 1996, § 4, at 7.
145. *See* Pear, *supra* note 65, at A1.
146. Families USA, *supra* note 48. U.S. Healthcare has since removed the gag clause from its provider contracts; *see infra* note 178 and accompanying text.

1. *The MCOs' Position on Gag Clauses*

MCOs assert that gag clauses are necessary to prohibit physicians from disparaging the MCOs.[147] MCOs contend that gag clauses will ensure that physicians who are unhappy with their MCOs will discuss their frustrations with the MCO rather than denigrate the MCO to their patients.[148] Further, MCOs assert that because they are engaged in a competitive industry, gag clauses are vital to prohibit physicians from disclosing otherwise proprietary information such as how physicians are compensated or how the MCO conducts utilization reviews.[149] MCOs also worry that in situations where an MCO drops a physician from the plan, the physician will encourage a patient to switch MCOs by disparaging one MCO in favor of another MCO.[150] From the MCO's perspective, gag clauses are necessary to compete effectively in an industry that is becoming increasingly aggressive.[151]

2. *The Dark Side of Gag Clauses*

The AMA recognizes that gag clauses that are limited to protecting proprietary information and preventing disparaging remarks serve a legitimate purpose.[152] However, gag clauses that may appear innocuous on the surface have a dark side.[153] Anecdotal information exists that suggests that MCOs use disparagement clauses in a negative fashion.[154] For example, a psychologist alleged that his MCO dropped him from the plan after he told a patient's mother that her daughter needed more therapy sessions, but that the plan may not cover the costs of additional sessions.[155] Another doctor was terminated from his MCO after he appeared on a national television show and criticized his MCO for its use of gag clauses.[156]

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147. *See* Karen Ignagni, *What Managed Care Plans Can Do To Counter the Horror Stories*, 6 MANAGED CARE WEEK, June 17, 1996, *available in* 1996 WL 8690222.

148. *See* Pear, *supra* note 144, § 4, at 7.

149. *See* Families USA, *supra* note 48.

150. *See* Pear, *supra* note 65, at A1.

151. *See* Paul J. Kenkel, *Cincinnati HMO Imposing "Gag Clause" in Effort to Mute Criticism by Physicians*, MODERN HEALTHCARE, Feb. 1, 1993, at 24.

152. *See* Michael Pretzer, *Why You Should Have Been at the Health Lawyers' Convention*, 73 MED. ECON. 160, 163 (Aug. 26, 1996).

153. *See id.*

154. *See e.g.*, Susan Brink, *How Your HMO Could Hurt You*, U.S. NEWS & WORLD REPORT, Jan. 15, 1996, at 62, 64 (stating that a provider's contract was canceled after the provider "criticized the HMO's payment incentives"); Families USA, *supra* note 48 (stating that a physician almost lost his contract with an MCO after telling a patient that the HMO refused a test because the HMO considered that information to be disparaging of the HMO).

155. *See* Brink, *supra* note 154.

156. *See* Gray, *supra* note 82, at 50.

Even the following hypothetical shows the potential negative impact of a gag clause. Imagine that a patient's mammogram exposes a suspicious shadow.[157] The doctor would like to run another test, but knows that the MCO will not pay for it.[158] The doctor is faced with a Hobson's choice: fulfill her duty to the patient by discussing the non-covered test with the patient, thereby risking deselection by the MCO or keep silent about the alternative test, disregarding her duty to the patient.[159]

A physician has a duty to disclose "all reasonable alternatives for diagnosis and treatment—including benefits, risk, and cost."[160] A gag clause restricts complete disclosure to patients whenever the clause prevents physicians from discussing treatment options that the MCO does not cover.[161] For example, a gag rule could prevent a physician from advising a patient to extend a hospital stay beyond the time covered by the MCO.[162] MCOs have also interpreted gag rules in physicians' contracts as prohibiting physicians from disclosing the financial incentives they receive from MCOs.[163] Gag clauses could also prohibit physicians from referring patients to specialists who are not part of the MCO.[164] In fact, recently a California physician who referred a patient to a specialist who was not in the network received a reprimand from her MCO.[165] The reprimand letter stated that "a future occurrence may result in suspension of referral privilege or, in an extreme case, a recommendation for termination."[166] A physician who was reprimanded by her HMO for recommending a treatment to a patient before confirming that the MCO would cover it, summed up gag orders by stating that "[i]t was as if I was a store vendor and was only supposed to advertise the products we offered."[167] The effect of gag clauses can be detrimental because if physicians are not open with patients, patients will not know when information has been withheld and thus will not seek second opinions.[168]

157. *See* Suzanne Gordon, *Is That A Hippocratic or Hypocratic Oath?*, NEWSDAY (Nassau and Suffolk), Jan. 25, 1996, at A44.

158. *See id.*

159. *See id.*

160. Pretzer, *supra* note 152, at 163 (quoting Carol O'Brien, AMA Senior attorney).

161. *See HMOs Shouldn't Be Allowed to Put Gags on Doctors Talking to Their Patients*, BUFFALO NEWS, Dec. 18, 1996, at 2B.

162. *See id.*

163. *See* Gray, *supra* note 82, at 50.

164. *See* Pear, *supra* note 65, at A1.

165. *See* David R. Olmos & Shari Roan, *HMO 'Gag Clauses' on Doctors Spur Protest*, L.A. TIMES, Apr. 14, 1996, at A1.

166. *Id.* (quoting reprimand letter sent by the managed care group to a Santa Monica oncologist).

167. Gray, *supra* note 82, at 50 (quoting a former CIGNA HealthCare neurologist).

168. *See* Olmos & Roan, *supra* note 165, at A1.

If an MCO contracts with a physician in a way that the physician breaches a duty to a patient, the contract provision arguably should be void as a matter of public policy.[169] Notwithstanding that argument, doctors can be liable for negligent nondisclosure.[170] The Texas Legislature recognized that a doctor could be liable for negligence by "fail[ing] . . . to disclose or adequately to disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician."[171] The Texas Medical Disclosure Panel (Panel) determines the risks and hazards that physicians should disclose for various procedures and treatments.[172] If the Panel has not made a determination with respect to a certain treatment, a physician nonetheless has a duty "to disclose all risks or hazards which could influence a reasonable person in making a decision to consent to the procedure."[173] A physician must disclose all material information that a reasonable person would rely upon in deciding whether to consent to a treatment or procedure.[174] Thus, a physician who is silenced by a gag clause not only hurts the patient, but hurts herself because the physician could be liable for negligent nondisclosure.[175]

3. *Putting Out the Fire—MCOs' Responses to Gag Clauses*

MCOs, in an attempt to combat their sagging public image[176] and fend off government regulation,[177] recently began removing gag clauses from their providers' contracts.[178] Further, the American Association of Health Plans (AAHP), an HMO trade group, acknowledged that some gag provisions are unclear and urged MCOs to clarify the language so that the gag orders cannot be interpreted to effect physician-patient relations.[179] Six months later, AAHP issued an antigag rule, which AAHP expected all of its members would implement.[180] The antigag rule encourages a

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169. *See* RESTATEMENT (SECOND) OF CONTRACTS § 178 cmt. a, illus. 6-8 (1981) (stating that promise to commit a tort or to induce one to commit a tort is unenforceable on public policy grounds).

170. *See* TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.02 (Vernon Supp. 1997) (Medical Liability and Insurance Improvement Act).

171. *Id.*

172. *See id.* § 6.03(a) (Vernon Supp. 1997).

173. Winkle v. Tullos, 917 S.W.2d 304, 313 (Tex. App.—Houston [14th Dist.] 1996, writ denied) (quoting Peterson v. Shields, 652 S.W.2d 929, 931 (Tex. 1983)).

174. *See id.*

175. *See* TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.02 (Vernon Supp. 1997).

176. *See* Pear, *supra* note 65, § 4, at 7.

177. *See* Steven Findlay, *Despite New Standards, HMOs Still Face Regulation*, USA TODAY, Dec. 18, 1996, at 4A.

178. *See* Chuck Hutchcraft, *Humana to Modify Doctors' Contracts: AMA Welcomes Removal of a 'Gag Clause', Other HMO Plans Expected to Follow Suit*, CHI. TRIB., Oct. 30, 1996, at 1 (stating that Humana, Inc. and U.S. Healthcare removed gag clauses from their providers' contracts).

179. *See* Ignagni, *supra* note 147.

180. *See* Rich, *supra* note 135, at A2.

physician to provide the patient with information concerning the patient's medical needs, "even if that treatment is not covered by th[e] plan."[181] AAHP included the antigag rule as part of its "Patients First" campaign, which also encourages MCOs to summarily disclose how they pay their physicians, how they conduct utilization review, and how they determine whether a treatment is experimental.[182] Several physician groups, including the American Academy of Family Physicians, the American College of Physicians, and the American College of Obstetricians and Gynecologists support AAHP's "Patients First" initiative.[183] In fact, the American Academy of Family Physicians prefers AAHP's approach to dealing with gag clauses rather than enacting legislative initiatives to address the concern.[184]

4. *State and Federal Legislation*

Notwithstanding MCOs' efforts to deter government intervention, state legislators have entered into the fray and managed-care regulations are mushrooming over the managed-care landscape.[185] Numerous states have passed legislation concerning gag clauses.[186] For example, California prohibits MCOs from including contract provisions that prevent physicians from communicating with their patients regarding treatment options and renders such gag clauses void and unenforceable.[187] California legislators wanted to go further; they also attempted to bar financial incentives and treatment denials without a second opinion.[188] However, both propositions failed after a massive advertising campaign by California MCOs asserted that health care costs would increase by ten to fifteen percent if voters supported the propositions.[189] Georgia's antigag statute states that a provider will not "be penalized for discussing medically necessary or appropriate care with . . . his or her patient."[190] Similarly, Indiana

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181. *Id.*

182. *See AAHP's "Patients First" Campaign as Legislative Deterrent: Will it Work?*, 50 MED. & HEALTH, Dec. 23, 1996, *available in* 1996 WL 7993829.

183. *See id.*

184. *See id.*

185. *See 40 States Trying to Bandage HMO Ills*, COLUMBUS DISPATCH, Mar. 15, 1996, at 1A (stating that legislators proposed some 400 bills in the first three months of 1996).

186. *See, e.g.*, CAL. BUS. & PROF. CODE § 2056.1 (West Supp. 1997); GA. CODE ANN. § 33-20A-7 (Harrison Supp. 1996); IND. CODE ANN. § 27-8-11-4.5 (West Supp. 1996); ME. REV. STAT. ANN. tit. 24-A, § 4303(3) (West 1996); TENN. CODE ANN. § 56-7-2349 (Supp. 1996); VA. CODE ANN. § 38.2-3407.10(J) (Michie Supp. 1996).

187. *See* CAL. BUS. & PROF. CODE § 2056.1 (West Supp. 1997).

188. *See* Daniel Sneider, *California's HMO Battle: Cost vs. Care*, CHRISTIAN SCI. MONITOR, Oct. 2, 1996, at 4.

189. *See id.*

190. GA. CODE ANN. § 33-20A-7 (Harrison Supp. 1996).

prohibits insurers from interfering with providers' discussions with their patients concerning treatment options and prevents insurers from penalizing providers for making such disclosures.[191]

State laws are less effective when an MCO includes a contract provision that allows the MCO to terminate physicians' contracts without cause with thirty to sixty days notice.[192] A no-cause termination contract provision allows an MCO to muzzle a physician indirectly, even though it cannot do so directly, because the MCO need not provide a reason for terminating the physician.[193] Some states have mitigated the potential of MCOs indirectly gagging physicians by including antiretaliatory provisions within their antigag clauses.[194] Another approach used to guard against indirect gagging is to afford physicians minimal due process guarantees before an MCO can terminate a physician from the plan.[195]

Members of the 75th Texas legislative session have introduced numerous bills that would regulate managed care.[196] Senators Sibley, Nelson, Harris, Madla, and Cain, members of the Senate Interim Committee on Managed Care and Consumer Protections,[197] have introduced antigag legislation that would amend the Texas Health Maintenance Organization Act.[198] The antigag legislation states:

> A health maintenance organization shall not . . . prohibit, attempt to prohibit, or discourage a physician or provider from: (A) discussing with or communicating to a . . . patient, information or opinions regarding the patient's health care, including but not limited to the patient's medical condition, treatment options, or other health care services; or (B) discussing with . . . a patient, information or opinions regarding the provisions, terms, requirements, or services of the health care plan.[199]

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191. *See* IND. CODE ANN. § 27-8-11-4.5 (West Supp. 1996).

192. *See* Olmos & Roan, *supra* note 165, at A1.

193. *See* Charter Med. Corp. v. Miller, 605 S.W.2d 943, 951-52 (Tex. App.—Dallas 1980, writ ref'd n.r.e.) (stating that a private hospital need not afford a terminated physician due process).

194. *See, e.g.*, GA. CODE ANN. § 33-20A-7 (Harrison Supp. 1996) ("No health care provider may be penalized for discussing medically necessary or appropriate care with or on behalf of his or her patient."); IND. CODE § 27-8-11-4.5(b) (West Supp. 1996) (stating that "[a]n insurer may not penalize a provider financially or in any other manner" for disclosing all available treatment options).

195. *See infra* notes 283-93 and accompanying text.

196. *See, e.g.*, Tex. S.B. 383, 75th Leg., R.S. (1997); Tex. S.B. 384, 75th Leg., R.S. (1997); Tex. S.B. 385, 75th Leg., R.S. (1997); Tex. H.B. 609, 75th Leg., R.S. (1997); Tex. H.B. 900, 75th Leg., R.S. (1997). As of February 18, 1997, all of these bills have been introduced and referred to various committees.

197. *See* Peggy Ficak, *Lawmakers File Bills to Protect HMO Members*, AUSTIN AMERICAN-STATESMAN, Jan. 31, 1997, at D3.

198. TEX. INS. CODE ANN. arts. 20A.01-20A.36 (Vernon 1981 & Supp. 1997).

199. Tex. S.B. 385, 75th Leg., R.S. (1997) (proposing amendment to TEX INS. CODE ANN. art. 20A.14); *see also* Tex. H.B. 894, 75th Leg., R.S. (1997) (introducing companion legislation into the Texas House of Representatives).

The legislation includes a retaliatory clause, which provides that "[a] health maintenance organization shall not in any way penalize, terminate, or refuse to compensate . . . a physician or provider for discussing or communicating with a . . . patient . . . pursuant to this section."[200] A similar provision is proposed as an addition to the Texas Civil Practices and Remedies Code.[201] The proposed legislation also affords physicians and other health care providers minimal due process protections.[202]

Should the proposed legislation pass, Texas would join at least sixteen other states who already prohibit MCOs from gagging their doctors.[203] State legislation alone, however, is not enough for at least two reasons. First, the Employee Retirement Income and Security Act (ERISA)[204] hampers state initiatives by excluding private self-insurers from state legislation.[205] Consequently, qualified benefit plans escape liability for state claims because ERISA prevents state claims related to certain benefit plans.[206] *Corcoran v. United HealthCare, Inc.* provides an example of the negative impact that ERISA preemption can have.[207] The plaintiffs in *Corcoran* brought a malpractice action against a company who contracted with the plaintiff's MCO to perform utilization review, alleging that their unborn child died as a result of a negligent utilization review process.[208] The Fifth Circuit affirmed the trial court's decision to dismiss the claim, concluding that ERISA preempted the utilization review decision.[209] Thus, ERISA precluded the plaintiffs from bringing a claim that state law

200. Tex. S.B. 385, 75th Leg., R.S. (1997) (proposing amendment to TEX. INS. CODE ANN. art. 20A.14); *see also* Tex. H.B. 894, 75th Leg., R.S. (1997) (introducing companion legislation into the Texas House of Representatives).

201. *See* Tex. S.B. 386, 75th Leg., R.S. (1997) ("A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.").

202. *See id.* (stating that an MCO shall explain to the physician the reasons for termination from the plan and that an advisory review panel, composed of physicians and providers, can review the MCO's decision).

203. *See* Robert Pear, *A Prescription for Communication: Sixteen States Pass Laws to Prevent HMOs from Restricting What Doctors Tell Patients*, ROCKY MTN. NEWS, Sept. 22, 1996, at 2B (stating that California, Colorado, Delaware, Georgia, Indiana, Maine, Maryland, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, and Washington have adopted antigag legislation).

204. 29 U.S.C. §§ 1001-1461 (1994).

205. *See id.* § 1144(a) (1994).

206. *See* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 192 (1996).

207. 965 F.2d 1321 (5th Cir. 1992).

208. *See id.* at 1324.

209. *See id.* at 1331. The court relied on section 1144(a) of ERISA, which states that ERISA supersedes "any and all [s]tate laws insofar as they . . . relate to any employee benefit plan". *Id.* at 1328.

would otherwise allow.[210] Second, state legislation alone is insufficient because only about one-third of states have passed antigag legislation and of those states that have such legislation, the level of protection is inconsistent among the states.

Inconsistent state laws and ERISA preemption laws demonstrate the need for federal antigag legislation. The U.S. Congress, in 1996, attempted to prohibit MCOs from gagging doctors, but the effort was unsuccessful.[211] Apparently, legislators were concerned that if they outlawed gag clauses, physicians could be liable for failing to disclose medical treatments that they considered morally objectionable, such as abortion.[212] As Congress continues to scrutinize managed care, it is likely that Congress will pass legislation in 1997.[213] The United States Department of Health and Human Services recently announced a federal initiative that prohibits MCOs who serve Medicare patients from restricting the physician from "counseling or advising the beneficiary" about medically necessary treatments.[214] However, the edict is limited because it only applies to Medicare providers.[215]

At a minimum, it is imperative that Texas legislators pass a comprehensive antigag statute that prohibits gag clauses that either directly or indirectly prevent physicians from communicating freely with their patients. It is also crucial that the federal government enact antigag legislation to prevent MCOs from suffocating doctors.

C. Economic Credentialing—Economics and Quality Share the Same Bottom Line

A hospital must credential a physician before the physician can admit and treat patients at the hospital.[216] The Joint Commission on Accreditation of Hospitals (JCAHO) is responsible for accrediting hospitals.[217] Although JCAHO cannot legally require that a hospital obtain JCAHO

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210. *See* Blum, *supra* note 206, at 193.

211. *See Omnibus Bill Quiets the Gag Rule Ban, But Advances Other Health Policy Issues*, 22 HEALTH LEGIS. & REG., Oct. 2, 1996, at 2 (stating that the antigag legislation, offered as an amendment to the FY 97 appropriations bill, was not successful).

212. *See Managed Care Legislation Seen Likely in 1997*, 51 MED. & HEALTH, Jan. 13, 1997, *available in* 1997 WL 8688881.

213. *See id.*

214. *HMOs Shouldn't Be Allowed to Put Gags on Doctors Talking to Their Patients*, BUFFALO NEWS, Dec. 18, 1996, at 2B.

215. *See id.*

216. *See* FURROW ET AL., *supra* note 68, at 93; *see also* Darling v. Charleston Community Hosp., 211 N.E.2d 253, 257-58 (Ill. 1965) (holding that a hospital could be liable if it negligently failed to monitor its physicians' competence).

217. *See* Jane C. Taber & Janna P. King, *Caught in the Crossfire: Economic Credentialing in the Health Care War*, DET. C.L. REV. 1179, 1184 (1994).

accreditation, accreditation is necessary as a practical matter because a hospital cannot receive Medicare funds without it.[218]

JCAHO requires, among other things, that hospitals establish physician credentialing procedures and include those procedures in their bylaws.[219] A hospital's governing board is ultimately responsible for credentialing physicians and terminating appointments.[220] However, the governing board typically will delegate part of its authority to a hospital committee composed of medical professionals who evaluate a physician's "experience, competence, ability, and judgment"[221] and make staff recommendations to the governing board.[222]

The Texas Legislature has granted hospitals broad discretion in their credentialing decisions.[223] Courts defer to a hospital's credentialing decisions because hospitals are "uniquely qualified" whereas the court's "expertise is profoundly lacking."[224] Generally, as long as a hospital credentials its physicians using criteria that are rationally related to the hospital's objectives and operations, courts will not interfere.[225] However, a hospital must include its credentialing criteria in its bylaws[226] and apply those criteria even-handedly to all of its physicians.[227] Absent those requirements, courts should defer to a hospital's judgment, rather than direct a hospital's staffing decisions, because substituting a court's judgment for the hospital's judgment could impair a hospital's confidence in its medical staff.[228] In addition, a court's involvement makes the credential-

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218. *See id.*

219. *See id.* at 1184-85.

220. *See* TEX. REV. CIV. STAT. ANN. art. 4495b, § 1.02(9) (Vernon Supp. 1997).

221. FURROW ET AL., *supra* note 68, at 93.

222. *See* Taber & King, *supra* note 217, at 1185.

223. *See* TEX. REV. CIV. STAT. art. 4495b, § 1.02(9) (stating that hospitals can adopt reasonable rules and regulations relating to physician credentialing as long as those rules and regulations are reasonable and "free of arbitrariness, capriciousness, or unreasonableness").

224. Walls Reg'l Hosp. v. Altaras, 903 S.W.2d 36, 42-44 (Tex. App.—Waco 1994, orig. proceeding) (holding that trial court abused its discretion when it interfered with a hospital's decision to terminate privileges of two physicians); *see also* Hodges v. Arlington Neuropsychiatric Ctr., Inc., 628 S.W.2d 536, 538 (Tex. App.—Fort Worth 1982, writ ref'd n.r.e.) (stating that hospital board of directors has authority to make rules and to manage staff credentialing process).

225. *See* Sosa v. Board of Managers of the Val Verde Mem. Hosp., 437 F.2d 173, 176-77 (5th Cir. 1971).

226. The bylaws constitute a contract between the medical staff and the hospital or MCO and generally cannot be changed unilaterally. *See* Brad Dallet, Note, *Economic Credentialing: Your Money or Your Life!*, 4 HEALTH MATRIX 325, 338 (1994). An interesting question arises, however, if economic credentialing is characterized as a business decision, rather than a quality of care determination. In that situation, arguably, the hospital or MCO could implement economic credentialing without the consent of the medical staff. *See* John D. Blum, *Hospital-Medical Staff Relations in the Face of Shifting Institutional Business Strategies: A Legal Analysis*, 14 U. PUGET SOUND L. REV. 561, 587 (1990-91).

227. *See* Taber & King, *supra* note 217, at 1186.

228. *See Sosa*, 437 F.2d at 177.

ing process less effective and discourages physicians and hospitals from adhering to the credentialing process as defined in their bylaws.[229]

The AMA defines economic credentialing as the "use of economic criteria unrelated to quality of care or professional competency in determining qualifications for initial or continuing medical staff memberships or privileges."[230] MCOs are currently the predominate users of economic credentialing.[231] In recent times, however, hospitals are incorporating economic criteria into their credentialing decisions because they are faced with increasing pressures to remain competitive.[232] A hospital faced with the potential for its own demise because of aggressive managed care competitors must focus on more than the quality of health care; it must strive for efficiency.[233] A common way for hospitals to credential physicians is through the use of physician profiles.[234] A profile is composed of statistics that summarize a physician's practice patterns.[235] A hospital makes credentialing decisions by comparing a particular physician's profile against other physicians' profiles or against standardized targets.[236] For example, a hospital could create a physician profile based on the number of hospital admissions, patients' lengths of stay, and number of tests ordered and compare that profile to target levels or to other physicians' profiles.[237] If a physician's profile is inconsistent with either the target profile or with other physicians' profiles, the hospital could terminate the physician.[238]

The few courts that have considered the use of economic credentialing have concluded that MCOs and hospitals can make medical staff decisions based on cost factors.[239] In *Hassan v. Independent Practice Associates*,

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229. *See Walls*, 903 S.W.2d at 42.

230. Richard A. Feinstein, *Economic Credentialing and Exclusive Contracts*, 9 HEALTH LAW. 4, 1 (Fall 1996) (quoting AMERICAN MEDICAL ASSOCIATION, ECONOMIC CREDENTIALING: CAN PHYSICIANS AND HOSPITALS FIND COMMON GROUND (1993)).

231. *See* Leonard A. Hagen, *Physician Credentialing: Economic Criteria Compete with the Hippocratic Oath*, 31 GONZ. L. REV. 427, 441 (1996).

232. *See* Taber & King, *supra* note 217, at 1182.

233. *See* Dallet, *supra* note 226, at 326.

234. *See* Feinstein, *supra* note 230, at 5.

235. *See id.*

236. *See* Hagen, *supra* note 231, at 441. Software packages are available to assist hospitals and others with physician profiling. *See* Taber & King, *supra* note 217, at 1208.

237. *See* Feinstein, *supra* note 230, at 5.

238. *See* Blum, *supra* note 226, at 593-94. Harford Hospital in Maryland provides a useful example of economic credentialing because it has implemented an economic efficiency program. *See id.* at 593. The Harford program evaluates a physician's days and charges above-standard amounts, as well as medical malpractice rates and denials for inappropriate utilization. *See id.* If a physician's profile lies outside the expected ranges, the hospital examines additional criteria. *See id.* at 593-94. The hospital gives a physician who deviates from the expected targets several opportunities to remedy behavior before terminating the physician. *See id.* at 594.

239. *See* FURROW ET AL., *supra* note 68, at 101.

an independent practice association terminated physicians after they performed excessive tests on patients.[240] The court concluded that the IPA's conduct was justifiable because its purpose was to enhance its efficiency.[241] Courts have also generally upheld exclusive contracts by concluding that the making of such contracts is a reasonable exercise of the hospital's power.[242]

The most widely cited economic credentialing case is *Rosenblum v. Tallahassee Memorial Regional Medical Center*.[243] In *Rosenblum*, a surgeon sued Tallahassee Memorial Regional Medical Center (TMRMC) after the hospital declined to renew the surgeon's staff privileges.[244] TMRMC refused to recredential the surgeon because the surgeon had privileges at Tallahassee Community Hospital (TCH) as well, and TMRMC wanted to avoid competing with TCH.[245] TMRMC was concerned that the surgeon would steer patients from its facility to TCH or encourage nurses from TMRMC to transfer to TCH.[246] The court granted TMRMC's motion for summary judgment in *Rosenblum*, concluding that the hospital acted reasonably when it considered the economic effect of the surgeon's contract with TCH.[247]

Similarly, when a hospital terminates a physician for economic reasons, the physician may have little recourse.[248] In *Knapp v. Palos Community Hospital*, the hospital declined to renew several physicians' privileges after the hospital concluded that the physicians overutilized certain services, excessively used certain diagnostic tests, and overutilized the hospital.[249] The appellate court in *Knapp* held that as long as a private hospital followed its bylaws when it declined staff privileges, the court would not second guess the hospital's decisions.[250] In reaching its decision, the court reasoned that hospital credentialing decisions were "not subject to judicial review" unless the hospital did not adhere to its bylaws when it made its credentialing decisions because the court wanted to avoid substituting its judgment for the judgment of the hospital.[251]

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240. 698 F. Supp. 679, 694 (E.D. Mich. 1988).

241. *See id.*

242. *See* Gonzalez v. San Jacinto Methodist Hosp., 880 S.W.2d 436, 441 (Tex. App.—Texarkana 1994, writ denied); Feinstein, *supra* note 230, at 8 (stating that "most challenges to exclusive contracts have been unsuccessful").

243. *See* Feinstein, *supra* note 230, at 5.

244. *See id.* at 6.

245. *See* Dallet, *supra* note 226, at 341-42.

246. *See id.* at 341 n.97.

247. *See* Feinstein, *supra* note 230, at 6.

248. *See* Knapp v. Palos Community Hosp., 465 N.E.2d 554, 565 (Ill. App. Ct. 1984).

249. *Id.* at 560-61.

250. *See id.* at 563.

251. *Id.* at 565.

Even though the case law regarding economic credentialing generally favors hospitals, *Harper v. Healthsource New Hampshire, Inc.* provides physicians some protection against arbitrary terminations.[252] In *Harper*, the defendant MCO used a no-cause termination clause to deny privileges to a physician to practice as a surgeon, but did recredential him as a primary-care physician.[253] The physician argued that the no-cause termination provision was contrary to public policy.[254] The court stated that every contract contains an implied covenant of good faith and fair dealing.[255] Consequently, the court held that the MCO could not terminate the physician for any reason that is contrary to public policy.[256] In addition, the court held that a "terminated physician is entitled to review of the termination decision."[257]

Thus, hospitals are generally free to terminate physicians or decline to recredential them for purely economic reasons because courts recognize economic credentialing as a component of a hospital's medical staff decision-making authority. As a consequence, little protection is available for a physician or the public if a hospital or MCO terminates otherwise qualified physicians to boost profits.

When a hospital uses economic criteria exclusively to credential a physician, the hospital is using pure economic credentialing.[258] Pure economic factors include the amount of profit generated by a physician, resource utilization in dollars, revenue per physician, admissions rates, and patient mix.[259] For example, a hospital uses pure economic credentialing if the hospital terminates a physician solely because the physician has a higher than average number of Medicaid patients. Such a patient mix contributes little to the hospital's bottom line because Medicaid reimbursement rates generally are lower than the hospital's actual costs.[260]

Exclusive contracting is a controversial form of pure economic credentialing.[261] Physicians and other health care professionals are generally opposed to exclusive contracting because they see it "as a way to circumvent [their] decision-making authority over credentialing."[262] An exclusive contract is an arrangement between a hospital and a physician where the hospital allows a sole physician to provide particular services for

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252. 674 A.2d 962 (N.H. 1996).
253. *See id.* at 963.
254. *See id.* at 964.
255. *See id.* at 965.
256. *See id.* at 966.
257. *Id.*
258. *See* Dallet, *supra* note 226, at 339; Taber & King, *supra* note 217, at 1208-09.
259. *See* Feinstein, *supra* note 230, at 5.
260. *See* Dallet, *supra* note 226, at 342.
261. *See* Blum, *supra* note 206, at 181.
262. *Id.*

the customers of the hospital.[263] Exclusive contracts typically cover hospital based services such as radiology or pathology, or the contract may involve specialty surgical services.[264] An exclusive contract benefits a hospital because the contract gives a hospital greater control over the physician than it may otherwise have.[265] Further, a hospital can consider contracting only with a physician whom the hospital believes will practice in a cost-effective manner.[266]

Physicians and medical societies generally oppose pure economic credentialing, contending that economic considerations are not relevant in assessing the quality of care to a patient.[267] Pure economic credentialing poses several problems. First, if a hospital focuses exclusively on economic criteria, it could be liable for failing to adequately evaluate a physician's competence.[268] Second, although distinguishing between the pure and hybrid models of economic credentialing is theoretically possible, in reality the line of demarcation between the two is a mere fiction because it is difficult to separate a physician's competence from economic factors.[269] In fact, even medical societies disagree as to which factors hospitals should appropriately consider as part of the credentialing process.[270]

Pure economic credentialing raises grave public policy concerns because it shifts the focus of health care from quality to profits.[271] Hospitals and other health care delivery systems are obligated to act within the public's best interests because ultimately it is the public that physicians must treat.[272] Even more importantly, the public must rely on the expertise and good judgment of hospital staffs and governing boards to competently select qualified physicians.[273] Yet, MCOs cannot meet their obligations to the public by pursuing higher profit margins at the expense of quality health care.[274]

The second type of economic credentialing is hybrid economic credentialing, which evaluates a physician's competence by combining economic and clinical factors.[275] Examples of hybrid factors include

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263. *See* Feinstein, *supra* note 230, at 8.
264. *See* Blum, *supra* note 226, at 565.
265. *See id.*
266. *See id.*
267. *See* Feinstein, *supra* note 230, at 4 (stating that the American Medical Association and the California Medical Association are opposed to the use of economic criteria in credentialing).
268. *See* Taber & King, *supra* note 217, at 1211.
269. *See* Feinstein, *supra* note 230, at 4.
270. *See id.* at 5.
271. *See* Dallet, *supra* note 226, at 343.
272. *See id.* at 343-45.
273. *See id.* at 343.
274. *See id.* at 346-47.
275. *See* Taber and King, *supra* note 217, at 1206.

patients' lengths of stays, number of admissions versus outpatient services use, and use of lab tests and ancillary services.[276] The theory behind hybrid credentialing is that economic factors are inextricably intertwined with the quality of health care and the two cannot be separated, nor should they be, when evaluating a physician's competence.[277] In fact, a hospital arguably has a duty to perform economic credentialing because it has the responsibility of overseeing the financial affairs of the hospital.[278] The hospital cannot adequately perform its duties without considering the economic efficiency of its physicians and potential physicians.[279] Combining clinical and economic factors through hybrid economic credentialing does not pose the same problems as pure economic credentialing because quality of care remains an important factor in hybrid credentialing.

Various legislative measures related to economic credentialing due process protections have been proposed at both the federal and state level. The Health Quality and Fairness Act of 1995 was a federal initiative, which would have allowed plans to use economic criteria to credential physicians as long as the criteria were objective and the plan made the criteria available to physicians and plan enrollees.[280] However, Congress did not enact the Health Care Quality and Fairness Act of 1995.[281] Similar legislation was also introduced, but Congress was not successful in passing that legislation either.[282]

Although Texas physicians are already entitled to procedural due process when a hospital considers them for medical staff membership,[283] Texas legislators are currently considering additional due process protections for physicians and other health care providers.[284] One provision of the proposed legislation would require an advisory review panel to review proposed physician terminations.[285] Peers of the affected physician would compose the advisory review panel, whose decision is advisory only and without binding effect.[286]

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276. *See id.*; Feinstein, *supra* note 230, at 5.

277. *See* Taber & King, *supra* note 217, at 1206.

278. *See* Blum, *supra* note 226, at 588.

279. *See id.*

280. *See* Feinstein, *supra* note 230, at 8.

281. *See id.*

282. *See id.* (discussing Medicare Health Care Quality Act of 1995, S. 1024, 104th Cong., 1st Sess. (1995); Patient Protection Act of 1994, S. 2196, 103d Cong., 2d Sess. (1994)).

283. *See* TEX. HEALTH & SAFETY CODE ANN. § 241.101(c) (Vernon 1992 & Supp. 1997).

284. *See, e.g.*, Tex. H.B. 893, 75th Leg., R.S. (1997); Tex. S.B. 383, 75th Leg., R.S. (1997); Tex. S.B. 385, 75th Leg., R.S. (1997). The proposed legislation would essentially codify regulations issued by the Texas Department of Insurance. *See* 28 TEX. ADMIN. CODE § 3.3705(4) (West 1996) (Tex. Dept. of Ins., Procedure to Assure Adequate Treatment) (stating that before insurer terminates a physician, the insurer shall make an advisory panel available to the physician to review the termination decision).

285. *See* Tex. S.B. 385, 75th Leg., R.S. (1997).

286. *See id.* Tex. H.B. 893, 75th Leg., R.S. (1997); Tex. S.B. 383, 75th Leg., R.S. (1997).

Another provision of the proposed legislation would require the MCO to provide the affected physician with a written explanation for the termination and an opportunity for discussion.[287] The proposed legislation also guarantees that a physician would have access to the economic profile that the MCO used as well as the MCO's credentialing criteria.[288] In addition, the legislation would require an MCO that uses an economic profile to account for variations in a physician's practice that may explain fluctuations from expected costs.[289]

Economic considerations ultimately impact the quality of health care because a hospital's economic efficiency cannot be separated from the quality of services that it delivers.[290] A governing board has a fiduciary duty to act in the best interest of the hospital.[291] This fiduciary duty obligates the hospital to take steps towards becoming more efficient, especially in a competitive environment.[292] Courts "will likely support hospital credentialing decisions that stem from quality problems having very clear cost implications."[293] Thus, MCOs and hospitals should implement hybrid economic credentialing programs that include minimum due process requirements.

IV. CONCLUSION—WHAT IS THE PROGNOSIS?

Capitation, gag clauses, and economic credentialing clearly pose dilemmas for physicians. Reconsider the introductory hypothetical of Dr. Wong, the physician who failed to refer you to a specialist. Although capitation creates a conflict between Dr. Wong's duty to you and her own economic interests, she now realizes that capitation is not the evil that she once perceived. Instead, stop-loss insurance, large patient pools, and carve-outs help mitigate the risk that capitation presents to Dr. Wong. Further, capitation makes Dr. Wong accountable for health care costs, which is a necessary component of cost containment. Dr. Wong concludes that capitation works; it helps control costs without any empirical evidence that it compromises the quality of care.

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287. *See* Tex. H.B. 893, 75th Leg., R.S. (1997).

288. *See id.*; Tex. S.B. 383, 75th Leg., R.S. (1997); Tex. S.B. 385, 75th Leg., R.S. (1997); *see also* 28 TEX. ADMIN. CODE § 3.3705(5) (West 1996) (Tex. Dept. of Ins., Procedure to Assure Adequate Treatment) (stating that an insurer who uses economic profiling to terminate a physician shall make economic profile and written criteria available to the physician). The court, in *Texas Medical Ass'n v. Aetna Life Insurance Co.*, held that no private cause of action exists for the enforcement of PPO rules. 80 F.3d 153, 158 (5th Cir. 1996).

289. *See* Tex. H.B. 893, 75th Leg., R.S. (1997); Tex. S.B. 383, 75th Leg., R.S. (1997); Tex. S.B. 385, 75th Leg., R.S. (1997).

290. *See* Blum, *supra* note 226, at 597.

291. *See id.* at 598.

292. *See id.*

293. *Id.* at 597.

Dr. Lopez, the physician who feared the gag clause, does not fare as well. He now realizes that gag clauses are unacceptable because they restrict what he discloses to his patients. Dr. Lopez knows that nothing should come between a physician and his patient. As a result, he supports pending legislation introduced in Texas, as well as similar federal legislation, that would effectively do away with gag clauses.

Finally, Dr. Lopez learned about the dark side of economic credentialing when your HMO terminated him because he was "economically inefficient." He concludes that, although pure economic credentialing is not desirable, hybrid economic credentialing is a useful tool to help arrest escalating health care-costs. The economic efficiency of physicians directly impacts the health of an MCO, which could ultimately affect the public. Hybrid economic credentialing focuses on both economics and quality, two necessary and inescapable elements in the managed care environment.

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