MANAGED CARE AND THE ELUSIVE QUEST FOR ACCOUNTABLE HEALTH CARE

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I. WHY ACCOUNTABILITY IS BECOMING A PUBLIC ISSUE

Health care has become a major public issue. There are increasing pressures for accountability in health care, even though those who call for it are often unclear as to what accountability entails or how best to achieve it.[1] Why is there concern over accountability?

First, there are doubts about the value we receive for the money we spend. The U.S. spends a greater share of national income on health care than any other country, and our health care spending continues to increase.[2] This raises several questions. Are public and private funds being squandered? Are the medical services we receive provided

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1. *See* Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 10 AM. J.L. & MED. 147 (1994); Sidney Wolfe, *How You Can Make HMOs More Accountable*, HEALTH LETTER (Public Citizen Health Research Group), Nov., 1991, at 1.

2. In 1993 the U.S. spent 13.9% of its Gross Domestic Product on health care. Despite this spending, in 1992 17.4% of the non-elderly population was uninsured. The most notable change in health care spending between 1991 and 1993 is that the federal share of health care spending as a percentage of all health spending has increased dramatically; the federal government paid for 31.7% of the nation's health care in 1993. Federal and state spending on Medicaid increased at a rate of 16% from 1990 to 1993, which is almost twice the rate of increase for overall health care spending. Katherine R. Levit et al., *National Health Expenditures*, 16 HEALTH CARE FINANCING REV. 247, 249 (1994). If tax expenditures are counted (i.e., losses from tax revenue due to tax-deductions and credits for various programs subsidizing the private purchase of health insurance and services), that percentage would be even larger. *Id.* For a further analysis of federal and state government health care spending, see Stewart H. Altman & Marc A. Rodwin, *Halfway Competitive Markets and Ineffective Regulation: The American Health Care System*, 13 J. HEALTH POL. POL'Y & L. 323 (1988).

efficiently? Are the medical treatments effective? How good is the quality? Why do many people in need of care lack access to medical services?

Second, the increasing complexity and rapid transformation of our medical care system make it difficult for the public, as well as those who work in medical care, to understand what is occurring and where sources of responsibility lie.[3] Medicine has changed from a small scale, locally run cottage industry to a capital intensive, high technology, national industry linked to major private firms and public institutions.[4] In the past, individual practitioners were mainly guided by their own norms or those of professional colleagues, often informally.[5] Today, medicine is practiced in organizations that influence the conduct of practitioners. Decision making is subject to formal or bureaucratic controls.[6]

Medicine is also disciplined by markets and subject to pressures by groups other than the medical profession.[7] Large firms that purchase health care -- often working together through purchasing cooperatives -- tell medical care providers what services they want and how they should be produced.[8] Third-party payers, investors, and other market players

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3. Most Americans today receive their health care coverage through the workplace. Those firms that provide health insurance purchase it as a group plan from a number of providers, often some form of Managed Care Organization (MCO). The details of that coverage are controlled by the arrangement between the provider and the firm, not by the individual. There are a number of different entities involved in the provision of health care in such a system: the employer, the insurance companies, the provider organization, the individual doctors, and finally, the patient. Robert J. Blendon et al., *What Should be Done Now That National Health System Reform is Dead?*, 273 JAMA 243, 243 (1995).

4. *See generally* Arnold S. Relman, *Medicine as a Profession and a Business*, in THE TANNER LECTURES ON HUMAN VALUES 283-313 (McMunnin, ed. 1986); Arnold S. Relman, *Practicing Medicine in the New Business Climate*, 316 NEW ENG. J. MED. 1150 (1987); Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980).

5. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 420 (1982).

6. *See* Jerome P. Kassirer, *The Use and Abuse of Practice Profiles*, 330 NEW ENG. J. MED. 634 (1994) (discussing how financial managers often review medical decisions of the physician staff).

7. More and more businesses attempt to control their medical costs by purchasing managed care. MCOs aim to please the businesses that pay the bill. *See* Jerome P. Kassirer, *Access to Specialty Care*, 331 NEW ENG. J. MED. 1151, 1151 (1994).

8. Purchasing cooperatives combine the resources of individual businesses in order to minimize health insurance expense. The two most well-known purchasing cooperatives are the Council on Small Business Enterprises (C.O.S.E.) in Cleveland, and the Pacific

also make demands regarding performance. The law, too, now sets standards governing both the patient-physician relationship as well as relations between physicians and medical care organizations.[9]

As a consequence, responsibility for medical care, formerly the concern primarily of physicians and patients, now is shared with other individuals and organizations. Individual physicians must now take account of institutional protocols established by hospitals, managed care organizations (MCOs), utilization review firms, national standard setting organizations, federal and state governments, and other groups.

Third, market restructuring is also spurring demands for accountability.[10] Our health care system is being reconfigured by market forces such as the integration of health care delivery, innovations in the roles of insurers and providers, new market incentives, and the growth of managed care.[11] These changes raise questions about the public role in managing the complex health care market.[12] Attempts to encourage

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Business Group on Health (formerly the Bay Area Group on Health) in California. These groups often use their economic muscle to demand certain services from providers. Some have even required that health care providers submit data on the quality of their services and outcomes of patients they treat before the cooperatives will subscribe to their service.

9. For a series of articles on the law governing the patient-physician relation, see GEORGE ANNAS, STANDARD OF CARE (1993). *See also* GEORGE J. ANNAS, JUDGING MEDICINE (1988); GEORGE J. ANNAS, THE RIGHTS OF PATIENTS: THE BASIC ACLU GUIDE TO PATIENT RIGHTS (1989). When a doctor is responding to the needs of the patient, the doctrine of informed consent becomes a major factor. Patients are entitled to full information regarding any procedure, and possibly information regarding the doctor's financial arrangement with the provider organization. *See generally* PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (1987). For a history of informed consent law, see RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986). The two leading cases addressing informed consent are Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972) and Cobbs v. Grant, 502 P.2d 1 (Cal. 1972).

10. The quick pace of health care restructuring through private markets has led the Robert Wood Johnson Foundation to establish a program to monitor changes. *See* Paul B. Ginsburg et al., *A Robert Wood Johnson Program to Monitor Health System Change*, 14 HEALTH AFF. 287 (1995). *See also* George Anders & Hilary Stout, *A Dose of Reform: With Congress Stalled, Health Care Is Shaped by the Private Sector*, WALL ST. J., Aug. 26, 1994 at A1. For a discussion of some proposals for reform of the private insurance market, see MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE (1994).

11. *See generally* MARSHA GOLD ET AL., ARRANGEMENTS BETWEEN MANAGED CARE PLANS AND PHYSICIANS: RESULTS FROM A 1994 SURVEY OF MANAGED CARE PLANS (1995); HEALTH CARE ADVISORY BOARD, THE GRAND ALLIANCE: VERTICAL INTEGRATION STRATEGIES FOR PHYSICIANS AND HEALTH SYSTEMS (1993).

12. Although the 103rd Congress passed no significant health care reform and the

markets or address problems that markets create also raise questions about the appropriate role of federal and state government and public accountability.[13]

If accountable health care is to become a viable public policy rather than a slogan, we will need to address five questions. What do we mean by accountability? To what individuals and interests will health care be accountable? For what goals and actions should health providers be held accountable? To what standards should individuals and organizations be held accountable? What are the pros and cons of various measures used to promote accountability?

II. THE CONCEPT OF ACCOUNTABILITY

A. What is Accountability?

Can accountability be defined or measured? How do we know when we have achieved accountability?[14] Accountability, I suggest, includes

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chances of national legislation any time soon are slight, the issues raised in the recent national debate over health care reform are likely to be present for a long time. *See generally* Blendon et al., *supra* note 3, at 243 (outlining the recent failure of Congress to enact any major reform, and suggesting steps for "incremental reform").

Congress originally enacted legislation that fostered the development of HMOs as part of an effort to control medical spending and reform the medical care market. *See* LAWRENCE BROWN, POLITICS AND HEALTH CARE ORGANIZATIONS: HMOS AS FEDERAL POLICY (1983). Current Republican congressional leaders are now proposing to increase the number of Medicare beneficiaries enrolled in MCOs to help cut medical spending. President Clinton's proposal for health reform is summarized in WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE (1993). For a discussion and defense of the proposal, see PAUL STARR, THE LOGIC OF HEALTH CARE REFORM (1994).

13. This debate was a major theme during the 1994 elections in which Republicans won control of the House of Representatives and the Senate. Their platform was centered on a theme of less government and more individual accountability. That basic tension between the state and the individual impacts the debate over how government agencies and health care providers should be held accountable. Such concerns have been more common in countries like Britain, where the government has a more direct involvement in health care delivery. *See, e.g.*, RUDOLF KLEIN, COMPLAINTS AGAINST DOCTORS (1973); DIANE LONGLEY, PUBLIC LAW AND HEALTH SERVICES ACCOUNTABILITY (1993); Rudolf Klein, *Accountability in the National Health Service*, 42 POL. Q. 363 (1971); Rudolf Klein, *Control, Participation, and the British National Health Service*, 57 MILBANK Q. 70 (1979); Rudolf Klein, *The Doctor's Dilemma for Accountability*, 17 PUB. ADMIN. BULL. 31 (1976).

14. *See generally* Ezekiel J. Emanuel & Linda L. Emanuel, *What is Accountability in*

several related ideas. The four most important are control, responsibility, *answerability*, and *responsiveness*. Individuals or organizations are considered accountable for something if they exercise *control* over it. Similarly, individuals or organizations are accountable for performance if they are *responsible* for it. These two ideas are related yet distinct. Individuals may exercise control but not be the responsible parties. Similarly, a party may be deemed responsible but not have actual control.[15]

Another way to determine accountability is the extent to which individuals or organizations are required to answer for their actions.[16] *Answerability* refers to the processes by which individuals or organizations must explain and justify their performance and by which other parties monitor or supervise their conduct. *Responsiveness* is a way to gauge answerability. An individual who is answerable will respond when signalled appropriately.

When we use the term accountability we are speaking about control, responsibility, answerability or responsiveness.[17] These terms, however,

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Healthcare?, 124 ANNALS INTERNAL MED. 229 (1996); Amitai Etzioni, *Alternative Conceptualization of Accountability: The Example of Health Administration*, 35 PUB. ADMIN. REV. 279 (1975).

15. "[T]he social concept of responsibility allows for imputation of responsibility for possible rather than actual consequences . . . ." Nelson Potter, *The Social and Causal Concepts of Responsibility*, 10 S.J. PHIL. 97, 97 (1972) (discussing the relationship between responsibility and causality). *See generally* GEORGE AGICH, RESPONSIBILITY IN HEALTHCARE (1982); LARRY MAY, THE MORALITY OF SOCIAL GROUPS: COLLECTIVE RESPONSIBILITY, GROUPS BASED HARM AND CORPORATE RIGHTS (1987); RESPONSIBILITY (Carl J. Friedrich ed., 1960) [hereinafter FRIEDRICH]; RESPONSIBILITY (Jonathan Glover ed., 1970) [hereinafter GLOVER]; Arch Dotson, *Fundamental Approaches to Administrative Responsibility*, 10 W. POL. Q. 701 (1957); Michael Phillips, *Corporate Moral Personhood and Three Conceptions of the Corporation*, 2 BUS. ETHICS Q. 435 (1992); W. H. Walsh, *Pride, Shame and Responsibility*, 20 PHIL. Q. 1 (1978).

16. *See* FRIEDRICH, *supra* note 15; GLOVER, *supra* note 15; MAY, *supra* note 15; Phillips, *supra* note 15; Potter, *supra* note 15.

17. We also use the term accountability in both a positive and normative sense. When people say that an individual is accountable, they sometimes mean that the individual *is* answerable; other times that the individual *should be answerable*. People may say that a person is accountable when they actually mean that the person *should be* accountable (i.e., answerable or responsive). The aim here is to make claims of accountability to invoke the aid of groups with power to make the offending party answer for his or her conduct. The concept of accountability in this sense is like the concept of rights, which also has a positive and normative tradition. DEBORAH A. STONE, POLICY PARADOX AND POLITICAL REASON ch. 14 (1988).

are open ended. Accountability is elusive because it is a dynamic process rather than a thing or static state. Attempts to gauge or measure accountability are like snapshots of a body in motion. We will capture one moment rather than the process or movement. We may, therefore, better understand and further accountability by focusing on different dimensions of and approaches to promoting control, responsibility, answerability and responsiveness.

B. On Promoting Accountability

In the past we have promoted accountability in several ways and with a variety of tools. For example, accountability has been advanced through: 1) ethics and professional norms; 2) politics (representation); 3) finance and economics (mainly, markets); 4) administrative process; and 5) law.[18] These categories represent the principle methods through which we hold individuals or organizations responsible; ways that individuals and organizations can exercise control; and ways in which others may hold them accountable.[19] These categories also represent different dimensions of accountability and the tools used to promote it. Promoting accountability is difficult because different approaches sometimes conflict with each other. Increasing legal accountability, for example, may diminish a sense of personal responsibility by defining the individual's primary ethical obligation as fidelity to the law.[20] Furthermore, individuals can be accountable for several different aspects of their conduct, in varying degrees, and to different parties.[21] Another complication is that accountability must often be shared between individuals and groups.[22] Finally, measures designed to promote or assess accountability need to be tailored to specific goals. In health care these

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18. One can distinguish other sources of control and responsibility, such as managerial authority, professional controls, informal networks, and other norms. There is a well developed sociological literature on these factors.

19. Barbara S. Romzek & Melvin Dubnick, *Accountability in the Public Sector: Lessons from the Challenger Tragedy*, PUB. ADMIN. REV., May-June, 1987, at 227, 228-30 (discussing various "accountability systems" in the public sector).

20. For an interesting discussion of this tension, see Eugene Bardach and Robert Kagan, *Accountability v. Responsibility*, *in* SOCIAL REGULATION: STRATEGIES FOR REFORM 347 (1982). *See also* Bruce C. Hafen, *The Rise of the Regulatory State: The Age of Declining Moral Concensus*, *in* VITAL SPEECHES OF THE DAY 719 (1994).

21. *See* Potter, *supra* note 15, at 97.

22. Dennis F. Thompson, *Moral Responsibility of Public Officials: The Problem of Many Hands*, 74 AM. POL. SCI. REV. 905, 907 (1980).

goals are multiple, divergent and complex.

The timing of measures is also important. One kind of accountability aims to make parties answer for their conduct after they have acted through the use of sanctions and rewards. Another approach attempts to make the parties responsive prior to any act. We typically think of accountability in terms of performance of specific tasks or objectives. In health care, however, it is far more important to consider the responsiveness of individuals and organizations over time.

Some writers have proposed measuring organizational accountability by examining the extent to which outside actors exercise influence over the organization.[23] This approach disregards the influence of insiders. It may also be difficult to gauge the extent of influence, especially if several parties exert influence simultaneously. Despite difficulties in measurement, however, the concept of accountability helps focus inquiries in more precise ways, directs questions and highlights key problems.

C. The Role of MCOs in Promoting Accountability

Managed care changes traditional indemnity insurance and fee-for-service practice by integrating the financing and delivery of medical services.[24] MCOs manage both patients and physicians through policies that restrict patients' choice of providers and medical options, and limit the clinical autonomy of doctors.[25]

MCOs use a variety of approaches to change the decisions of doctors

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23. *See* Michael G. O'Loughlin, *What is Bureaucratic Accountability and How Can We Measure It?*, 22 ADMIN. & SOC. 275 (1990).

24. The term "managed care" covers a wide range of organizations with different organizational structures, financial incentives and corporate cultures. Several commentators have noted that there are great differences between different kinds of managed care organizations. For a discussion of those differences, and an attempt to provide a taxonomy of different kinds of MCOs, see generally Alan L. Hillman et al., *Toward New Typologies for HMOs*, 68 MILBANK Q. 221 (1990); Robert E. Hurley & Deborah A. Freund, *A Typology of Medicaid Managed Care*, 26 MED. CARE 764 (1988); James C. Robinson, *Payment Mechanisms, Non-price Incentives, and Organizational Innovation in Health Care*, 30 INQUIRY 328 (Fall 1993); Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL. POL'Y & L. 74 (1993).

25. *See* David C. Hadorn, *Emerging Parallels in the American Health Care and Legal-Judicial Systems*, 18 AM. J.L. & MED. 76 (1992). *See also* BRADFORD GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS (1991); ROBERT E. HURLEY ET AL., MANAGED CARE IN MEDICAID: LESSONS FOR POLICY AND PROGRAM DESIGN (1993).

and providers.[26] They may use case managers to coordinate medical care in expensive cases;[27] financial incentives to encourage physicians to make medical decisions that conserve resources; gatekeepers to control referrals for specialty services; and administrative rules or protocols to guide the delivery of medical services.[28] Managers can review medical records and deny physicians payment for medical care they deem unnecessary, thereby rationing certain services explicitly as well as implicitly.[29] The common element to these approaches is that organizations and institutional arrangements control choices traditionally made exclusively within the patient-physician relationship. Indeed, managed care is reshaping the patient-physician relationship.

In the future, debate over accountability will focus on managed care for three reasons. First, MCOs play a strategic role in health policy. They can control resource allocation,[30] control quality by monitoring the performance of physicians and providers, and help implement federal and state health policies.[31] The federal government requires many MCOs (federally qualified health maintenance organizations) to set premiums by community rating and to provide minimum benefit packages.[32] Federal

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26. *See* Alan Hillman, *Managing the Physician: Rules Versus Incentives*, 10 HEALTH AFF. 138 (1991) (discussing the impact of management policies on individual physicians).

27. *See infra* notes 69-71 and accompanying text.

28. *See generally* Hillman, *supra* note 26.

29. *See generally* THE INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE?: THE ROLE OF UTILIZATION MANAGEMENT (Bradford H. Gray & Marilyn J. Fields eds., 1989).

30. *See generally* ROBERT E. HURLEY ET AL., MANAGED CARE IN MEDICAID: LESSONS FOR POLICY AND PROGRAM DESIGN (1993); Eleanor Cheminsky, Assistant Comptroller General, *Medicare Part B: Inconsistent Denial Roles For Medical Necessity Across Six Carriers*, Statement Before the SubCommittee on Regulation, Business Opportunities and Technology, Committee on Small Business, House of Representatives in Washington, D.C. (March 29, 1994).

31. The development of HMOs was fostered by federal legislation, as part of an effort to control medical care spending and redesign medical care markets. 42 U.S.C. § 417.101 et seq. (1994). *See also* LAWRENCE D. BROWN, POLITICS AND HEALTH CARE ORGANIZATION: HMO'S AS FEDERAL POLICY (1983). In a more recent effort to control health care spending, Republican leaders of the 104th Congress have proposed to increase the number of Medicare beneficiaries that will be enrolled in MCOs.

32. Health Maintenance Organization Act of 1993, 42 U.S.C. § 300e (1994). Under "community rating", premiums are set at the same level for all individuals or all individuals within a certain class. This is an alternative to individual risk rating under which the health insurance premium is adjusted for the individual's health status or health risk based on individual characteristics. For a comparison of risk rating and community rating, see

and state governments are likely to use MCOs as instruments to contain health care costs, improve the quality of care, and bypass or avoid government bureaucracy. Governments will create incentives and perhaps regulations to encourage MCOs to fulfill these roles and to promote other public policies.[33]

Second, many issues now debated as questions of national or state policy will be significantly affected by the kinds of practices MCOs adopt; e.g. the coverage individuals receive, the services that are provided or denied, and the ways resources are rationed or allocated through incentives, rules or organizational culture.[34] The way MCOs are governed and managed also evokes competing philosophies of the appropriate relationship between the private and public sectors, and what roles providers, payers, patients and the public play in our health care system.[35]

Finally, the means by which MCOs promote accountability of

Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (1993).

33. For example, the Attorney General of Massachusetts has proposed guidelines for community benefit for non-profit HMOs doing business in the state, MASSACHUSETTS ATTORNEY GENERAL, COMMUNITY BENEFITS GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS (June 1994), and after discussion with MCOs, issued voluntary community benefit guidelines to which the state's HMOs have agreed to adhere. *Attorney General Unveils Voluntary Community Benefits Guidelines for HMOs*, 4 Health Care Pol'y Rep. (BNA) No. 10, at 379 (March 4, 1996). Many hospitals and MCOs now state that they are or should be accountable to the community at large, not just the individuals who use their services. *See, e.g.*, AMERICAN HOSPITAL ASSOCIATION, TRANSFORMING HEALTH CARE DELIVERY: TOWARD COMMUNITY CARE NETWORKS (1994). Commentators agree. *See* David Seay & Robert Sigmond, *Community Benefit Standards for Hospitals: Perceptions and Performance*, 3 FRONTIERS OF HEALTH SERVS. MGMT. 39 (1989); David Seay, *Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit*, 2 HEALTH MATRIX 35 (1992).Robert Sigmund & David Seay, *In Health Care Reform, Who Cares for the Community?*, 12 J. HEALTH ADMIN. EDUC. 259 (1994).

34. HMOs often have protocols on determining medical necessity and what practices are appropriate or desirable. Many of these are informal and part of organizational culture. Some, however, are explicit rules. *See* PETER JACOBSON ET AL., DEFINING MEDICAL NECESSITY: AN EXPLORATORY STUDY (1995); Wendy K. Mariner, *Patients' Rights After Health Care Reform: Who Decides What Is Medically Necessary?*, 84 AM. J. PUB. HEALTH 1515 (1994). For an example of the role of guidelines in allocating health care resources for specific procedures, see David C. Haden, *Emerging Parallels in the American Health Care and Legal-Judicial Systems*, 18 AM. J.L. & MED. 73 (1992).

35. For a discussion of HMO practices, see HAROLD S. LUFT, HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE (1987). *See also supra* note 13 (discussing the national debate on health care).

physicians and other providers are less available or even unavailable in *un*managed care settings (i.e., fee-for-service practice with traditional indemnity insurance).[36] However, MCOs may not live up to their potential. There is always the possibility of organizational failure, mismanagement or pathologies.[37] Scandals over marketing practices in California Medicaid MCOs in the 1970s prompted California to enact legislation to alleviate these abuses.[38] Unscrupulous managed care promoters enrolled Medicaid recipients who were unaware of what they were joining, and then did not deliver what they had promised.

The key accountability issue for the future will be to whom should MCOs be accountable? Patients? Consumers? Managers? Shareholders or other owners? Or should MCOs serve the general public or some public authority such as a government agency? Many of the choices that

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36. The problems inherent in the traditional, "un-managed" system, such as uncontrolled growth of health care spending, overutilization of resources and lack of effective quality assurance, created the need for stricter controls by government and the private sector. *See* ELI GINSBERG, HEALTH SERVICES RESEARCH: KEY TO HEALTH POLICY (1991); ANNE STOLINE & JONATHAN P.WEINER, THE NEW MEDICAL MARKET PLACE: A PHYSICIAN'S GUIDE TO THE HEALTH CARE REVOLUTION (1988). There was less coordination of resources and efforts under indemnity insurance than is possible under managed care.

37. A recent series of investigative articles reported instances when quality monitoring by HMOs broke down with serious consequences. *See* Fred Schulte & Jenni Bergal, *Profits From Pain*, FLA. SUN-SENTINEL, Dec. 11-15, 1994; Fred Schulte & Larry Keller, *The HMO Maze: How Medicare Fails Seniors*, FLA. SUN-SENTINAL, Nov. 7-11, 1993; Fred Shulte et al., *Risky Rx: The Gold Plus Plan for the Elderly*, FLA. SUN-SENTINAL, Oct. 21-24, 1990. *See also* Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1319 (1996); Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. (forthcoming 1996). For a recent discussion of similar problems in California, see Claire Spiegel & Virginia Ellis, *HMO Wins Medi-Cal Pact Despite Critical Audits*, L.A. TIMES, Dec. 18, 1994, at A30. *See also*, GENERAL ACCOUNTING OFFICE, MEDICAID MANAGED CARE: MORE COMPETITION AND OVERSIGHT WOULD IMPROVE CALIFORNIA'S EXPANSION PLAN (Apr. 1995).

38. Knox-Keene Health Care Service Plan Act of 1975, CAL. HEALTH & SAFETY CODE §§ 1340-1399.64 (Deering 1995); Waxman-Duffy Prepaid Health Plan Act, CAL. WELF. & INST. CODE §§ 14200-14482 (Deering 1995).

For a discussion, see Bruce Spitz, *When A Solution Is Not a Solution: Medicaid and Health Maintenance Organizations*, 3 J. HEALTH POL. POL'Y & L. 498 (1979). *See also* David F. Chavkin & Anne Treseder, *California's Prepaid Health Plan Program: Can the Patient Be Saved?*, 28 HASTINGS L.J. 685 (1977); Carol D'Onofrio & Patricia Dolan Mullen, *Consumer Problems with Prepaid Health Plans in California*, 92 PUB. HEALTH REP. 121 (1977).

arise in managed care are cast as technical matters for specialists, yet at heart they are issues of values and politics. Struggles will be likely among providers of health services, employers and other institutional purchasers of medical services, owners and trustees of MCOs, government agencies with responsibility for oversight, consumers of health services, and other groups, each of which will have diverging goals and interests.

For example, MCOs seek to hold doctors accountable to organizational standards. Doctors, in turn, try to hold the MCOs accountable to their own professional standards, thus retaining their professional autonomy. Some physicians criticize MCO policies or assert their professional norms in making clinical decisions. In addition, physician groups now propose that doctors should own MCOs so that they can exercise full professional control.[39]

Until now, consumer groups have emphasized the importance of due process remedies, such as grievance mechanisms and appeals, as ways to further their interests when doctors in MCOs decide that medical care is not necessary or appropriate.[40] Yet as concerns of consumers and other stakeholders escalate, both may shift their attention from grievance mechanisms to governance of MCOs,[41] and to other forms of

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39. *See, e.g.*, Arnold A. Relman, *Medical Practice Under the Clinton Reform: Avoiding Domination by Business*, 329 NEW ENG. J. MED. 1574 (1993); Adam Yarmolinski, *Supporting the Patient*, 322 NEW ENG. J. MED. 602 (1995). However, the physicians managing an MCO are likely to have perspectives that differ from those who spend most of their time providing clinical services.

40. *See, e.g.*, 42 C.F.R. §§ 417.600-694 (1994) (establishing a formal system of appeals for Medicare beneficiaries and providers). *See also* Timothy P. Blanchard, *"Medical Necessity" Denials as a Medicare Part B Cost Containment Strategy: Two Wrongs Don't Make it Right or Rational*, 34 ST. LOUIS U. L.J. 939 (1990); Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COL. L. REV. 1674 (1994). Some managed care plans have an ombudsman, like Health Insurance Plan of Greater New York. Other MCOs, such as Kaiser Permanente, require that disputes over covered services be settled by binding arbitration. *See* Michael A. Hiltzik & David R. Olmos, *"Kaiser Justice" System's Fairness Is Questioned*, L.A. TIMES, Aug. 30, 1995, at A1. A California trial court found the arbitration system "unconscionable" and "corrupt . . . in general." Engalla v. Permanente Med. Group, 43 Cal. Rptr. 2d 621, 640, 644-45 (Cal. Ct. App.), *review granted*, 905 P.2d 416 (1995). The court of appeals found that the trial court's findings of fraud and unconscionability were not supported by substantial evidence and stated that if Kaiser had used the arbitration process to their own advantage, such actions would be improper and morally reprehensible, but not actionable. *Id.*

41. It is sometimes costly and difficult to take advantage of grievance mechanisms. *See* Julie Johnson, *Dad's Protest Lead to Record Fine Against California HMO*, AM. MED.

representing their interests, such as forming cooperatives that can influence MCOs through purchasing decisions.[42]

NEWS, Dec. 12, 1994, at 1, 14. The American Medical News reports that Take Care Health Plan had denied Harry Christie a referral to a specialist for his daughter who had Wilms' Tumor, a rare form of cancer. Although The National Cancer Institute patient protocols called for treatment by specialists, the MCO did not allow the referral. The appeal procedure would have taken too long to complete without endangering the child's life, so the family had the specialist perform the surgery in the same hospital Take Care would have used. The surgery was performed at the Christies' expense, and they then sought reimbursement from the MCO. Take Care not only refused to pay the surgeon's fee, but also refused to pay all of the hospital costs which it would have borne had it chosen a surgeon to perform the surgery. The Christies then exhausted the Take Care grievance procedure and Take Care turned down their appeal. The Christies turned to an arbitrator as their contract with the MCO allowed. The arbitrator sided with the Christies, who then filed a complaint with the California Department of Corporations. Take Care was fined $500,000 for a quality violation and for endangering a patient's life.

The Christie family, unlike many MCO subscribers that may find themselves in a similar situation, had connections with doctors, and the requisite resources and tenacity to pursue Take Care. Poor, uneducated or otherwise disadvantaged individuals may be able to rely on their due process rights for protection. *See* JOEL HANDLER, THE CONDITIONS OF DISCRETION: AUTONOMY, COMMUNITY, BUREAUCRACY (1986); JOEL HANDLER, LAW AND THE SEARCH FOR COMMUNITY (1990).

For a study of the cost involved in bringing the appeals in the classic case of *Matthews v. Eldridge*, see PHILLIP COOPER, PUBLIC LAW AND PUBLIC ADMINISTRATION app. A (2d ed. 1988) (*Mathews v. Eldridge*: The Anatomy of an Administrative Law Case).

42. There are few models of significant consumer representation in MCOs. One exception is Group Health of Puget Sound, which is a cooperative. The issue of consumer representation in health care was a major theme in the health care reform proposed by President Clinton. For a discussion of the issues, see Walter A. Zelman, *Who Should Govern the Purchasing Cooperative?*, 12 HEALTH AFF. 49 (1993); Marc A. Rodwin, *Consumer Protection and Managed Care: The Limitations of Reform Proposals and the Need for Organized Consumer Advocacy*, 15 HEALTH AFF. (forthcoming Fall 1996). The difficulty of promoting effective consumer representation in health planning offers sobering lessons. For a discussion, see JAMES A. MORONE, THE DEMOCRATIC WISH (1990). *See also* James A. Morone & Theodore R. Marmor, *Representing Consumer Interests: The Case of American Health Planning*, 91 ETHICS 431 (1981); Bruce C. Vladeck, *Interest-Group Representation and the HSAs: Health Planning and Political Theory*, 67 AM. J. PUB. HEALTH 23 (1977).

More recently women's groups, people with disabilities, and individuals with particular diseases such as AIDS or breast cancer have organized to advocate for their interests. *See* Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patient's Rights, Women's Health and Disability Rights Movements*, 20 AM. J.L. MED. 147 (1994); Robert Wachter, *AIDS Activism and the Politics of Health*, 326 NEW ENG. J. MED. 128 (1992).

III. ACCOUNTABILITY AND CONFLICTING INTERESTS IN MANAGED CARE[43]

A. Two Models of Managed Care

One can distinguish a consensus and a conflict model of managed care. In the consensus model the goals of managed care are mutually reinforcing, the interests and goals of the actors – patients, physicians, managers, institutional providers and MCOs – are consistent, and each set of actors has either a single dominant interest or interests that are compatible.[44] A series of concentric circles, the larger containing the smaller, illustrate this model. The smallest circle symbolizes patients; the largest circle represents managed care organizations (fig.1). This article uses a *conflict model*, which assumes that MCOs have multiple goals which can diverge, multiple actors with distinct interests (only some of which overlap), and that each actor may have several conflicting interests.[45] A Venn diagram of overlapping circles illustrating the conflicts among different actors (which is one of the three kinds of conflicts mentioned below), depicts this model (fig. 2).

B. Three Conflicts in Managed Care

1. Conflicting Policy Goals

Managing medical care requires balancing goals which can conflict: reducing expenditures and the use of services; increasing efficiency; eliminating unnecessary and potentially harmful treatments; providing better or more desirable treatment for patients; expanding the range of services offered; or even improving patients' quality of life.

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43. This section is based on my previous article, Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604 (1995).

44. For a discussion of the concept of interest, see Isaac Balbus, *The Concept of Interest in Pluralist and Marxist Analysis*, POL. & SOC'Y, Feb., 1971, at 151; Connolly William, *On 'Interests' in Politics*, POL. & SOC'Y, Summer, 1972, at 459.

45. DEBORAH A. STONE, POLICY PARADOX AND POLITICAL REASON (1988). For a discussion on representation of conflicting interests in health policy, see James A. Morone & Theodore R. Marmor, *Representing Consumer Interests: The Case of American Health Planning*, 91 ETHICS 431 (1981); Bruce C. Vladeck, *Interest-Group Representation and the HSAs: Health Planning and Political Theory*, 67 AM. J. PUB. HEALTH 23 (1977).

These diverse objectives are often mutually reinforcing. Eliminating inappropriate medical services can reduce expenditures and improve the quality of life for patients. Coordinating activity can lead to greater efficiency and expand the use of services. Using protocols can eliminate clinical errors and enable physicians to spend more time with patients for non-routine matters.

However, there are also tensions among these objectives. Reducing expenditures, for instance, may limit desirable services and decrease the quality of life for patients. Relying strictly on protocols can lead to poorer quality of medicine, particularly in complex or uncertain cases. Increasing efficiency may result in patients receiving less individual attention.[46] Often, measures to promote one objective require trade-offs with another.

2. Actors with Conflicting Interests

A second tension in managed care is the presence of multiple actors with diverging interests and loyalties: patients, physicians, managers, institutional providers of medical care, and MCOs. These groups often come together to achieve common objectives, but each group also has loyalties and interests that may conflict with those of other actors.

Take physicians, for example. They are agents for their patients. But they are also often employees of, or enter into contracts with MCOs, and are therefore obliged to serve them. MCOs, in turn, have legal obligations to the interests of owners or shareholders as well as patients. Moreover, when doctors are partners or shareholders in closely-held medical care organizations, they have legal obligations to act in a way that does not jeopardize the financial interests of other partners or shareholders.[47]

Managers owe their primary loyalty to their employer rather than to patients. Hospitals and other institutional providers hired by MCOs have both contractual obligations to the MCO, and their own missions. These can include research and earning profits as well as promoting patient care and the other goals of the MCO. Thus, physicians, managers, institutional providers and MCOs all have loyalties that conflict with their

46. MCOs that reduce expenditures may seem inefficient from the patient's perspective. For example, some MCOs may reduce the length of stay in a hospital which will often force the patient's family to provide the necessary home care.

47. *See* R.C. CLARK, CORPORATE LAW 141-50 (1986) (discussing conflicts of interest and the duty of loyalty to corporate shareholders). MODEL BUSINESS CORPORATION ACT ANNOTATED § 8.30 (1984) (detailing the duties of corporate directors).

obligations to patients.[48]

The financial and other interests of these actors also vary. Cost savings by the MCO may impose costs on patients or reduce the revenue of hospitals. Patients may have little incentive to be frugal in using services, but physicians participating in risk-sharing arrangements, managers, and MCOs, may actually earn more money if fewer services are provided or costs are lowered in other ways.[49] Parties with diverse goals and differing interests frequently cooperate – buyers and sellers, for example, further their respective interests through bargaining, negotiation, contracting and trading.[50] Still, these market mechanisms are often imperfect or fail, and vulnerable parties may be taken advantage of, especially when there is a disparity in information or power.

3. Actors with Conflicting Goals

Each of these groups listed above may also have conflicting goals. Patients, for example, have an interest in receiving good, perhaps the best, medical care, and this can increase spending. Patients, however, also pay premiums and deductibles and so have an interest in lowering medical costs. Thus the patients' interests as payer and recipient of medical care may conflict. Physicians have an interest in maintaining or raising their income. At the same time, however, they have an interest in maintaining their reputation among peers as good professionals and in being viewed as cost-effective by managers and employers. MCOs have an interest in reducing expenditures to increase their short-run profit or revenue surplus. Yet they also have an interest in their reputation for delivering high quality medical care without skimping, since this also encourages members to stay and new ones to join – both essential for long-run profitability.

C. Fiduciary Relations and Conflicts of Interest

The conflicts between goals and multiple roles of various managed care actors create strains and conflicts of interest – a classic accountability problem, particularly in fiduciary relationships.

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48. CLARK, *supra* note 47, at 141-50.

49. *See generally* MARC A. RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST (1993).

50. Economic and negotiation theory suggest that voluntary market transactions can increase the collective welfare. *See* R. FISHER, GETTING TO YES (1981); L. SUSSKIND, BREAKING THE IMPASSE: CONSENSUAL APPROACHES TO RESOLVING PUBLIC DISPUTES (1987).

A fiduciary is a person with power over the affairs of another party whom the law requires to act in that party's behalf. The law holds fiduciaries to the highest standards of conduct.[51] Rather than acting in an arm's length relationship, fiduciaries are expected to be loyal to the party for which they act and, in exercising their discretion and independent judgement, to act for that party's exclusive benefit. The law explicitly defines some relations as fiduciary, including the trustee-beneficiary relation, the lawyer-client relation, the corporate officer-shareholder relation, relations among partners, and the public servant in relation to government.[52] The law has held that physicians, nurses and medical care institutions are fiduciaries for patients, but only in limited contexts.[53] Still, it is generally assumed that medical personnel should act as fiduciaries of patients.[54] Anything that compromises the fiduciary's loyalty to the fiducie (a term I invented to refer generally to the party for whom the fiduciary acts)[55] or the fiduciary's ability to exercise

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51. *See generally* P.D. FINN, FIDUCIARY OBLIGATIONS (1977); Kenneth B. Davis, Jr., *Judicial Review of Fiduciary Decisionmaking--Some Theoretical Perspectives*, 80 N.W. U. L. Rev. 1 (1985); Robert Flannigan, *The Fiduciary Obligation*, 9 OXFORD J. LEGAL STUD. 285 (1989); Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795 (1983); Eileen Scallen, *Promises Broken vs. Promises Betrayed: Metaphor, Analogy, and the New Fiduciary Principle*, 4 U. ILL. L. REV. 897 (1993); L. S. Sealy, *Fiduciary Relationships*, CAMBRIDGE L.J. 69 (1962); L. S. Sealy, *Some Principles of Fiduciary Obligation*, CAMBRIDGE L.J. 119 (1963); Austin W. Scott, *The Fiduciary Principle*, 37 CAL. L. REV. 539 (1949); Ernest J. Weinrib, *The Fiduciary Obligation*, 25 U. TORONTO L.J. 22 (1975).

52. Frankel, *supra* note 51, at 795.

53. *E.g.*, Miller v. Kennedy, 522 P.2d 852 (Wash. App. 1974); Canterbury v. Spense, 464 F.2d 772 (D.C. App. 1972); Cobbs v. Grant, 104 Cal. Rptr. 505 (Cal. 1972); Lockett v. Goodill, 430 P.2d 589 (Wash. 1967); Hammonds v. Aetna Casualty & Surety Co., 243 F. Supp. 793 (Ohio 1965).

54. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MEDICAL ASS'N, CONFLICTS OF INTEREST (1986); K. Carr, *Fiduciary Duty and Conflicts of Interest, in* ETHICS IN HEALTH SERVICES MANAGEMENT 87 (1987).

55. There have been other attempts to use a common term for the party on whose behalf the fiduciary acts. Some commentators use the term beneficiary. This term, however, suggests that the party is receiving something, such as a gift, and this is not always the case. It also does not convey a central feature of the relationship: that the party is entitled to expect certain things from the fiduciary. Tamar Frankel has coined the term *entrustor*, which conveys this sense with regard to the person on whose behalf the fiduciary acts. Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 808 (1983). This term also has limitations, however. It suggests that the entrustor is giving power or authority to the trustee, which is not so in all situations. Sometimes a third party grants the authority or power to the fiduciary for the benefit of another. The term fiducie does not suggest any particular kind of fiduciary relationship and clearly links the fiduciary to the

independent judgement on the fiducie's behalf, creates a conflict of interest. There are two major categories: 1) conflicts stemming from financial and other personal interests; and 2) conflicts stemming from divided loyalties because of competing obligations. Conflicts of interest exist prior to any breach of trust. They signal an increased risk that the fiduciary may not act as expected.

Fiduciary obligations are a legal device to hold fiduciaries accountable to their fiducie. Two of the characteristics of the fiduciary relationship are that it requires one party to be loyal to another and that it restricts activities that may compromise that loyalty. In effect, fiduciary law promotes accountability by clarifying who is supposed to benefit from the relationship, limiting the discretion of the fiduciary, and imposing sanctions for misconduct. In examining accountability problems outside of fiduciary relationships we often draw on the ideal of loyalty, and the ways it may be compromised by conflicts of interests. Let me illustrate three divisions in loyalty that create conflicts of interest in managed care and raise the issue: to whom is the physician or medical provider accountable?

D. Dealing with Conflicts in Managed Care

1. Financial Incentives for Physicians to Reduce Spending

In an effort to hold physicians accountable for their performance, most MCOs use financial incentives and organizational rules to manage physician behavior. Such organizational controls over the behavior of employees are prevalent outside of medicine as well. An issue regarding the use of incentives in medicine is that efforts to make physicians accountable to the MCOs may make them less accountable to patients. Many financial incentives for physicians to control costs, for example, create conflicts of interest that compromise the interests of patients. Most people still believe that doctors owe their primary loyalty to patients.

Most health maintenance organizations and a few preferred provider organizations increase or decrease physician compensation depending on the cost implications of their clinical choices or on the organization's profitability.[56] They often decrease a physician's income if the number

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party on whose behalf he or she acts.

56. *See* MARC A. RODWIN, MEDICINE MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST chs. 5, 6 (1993). *See also* GOLD ET AL., PHYSICIAN PAYMENT REVIEW COMMISSION, ARRANGEMENTS BETWEEN MANAGED CARE PLANS AND

of referrals, tests ordered or other medical choices cost more than the threshold amount that the organization sets. They may also decrease physician income based on the organization's financial performance.[57] In addition, MCOs simply may not renew contracts with physicians who practice medicine in a manner they consider unnecessarily costly.[58] Typically, MCOs make primary care physicians gatekeepers and provide incentives to limit referrals to specialists. Such arrangements create a direct incentive to limit the use of resources. Some MCOs spread the financial risk among groups of doctors. All such incentives create conflicts of interest since physicians have an incentive to reduce services even when it is in the patient's best interest to receive them.[59]

2. Patient Choice and Informed Consent

The legal doctrine of informed consent requires that physicians explain to patients the choices available, the risks and benefits of the proposed treatments and alternatives, and obtain the patient's consent before performing any medical procedure or therapy.[60] Under traditional fee-for-service practice, patients have a broad choice of providers, therapies and procedures. However, MCOs structure the delivery of medical care to reduce patient choice and control.

PHYSICIANS: RESULTS FROM A 1994 SURVEY OF MANAGED CARE PLANS (1995); LOUIS SULLIVAN, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PUB. NOS. 90-20263/AS & 90-202646/AS, INCENTIVE ARRANGEMENTS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS TO PHYSICIANS (1990); Alan Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743 (1987); Alan L. Hillman et al., *Contractual Arrangements Between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools*, 30 MED. CARE 136 (1992).

57. *See generally* Hillman, *supra* note 56; RODWIN, *supra* note 56; SULLIVAN, *supra* note 56.

58. Julie Johnson, *'Deselection' Suit Dismissed in Texas*, AM. MED. NEWS, Sept. 12, 1994, at 3, 31; Julie Johnson and M. Mitka, *Managed Care Maelstrom*, AM. MED. NEWS, July 25, 1994, at 1.

59. RODWIN, *supra* note 56.

60. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972) (holding that the physician's duty to disclose relevant information "is governed by the same legal principles applicable to others in comparable situations . . . ."); Cobbs v. Grant, 502 P.2d 1 (Cal. 1972) (holding that "as an integral part of the physician's overall obligation to the patient there is a duty of reasonable disclosure . . ."). *See also* APPELBAUM ET AL, *supra* note 9, at 35-65 (discussing the legal requirements for disclosure and consent); FADEN & BEAUCHAMP, *supra* note 9.

MCOs reduce choice by implicitly excluding medical services through management decisions that limit resources available to physicians (such as reducing budgets for the purchase of equipment); by rules and incentives that encourage physicians to practice more frugally and thus not consider or recommend certain medical options;[61] and by explicitly excluding medical services from the benefit package.

The first two ways of limiting the range of services hide from patients their limited choices. Such practices compromise the values underlying informed consent because doctors and providers do not inform patients that their clinical choices are restricted.

If managed care providers use the third method to limit services, and exclude clearly defined broad categories of medical care up-front, consumers – in theory – will be able to inform themselves about policy limits and choose between different MCOs. Such choice, some people argue, will preserve the values underlying informed consent.[62]

However, unless already ill, most people are unable to predict what services they will need, which undermines meaningful choice between policies with different exclusions. Informed choice is further eroded if particular therapies are excluded, since most people will not understand the significance of these exclusions until they seek the advice of a doctor.[63]

If MCOs do not fully disclose policies limiting services, should physicians? Should physicians also inform patients of medical options that MCOs exclude? And, should doctors inform patients of their own financial incentives to reduce services?

Malpractice law imposes liability on physicians for "failure to disclose" in obtaining consent.[64] Courts have not yet made clear whether limitations on services in managed care need to be disclosed.[65] This will

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61. Alan L. Hillman, *Managing the Physician: Rules Versus Incentives*, 10 HEALTH AFF. 138, 140 (1991).

62. Mark A. Hall, *Informed Consent to Rationing Decisions*, 71 MILBANK Q. 645, 656 (1993).

63. *See* Paul S. Appelbaum, *Must We Forego Informed Consent to Control Health Care Costs?: A Response to Mark A. Hall*, 71 MILBANK Q. 669 (1993).

64. Canterbury v. Spence, 464 F.2d at 782, 783. *See also* APPELBAUM, *supra* note 60.

65. Several cases have been filed, but were settled before a final judicial decision. For examples of such cases, see the pleadings on file with the author: Anthony Tetti Sr. v. U.S. Healthcare, Inc., C.A. 89-9808 (E.D. Pa. Dec. 27, 1988); Kelly Anne Swede v. CIGNA Health Plan of Delaware, C.A. No. 87C-SE-171-1-CV (Del. Super., New Castle County Sept. 1988); Boyde v. Albert Einstein Medical Center, C.A. No. 4887 (Pa. Ct. Common Pleas, Civ. Div., Phila. July 1983). An additional case is still before the court. Lynch v.

be a major issue in the future, however, especially if physicians who fail to disclose have financial incentives to reduce services. Disclosure of organizational policies is not a panacea for service limitations in managed care, but it may reduce the risk of legal liability.[66]

Informed consent law assumes that physicians will fully disclose relevant information and give impartial advice. But physicians working in MCOs are under pressure to pass over some options silently or to downplay their benefit and heighten their risk. In some cases primary care physicians are prohibited from informing their patients that they are seeking a referral until they have received authorization.[67] They have difficulty reconciling their dual obligations: on the one hand, to inform patients of clinical options and risks and allow them to make the major medical care choices; on the other, to follow the organizational policies that limit patient choice. Public policy should preserve meaningful choice for patients. This requires not only that physicians disclose restrictions on choice at the point of service but, even more important, in the creation of public policies that minimize the physician's role as a double agent.[68]

Intergroup Healthcare Corp., C.V. 94-15694 (Ariz. Super., Maricopa County Dec. 29, 1994).

66. Marc A. Rodwin, *Conflicts of Interest: The Limitations of Disclosure*, 321 NEW ENG. J. MED. 1405 (1989).

67. Douglas F. Levinson, *Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans*, 317 NEW ENG. J. MED. 1729, 1730 (1987) (discussing aspects of "gatekeeping" arrangements and calling for increased disclosure of their terms). The contracts between MCOs and providers often include such clauses. The Ohio Permanente Medical Group contract states "[d]o not discuss proposed treatment with Kaiser Permanente members prior to receiving authorization." *Ganske, Markey Seeking to Outlaw "Gag clauses" in Provider Contracts*, 4 Health Care Pol'y Rep. (BNA) No. 10, at 373 (Mar. 4, 1996). A contract between U.S. Health Care and physicians states "[p]hysicians shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, . . . and [p]hysicians shall keep the Proprietary Information [payment rates, utilization review procedures, etc.] and this Agreement strictly confidential." *See* Steffie Woolhandler & David Himmelstein, *Extreme Risk: The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706, 1706 (1995).

There have been recent legislative efforts to address such "gag clauses" at state and federal levels. *See* Patient Right to Know Act of 1966, H.R. 2976, 104th Cong., 2d Sess. (1996). The bill was introduced on February 27, 1996, by Representatives Greg Ganske (R-Iowa) and Ed Markey (D-Mass.). Such statutes will be hard to enforce since MCOs can choose not to renew a contract with a doctor without cause or any explanation.

68. *See generally* DAVID MECHANIC, FROM ADVOCACY TO ALLOCATION: THE EVOLVING AMERICAN HEALTH CARE SYSTEM (1986); Marsha Angell, *The Doctor as Double*

3. The Case Manager

Case managers are employed by MCOs to coordinate medical care and benefits in cases that have potentially high costs: for example, when a person suffers a head injury or partial paralysis.[69] Although case managers are supposed to improve the quality of medical care, how well they do so depends on many variables.[70] Case managers can question physicians about their clinical choices and limit the provision of medical services, inform physicians and patients of alternatives, and authorize the use of funds for purchases and treatments that are not allowed in the standard benefit package. Supplemental benefits (such as altering a home to enable a person using a wheelchair to recuperate or receive treatment) make possible treatment in a less expensive setting than a hospital. Such benefits can save money for providers and may improve quality for patients.[71]

Case managers, paid by MCOs, can be expected to be loyal to their employer. Yet because case managers supervise medical care, patients should be able to expect that case managers will not take actions contrary to their interests. As yet there is no organized way for patients to monitor case managers or to hold them accountable.

There are ways to address this problem. Public policy could encourage the development of professional norms for case managers as well as codes of conduct. Such norms and codes would be a countervailing force to interests that favor MCOs over patients. Faced with pressure from employers to make decisions that are not in the patient's interest, case managers could point to these codes as their basis of refusal.

Public policy could also create legal obligations for case managers and provide the means to enforce these obligations. Independent review

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Agent, 3 KENNEDY INST. ETHICS J. 279 (1993).

69. J.C. Merrill, *Defining Case Management*, BUS. & HEALTH, July/Aug., 1985, at 5, 9.

70. Variables affecting quality of case management include: the number of cases a manager can effectively handle at one time; whether or not the case manager regularly visits the site where care is provided; and the level of cooperation in the relationship between the case management program and the provider organization. Mary G. Henderson & Anne Collard, *Measuring Quality in Medical Case Management Programs*, 14 QUAL. REV. BULL. 33, 36-39 (1988). *See also* Mary G Henderson et al., *Private Sector Initiatives in Case Management*, HEALTH CARE FIN. REV. (Supp. 1988); Jack L. Franklin et al., *An Evaluation of Case Management*, 77 AM. J. PUB. HEALTH 674 (1987).

71. Mary G. Henderson & Stanley S. Wallack, *Evaluating Case Management for Catastrophic Illness*, BUS. & HEALTH, Jan., 1987, at 7 (evaluating the available data on the cost-effectiveness and quality of case management programs).

organizations could monitor the conduct of case managers to ensure that their decisions follow norms. If decisions of case managers were monitored it might also be possible to deny compensation to case managers who abuse their discretion.

Another approach would be to allow patients to share in the decision on who would be the case manager. Case managers could hold the status of an independent contractor and neutral party -- similar to an arbitrator -- and could be jointly chosen by the patient and MCO. Associations of case managers could provide lists of individuals to choose from. Records of case managers' decisions could be made public (with provisions to preserve patient confidentiality) so that patients and MCOs could assess their performance, and patients could interview prospective case managers. Even if patients were unable to assess case managers, patient advocacy groups could, and then publish their findings. Such procedures would provide greater accountability to patients and decrease the chance that case managers could skew decisions in favor of MCOs.

IV. CONCLUSION

Concern for our health care system drives public demands for accountability; i.e. increased control, responsibility, answerability and responsiveness. As in the past, society is likely to promote accountability with a variety of approaches including the use of ethics and professional norms, representation of interests, markets and economic incentives, administrative process and the law. It is possible to promote increased accountability through carefully combining these tools. However, it is also possible that the use of multiple approaches to promote accountability will work at cross purposes.

In its quest for accountable health care, the United States is using the MCO as a primary vehicle. But achieving accountability will not be easy and may be elusive. The idea of accountability hides important conflicts. These include conflicts among multiple groups, competing goals, and different policy approaches. The key issue for the future will be to determine to whom MCOs should be held accountable. Prepare for a fight as different stakeholders try to make MCOs serve their own interests.

Health law and lawyers will play a central role in public debate over accountable health care for three reasons. One is that the notion of accountability is at heart a legal idea that invokes conceptions about responsibility, control, governance, grievance, and fair process. In addition, the hortatory goal of accountability hides an array of conflicts among competing goals, interests and policy approaches; and where there

is conflict there is room for law. Finally, although we use the concept of accountability in our daily lives, it is subject to interpretation. What we mean by accountability in a particular context will be made explicit by the kinds of institutions and processes we develop. Here too, there will be room for lawyers to participate in developing these institutions and for legal scholars to analyze the ideas and concepts.

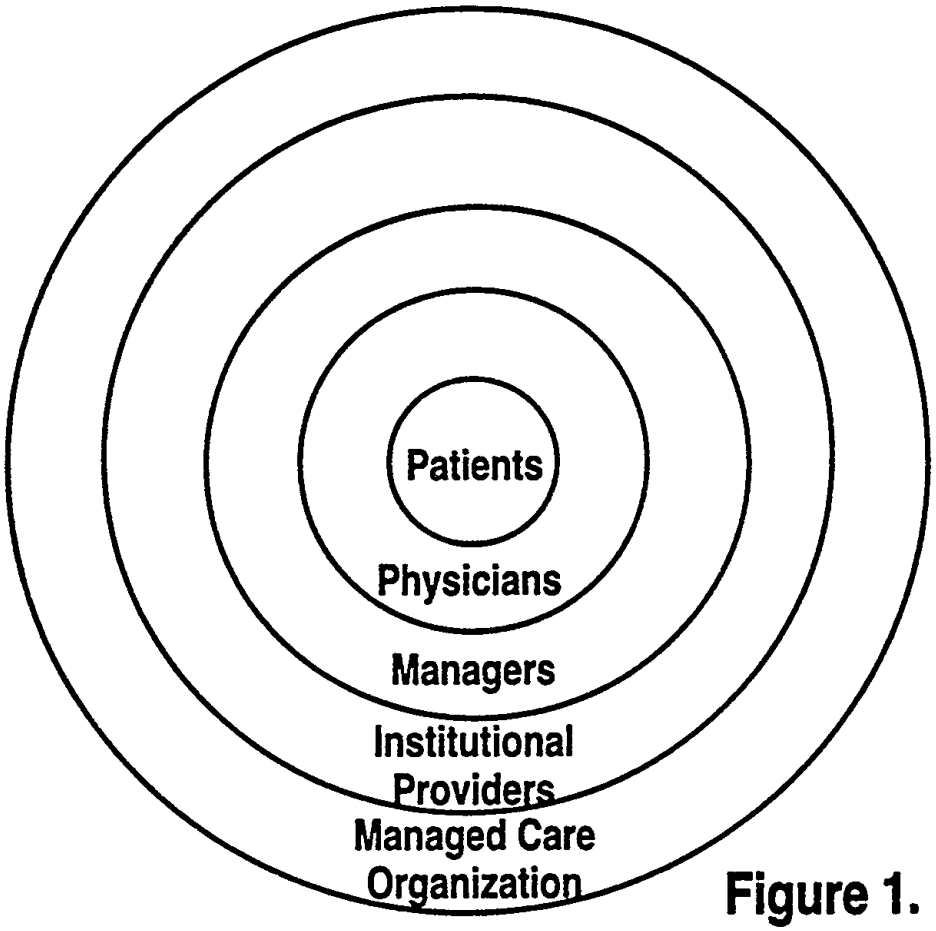

Figure 1.

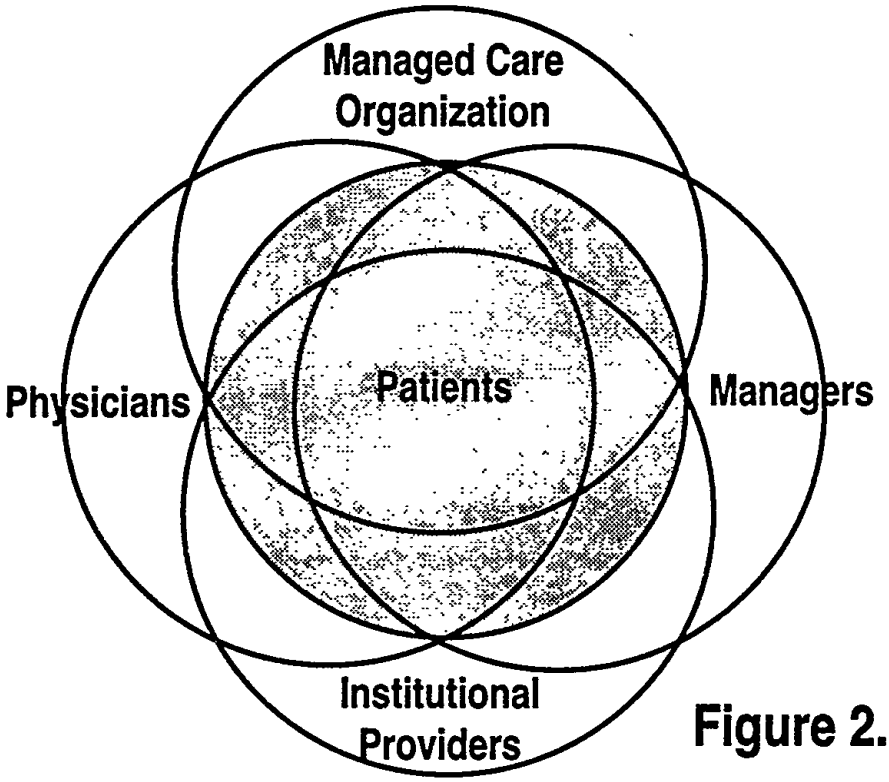

Figure 2.