

University of Michigan Journal of Law Reform

Volume 30

1996

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Recommended Citation

Kent G. Rutter, *Democratizing HMO Regulation to Enforce the "Rule of Rescue"*, 30 U. MICH. J. L. REFORM 147 (1996).

Available at: <https://repository.law.umich.edu/mjlr/vol30/iss1/5>

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DEMOCRATIZING HMO REGULATION TO ENFORCE THE "RULE OF RESCUE"

Kent G. Rutter*

Despite heightened public concern about HMOs, misguided regulatory measures have not guaranteed HMO patients access to the treatment options many consider vital. This Note recommends four changes to the current regulatory system that would preserve HMOs' ability to control health care costs while allowing patients and doctors, rather than lawmakers or HMO administrators, to set health care priorities.

"Beware your HMO,"¹ the media have advised managed health care patients,² and patients are no doubt wary. They have heard the HMO horror stories: A California woman died of breast cancer after her HMO denied coverage for a bone marrow transplant.³ Another HMO refused to provide a drug needed to keep a patient's prostate cancer in check, insisting instead on a more "cost effective" solution—surgery to remove the man's testicles.⁴ A Florida man died of a heart attack in his daughter's car outside an HMO clinic after the HMO declined to hospitalize him.⁵ An HIV positive patient may find that his HMO does not provide access to a specialist with experience in treating HIV; as a consequence, he can

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1. A Health Maintenance Organization (HMO) is an entity that, for a fixed premium, covers health care services generally provided by HMO doctors or doctors to whom employees are referred by the HMO. See 2 BARRY R. FURROW ET AL., *HEALTH LAW* § 11-11(a), at 53-54 (1995); see also *infra* Part I.

2. See Ellyn E. Spragins, *Beware Your HMO*, *NEWSWEEK*, Oct. 23, 1995, at 54; see also Maggie Mahar, *Time for a Checkup*, *BARRON'S*, Mar. 4, 1996, at 29, 30 ("As if smelling blood in the water, newspapers and magazines have turned from cheerful if boring tales of HMOs' ability to contain costs to horror stories about patients who requested a particular procedure, were turned down by HMO administrators, and subsequently died.")

3. See Erik Eckholm, *\$89 Million Awarded Family Who Sued H.M.O.*, *N.Y. TIMES*, Dec. 30, 1993, at A1.

4. See *Treatment Trouble*, *SUN-SENTINEL*, Nov. 7, 1993, at 25A.

5. See Larry Keller & Fred Schulte, *Grievance System Criticized*, *SUN-SENTINEL*, Nov. 10, 1993, at 1A.

expect the virus to develop into symptomatic AIDS.⁶ *Newsweek* has advised HMO enrollees: "If your employer offers an old-fashioned fee-for-service indemnity plan, consider switching."⁷

For several reasons, such advice has not yet halted the rapid growth of HMOs. First, employers providing health insurance favor the low cost of HMO care, and many no longer offer employees more expensive health care options.⁸ Second, HMOs typically offer a generous array of those benefits that a healthy employee may expect to utilize repeatedly or in the short term, such as low-cost prescription medications and pediatric care.⁹ Young people in particular may simply dismiss the unlikely prospect of a serious illness.¹⁰ Finally, enrollees may speculate that even if the horror stories are true¹¹ they are probably anomalies, not the typical experience of a seriously ill HMO patient.

But the horror stories remind patients that at least occasionally, managed care companies victimize their own enrollees. The inference is not difficult: the same HMO that eagerly provides cheap prescription drugs and brochures on cardiovascular health may deny expensive but vital care to its patients when they are sickest and most vulnerable. One disgruntled subscriber complained: "These HMOs are fine

6. See Lawrence K. Altman, *Survival of AIDS Patients Linked to Experience of Their Doctors*, N.Y. TIMES, Feb. 1, 1996, at A12; Elisabeth Rosenthal, *Managed Care Has Trouble Treating AIDS, Patients Say*, N.Y. TIMES, Jan. 15, 1996, at A1. The same is true of other conditions, such as diabetes. Cf. T.M. Hayes & J. Harries, *Randomised Controlled Trial of Routine Hospital Clinic Care Versus Routine General Practice Care for Type II Diabetics*, 289 BRIT. MED. J. 728, 729-30 (1984).

7. Spragins, *supra* note 2, at 56.

8. See GUY M. MASTERS ET AL., HEALTH CARE CAPITATION AND RISK CONTRACTING MANUAL §§ 130, 1100 (1995). *But cf.* BERNARD D. HIRSH & DONALD P. WILCOX, THE LAW OF MANAGED CARE 7-8 (1994) (noting consulting firm's findings that employers in the Houston, Texas, area pay more on average for HMO coverage than for fee-for-service coverage, perhaps because of "richer benefits" or lower deductibles).

9. See Nancy J. Perry, *A Report Card on HMOs*, FORTUNE, June 28, 1993, at 110.

10. See Martin Gottlieb, *Picking a Health Plan: A Shot in the Dark*, N.Y. TIMES, Jan. 14, 1996, § 3, at 9 (noting that because young people "are less concerned about getting sick" they evaluate health care plans based on cost, not the providers' reputation for quality); Perry, *supra* note 9, at 112 (reporting that young people are most likely to join HMOs).

11. See Mahar, *supra* note 2, at 30 ("The tales tend to be just a little fuzzy about whether the patient died *because* he was denied treatment, but then one doesn't read horror stories for their tight causal connections.").

for the average person who is not sick. The minute they get ill, [HMOs] look for ways to cut corners.’”¹²

In short, participation in HMOs has increased¹³ at the same time that public confidence in HMO care for the seriously ill has been badly shaken. This widespread concern has fueled extensive efforts to regulate HMOs at both the state and federal levels.¹⁴ HMO regulation has attempted to respond to the need for comprehensive coverage of routine and low-cost treatments, as well as coverage of less frequent but more expensive care. This Note contends that existing regulation of private HMOs does not adequately reconcile these demands with the public policy of containing national health care expenditures.¹⁵

Part I of this Note defines an HMO as a managed care entity, acting as both insurer and health care provider, that employs certain cost-containment techniques within the bounds of a customized regulatory framework. Part II examines widely held convictions about medical care, including the “Rule of Rescue,” and identifies compatible cost-reducing HMO behaviors that ideal HMO regulations should encourage. Part III provides a brief critical overview of existing regulatory mechanisms, including federal and state legislation and common law rules.

Finally, in Part IV this Note sets forth four principles for improved state legislation. First, state legislatures should prohibit HMOs from using systems of physician bonuses and penalties that are likely to induce drastic reductions in patient care. Second, HMOs should be required to disclose physician incentives to patients. Third, HMO patients who believe that they have been wrongly denied health care should be guaranteed access to quick, informal, and binding

12. *Treatment Trouble*, *supra* note 4, at 25A.

13. See 1 BARRY R. FURROW ET AL., *HEALTH LAW* § 8.1, at 478 (1995).

14. See discussion *infra* Part III.

15. Many of the principles raised in this Note are at least partially applicable to other forms of managed care, including HMOs serving Medicare and Medicaid clients. Recipients of Medicare and Medicaid benefits who enroll in HMOs enjoy federal protections currently unavailable to patients in the private market, including access to an extrajudicial appeals process and enhanced grievance-resolution procedures. In practice, however, the protections afforded by these mechanisms may be more illusory than genuine. See Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1690-1701 (1994). A full discussion of how these principles could be applied outside of the private HMO market, however, is beyond the scope of this Note.

dispute resolution procedures. Finally, three common types of state legislation that restrict HMOs, increase costs, and do little to improve patient care should be repealed. Together, these reforms would yield cost-effective care better reflecting the priorities of patients rather than health care administrators or regulators.

I. THE HEALTH MAINTENANCE ORGANIZATION

Alarmed by rising health care costs,¹⁶ government regulators and actors in the private health care market have steered patients away from traditional health insurance plans and toward managed care. Both traditional plans and HMOs provide insurance: enrollees or their employers pay a premium that remains "fixed without regard to the frequency, extent, or kind of health service . . . actually furnished."¹⁷ In return, conventional "fee-for-service" plans reimburse their patients for medical services provided by independent doctors and hospitals chosen by the patient. In contrast, an HMO enrollee must use "networks" of providers affiliated with the HMO as either employees or independent contractors.¹⁸ A typical HMO provider network includes primary-care physicians, medical specialists, nurses, hospitals, laboratories, and clinics.¹⁹ Except in emergencies or where specific referral procedures are followed, the enrollee must pay for any care obtained from sources outside the network.²⁰ Thus, an HMO is both an insurer and a provider of medical services.²¹

This dual role underlies the attractiveness of the HMO concept. As an insurer, an HMO has an incentive to hold

16. Health care expenditures rose from about 7.6% of the nation's gross domestic product (GDP) in 1973, to 10.6% of the GDP in 1983, and 13.9% of the GDP in 1993. See BUREAU OF CENSUS, U.S. DEPT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 109 (115th ed. 1995).

17. 42 U.S.C. § 300e(b)(1)(B) (1994) (describing the basic health care payment system under the federal statute). See generally ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 9-15 (1987) (explaining that an insured pays an insurer an agreed sum to "assume a risk" by accepting responsibility for uncertain future expenses).

18. See 2 FURROW ET AL., *supra* note 1, § 11-11(a), at 54.

19. See Barbara A. Shickish, *Legal Characteristics of the Health Maintenance Organization*, in HEALTHCARE FACILITIES LAW 1066 (Anne M. Dellinger ed., 1991).

20. See 2 FURROW ET AL., *supra* note 1, § 11-12, at 60 (distinguishing HMOs from preferred provider organizations on this basis).

21. See *id.* § 11-11(a), at 53-54.

down its health care expenditures; as a provider it has the ability to do so. Regulators have acknowledged the potential rewards of combining these roles in one entity, noting that the HMO "provides a mechanism to analyze costs, expenses and utilization of services, and affords a means to implement measures to enhance efficiency."²² Although the implementation of these measures varies somewhat, all HMOs employ some form of the same four cost-reduction techniques:²³ provider selection,²⁴ controlled access to specialists,²⁵ physician financial incentives,²⁶ and utilization review.²⁷

Together, these four practices reduce HMO expenditures by imposing heightened cost awareness at each stage of the care process. Generally, this process begins when an HMO enrollee complains of symptoms to her primary-care physician.²⁸ The

22. HEALTH MAINTENANCE ORG. MODEL ACT § 1 introductory cmt. (National Ass'n of Ins. Comm'rs 1991).

23. See Joan B. Trauner & Sibyl Tilson, *Utilization Management and Quality Assurance in Health Maintenance Organizations: An Operational Assessment*, in COMMITTEE ON UTILIZATION MANAGEMENT BY THIRD PARTIES, INSTITUTE OF MED., CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 205 app. B at 215-16 (Bradford H. Gray & Marilyn J. Field eds., 1989) [hereinafter CONTROLLING COSTS] (identifying four basic cost-reduction techniques); 1 FURROW ET AL., *supra* note 13, § 8-1, at 480.

24. An HMO includes in its network of eligible providers only those it believes to be cost-effective. See 1 FURROW ET AL., *supra* note 13, § 8-1, at 480.

25. With certain exceptions (emergencies, for example), an HMO will pay only for care either provided by a network primary care physician or approved by one. Thus, these general practice doctors serve as "gatekeepers" who must pre-approve a patient's visit to a more expensive medical specialist. See *id.*

26. Through bonuses, penalties, and withholding mechanisms, most HMOs financially reward network physicians who stay within pre-set spending goals by limiting their patients' access to treatments, medical specialists, and inpatient hospital care. See *id.*

27. Like all health care plans, HMOs review physicians' decisions to order care, and pay only for care found to be necessary and appropriate. While review by a fee-for-service insurer is retrospective, HMOs frequently review physicians' decisions before the care is administered. See Ruth Simon, *A Flawed Remedy: Managed Care*, MONEY, Apr. 1, 1993, at 114, 119.

28. Alternatively, a patient may appear at a hospital emergency room. Every HMO will pay for "emergency" care received outside its provider network. Emergency room doctors, however, know that an HMO patient may face an expensive bill if the HMO determines that the situation was not an actual "emergency." Consequently, they feel pressure to delay treatment, where possible, until an HMO patient's primary care physician can be contacted for approval. See Susan Brink, *How Your HMO Could Hurt You*, U.S. NEWS & WORLD REP., Jan. 15, 1996, at 62, 64. Some states have proposed or enacted legislation to circumvent this problem. See, e.g., COLO. REV. STAT. § 10-16-407(2)(1994) ("[A] 'life or limb threatening emergency' means any event which the enrollee believes threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health."); Stayn, *supra* note 15, at 1718-19 (approving the Colorado statute and the

patient's complaints or a physical examination may yield an obvious diagnosis suggesting a clear course of treatment.²⁹ More often, however, physicians must make judgment calls because the diagnosis is uncertain, the effectiveness of a possible treatment is unproven, the best treatment option among available alternatives is a matter of opinion, or the patient exhibits a strong preference for one treatment option over others.³⁰ In these cases, the physician must exercise her discretion. Should she perform diagnostic tests, prescribe medication, or perform a procedure herself? Should she hospitalize the patient, or perhaps refer him to a medical specialist for further evaluation and treatment?

As she reflects on these questions, an HMO physician may weigh a number of considerations. Naturally, as a physician she has an ethical duty to her patient,³¹ reinforced by concern for her reputation and the constant peril of malpractice liability.³² At the same time, she may sacrifice a bonus or suffer a financial penalty if she exceeds spending targets, hospitalizes a patient, or refers a patient to a medical specialist.³³ The primary care physician whose contract prohibits certain referrals faces a more limited choice: she must either deny care that under conventional insurance would have been provided by a medical specialist such as a surgeon, or attempt to perform the procedure herself.³⁴

definition of "emergency services" included in the laws of Maryland and Texas); Michael A. Stocker, *The Ticket to Better Managed Care*, N.Y. TIMES, Oct. 28, 1995, at 21 (opinion of president and chief executive officer of Empire Blue Cross/Blue Shield, endorsing similar legislation in New York).

29. See DAVID MECHANIC, *MEDICAL SOCIOLOGY* 95-99 (2d ed. 1978).

30. See *id.*

31. See Nathan T. Sidley, *Medical and Professional Ethics*, in *LAW AND ETHICS* 383-409 (Nathan T. Sidley ed., 1985).

32. See PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 146-49 (1985); Carol S. Weisman et al., *Practice Changes in Response to the Malpractice Litigation Climate: Results of a Maryland Physician Survey*, 27 *MED. CARE* 16, 17 (1989).

33. See HIRSH & WILCOX, *supra* note 8, at 59.

34. See Karen Cheney, *What You Can Learn from an M.D. Mutiny in a Managed-Care Plan*, MONEY, Dec. 1995, at 21, 21. Primary care doctors are naturally reluctant to provide specialized care without adequate training. In Tucson, Arizona, for example, one-half of the 100 primary care physicians affiliated with Intergroup of Arizona decided to leave the plan in 1995 rather than sign a revised contract requiring them to perform specialized procedures such as resetting dislocated shoulders and performing tracheotomies. Said one physician: "Don't get me wrong. I'd attempt a tracheotomy if the patient was stuck at the bottom of the Grand Canyon. . . . But in Tucson, it's not as if we don't have access to surgeons." *Id.*

Apart from these concerns, an HMO physician may worry that her treatment decisions will jeopardize her practice. A typical contract between a doctor and an HMO requires annual renewal, and at that time the HMO may drop from its network a physician it perceives not to be cost effective.³⁵ Although contract cancellations are rare, they do deter renegade physicians because doctors who primarily serve HMO enrollees can ill afford this consequence of a liberal practice style.³⁶ In making care decisions an HMO doctor may well adopt the approach suggested by one provider: "You just don't risk making these people angry."³⁷

An HMO physician moved despite these concerns to prescribe abundant care knows that this decision is not hers alone. As part of "utilization review," the typical HMO requires a physician or enrollee to obtain its permission before ordering hospitalization or an expensive outpatient procedure.³⁸ When a doctor requests permission for such treatments, a computer program scans the requests for features that trigger review by a nurse,³⁹ who in turn designates a few of these requests for physician analysis.⁴⁰ The HMO's reviewing physician⁴¹ may grant the request, override it, or attempt to compromise with the requesting physician by suggesting a less expensive course of treatment.⁴² Reviewing physicians often question inpatient procedures, and some plans report up to forty percent fewer hospitalizations.⁴³

35. See MASTERS ET AL., *supra* note 8, § 1132.7; see also Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 44, 50 (describing the physician contract used by Health Net, a major HMO, which requires annual renewal).

36. See HIRSH & WILCOX, *supra* note 8, at 35 (alleging that doctors "are obliged to compete with each other in denying medically indicated or preferred modes of patient treatment on the basis of cost, and only those physicians who are shown by the computer to deny the most care survive"); Larson, *supra* note 35, at 50.

37. Brink, *supra* note 28, at 64; see also Bob Herbert, *Torture by HMO*, N.Y. TIMES, Mar. 15, 1996, at A29 (relating experience of physicians advised by colleagues to "wise up to 'the new medical-economic reality'" and "not to push the H.M.O. too far" before contract renewal).

38. CONTROLLING COSTS, *supra* note 23, at 3, 17-18, 66. This aspect of affiliation with an HMO stirs considerable resentment among physicians. See, e.g., Kevin Grumbach & Thomas Bodenheimer, *Mechanisms for Controlling Costs*, 273 JAMA 1223, 1227 (1995) (noting that utilization review has "come under fire as a process of micromanagement that intrudes into the physician-patient relationship and places an unwelcome administrative hassle on physicians and other caregivers").

39. See CONTROLLING COSTS, *supra* note 23, at 71-73.

40. See *id.* at 73-77.

41. An HMO may employ its own personnel to perform utilization review, or it may contract with an outside review firm or non-network physicians. See *id.* at 74-75.

42. See *id.* at 73-78.

43. See BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS* 298-302 (1991) (summarizing the effects of

While the mechanics of these procedures are clear, their net effect on HMO medicine is controversial. HMOs maintain that their plans reduce health care costs by cutting waste and by avoiding serious illness through an emphasis on preventative care.⁴⁴ Critics charge, however, that as applied by many HMOs, these cost-reducing techniques not only eliminate waste but also deny patients the "medically necessary" treatment that HMOs are obligated to provide.⁴⁵ The regulatory system has responded to this criticism by adopting several strategies to compel the provision of necessary care while allowing HMOs to refuse to fund wasteful medicine.

II. DISTINGUISHING "WASTE" FROM GOOD MEDICINE: REGULATORY GOALS

HMO providers and administrators make daily decisions to provide or deny access to medical care. In doing so, these decisionmakers operate within various regulatory constraints. Successful regulations will be targeted carefully to deter an HMO from denying those treatments it ought to provide. Overintrusive regulations, in contrast, will impede even proper denials and thereby limit an HMO's power to prevent waste. The law regulating HMO care decisions should distinguish essential services from wasteful ones.

A. Overtreatment: Ineffective and Unwanted Care

In some instances, HMOs have identified and reduced needless expenditures without diminishing the quality of patient care. For example, HMOs have negotiated reductions

utilization management programs on hospital admissions). Other studies show less drastic effects and suggest that the amounts saved may not be attributable solely to utilization management programs. See Howard L. Bailit & Cary Sennett, *Utilization Management as a Cost-Containment Strategy*, HEALTH CARE FINANCING REV., 1991 Ann. Supp., at 87, 87-88; T.M. Wickizer, *The Effect of Utilization Review on Hospital Use and Expenditures: A Review of the Literature and an Update on Recent Findings*, 47 MED. CARE REV. 327, 351, 353, 358 (1990).

44. See DAVID MECHANIC, THE GROWTH OF BUREAUCRATIC MEDICINE 85-97 (1976); see also Simon, *supra* note 27, at 122 ("Managed-care firms argue that, since they target only 'wasteful' spending, they do not imperil the quality of care.")

45. See, e.g., Rosenthal, *supra* note 6, at A1; Spragins, *supra* note 2, at 54; Stayn, *supra* note 15, at 1685-90.

in the steep markups on certain cancer drugs.⁴⁶ HMOs have also worked to discourage medicine that is undesirable at any cost—care that provides no benefit the patient desires. By all accounts, overtreatment is widespread. A widely cited set of studies examining the use of three medical procedures found that doctors inappropriately prescribed these procedures one-sixth to one-third of the time.⁴⁷ Other estimates support these claims, finding that ten to thirty percent of all medical treatments are inappropriate.⁴⁸ Thus, certain reductions in care may not only be tolerable, but desirable.⁴⁹ Researchers have concluded: “The balance of the evidence currently suggests that increasing the intensity of medical care does not inexorably lead to improved outcomes. Any benefit accruing from more intense medical care may be offset by harm.”⁵⁰

Why do doctors overtreat their patients? One explanation places the blame on the unrealistic expectations of the patients themselves. More than half of the patients who present symptoms to a physician are said to be “‘worried well,’ people with no diagnosable disorder.”⁵¹ These patients may expect medical intervention regardless of whether it is warranted, and “doctors must be sorely tempted to treat what seem to be imaginary diseases with imaginary remedies.”⁵² A similar temptation arises where a patient demanding intervention has a serious but untreatable condition. A disappointed patient or family may blame a doctor who refuses to pursue every conceivable

46. See, e.g., Bill Alpert, *Painful Profit: Cancer-Treatment Firms May Soon See Their Plump Margins Slashed*, BARRON'S, Feb. 26, 1996, at 20, 20–21.

47. See Mark P. Chassin et al., *Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures*, 258 JAMA 2533, 2536 (1987) (discussing the results of a study examining the appropriateness of physicians performing coronary angiography, carotid endarterectomy, and upper gastrointestinal tract endoscopy in certain elderly Medicare populations); Peter Franks et al., *Gatekeeping Revisited—Protecting Patients from Overtreatment*, 327 NEW ENG. J. MED. 424, 425 (1992); Rolla Edward Park et al., *Physician Ratings of Appropriate Indications for Three Procedures: Theoretical Indications vs. Indications Used in Practice*, 79 AM. J. PUB. HEALTH 445, 447 (1989).

48. See STAFF OF THE SUBCOMM. ON EDUC. AND HEALTH, JOINT ECON. COMM., 101st CONG., MEDICAL ALERT: A STAFF REPORT SUMMARIZING THE HEARINGS ON “THE FUTURE OF HEALTH CARE IN AMERICA” 3, 31 (Joint Comm. Print 1989); Albert L. Siu et al., *Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans*, 315 NEW ENG. J. MED. 1259, 1261–64 (1986).

49. See MASTERS ET AL., *supra* note 8, § 901 (discussing and rejecting “the belief that the more one spends, the more quality one receives”).

50. Franks et al., *supra* note 47, at 427.

51. Nicholas Wade, *The Spin Doctors*, N.Y. TIMES, Jan. 7, 1996, § 6 (Magazine), at 16.

52. *Id.*

option. Thus, a physician may be wary that a malpractice claim will result if she refuses last-ditch efforts even if those efforts are virtually certain to fail.⁵³ Another explanation for overtreatment observes that physicians' practice styles are often related to their financial incentives: physicians who are reimbursed for almost any service provided, as under a traditional fee-for-service plan, tend to pursue more aggressive interventions.⁵⁴

Both inside and outside managed care, physicians have been urged to resist these twin pressures and to order treatment only where the expectation of benefit to the patient is realistic.⁵⁵ However, a desire to provide the extensive care a patient demands, and the ability to profit by doing so often combine to sway a physician's judgment, leading her to "follow the axiom of 'when in doubt, do more.'"⁵⁶ A study of in vitro fertilization clinics, for example, found that clinics primarily serving women in fee-for-service plans may realize a \$3000 profit on each \$11,000 "cycle," or surgical fertilization attempt.⁵⁷ Some clinics encouraged women who did not initially become pregnant to undergo additional cycles, and couples eager to conceive a child rarely questioned this approach.⁵⁸ These clinics often did not inform patients that, especially in the case of older women, subsequent attempts rarely succeed where initial cycles have failed.⁵⁹ In contrast, where an HMO provided the fertilization services, women were less likely to undertake additional ineffective surgeries because doctors were more likely to tell

53. See DANZON, *supra* note 32, at 146-49; Weisman et al., *supra* note 32, at 17.

54. See WILLIAM A. GLASER, *PAYING THE DOCTOR: SYSTEMS OF REMUNERATION AND THEIR EFFECTS* 139-45 (1970); see also Bruce J. Hillman et al., *Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self-Referring and Radiologist-Referring Physicians*, 323 *NEW ENG. J. MED.* 1604, 1604-06 (1990) (finding that physicians with a financial interest in performing certain tests recommend them more often).

55. See David M. Eddy, *Principles for Making Difficult Decisions in Difficult Times*, 271 *JAMA* 1792, 1796 (1994) (calling on physicians to refrain from ordering a treatment if it merely " 'might be beneficial,' if it provides 'any hope of benefit,' if it is 'all we have to offer,' or if it is 'the patient's only hope,'" and urging that physicians "do [their] best to determine that there actually is benefit, and . . . [to] estimate the magnitude of the benefit").

56. Donald R. Cohodes, *The Loss of Innocence: Health Care Under Siege*, in *HEALTH CARE AND ITS COSTS* 64, 70 (Carl J. Schramm ed., 1987).

57. See Trip Gabriel, *High-Tech Pregnancies Test Hope's Limit*, *N.Y. TIMES*, Jan. 7, 1996, § 1, at 1.

58. See *id.*

59. See *id.*

their patients when to give up.⁶⁰ As a result, the women in HMOs were about as likely to become pregnant as their fee-for-service counterparts although HMOs spent about half as much per pregnancy.⁶¹

Other services may be certain to “work” from a medical viewpoint but are nevertheless wasteful overtreatment because the results are undesirable to the patient. This aspect of overtreatment frequently arises in the context of expensive technology-intensive treatments that can extend the lives of patients near death. Although doctors tend to favor such technology,⁶² patients’ increased interest in living wills and medical powers of attorney suggest that few patients would choose aggressive medical interventions that prolong life but do not improve it.⁶³ Because of incentives to reduce costs, managed care providers are naturally disinclined to provide these or other expensive treatments to patients who do not want them.⁶⁴

B. HMOs and Rationing

A second variety of “waste” encompasses treatments whose costs clearly exceed their benefits. HMOs insist that in making decisions to provide or deny health care, they assess only medical criteria and not financial considerations. Thus, their contracts with enrollees typically ignore matters of cost and promise that the HMO will provide any treatment that is “medically necessary.”⁶⁵ This language appears consistent with assertions by HMO representatives that HMOs reduce

60. See *id.*

61. See *id.*

62. See John E. Wennberg, *Outcomes Research, Cost Containment, and the Fear of Health Care Rationing*, 323 NEW ENG. J. MED. 1202, 1203 (1990) (noting that doctors are generally more aggressive, and patients more risk-averse, in selecting treatments).

63. See Linda L. Emanuel et al., *Advance Directives for Medical Care—A Case for Greater Use*, 324 NEW ENG. J. MED. 889, 891 (1991); Wennberg, *supra* note 62, at 1203.

64. Of course, managed care providers may also be disinclined to provide these expensive treatments to patients who *do* want them. See *infra* Part II.C (explaining why some patients may desperately want such treatments); see also *infra* Part IV (suggesting how the law could better facilitate treatment decisions that respect patients’ individual desires to receive or avoid particular types of care).

65. See HIRSH & WILCOX, *supra* note 8, at 12.

expenditures “not by rationing but by coordinating better care”⁶⁶ and “target[ing] only ‘wasteful’ spending.”⁶⁷

Despite these assertions, however, the concept of rationing is implicit in promises to cut waste. Most people understand that HMOs actually do factor cost into treatment decisions, and indeed expect them to do so.⁶⁸ Thus, although the urgency of the health care “crisis” is open to debate,⁶⁹ many Americans agree that some of the cost-reduction measures introduced by managed care should be accepted, or at least tolerated.⁷⁰

66. Karen Ignagni, Letter to the Editor, *H.M.O.’s Insure Access to Transplants*, N.Y. TIMES, Mar. 20, 1996, at A18 (explaining the American Association of Health Plans’ position that HMOs reduce costs by increasing efficiency).

67. Simon, *supra* note 27, at 114, 122.

68. See *id.* at 117 (citing a poll in which 72% of respondents supported reform of the traditional fee-for-service health insurance system); Stuart Auerbach, *Managed Care Backlash*, WASH. POST, June 25, 1996, at 12 (discussing finding by Robert Wood Johnson Foundation Analysts that only 28% of Americans disapprove of the trend toward managed care). *But see* KARLYN H. BOWMAN, PUBLIC ATTITUDES ON HEALTH CARE REFORM: ARE THE POLLS MISLEADING THE POLICY MAKERS? 1–29 (1994) (reviewing several types of polls and survey questions and suggesting that they are meaningless as a guide to policymakers because the public is often ill-informed about the details and consequences of reform, resulting in uncertainty about what Americans really believe or want).

69. For a statement of the prevailing view, see Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1755–56 (1992). Professor Havighurst writes: “Until the nation finds ways to curb the health care sector’s propensity to squander substantial resources—perhaps whole percentage points of GNP—on low-priority services, it will continue to neglect such needs as improved education and job-creating capital investment.” *Id.* Professor Stephen Utz counters, however, that it is incorrect to assume

that if paying for health consumes an ever greater fraction of the gross domestic product, society as a whole is less well off, just as a household suffers if its health costs steadily rise. . . . Money spent on health care does not go up in smoke. It goes to pay health care providers’ salaries and provide profits for investors in health care and insurance firms. The salaries and profits are spent or saved in this country. . . .

Accordingly, the significance of accelerating health care costs is not as straightforward as many members of the public assume. If health care cost increases are slowed, the result will be, in part, not just to stanch waste but also to curtail a growing industry that has fewer externalities than others that may replace it.

Stephen Utz, *Federalism in Health Care: Costs and Benefits*, 28 CONN. L. REV. 127, 131 (1995); see also Charles R. Morris, ‘Runaway’ Health Care Spending? It’s the Engine of New U.S. Economy, L.A. TIMES, Jan. 14, 1996, at M2 (arguing that the U.S. will benefit from health care spending and predicting that the size of this “high productivity, good-wage, rapid-growth, high-technology industry” will double before leveling off).

70. See Auerbach, *supra* note 68, at 13; cf. Simon, *supra* note 27, at 117.

Consider, for example, a recently developed fluid used by doctors to take internal X-rays. Like the substances used conventionally, the new fluid is administered to patients by injection and makes their blood vessels and some internal organs more visible on the X-rays.⁷¹ Although this new fluid reduces the risk of fatal allergic reaction from one in 30,000 to one in 250,000, entirely replacing the old fluid with the new one would cost an additional \$1 billion annually.⁷²

If an HMO refuses to pay for the new X-ray solution, opponents of managed care would doubtless decry the decision as "rationing" while advocates might praise the same policy as "cutting waste." In a sense, the rhetoric of each side is accurate. An HMO that decides limited resources should not be spent to avoid a minimal risk is by definition "rationing." At the same time, such a treatment may fairly be labeled "wasteful" although it provides some benefit because the money spent to provide the marginally beneficial treatment could better be used to fund higher-priority medicine.⁷³ In other words, "wasteful" treatments are not just those that are ineffective or unwanted; from a global perspective a treatment is "wasteful" if it consumes health care resources disproportionate to the benefits it provides.⁷⁴

C. Cost-Based Denials and the "Rule of Rescue"

The American public does not distrust HMOs merely because they refuse to turn a blind eye to matters of cost; surely, few people would be outraged if their managed care plans refused to provide the new billion-dollar X-ray fluid. Rather, patients have lost faith in HMOs because a myopic fixation on cost has led HMOs to deny truly essential services. If the HMO industry is to survive attacks from a suspicious public, employers who

71. See Jan Blustein & Theodore R. Marmor, *Cutting Waste by Making Rules: Promises, Pitfalls, and Realistic Prospects*, 140 U. PA. L. REV. 1543, 1559 (1992) (citing Annetta Miller et al., *Can You Afford to Get Sick?*, NEWSWEEK, Jan. 30, 1989, at 44, 47).

72. See *id.* at 1559.

73. See *id.* at 1545, 1561 (noting that in the managed care debate, the term "waste" has become a "conceptual hodgepodge" commonly applied to ineffective and unwanted treatments, but also to desirable procedures that are not "allocationally efficient").

74. See *id.* at 1559-61.

are increasingly sensitive to employees' health care concerns,⁷⁵ and increasingly hostile legislatures, it must reform.⁷⁶ Where a bone marrow transplant has a realistic chance of success, and it promises the results for which the patient and her family desperately hope, an HMO must not find excuses to deny the treatment because it is not ready to spend the money.⁷⁷ The cost-containment devices used by HMOs must never exert such influence that providers will refuse to hospitalize patients showing signs of imminent cardiac arrest.⁷⁸ Enrollees who are HIV positive must be provided with knowledgeable specialists who can extend and improve their lives.⁷⁹ In short, action is needed to reassure patients that their HMOs will care for them when they need care most. The indignation inspired by the HMO horror stories⁸⁰ reveals that despite the high costs of medical care, people will not accept suffering or death where they are reasonably preventable.

This universal conviction can be traced to a well-established psychological and moral phenomenon that ethicist Albert Jonsen has dubbed the "Rule of Rescue."⁸¹ As Jonsen describes it:

Our moral response to the imminence of death demands that we rescue the doomed. We throw a rope to the drowning, rush into burning buildings to snatch the entrapped, dispatch teams to search for the snowbound. This rescue morality spills over into medical care, where our ropes are artificial hearts, our rush is the mobile critical care unit, our teams the transplant services. The imperative

75. See Arthur L. Dolinsky & Richard K. Caputo, *An Assessment of Employers' Experiences with HMOs: Factors that Make a Difference*, HEALTH CARE MGMT. REV., Winter 1991, at 25, 26 (explaining employers' concerns regarding health care quality and their typical means of assessing the quality of services); Mahar, *supra* note 2, at 30 (describing the pressure large companies are imposing on HMOs to improve the quality of their services).

76. See David C. Hadorn, *Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue*, 265 JAMA 2218, 2219 (1991) (observing that "any plan to distribute health care services must take human nature into account if the plan is to be acceptable to society").

77. See *supra* note 3 and accompanying text.

78. See *supra* note 5 and accompanying text.

79. See sources cited *supra* note 6.

80. See *supra* text accompanying notes 1-6.

81. Albert R. Jonsen, *Bentham in a Box: Technology Assessment and Health Care Allocation*, 14 LAW, MED. & HEALTH CARE 172, 174 (1986) (explaining the Rule of Rescue as an inherently anti-utilitarian, deontological principle, and asking, "How should law deal with this powerful moral imperative?").

to rescue is, undoubtedly, of great moral significance; but the imperative seems to grow into a compulsion, more instinctive than rational.⁸²

Not surprisingly, the Rule of Rescue also underlies attitudes toward managed health care when it is one's own life that may need rescuing. Moreover, although the command of the Rule of Rescue is most authoritative in matters of life and death, it is also compelling whenever an identified human being can be saved from pain or disability.⁸³

The Rule of Rescue plays an essential role in our evaluations of medical intervention, despite the strange results obtained by Oregon researchers who attempted to assemble a cost-sensitive ranking of essential health care services. The researchers relied on the results of a public survey to determine how services to Oregon Medicaid recipients should be rationed, but the list of ranked services was largely abandoned because it "did not comprehensively reflect public values."⁸⁴ To some observers, the list demonstrated the public's willingness to disregard the Rule of Rescue.⁸⁵ Indeed, the final list appeared to be a shocking confirmation of this assessment: straightening of crooked teeth, for example, ranked higher than treatments for Hodgkin's disease.⁸⁶

The Oregon results, however, are probably attributable to the methodology of the study, not actual patient preferences. In the poll, respondents were asked to prioritize health benefits, and their priorities were then adjusted for the costs of providing those benefits. For example, suppose that respondents said that a particular service was one percent as vital as a certain treatment with the potential to save lives. If the first service costs \$100 while the lifesaving treatment costs \$11,000, the low-cost treatment would be assigned a higher priority.⁸⁷ The patients' actual responses probably reveal nothing more than

82. *Id.* at 174.

83. *See* Hadorn, *supra* note 76, at 2219.

84. Caitlin J. Halligan, Note, "Just What the Doctor Ordered": Oregon's Medicaid Rationing Process and Public Participation in Risk Regulation, 83 GEO. L.J. 2697, 2713 (1995) (quoting OREGON HEALTH SERVS. COMM'N, PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND LEGISLATURE 11 (1991)).

85. *See id.* at 2719.

86. *See id.* at 2712 (citing Daniel M. Fox & Howard Leichter, *Rationing Care in Oregon: The New Accountability, in* FIVE STATES THAT COULD NOT WAIT 156 (Daniel M. Fox & John K. Iglehart eds., 1994)).

87. *See id.* at 2705-11; *see also* Hadorn, *supra* note 76, at 2218-19.

the difficulty of deriving precise ratios when comparing fundamentally different medical services. A truer lesson from the Oregon experiment may be that the almost universal rejection of the adjusted results demonstrates that the Rule of Rescue exerts a powerful hold even on those determined to find a rational means for allocating health care resources.

Health care planners have reason to be wary of the Rule of Rescue. The Rule is an imperfect moral compass because it includes "an emotional component . . . that can interfere with the development and implementation of fair allocation systems."⁸⁸ Because of this component, the effects of the Rule are most pronounced when three criteria—each standing in sharp contrast to pure need—are present.⁸⁹ First, the circumstances must be unusual enough to be seen as a crisis, and not merely an unfortunate, ongoing problem. Second, the Rule of Rescue is strongest where it is easy to identify with the potential victim. Finally, this identification is most likely in incidents with high symbolic value. Thus, "[a] prototypical example is a child who falls down a well," yet "we do not apply the rule of rescue to a homeless man dying of pneumonia over a steam grate."⁹⁰

Despite our troubling failure to apply the Rule of Rescue in certain cases, the impulse is deeply rooted in the human conscience and we resist attempts to disable the Rule of Rescue principle altogether. Perhaps we should not try to avoid the Rule of Rescue; it "might be seen as facilitating a sense of fairness in providing for the needs of others—a sense that might be poorly developed otherwise."⁹¹ As another commentator perceives the Rule, it "affirm[s] the value of life and the commitment of the community to individuals in distress."⁹²

Because the Rule of Rescue plays a central role in patients' value systems, HMOs must heed the Rule and consistently provide expensive but much-needed services. At the same time, the Rule should not defeat attempts to deny wasteful care.⁹³ Fortunately for managed care systems, which often must make

88. Hadorn, *supra* note 76, at 2219.

89. See Eddy, *supra* note 55, at 1796.

90. *Id.*

91. Hadorn, *supra* note 76, at 2219.

92. David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713, 1753 (1992).

93. See Hadorn, *supra* note 76, at 2219-20 (noting that the Rule of Rescue, if always followed, "would lead to an impossibly expensive system").

tradeoffs between cost and care, the influence of the Rule of Rescue is not unlimited.⁹⁴ Accordingly, HMO regulations must address the tension between the economic necessity of cost reduction and patients' firm commitment to the Rule of Rescue.

III. EXISTING HMO REGULATION

Popular distrust of HMOs does not stem from a lack of legislative attention. More than 500 bills directly affecting HMOs were introduced in state legislatures in 1994 and at least twenty-four HMO bills were actually enacted that year, along with insurance laws and other laws affecting managed care plans.⁹⁵ The pace is accelerating: in the first half of 1996 alone, thirty-three states enacted HMO laws.⁹⁶ HMOs are also subject to federal legislation, and HMO operations are affected to some degree by exposure to common law liability.⁹⁷ Effecting restrictive mandates can be "a rallying point for people who have bad feelings about managed care."⁹⁸ The laws enacted thus far, however, have done little to alleviate those "bad feelings," because they fail to assure enrollees that their HMOs will provide essential care should they become seriously ill.

A. State Legislation

Every state except Hawaii has adopted legislation explicitly authorizing and regulating HMOs.⁹⁹ The laws of twenty-eight states¹⁰⁰ are patterned after the Health Maintenance

94. See *infra* note 295 and accompanying text.

95. See Garry Carneal & A. Marlie Gallmetzer, *Legal Characteristics of the Health Maintenance Organization*, in *HEALTHCARE FACILITIES LAW* 261, 281-82 (Anne M. Dellinger ed., Supp. 1995).

96. See Richard A. Knox, *State Legislatures Take On HMOs' Managed-Care Policies*, *BOSTON GLOBE*, July 24, 1996, at A12 (discussing a report by Families USA, a consumer advocacy group, praising this "avalanche of state legislation").

97. See *infra* Parts III.B and III.C.

98. Keith H. Hammonds, *Newborn Babies, Bawling Moms*, *BUS. WEEK*, Jan. 8, 1996, at 40, 40 (discussing the current pressure on state legislators to enact laws requiring HMOs to pay for longer postpartum hospital stays).

99. See 2 *FURROW ET AL*, *supra* note 1, § 11-11(b), at 56.

100. See ALA. CODE §§ 27-21A-1 to -21A-32 (1986 & Supp. 1996); ALASKA STAT. §§ 21-86.010 to .900 (Michie 1996); ARK. CODE ANN. §§ 23-76-101 to -131 (Michie 1992 &

Organization Model Act (HMO Model Act) adopted by the National Association of Insurance Commissioners in 1973 and most recently amended in 1991.¹⁰¹ Most states, including those adopting the HMO Model Act, require that HMOs establish reasonable grievance procedures for members dissatisfied with an HMO's care.¹⁰² HMOs in most states must describe their grievance procedure to state authorities during the licensing process,¹⁰³ and must maintain records of enrollee complaints, which may be reviewed by the state insurance commissioner.¹⁰⁴ States adopting the Model Regulations accompanying the HMO Model Act require HMOs to resolve patient grievances, or at least make "a final determination," within ninety days.¹⁰⁵ In all but a few states, the mandated grievance procedure begins and ends within the HMO itself; an enrollee has no right to present a grievance to a non-HMO physician or other body for review.¹⁰⁶

Supp. 1995); COLO. REV. STAT. §§ 10-16-401 to -428 (1994 & Supp. 1996); GA. CODE ANN. §§ 33-21-1 to -21-29 (1992 & Supp. 1996); 215 ILL. COMP. STAT. 125/1-2 to /6-19 (West 1994); IND. CODE ANN. §§ 27-13-1-1 to -35-1 (West Supp. 1996); IOWA CODE ANN. §§ 514B.1 to .32 (West 1988 & Supp. 1996); LA. REV. STAT. ANN. §§ 22:2001-2027 (West 1995 & Supp. 1997); ME. REV. STAT. ANN. tit. 24-A, §§ 4201-42 (West 1990 & Supp. 1996); MINN. STAT. ANN. §§ 62D.01-.30 (West 1996 & Supp. 1997); MISS. CODE ANN. §§ 83-41-301 to -365 (Supp. 1996); MO. REV. STAT. §§ 354.400-.550 (1994); MONT. CODE ANN. §§ 33-31-101 to -405 (1995 & Supp. 1996); NEB. REV. STAT. § 44-3292-32,180 (1993); N.J. STAT. ANN. §§ 26:2J-1 to -44 (West 1996 & Supp. 1996); N.M. STAT. ANN. §§ 59A-46-1 to -42 (Michie Supp. 1996); N.C. GEN. STAT. §§ 58-67-1 to -185 (1994); N.D. CENT. CODE §§ 26.1-18.1-01 to -25 (1995); OHIO REV. CODE ANN. §§ 1742.01-.44 (Anderson 1992 & Supp. 1995); R.I. GEN. LAWS §§ 27-41-1 to -41-44 (1994 & Supp. 1996); S.C. CODE ANN. §§ 38-33-10 to -310 (Law Co-op. 1989 & Supp. 1995); TENN. CODE ANN. §§ 56-32-201 to -225 (1994 & Supp. 1996); TEX. REV. CIV. STAT. ANN. art. 20A.01-.36 (West 1981 & Supp. 1997); VT. STAT. ANN. tit. 8, §§ 5101-15 (1993 & Supp. 1996); VA. CODE ANN. §§ 38.2-4300 to -4321 (Michie 1994 & Supp. 1996); W. VA. CODE §§ 33-25A-1 to -25A-35 (1996 & Supp. 1996); WYO. STAT. ANN. §§ 26-34-101 to -134 (Michie 1991 & Supp. 1996).

101. See HEALTH MAINTENANCE ORG. MODEL ACT (National Ass'n of Ins. Comm'rs 1991).

102. See *id.* § 11(A); Stayn, *supra* note 15, at 1703 n.203 (citing 38 state statutes requiring reasonable internal grievance procedures).

103. See HEALTH MAINTENANCE ORG. MODEL ACT § 3(C)(11); Stayn, *supra* note 15, at 1703 n.204 (citing 37 state statutes imposing this requirement).

104. See HEALTH MAINTENANCE ORG. MODEL ACT § 11; Stayn, *supra* note 15, at 1705 n.209 (citing 23 state statutes imposing this requirement). Public access to these records, however, is not often guaranteed. See *id.* at 1705 & n.210.

105. MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVS. OF HEALTH MAINTENANCE ORGS. § 9(D)(3) (National Ass'n of Ins. Comm'rs 1991). Few of the HMO Model Act states have adopted these regulations. See 3 COLO. CODE REGS. § 702-4 (1993); MONT. ADMIN. R. 6.6.2501-.2510 (1987); N.D. ADMIN. CODE §§ 45-06-07-01 to -06-07-09 (1994); 69 S.C. CODE ANN. REGS. 22 (Supp. 1995); UTAH ADMIN. CODE R590-76-1 to -14 (1996); Va. Regs. Reg. 28 (1987).

106. A handful of states do provide for nonjudicial appeals outside the HMO. See CAL. HEALTH & SAFETY CODE § 1368(b) (West Supp. 1996); FLA. STAT. ANN. ch. 408.7056,

Enrollees may find it difficult to gauge the importance of this right because they lack the information necessary to assess their physicians' possible biases. The HMO Model Act proscribes only outright deception, prohibiting "provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation" in HMO contracts and other information provided to enrollees.¹⁰⁷ Thus, the states do not require HMOs to reveal to patients how their physicians are paid, or to explain how their compensation arrangements reward doctors who provide cheaper care.

In lieu of these safeguards, the HMO Model Act relies upon an "ongoing internal quality assurance program"¹⁰⁸ to ensure adequate levels of care.¹⁰⁹ Such a program requires a "written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care,"¹¹⁰ and a "system of ongoing evaluation activities"¹¹¹ that are "focused."¹¹² The statement must also include "[w]ritten plans for taking appropriate corrective action whenever, *as determined by the quality assurance program*, inappropriate or substandard services have been provided or services which should have been furnished have not been provided."¹¹³

641.511 (Harrison 1996); 215 ILL. COMP. STAT. 125/4-6, 125/4-10 (West 1994); MICH. COMP. LAWS ANN. §§ 333.21088, 333.20126 (1992); MINN. STAT. ANN. § 62D.11 (West 1996); W. VA. CODE § 33-25A-12 (1996).

107. HEALTH MAINTENANCE ORG. MODEL ACT §§ 8(A)(2), 8(C)(2). Professor Clark Havighurst suggests that physician incentives may violate the language of this HMO Model Act provision:

The striking fact about incentive arrangements in plan-provider agreements is that they are generally not disclosed or alluded to in plan-subscriber contracts. On the contrary, the latter contracts often deny any plan responsibility for the quality of care or hold out reassuringly that participating providers are governed by professional norms and standards. Such disclaimers and reassurances might be deemed to be misleading or unfair to consumers.

CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 122 (1995).

108. HEALTH MAINTENANCE ORG. MODEL ACT § 7(B).

109. *See id.* § 7(A) (providing that quality assurance programs must "assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice").

110. *Id.* § 7(B)(1).

111. *Id.* § 7(B)(2)(e).

112. *Id.* § 7(B)(2)(f).

113. *Id.* § 7(B)(5) (emphasis added); *cf. id.* § 7(B)(3)-(4) (requiring a "written statement describing the system [regarding]: . . . [p]roblem assessment, identification, selection, and study; [c]orrective action, monitoring, evaluation and reassessment; and

The HMO Model Act's confidence in internal quality checks is troubling. First, HMO self-evaluations tend not to be realistic: HMOs routinely overestimate the amount of preventative care they provide¹¹⁴ and overcount patients who profess satisfaction in the HMOs' own surveys.¹¹⁵ Moreover, this form of regulation leaves state authorities without real power over HMO operations. While the appropriate state agency may regulate an HMO's self-evaluation processes,¹¹⁶ it cannot require an HMO to take any "corrective action" that the HMO deems unnecessary.¹¹⁷ In other words, the HMO Model Act empowers state regulators only to ensure that a "quality assurance program" exists—not that it in fact works to assure quality.

These shortcomings are not addressed in the diverse state legislation enacted to supplement or replace the HMO Model Act. These laws typically rein in HMOs in ways not endorsed by the drafters of the HMO Model Act.¹¹⁸ Many of these initiatives fall into three categories. So-called "any willing provider" laws force an HMO to add to its network any provider that meets certain broad criteria,¹¹⁹ rendering it impossible to limit patients to the most thrifty providers. "Freedom of choice" laws achieve the same result by requiring coverage for services obtained outside an HMO's network.¹²⁰ And "mandated benefits" legislation prohibits the exclusion of certain treatments, even

[i]nterpretation and analysis of patterns of care rendered to individual patients by individual providers," and "identifying the method of topic selection, study, data collection, analysis, interpretation and report format"). Maryland requires external review of quality assurance plans. See MD. CODE ANN., HEALTH-GEN. I § 19-705.1(f) (1996 & Supp. 1996).

114. See Mahar, *supra* note 2, at 34.

115. See *id.* at 34–35 (comparing 98% satisfaction rate reported by HMOs with lower rate found in Gallup survey).

116. See HEALTH MAINTENANCE ORG. MODEL ACT § 3(C)(12) (requiring details of the proposed quality assurance program to be submitted with state license application); *id.* § 7(C) (allowing access by state regulators to the minutes of "proceedings of formal quality assurance program activities"); *id.* § 7(E) (allowing access by state regulators to enrollee clinical records).

117. See *id.* § 7(B)(5).

118. See Carneal & Gallmetzer, *supra* note 95, at 279–92.

119. See, e.g., N.M. STAT. ANN. § 59A-46-35 (Michie 1995); W. VA. CODE § 33-25A-31 (1996); see also Wendy Wendland, *Health Bills Would Give Patients Options*, DET. FREE PRESS, May 21, 1996, at 1B (describing proposed Michigan legislation mandating "open enrollment to new doctors every two years").

120. See, e.g., GA. CODE ANN. § 33-21-29 (Supp. 1996) (granting enrollees the right to select a "point-of-service option" which permits enrollees to obtain services outside of their HMO's provider network).

through an explicit policy provision.¹²¹ Some mandated benefits are common: twenty states require HMOs to provide mental health services, and twenty-seven states mandate coverage for the treatment of alcohol or substance abuse.¹²² Other provisions vary, and many states mandate an eclectic menu of required services. California, for example, requires HMOs to provide prenatal genetic screening in cases of high-risk pregnancy,¹²³ and New Mexico HMOs must provide acupuncture.¹²⁴ Critics of these provisions note their potential to increase health care costs by preventing the HMO and its enrollee from excluding expensive, unwanted coverages from the contract. "Any willing provider" laws, "freedom of choice" laws, and "mandated benefits" initiatives are considered "anti-managed care laws" by the HMO industry, which views them as fundamentally inconsistent with the concept of managed care.¹²⁵

B. The Federal HMO Act

Overlaid on state regulations is the federal Health Maintenance Organization Act of 1973 (HMO Act),¹²⁶ enacted by Congress to encourage the proliferation of HMOs.¹²⁷ Compliance with the Act is not mandatory, but only HMOs that meet its criteria qualify for its protections, including federal preemption of certain restrictive state laws.¹²⁸ Because provisions in the

121. See 2 FURROW ET AL., *supra* note 1, § 11-11(b), at 58-59.

122. See Carneal & Gallmetzer, *supra* note 95, at 286.

123. See CAL. HEALTH & SAFETY CODE § 1367.7 (West 1990).

124. See N.M. STAT. ANN. § 59A-46-36 (Michie 1995).

125. See Carneal & Gallmetzer, *supra* note 95, at 282, 284.

126. 42 U.S.C. § 300e to 300e-17 (1994).

127. See Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 1973 U.S.C.A.N. (87 Stat. 914) 3033-120.

128. As originally enacted, the HMO Act provided strong incentives for an HMO to qualify: many employers were required to offer employees a federally qualified HMO option, and federal grants, loans, and loan guarantees were available to qualified HMOs. See LAWRENCE D. BROWN, POLITICS AND HEALTH CARE ORGANIZATION: HMOs AS FEDERAL POLICY 239-67 (1983). Under the current HMO Act, federal support of qualified HMOs is limited. Certain employers offering their employees a federally qualified HMO option may not "financially discriminate against an employee who enrolls in such [an] organization." 42 U.S.C. § 300e-9(c) (1994). Additionally, the Act preempts the application to federally qualified HMOs of restrictive state laws requiring (1) medical society approval of HMO providers; (2) that physicians constitute all or part of an HMO's governing body; (3) that a percentage of physicians in the HMO's area be permitted to join the network as providers; or (4) that HMOs meet state insurance

HMO Act designed to protect enrollees generally mirror those found in state law applying to all HMOs, "the current federal system provides minimal substantive and procedural protections for non-Medicare members of HMOs."¹²⁹

Like HMOs regulated by most state laws, a federally qualified HMO must establish "meaningful procedures"¹³⁰ for an enrollee to take his complaint to the "appropriate HMO decisionmaking levels."¹³¹ However, the HMO need not allow a non-HMO physician or reviewing body to resolve grievances. As under state law, federal law does not require HMOs to disclose any methods of physician compensation that may reduce the level or quality of services provided.¹³² Federally mandated "quality assurance program[s]"¹³³ are also comparable to those required by the state HMO Model Act.¹³⁴ Federal quality assurance programs must "[s]tress[] health outcomes to the extent consistent with the state of the art"¹³⁵ and provide for "taking appropriate remedial action whenever, *as determined under the quality assurance program*, inappropriate or substandard services have been provided or services that ought to have been furnished have not been provided."¹³⁶

The HMO Act diverges somewhat from state law in its "mandated benefits" provisions, which form the primary hurdles to federal qualification. A qualified HMO must offer a broad array of "basic health services"¹³⁷ including, among other things, short-term physical therapy,¹³⁸ short-term mental health services,¹³⁹ treatment and referral services for alcohol and drug

regulations regarding initial capitalization and insolvency protections. *See id.* § 300e-10(a). The Act further provides that states may not prohibit a federally qualified HMO from "advertising its services, charges, or other nonprofessional aspects of its operation." *Id.* § 300e-10(b). With these exceptions, federally qualified HMOs must comply with the same state laws as non-qualified HMOs.

129. Stayn, *supra* note 15, at 1702.

130. *See* 42 U.S.C. § 300e(c)(5); 42 C.F.R. § 417.124(g) (1995).

131. 42 C.F.R. § 417.124(g)(1).

132. *See id.* § 417.124(b) (listing disclosure requirements).

133. *Id.* § 417.106.

134. *See* HEALTH MAINTENANCE ORG. MODEL ACT § 7(B) (National Ass'n of Ins. Comm'rs 1991); *supra* notes 109-13 and accompanying text.

135. 42 C.F.R. § 417.106(a)(1).

136. *Id.* § 417.106(a)(4) (emphasis added).

137. 42 U.S.C. § 300e(b)(1) (1994).

138. *See* 42 C.F.R. § 417.101(a)(2)(iii).

139. *See* 42 U.S.C. § 300e-1(1)(D); 42 C.F.R. § 417.101(a)(4). This mandated benefit may be only a partial solution to the problem of inadequate mental health coverage. According to psychiatrists, short-term mental health care is sufficient for some conditions but inadequate for others. *See* Daniel Goleman, *Critics Say Managed-Care*

abuse,¹⁴⁰ home health services,¹⁴¹ "a broad range of voluntary family planning services,"¹⁴² and infertility services.¹⁴³ Almost half of all HMOs do not satisfy these requirements and operate under state law without federal qualification.¹⁴⁴

C. Common Law Liability

Under the federal and state law outlined above, an HMO enrollee denied vital care must often choose to either forego the desired treatment or resort to litigation. The threat of litigation, against either the HMO itself or an HMO provider, may be the most effective deterrent of improper care denials currently available to enrollees. In some courts, an HMO itself may incur vicarious malpractice liability under principles of agency if the HMO "conducts itself in a fashion akin to a health care provider."¹⁴⁵ However, many states reject this ground of liability, providing by statute that an HMO itself is not to be deemed to practice medicine.¹⁴⁶

More common is the medical malpractice suit brought directly against an HMO physician who attempts to cut costs too radically.¹⁴⁷ In a recent California case,¹⁴⁸ for example, the family of a deceased HMO patient brought suit against her primary-care physician alleging that for several months, while

Savings Are Eroding Mental Care, N.Y. TIMES, Jan. 24, 1996, at C9. One study found the worst outcomes among seriously depressed patients enrolled in health plans limiting the number of treatment sessions. *See id.*

140. *See* 42 U.S.C. § 300e-1(1)(E); 42 C.F.R. § 417.101(a)(5).

141. *See* 42 U.S.C. § 300e-1(1)(G); 42 C.F.R. § 417.101(a)(7).

142. 42 C.F.R. § 417.101(a)(8)(i).

143. *See id.* § 417.101(a)(8)(ii).

144. *See* 2 FURROW ET AL., *supra* note 1, § 11-11(a), at 55.

145. 1 FURROW ET AL., *supra* note 13, § 8-2(b), at 484 (quoting *Decker v. Saini*, 14 Employee Benefits Cas. (BNA) 1556, 1991 WL 277590 (Mich. Cir. Ct., 1991)). Other courts have applied this doctrine. *See, e.g.,* *Schleier v. Kaiser Found. Health Plan of the Mid-Atl. States, Inc.*, 876 F.2d 174 (D.C. Cir. 1989); *Sloan v. Metro. Health Council of Indianapolis, Inc.*, 516 N.E.2d 1104 (Ind. Ct. App. 1987); *McClellan v. Health Maintenance Org. of Pa.*, 604 A.2d 1053 (Pa. Super. 1992), *aff'd*, No. 78E.D.1995, 1996 WL 717460, at *1 (Pa. Dec. 12, 1996); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. 1988).

146. *See, e.g.,* NEB. REV. STAT. § 44-32,170 (1993); S.D. CODIFIED LAWS § 58-41-15 (Michie 1996).

147. *See* MASTERS ET AL., *supra* note 8, § 1120.

148. *Ching v. Gaines*, No. CV 137656 (Super. Ct., Ventura County, Cal., Nov. 15, 1995).

the patient suffered abdominal pain and rectal bleeding, the doctor delayed ordering a test that would have diagnosed her colon cancer.¹⁴⁹ Although the physician denied that cost was a factor, the patient's family stressed that the entire cost of the \$450 test would have been absorbed by the physician himself under his contract with the HMO.¹⁵⁰ A jury awarded the family \$2.9 million.¹⁵¹

Where HMO administrators instead of a network physician have unreasonably withheld services, a contract-based claim or a tort-based bad faith action may also result in a sizable damage award. In one case, a forty-year-old woman died of breast cancer after her HMO denied her a bone marrow transplant.¹⁵² The HMO stressed that the transplant procedure was not a proven safe and effective treatment for advanced breast cancer.¹⁵³ Unsympathetic to the HMO's arguments, the jury found that the HMO had breached its contract and awarded damages of \$89.3 million—the highest award against an HMO to date.¹⁵⁴

Other potential theories of liability¹⁵⁵ are not consistently available to aggrieved HMO enrollees.¹⁵⁶ However, the availability of various theories is irrelevant to the many patients

149. For reports on this case, see Brink, *supra* note 28, at 62–64; Paul Elias, *Doctors Negligent in Woman's Cancer Death, Jury Finds*, L.A. TIMES, Nov. 16, 1995, at A3; *Notable Verdicts*, NAT'L L.J., Jan. 15, 1996, at A11.

150. See Brink, *supra* note 28, at 62.

151. This award was reduced to \$700,000 because of California's cap on non-economic damages. See *id.*

152. See Eckholm, *supra* note 3, at A1.

153. See *id.* at A12.

154. See *id.* The award was vacated on appeal, and the parties settled for an undisclosed amount. See Roger Parloff, *The HMO Foes*, AM. LAW., July/Aug. 1996, at 81, 85.

155. See William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 487 (1991) (listing negligent misrepresentation, intentional infliction of emotional distress, breach of an implied duty of good faith and fair dealing, tortious interference with the physician-patient relationship, and fraud).

156. See, e.g., Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 708–09 (1994) (noting inconsistent case law). One class action, however, has begun to pursue a novel theory of liability. See *Teti v. U.S. Healthcare*, No. 88-9808 (E.D. Pa. Nov. 21, 1989), *aff'd*, 904 F.2d 696 (3d Cir. 1990). As the attorney described the claim, "U.S. Healthcare signed up all these people but didn't disclose the tricky financial arrangements they have with their physicians." Faith Lyman Ham, *RICO Statute Violated by HMO, Suit Alleges*, PHILADELPHIA BUS. J., Jan. 9–15, 1989, at 1. The complaint, which was filed in federal court alleging violations of the Racketeer Influenced and Corrupt Organizations Act of 1970 (RICO), was dismissed for want of jurisdiction, and the plaintiffs have refiled in state court. See MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 348 & n.58 (1993).

who enroll in an HMO through an employee benefit plan. These patients' common-law claims against HMOs are generally precluded by the federal Employee Retirement Income Security Act of 1974 (ERISA),¹⁵⁷ which preempts "any and all State laws" that "relate to" an employee benefit plan.¹⁵⁸ ERISA was enacted before the rapid growth of managed care, with the intent to protect employees.¹⁵⁹ Now, however, ERISA effectively preempts the state law that provides the basis for most actions brought against HMOs, thereby depriving many aggrieved patients of any remedy. Claims based on an HMO's denial of coverage,¹⁶⁰ as well as actions alleging misrepresentations to enrollees or failure to disclose essential information,¹⁶¹ are preempted. Widespread disapproval with this result¹⁶² has yet to effectuate change.

The judicial remedies not preempted by ERISA are nevertheless a poor method of regulating HMOs. First, the mere availability of a remedy has little deterrent value. Evidence suggests that an HMO often will ignore obligations enforced through common law until a suit appears imminent, perhaps assuming that the HMO's enrollee is unaware that the HMO's action may be challenged in court or that the enrollee is unwilling to expend time and money to initiate litigation during a health crisis.¹⁶³ Second, the deterrent effect of common law

157. 29 U.S.C. §§ 1001-1461 (1994).

158. *Id.* § 1144(a). Although laws that "regulate insurance" are not preempted by ERISA, *id.* § 1144(b)(2)(A), an employee benefit plan, including an HMO that provides services to employees, cannot be "deemed . . . an insurance company" to avoid preemption. *Id.* § 1144(b)(2)(B).

159. *See, e.g.*, 120 CONG. REC. 29,197 (1974) (statement of Rep. Dent, an ERISA sponsor, citing "the protection afforded participants" as "the crowning achievement of this legislation").

160. *See, e.g.*, *Makar v. Health Care Corp. of the Mid-Atl. (Carefirst)*, 872 F.2d 80, 82 (4th Cir. 1989) (approving removal of a coverage dispute to federal court because of ERISA preemption); *Scullion v. Travelers Health Network*, 720 F. Supp. 530, 531 (W.D. Pa. 1989) (holding that plaintiff's claim against his HMO for refusal of coverage is governed by ERISA).

161. *See, e.g.*, *Degan v. Ford Motor Co.*, 869 F.2d 889, 893-94 (5th Cir. 1989) (holding that a state law claim based on alleged misrepresentations is preempted by ERISA).

162. *See, e.g.*, *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) ("Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees."); *see also Oversight Hearing on the Effect of ERISA's Preemption Provision on State Health Care Reform Before the Subcomm. on Labor-Management Relations of the House Comm. on Educ. and Labor*, 103d Cong. (1993).

163. *See* William P. Peters & Mark C. Rogers, *Variation in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer*,

liability is not accurately targeted toward unjustified denials of care. Where a suit does result, a court or jury confronted with complex and conflicting medical testimony will usually favor a sick patient over a corporate entity that claims a particular treatment is too expensive, experimental, or not medically necessary,¹⁶⁴ and may order an HMO to pay tremendous damages regardless of whether the HMO's conduct was truly unreasonable. As a result, when an enrollee hires a lawyer, the HMO may yield to almost any demand for a service—whether essential or wasteful. To the extent common law liability successfully deters HMO misconduct, it also interferes with HMOs' legitimate cost-containment efforts.¹⁶⁵

330 NEW ENG. J. MED. 473, 476 (1994) (discussing a finding by researchers at the Duke University Bone Marrow Transplant Program that insurers' coverage determinations for treatment of patients in certain clinical trials of cancer therapy seemed "arbitrary and capricious," frequently depending on whether the insured was represented by counsel); Susan Brink, *The Cancer Wars at HMOs*, U.S. NEWS & WORLD REP., Feb. 5, 1996, at 69, 69 (noting that an effective means of obtaining coverage is through hiring a lawyer as illustrated by the Duke University study).

164. See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1644-62 (1992) (describing and noting the impact of common judicial devices for stretching coverage beyond that provided in the contract to include care needed by ill patients); *id.* at 1676-81 (noting judicial biases toward individual versus group preferences).

165. See *id.* at 1658-62. Additionally, it would appear that these two aspects of judicial regulation may combine to encourage discrimination against an HMO's most seriously ill enrollees. Suppose, for example, that an HMO could achieve the cost savings it desires in two ways: it could either deny the unnecessary, but low-cost, treatments demanded by a thousand of its enrollees or deny the expensive treatments desperately needed by ten critically ill patients. Although each of the ten has greater incentive to sue the HMO, these seriously ill patients may be less aggressive because of their poor health and may be resigned to suffering continuing health problems. More significantly, HMO administrators might simply conclude that the probability of a lawsuit is lower if the HMO angers only ten enrollees rather than a thousand. The strength of the claims by the ten seriously ill patients may ultimately prove irrelevant; the HMO, alarmed by the size of the potential award in any suit, may predict that the number of claims against it will count far more than the merit of those claims. The HMO in this hypothetical might therefore provide the low-cost treatments and deny the high-cost ones without regard for their relative benefits. In this way, reliance on common law principles instead of statutory provisions may exacerbate HMOs' tendency to meet the needs of their healthiest enrollees first.

IV. REFORM

Because existing mechanisms fail to guarantee the vital care HMO patients justifiably expect, a shift in regulatory emphasis is needed. This Part endorses broad principles of regulation relying on patients, their physicians, and the health care market to strike a balance between cost reduction and comprehensive medical care. After setting forth four proposals, this Part concludes that together, these reforms would allow for cost containment while delivering to patients essential care as defined by the patients themselves.

Although a full evaluation of the merits of state versus federal regulation is beyond the scope of this Note,¹⁶⁶ the discussion below assumes for several reasons that the task of reform is best left to the states. First, permitting the states to regulate independently will allow a variety of innovations to be tested simultaneously while containing the consequences of less successful approaches.¹⁶⁷ Second, "health care is a product packaged and delivered in local markets,"¹⁶⁸ and the "financing and delivery of health care depend on relations between insurers and local providers of care."¹⁶⁹ Finally, two leading advocates of a federalist approach, Professors Jerry Mashaw and Theodore Marmor, note:

Political judgments about particular reform proposals are products of personal experience, political ideology, and local economic and social conditions. These factors change

166. An informative debate on this topic can be found in a recent issue of the *CONNECTICUT LAW REVIEW*. This issue features an article advocating a federalist approach by professors Jerry Mashaw and Theodore Marmor, see Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 *CONN. L. REV.* 115 (1995), along with critical responses from academics and health care professionals, see Commentary, *On the Future of State Health Care Reform*, 28 *CONN. L. REV.* 113 (1995).

167. See Mashaw & Marmor, *supra* note 166, at 117 ("If it is uncertain how any new proposal would work out in practice, why run a single experiment, which might fail, on the whole country at once?").

168. Cohodes, *supra* note 56, at 86; see also Mahar, *supra* note 2, at 32 (noting evidence "suggesting that local doctors and hospitals—not central administrators—can have the biggest influence on quality").

169. Cohodes, *supra* note 56, at 96; see also John E. Kralewski et al., *Strategies Employed by HMOs to Achieve Hospital Discounts: A Case Study of Seven HMOs*, *HEALTH CARE MGMT. REV.*, Winter 1991, at 9, 10, 15 (describing how HMOs expend efforts locally to negotiate the fees they pay network providers).

substantially as one moves about the United States. If change is to be workable and acceptable, it must take account of the real differences between New York and Idaho, Wisconsin and Louisiana.¹⁷⁰

Other commentators have called for federal law preempting state HMO regulation, citing the states' failure to enact adequate regulations thus far¹⁷¹ and the multistate presence of some HMOs and health care purchasers.¹⁷² While the four reform proposals below are directed toward state lawmakers, these principles could also be given effect through federal legislation.

170. Mashaw & Marmor, *supra* note 166, at 116.

171. In 1996, at least a few states are considering reform measures that may afford significant protections to enrollees. *See, e.g.*, Knox, *supra* note 96, at A12 (surveying recent state actions); Vincent J. Schodolski, *Alleged HMO Abuses Spur California Ballot Issues*, CHI. TRIB., Aug. 13, 1996, at 1 (quoting opinion of consumer-rights advocate that California has "led the race to the bottom in terms of quality," but noting that now the state is "poised to lead a national backlash" against HMO abuses); sources cited *supra* note 106; *infra* notes 179, 214-15, 221-24, 227-32 and accompanying text.

172. *See, e.g.*, K. Peter Schmidt, *Problems With Health Care Federalism*, 28 CONN. L. REV. 147, 147 (1995). Schmidt writes:

The "federalist" approach to health care . . . ignores one simple fact: many important health care actors are, in effect, citizens of the nation, or regions thereof, rather than citizens of a single state. . . .

. . . .

. . . . Quite understandably, the sponsors of plans that provide health care benefits in more than one state do not all view as a panacea "reforms" that subject them to a crazy quilt of varying state regulation.

Id. Professors Mashaw and Marmor respond that

multi-state employers within the United States must adapt their offerings to the realities of local health care provision. General Motors cannot, in good faith, offer its workers in Tennessee the same HMO package that it offers its workers in California. Differences in the availability of HMO services, the capacities of HMOs that exist, differential pricing policies from place to place, and differing state regulation of the practice of medicine all require that multi-state corporations already take into account of [sic] local differences when constructing employee health benefit options. No one can estimate reliably the marginal increase in this preexisting complexity that would result from increased state authority to regulate health insurance plans.

Jerry L. Mashaw & Theodore R. Marmor, *Federalism and Health Care: A Reply*, 28 CONN. L. REV. 161, 162-63 (1995).

A. Principles of Patient-Responsive Regulation

1. *Prohibit coercive physician incentives*—Legislatures should prohibit the most coercive physician incentives currently employed by HMOs. Until recently, methods of calculating physician pay endured considerable scrutiny but little legislative action. Representative Pete Stark of California proposed the elimination of all physician incentive systems in 1986.¹⁷³ The resulting federal statute¹⁷⁴ prohibits hospitals from offering financial rewards to physicians “as an inducement to reduce or limit services provided” to Medicare and Medicaid patients,¹⁷⁵ but its application to private-market HMOs was delayed after HMOs complained that the statute would prohibit widely accepted cost-reduction procedures.¹⁷⁶ A 1990 federal law prohibited Medicare HMOs from furnishing to physicians any “specific payment . . . as an inducement to reduce or limit medically necessary services,”¹⁷⁷ and Congress has considered several health care reform bills that would have subjected private health care plans to this prohibition.¹⁷⁸ Some states are now preparing similar legislation. Massachusetts, for example, is considering a bill that would prohibit HMOs from entering into “any compensation arrangement with a health care provider that may directly or indirectly have the effect of reducing or limiting services furnished to any person enrolled in a health plan.”¹⁷⁹ If enacted, the effects of such legislation

173. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313(c), 100 Stat. 1874, 2003-04, amended by Pub. L. No. 100-203, § 4016, 101 Stat. 1330, 1330-64 (1987), Pub. L. No. 101-239, § 6207, 103 Stat. 2245 (1989). Taken literally, this elimination would be impossible; as one HMO advocate pointed out, “All pricing mechanisms for medical services have some inherent incentives.” Ham, *supra* note 156, at 1.

174. 42 U.S.C. § 1320a-7a(b)(1) (1994).

175. *Id.*

176. See 1 FURROW ET AL., *supra* note 13, § 8-2(d), at 488 n.33; Hall, *supra* note 156, at 707; Alan L. Hillman et. al., *Contractual Arrangements Between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools*, 30 MED. CARE 136, 136 (1992).

177. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4204(a)(1), 104 Stat. 1388, 1388-108 to -109 (codified at 42 U.S.C. § 1395mm(i)(8)(A)(i) (1994)). Rules implementing this legislation have been repeatedly delayed. See Carol Jouzaitis & David S. Cloud, *HMO Reforms Delayed: Critics Blame Politics*, CHI. TRIB., July 9, 1996, § 1, at 1.

178. See, e.g., H.R. 3600, 103d Cong. (1993).

179. Alex Pham, *Limits on HMOs Win Backing of Trade Group: Bill to Curb Financial Incentives to Doctors to Cut Costs of Care*, BOSTON GLOBE, July 10, 1996, at

would be far-reaching: sixty-eight percent of HMOs employing their own physicians, and eighty-four percent of other HMOs, reduce costs through some type of physician financial incentive.¹⁸⁰

Although these measures show that lawmakers have identified a primary cause of improper care denials, the aggressive proposals to date may have overstated the problems of physician incentives. First, the potential dangers of these incentives are mitigated by physicians' natural loyalty to patients and their perception of good medicine.¹⁸¹ Moreover, the less drastic incentives to cut costs may well serve a legitimate purpose by counteracting physicians' tendencies to perform certain unwanted and ineffective procedures.¹⁸² Lawmakers should therefore abandon efforts to extinguish every physician financial incentive, and focus instead on those payment schemes most likely to subvert doctors' independent medical judgments.¹⁸³

Perhaps the most controversial cost control is a system of physician compensation known as "capitation."¹⁸⁴ In its purest form, a doctor contracts with the HMO to serve as the primary care physician for a specified group of HMO enrollees.¹⁸⁵ Instead of reimbursing the doctor for the care he actually provides, the HMO provides a flat monthly payment for each enrollee assigned to him.¹⁸⁶ The physician receives this per

40. Curiously, the bill specifically does not ban capitation, one type of particularly powerful incentive. See *id.* California voters rejected similar proposals when they considered two ballot initiatives in November of 1996. See David R. Olmos, *Experts Foresee More Efforts to Reform HMO Regulation*, L.A. TIMES, Nov. 7, 1996, at D4; cf. Schodolski, *supra* note 171, at 1.

180. See Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make With Physicians*, 333 NEW ENG. J. MED. 1678 (1995).

181. See ELIOT FREIDSON, *DOCTORING TOGETHER: A STUDY OF PROFESSIONAL SOCIAL CONTROL* 86-101 (1971).

182. See *supra* note 54 and accompanying text.

183. The American Medical Association has noted: "The greater the strength of the incentive, the more likely it will create a serious conflict of interest which could lead to patient harm." Joseph F. Sullivan, *Officials Scrutinizing Doctor Bonuses in Managed Care Plans*, N.Y. TIMES, Sept. 21, 1995, at B6 (quoting 1994 report from the AMA's Council on Ethical and Judicial Affairs).

184. A 1995 study found that 56% of HMOs contracting with outside physicians and 34% of HMOs employing their own physicians use capitation as their chief method of physician compensation. See Gold et al., *supra* note 180, at 1681 tbl.3. "Many health care futurists are predicting that capitation will become a predominant method of reimbursement to providers for health care services by the end of the decade," in large part because of increased participation in HMOs. MASTERS ET AL., *supra* note 8, § 110.

185. See MASTERS ET AL., *supra* note 8, § 170.

186. See *id.* § 1100.

capita payment each month regardless of whether the patient seeks care, and regardless of the time and money the doctor spends caring for the patient.¹⁸⁷ Thus, pure capitation exactly reverses the financial incentives of a physician accustomed to fee-for-service reimbursement: "every time a patient comes into the doctor's office it's a liability, not an asset."¹⁸⁸ In effect, the physician himself underwrites his patients' care.¹⁸⁹

The incentives of capitation can be overpowering when a patient becomes critically ill because these patients pose the greatest danger to a provider's financial stability.¹⁹⁰ Capitation may also adversely affect patients who only need minor care. As one hospital administrator explained: "If you are a bunch of doctors or a hospital, and you see you are over budget, you begin to cut corners."¹⁹¹ To increase profitability, a provider may take on additional patients or spend less time and money on each current enrollee.¹⁹² While capitation may lead to patient complaints,¹⁹³ physicians themselves are often the most vocal critics. Doctors recognize that "it's the morals and ethics of physicians that will make the system work"¹⁹⁴ but some fear that "this system is robbing physicians of their essential goodness."¹⁹⁵ One doctor noted that to profit-motivated capitated care providers, "the best possible outcome is that the patient die without receiving any care just after the capitation payment arrives. This isn't a slippery slope; it's a cliff."¹⁹⁶

187. See *id.* § 170.

188. Larson, *supra* note 35, at 47.

189. See MASTERS ET AL., *supra* note 8, § 1100.

190. See Michael T. Isbell, *AIDS and Access to Care: Lessons for Health Care Reformers*, 3 CORNELL J.L. & PUB. POL'Y 7, 24 (1993).

191. Suzanne Woolley, *Physician, Restrain Thyself*, BUS. WK., Sept. 13, 1993, at 34.

192. See *id.* at 32; Mechanic, *supra* note 92, at 1731 ("Most physicians are individually responsible for at least several hundred patients and must apportion their time and efforts in some reasonable relationship to their competing patients' needs—as well as to their own needs for leisure.").

193. One patient complained of his HMO doctor: "We were being herded through like cattle." Woolley, *supra* note 191, at 32.

194. Perry, *supra* note 9, at 110, 114 (quoting Dr. Thomas Reardon, a trustee of the American Medical Association).

195. Larson, *supra* note 35, at 46 (quoting Dr. Roy B. Jones, a University of Colorado bone marrow transplant specialist).

196. Norman A. Paradis, Letter to the Editor, *Market Forces Can't Drive Doctors' Decisions*, N.Y. TIMES, Dec. 28, 1995, at A20. *But cf.* J. Kevin McCurren, *Factors for Success: Capitated Primary Physicians in Medicare HMOs*, HEALTH CARE MGMT. REV., Spring 1991, at 49, 52 (surveying physicians chosen for the study by their HMOs and finding that the doctors stressed "the positive aspects" of capitation and dismissed "the risk aspect" of capitation).

Legislation curbing these effects might allow capitation only when tempered by other mechanisms designed to ensure quality care. In some HMOs, for example, capitated physicians are eligible for year-end bonuses based on surveys of patient satisfaction.¹⁹⁷ Legislation might mandate this practice or allow HMOs to substitute other measures of quality, perhaps rewarding capitated physicians on the basis of how many patients receive immunizations or other services indicating physician attention.¹⁹⁸ Still, this proposal is hardly a panacea: survey responses by healthy enrollees say little about whether a capitated doctor would spend his own money to provide extensive care to a chronically ill enrollee.¹⁹⁹ Doctors might respond to such requirements by boosting their low-cost services without increasing the care they provide to their patients who need more expensive services.

A more effective measure would simply abolish capitation, forcing HMOs to employ less drastic incentives to cut costs. An HMO may, for example, use a system of bonuses to influence its primary-care physicians in their role as "gatekeepers," discouraging them from referring patients to medical specialists unnecessarily. In one HMO, if the 925 patients assigned to one primary-care physician use specialist care in a given month costing the HMO \$14.49 or less per patient, the HMO awards the doctor a bonus of \$1323, but if the average cost of specialist care rises to \$30.49 the doctor gets nothing.²⁰⁰ A "withhold" is a similar incentive and achieves the same results. For example, the HMO could reimburse the physician eighty percent of the cost of his services, while withholding the remaining twenty percent until the end of the fiscal year. At that time, the HMO might deduct from the withheld amount one dollar for every ten dollars by which the physician exceeded the target for his total annual expenditures.²⁰¹

197. See *Performance-Based Payment Yields Cost, Quality Pluses*, PHYSICIAN MANAGER, Jan. 6, 1995, at 8.

198. See MASTERS ET AL., *supra* note 8, §§ 950-958 (describing how to measure health care quality through "consumer research").

199. See Brink, *supra* note 28, at 64.

200. The physician bonuses used in this example are actual incentives used by U.S. Healthcare. See Paul Gray, *Gagging the Doctors*, TIME, Jan. 8, 1996, at 50, 50 (providing "examples of the U.S. Healthcare incentive system, taken from its own documents").

201. See HIRSH & WILCOX, *supra* note 8, at 17; Sullivan, *supra* note 183, at B6.

Bonuses and withholds may be preferable to pure capitation as a significant but weaker determinant of physician behavior.²⁰² In the previous example, the difference between a low average specialist cost and a high average cost is worth at least \$14,800 to the HMO, but at most \$1323 to the physician. Within this range, the physician bears some responsibility for the specialist costs she incurs, which discourages needless referrals. Because her monetary stake is always less than ten percent of the referral costs, however, this incentive is not overwhelming. Moreover, the physician has no additional incentive to refer so few patients to specialists that their average cost falls below \$14.49, and if in her judgment a few of her patients require extremely expensive specialist services she stands to lose no more than \$1323. In this way, the sharing of costs between doctors and HMOs—a central feature of managed care—is preserved without seriously compromising patient care.

2. *Mandate disclosure of physician incentives*—HMOs should be required to disclose how their care providers are compensated in marketing materials and at enrollment.²⁰³ In the absence of mandated disclosure, most enrollees remain ignorant of physician incentive systems.²⁰⁴ Patients contemplating HMO enrollment do not learn how the HMO's providers are paid from the plan's brochures,²⁰⁵ and HMOs do not volunteer this information in contracts or other post-enrollment materials.²⁰⁶ Patients rarely ask physicians directly how their pay is calculated, both out of embarrassment and because they do not know what questions to ask.²⁰⁷ Moreover, physicians may be prohibited by so-called "gag" clauses in their HMO contracts from revealing their financial arrangements with HMOs.²⁰⁸ Not

202. See Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743, 1748 (1987).

203. See Douglas F. Levinson, *Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans*, 317 NEW ENG. J. MED. 1729, 1729 (1987); Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?*, 83 GEO. L.J. 1821, 1824–25 (1995).

204. See McGraw, *supra* note 203, at 1836–37; see also CLARK C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY 78–83 (1982) (noting that patient ignorance impedes operation of the health care market).

205. See Brink, *supra* note 28, at 63.

206. See HAVIGHURST, *supra* note 107, at 122.

207. See Brink, *supra* note 28, at 62–63 (quoting researcher Marsha Gold: "What I do is look at health care incentives, and it took me two years to figure out this stuff.").

208. See *id.* at 63; Robert Pear, *Doctors Say HMOs Limit What They Can Tell Patients*, N.Y. TIMES, Dec. 21, 1995, at A1. HMOs argue that "gag" clauses are

surprisingly, the majority of new HMO enrollees in one study incorrectly believed that "in this plan the doctor is only concerned about my health and not limiting the plan's cost."²⁰⁹

Awareness of an HMO's physician compensation arrangement before enrollment is critical because it is one of few concrete predictors of how aggressively an HMO will respond to serious illness. HMO telephone representatives sometimes provide information to prospective enrollees that is incomplete, false, or misleading.²¹⁰ Quality ratings and accreditation surveys by independent organizations are controversial, incomplete, and confusing.²¹¹ Advance disclosure of physician compensation arrangements would empower each prospective enrollee to select a plan geared to the types of care she desires. Those prospective enrollees most concerned with the availability of high-cost interventions to combat serious illness, for example, might be willing to pay higher premiums or forego other benefits to join an HMO with less coercive incentives or no incentives at all. Improved disclosure could also educate enrollees about the benefits and drawbacks of managed care, reducing disputes stemming from enrollees' unrealistic expectations.²¹²

Many doctors support advance disclosure, arguing that telling patients up front about physician incentives is the only way to preserve patients' trust in the profession.²¹³ Currently, patients often learn of physician incentives only when they become seriously ill and seek to discover why their doctors will not

intended only to protect trade secrets, to prevent physicians who contract with multiple plans from encouraging patients to continue to receive their services under a different plan, and to discourage doctors from stirring unnecessary anxiety which may lessen the effectiveness of patient care. See *id.* An AMA lawyer reports anecdotal evidence that doctors will answer such questions even if forbidden by their contracts with the HMO. See Brink, *supra* note 28, at 63.

209. Mechanic, *supra* note 92, at 1732 (citing David Mechanic et al., *Choosing Among Health Insurance Options: A Study of New Employees*, 27 INQUIRY 14, 17 tbl.2 (1990)).

210. See Lisa W. Foderaro, *Public Advocate Report Says H.M.O.'s Vary Widely in Quality and Benefits*, N.Y. TIMES, Jan. 5, 1996, at B4 (quoting the opinion of New York City's Public Advocate that "H.M.O.'s routinely distribute vague, false, conflicting or inadequate information to prospective enrollees" over the telephone about, for example, the qualifications of HMO physicians).

211. See Gottlieb, *supra* note 10, at 9. Gottlieb notes that in surveys, "[s]icker people tend to be more critical of plans even when they perform well. Older people are often more generous in their assessments, especially if doctors or nurses take interest in them." *Id.*

212. See generally Levinson, *supra* note 203; McGraw, *supra* note 203.

213. See Brink, *supra* note 28, at 63.

administer expensive treatments or provide referrals to medical specialists. An enrollee who learns at this late point that her physician has a financial stake in reducing the care available to her is likely to feel betrayed.

Increasing alarm about undisclosed physician financial incentives has led to initial efforts at regulation. Massachusetts and Delaware considered measures requiring disclosure as early as the late 1980s,²¹⁴ and lawmakers in other states²¹⁵ are now weighing similar proposals. Federal lawmakers have recently addressed this issue once again, but are reluctant to adopt such measures over industry opposition.²¹⁶ HMOs have resisted disclosure requirements, calling them “burdensome” and asserting that they would impair their ability to negotiate discounted fees with their affiliated providers.²¹⁷ Lawmakers should reject such arguments and implement these proposals so that HMO physicians may be a source of patient information, not misgivings.

3. *Require binding review of HMO denials of care*—Every HMO patient who believes that he has been denied services improperly should be guaranteed access to informal, quick, and inexpensive dispute resolution. Under existing law, most such

214. See Harris Meyer, *MD Incentives Suit Against HMO Dismissed; Issue Lingers*, AM. MED. NEWS, Jan. 12, 1990, at 1.

215. See, e.g., Thomas L. Bromwell, Letter to the Editor, *Compromising Health Care*, WASH. POST, June 16, 1996, at C8 (chairman of Maryland Senate Finance Committee promising that in 1997 he will “introduce legislation to require health care insurers and HMOs to inform their patients about how they pay their doctors and explain, in plain English, how their payment plans work”); Richard N. Gottfried & Alexander B. Grannis, Letter to the Editor, *It's Time to Put Limits on Power of H.M.O.'s*, N.Y. TIMES, Mar. 19, 1996, at A22 (the chairs of the New York State Assembly committees on health and insurance describing New York legislative efforts to mandate disclosure of physician incentives); Wendland, *supra* note 119, at 1B (describing proposed Michigan legislation); see also Editorial, *Unmuzzling HMO Physicians: State and Federal Bills Aim at Treatment Option 'Gag Rules'*, L.A. TIMES, July 2, 1996, at B6 [hereinafter *Unmuzzling HMO Physicians*] (discussing with approval a provision in proposed California ballot initiative SB 1064). This initiative was rejected by California voters in November of 1996. See Olmos, *supra* note 179, at D4.

216. See, e.g., *Unmuzzling HMO Physicians*, *supra* note 215, at B6 (noting that after compromises in Congress, the proposed Federal Patient Right to Know Act fails to mandate disclosure of physician incentives).

217. See Wendland, *supra* note 119, at 2B (noting one HMO's objection that Michigan's proposed mandated disclosures would “use a lot of paper and quickly be out-of-date”); cf. *HMO Gag Rules*, N.Y. TIMES, Jan. 6, 1996, at 18 (advocating rules to require disclosure of compensation schemes without revealing precise dollar amounts so that HMOs will retain their power to bargain for discounted fees with individual physicians).

enrollees must either forego treatment or file suit.²¹⁸ The delays and costs of litigation make it undesirable for both enrollee and HMO, and the judicial process is an inadequate means of achieving fair, informed resolutions of medical disputes.²¹⁹

States may avert much of the litigation between patients and HMOs by mandating an informal arbitration process for aggrieved enrollees.²²⁰ A state pursuing this route might choose to follow the example of Illinois, which provides for neutral physician review of an HMO's determination that a covered service is not "medically necessary."²²¹ When an Illinois HMO refuses to provide a service recommended by the primary-care physician, the enrollee seeking review, his doctor, and the HMO jointly select a physician unaffiliated with the HMO to provide a second opinion.²²² If the reviewing physician finds that the service is medically necessary, the HMO must provide coverage.²²³ Moreover, the HMO may not retaliate against the physician who recommended the service in any matter affecting his contract or employment.²²⁴ A state establishing similar arbitration procedures might vary the Illinois approach by selecting a state-sponsored network of physicians to perform such reviews instead of asking the enrollee, physician, and HMO to agree on a reviewing physician.²²⁵

Alternatively, a state might establish an administrative appeals procedure for enrollees dissatisfied with their HMOs' services.²²⁶ The reviewing agency might make its determination after reviewing documents submitted by the HMO and the enrollee,²²⁷ and might hold an informal hearing in an especially

218. See discussion *supra* Part III.A-B.

219. See discussion *supra* Part III.C.

220. See IRVING LADIMER, *DEMOCRATIC PROCESSES FOR MODERN HEALTH AGENCIES* 149-69 (1979) (detailing the mechanics of designing and contracting for arbitration within HMOs).

221. 215 ILL. COMP. STAT. 125/4-10 (West 1994).

222. See *id.*

223. See *id.*

224. See *id.*

225. This approach is taken by the federal Health Care Financing Administration (HCFA), which hears Medicare HMO appeals. The HCFA initiated this practice as the result of a class action by Medicare beneficiaries alleging unreasonable delays in HCFA's resolution of HMO appeals. See *Levy v. Bowen, Medicare & Medicaid Guide (CCH) ¶ 38,202* (C.D. Cal. June 20, 1989); *Levy v. Sullivan, Medicare & Medicaid Guide (CCH) ¶ 37,809* (C.D. Cal. Mar. 14, 1989).

226. Few states now provide this important safeguard to residents who enroll in HMOs. See *supra* note 106 and accompanying text.

227. See, e.g., 215 ILL. COMP. STAT. 125/4-6 (West 1994).

complex case.²²⁸ The agency hearing the appeal should be free to consult a physician for additional medical expertise.²²⁹ A state might also allow the usual decisionmakers to refer a complaint to a more appropriate governmental agency.²³⁰ Where an enrollee is required first to exhaust a grievance procedure within the HMO, a deadline should be imposed for the HMO's decision and an expedited timetable should be established for enrollees seeking urgent care.²³¹ Finally, HMOs should be required to notify enrollees of their right to an administrative appeal both upon enrollment and upon any denial of services.²³² Effective notification is critical to administrative review because otherwise a patient may be likely to submit to an HMO's decision in the mistaken belief that her only recourse is an appeal to the same organization that initially denied her care.

Any mechanism a state provides should be subject only to limited review in court.²³³ Judicial inquiries should be confined to concerns about the arbitration or administrative appeal process: Did the HMO or enrollee exert improper influence over a "neutral" reviewing physician? Did the state panel deny a

228. See, e.g., CAL. HEALTH & SAFETY CODE § 1368(b)(4) (West Supp. 1996) (granting state agency the discretion to "hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or complaint, or who are otherwise assisting or advocating on behalf of the subscriber or enrollee").

229. See, e.g., FLA. STAT. ANN. ch. 408.7056(1)(a) (Harrison 1995).

230. See, e.g., CAL. HEALTH & SAFETY CODE § 1368(b)(1)(C) (authorizing referral to the California Department of Aging "or any other appropriate governmental entity").

231. See, e.g., *id.* § 1368(b)(1)(A) (requiring an enrollee to complete the HMO's grievance process or to "participat[e] . . . for at least 60 days" before initiating an administrative appeal, but waiving this requirement in any case "involving an imminent and serious threat to the health of the patient, including, but not limited to, the potential loss of life, limb, or major bodily function").

232. See, e.g., *id.* § 1368(b)(3) (requiring notice to be "prominently display[ed] in every plan contract, on enrollee and subscriber evidence of coverage forms, on the complaint forms . . . and on all written responses to grievances and complaints").

233. See Hall & Anderson, *supra* note 164, at 1705-09. Professors Hall and Anderson advocate significant procedural shortcuts:

An established reference point [for judicial review of arbitration decisions] is readily found in the existing body of constitutional due process jurisprudence. . . . In the proceedings following termination or denial of disability income, Medicaid, or Medicare benefits, the federal courts have held that it is constitutionally sufficient to employ an inquisitorial rather than adversarial process, to consult a physician retained by the agency who has not personally examined the patient, to limit the patient's personal presentation of evidence to a documentary record coupled with a toll-free phone line, to have different levels of review for different amounts in controversy, and to preclude judicial review altogether.

party the right to present information to support its position? Is the final outcome flatly inconsistent with the contract language or all of the medical evidence? Limiting the scope of review conserves judicial resources. It also helps eliminate the unfair advantage an HMO has over an enrollee who is disinclined to sue,²³⁴ as well as the advantage enjoyed by the enrollee who does sue in the trial court, a traditionally friendly forum.²³⁵ In addition, this approach is more "oriented toward the ex ante, insurance-purchasing perspective on the coverage issues"²³⁶ because limiting the scope of judicial review "place[s] the courts in a mindset that is aware of the public policies in favor of private, contractual remedies."²³⁷ In other words, a court charged only with the limited task of procedural review is probably less likely to rewrite the parties' agreement in light of post-contract events, and more likely to focus on the HMO's obligation, if any, to provide care under the terms of its bargain with the enrollee.

A grievance process based on arbitration or administrative review would also afford a more reasoned consideration of relevant medical issues, because decisionmakers would hear the opinions of impartial doctors instead of the slanted testimony of opposing expert witnesses who may contradict each other. This approach would lead to better-informed determinations of whether a service is "medically necessary" in a particular case, or whether a service is "experimental" or "investigational"²³⁸ and therefore properly excluded under the policy terms.

The latter determinations are especially dependent on medical expertise because the line between proven "experimental" or "investigational" medical practices is blurred, thus creating a "twilight zone between promising and unproven

234. Cf. *supra* note 163 and accompanying text.

235. See *supra* note 164 and accompanying text.

236. Hall & Anderson, *supra* note 164, at 1711.

237. *Id.* at 1710.

238. Generally, if the effectiveness of a treatment is widely doubted, the treatment is considered "experimental." A treatment already shown to be beneficial in some circumstances, but not others, is "investigational." See Hall & Anderson, *supra* note 164, at 1648 n.32. A typical policy excludes experimental care with language similar to the following: "To be considered medically necessary a service or supply must [be] . . . neither *educational nor experimental* in nature nor provided primarily for research purposes." *Id.* at 1647 n.32 (quoting policy at issue in *Dozsa v. Crum & Forster Ins. Co.*, 716 F. Supp. 131, 134 (D.N.J. 1989)).

treatments."²³⁹ For example, in the early years of treating breast cancer through bone marrow transplants, the practice was generally viewed as "experimental" because its effectiveness was supported more by doctors' hunches than by conclusive evidence.²⁴⁰ The procedure improved as it evolved; as with any treatment, greater experience led to safer and more effective techniques. Further improvements are still possible, but in light of the extensive research on the procedure few insurers still deny coverage on the ground that the transplants are experimental.²⁴¹

As once-experimental treatments become routine, new treatments raise the same questions. For example, HMOs sometimes balk at the practice of recommending a long-established drug for uses other than those approved by the FDA.²⁴² About half of all prescriptions in the U.S. are "off-label,"²⁴³ often only because a pharmaceutical company has not bothered to invest the time and money to obtain FDA approval for a new use of a drug that has already been proven safe.²⁴⁴ The practice received little attention from HMOs until desperate doctors began to prescribe expensive drugs in the hope that they might help patients with AIDS and advanced cancers.²⁴⁵

Where no evidence exists to support an "off-label" prescription, the HMO may deny the treatment as "investigational."²⁴⁶ Presumably, however, most prescribing physicians have at least some valid reason to believe that an unconventional use of the drug may be beneficial.²⁴⁷ Thus, whether such a prescription

239. Larson, *supra* note 35, at 45 (quoting a physician's description of bone marrow transplants for breast cancer patients); see Hall & Anderson, *supra* note 164, at 1648 n.32 (describing the evolution of a new medical treatment).

240. See Larson, *supra* note 35, at 48 (discussing insurers' attitudes toward bone marrow transplants).

241. See *id.* (estimating that three out of four insurers covered bone marrow transplants in the treatment of breast cancer by 1990).

242. See Christine Gorman, *Double-Duty Drugs*, TIME, Sept. 18, 1995, at 96, 96 (describing this "shadowland of medical practice"). Prescribing medication to treat an ailment for which it was not intended is known as "off-label prescribing." See *id.* For example, the nicotine patch may relieve intestinal inflammation, a cancer drug and an ulcer drug may be combined to induce abortion, and Prozac is sometimes used to treat obesity. See *id.* at 96-97.

243. *Id.* at 96 (citing the American Medical Association estimate).

244. See *id.*

245. See *id.*

246. See Hall & Anderson, *supra* note 164, at n.32.

247. See generally Gorman, *supra* note 242 (discussing the widespread use of off-label prescriptions).

is covered depends on the sufficiency of the medical evidence.²⁴⁸ Yet, HMOs will allegedly label a procedure “experimental” or “investigational” because of its high costs rather than its unproven merit.²⁴⁹ Instead of the court relying on biased expert testimony, a neutral physician, unaffiliated with either the patient or the HMO is best qualified to synthesize clinical studies and other evidence. Such physicians will be able to detect pretextual excuses for denying care yet still allow HMOs to refuse funding for treatments that scientific research has not shown to be beneficial. An administrative arbitration procedure could provide for such analysis.

4. *Repeal burdensome “mandated benefits,” “any willing provider,” and “freedom of choice” laws*—Legislation adopted to effect the three reform principles above, while preventing HMO abuses, may also result in increased operating costs for HMOs. This effect may be partially offset by freeing HMOs from the burdens of existing legislation that raises health care costs while affording enrollees minimal protection. Lawmakers’ continuing focus on “mandated benefits,” “any willing provider,” and “freedom of choice” provisions has diverted attention from measures that would better guarantee health benefits to the seriously ill.²⁵⁰ The repeal of these measures would restore basic cost-reducing elements of managed care. Moreover, by permitting each HMO the freedom to customize the package of benefits it offers and to select the providers from which its enrollees may obtain care, lawmakers could facilitate greater diversity in the health care marketplace.²⁵¹

248. See Hall & Anderson, *supra* note 164, at n.32.

249. One physician formerly employed by HMOs to conduct utilization reviews confessed: “If there was any way at all to claim that something requested was experimental or nonstandard, we took it. We looked for ways *not* to cover treatment.” Brink, *supra* note 163, at 70.

250. See Stephanie L. Stein, *Challenge to H.M.O.’s Maternity Limits*, N.Y. TIMES, Jan. 14, 1996, § 13, at L.I. 9 (noting doctors’ concern that the debate over a “mandated benefits” provision requiring 48-hour hospital stays following childbirth “allows politicians to take a popular stand while shirking the real problem of comprehensive . . . health care coverage”); cf. Freeman L. Farrow, Note, *Drive-Through Deliveries: In Support of Federal Legislation to Mandate Insurer Coverage of Medically Sound Minimum Lengths of Postpartum Stays for Mothers and Newborns*, 29 U. MICH. J.L. REFORM 1039 (1996) (supporting the recently enacted Newborns’ and Mothers’ Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874 (West, WESTLAW through 1996 2d Sess.)).

251. Greater diversity may not immediately result in more choices for HMO enrollees whose HMOs are selected by their employers. Employers, however, are increasingly responsive to employee concerns regarding HMO care. See Mahar, *supra* note 2, at 29–30; Dolinsky & Caputo, *supra* note 75, at 25, 26. With greater

The extensive "mandated benefits" initiatives enacted by most state legislatures require all HMOs within the state to cover a list of specific services, or to cover services generally supplied by certain providers.²⁵² A number of these initiatives may be unnecessary because they ensure the provision of the type of preventative, low-cost, and routine services that HMOs will provide without a mandate in order to remain attractive to enrollees.²⁵³

Lawmakers should be selective in choosing the benefits every HMO must provide. For example, these laws are appropriate for otherwise uninsurable risks that the legislature has reason to spread among all HMO enrollees, or in cases where public policy favors coverage to lessen the strain on social service agencies. More frequently, appropriate "mandated benefits" are those that the enrollee would not receive in the absence of legislation, even though he desires such benefits and would willingly pay higher premiums for it. The policy an enrollee signs may not cover such treatments because it is an adhesion contract, meaning that the enrollee and HMO do not actually bargain over each provision. "Mandated benefits" laws prevent HMOs from omitting certain desired coverages.

Problems arise, however, where "mandated benefits" laws successfully create coverages for which the HMO and enrollee would not otherwise have bargained. With each new "mandated benefits" provision, HMOs must either raise premiums or cut expenses elsewhere.²⁵⁴ As premiums go up, enrollees lose the cost benefits of subscribing to a managed care plan; where an HMO holds down prices by cutting back on services, patient care is compromised. Health care providers have voiced concern that "less money can be spent on basic health care as funds are rerouted to cover the mandates."²⁵⁵ The alternative is perhaps more frightening: "mandated benefits" coverage may threaten not only basic services but also expensive but potentially lifesaving services. An HMO may conclude that cuts in "basic" care will be apparent to enrollees, but that

differentiation between HMOs, more employers might be expected to allow employees to select from among several competing HMOs.

252. See *supra* notes 122-24 and accompanying text.

253. See Gottlieb, *supra* note 10, at 9 (noting that "services like home care and chiropractors" are factors potential enrollees use to distinguish HMOs that otherwise appear similar).

254. See Carneal & Gallmetzer, *supra* note 95, at 286.

255. *Id.*

the typical, relatively healthy enrollee will be unaware of the HMO's questionable case-by-case denials of costly services for the seriously ill.²⁵⁶ Either way, laws that force enrollees to purchase benefits they do not want lessen enrollees' ability to afford the coverage they do want.

"Mandated benefits" laws also create a powerful incentive for businesses to cancel their HMO contracts and self-fund their employee health plans instead.²⁵⁷ Employers selecting this option pay for the care provided to employees themselves but usually contract with insurers for claims processing and administration.²⁵⁸ An insurer eager to fill this role will attempt to hold down the employer's costs and may do so free of any protections employees might have enjoyed previously under state HMO law.

Other initiatives, known as "any willing provider" laws, generally require an HMO to accept into its network any provider willing to meet the HMO's terms.²⁵⁹ By broadening the array of doctors an enrollee may choose, sponsors of these laws hope to prevent HMOs from denying patients access to doctors that are more generous in recommending patient care.²⁶⁰ If an HMO, however, cannot hand-pick its providers, it must contract with the worst available physicians as well as the best.²⁶¹ The effectiveness of these laws is questionable, because physicians who most ardently oppose HMO cost-cutting measures are probably least likely to join an HMO network even if the HMO cannot keep them out. Finally, the Federal Trade Commission has advised nine states that "any willing provider" laws "pose a serious anti-competitive threat."²⁶² Responding to these

256. Of course, the protections against HMO misconduct proposed above in Part IV.A.1-3 might aid in preventing such misconduct. In doing so, however, these protections only will force an HMO squeezed by the costs of "mandated benefits" to resort to price hikes or the reduction of "basic" services.

257. See Cohodes, *supra* note 56, at 84 (estimating that for more than a decade, 60% of businesses with more than 5000 employees have self-funded their employee health plans).

258. See *id.*

259. See Carneal & Gallmetzer, *supra* note 95, at 282.

260. See Auerbach, *supra* note 68, at 15.

261. See HIRSH & WILCOX, *supra* note 8, at 39 (encouraging HMOs to eject incompetent doctors and doctors who overtreat patients in their provider networks); Mahar, *supra* note 2, at 34 (quoting the complaint of an employer's health care information manager that "[m]any plans will sign up just about any doctor in the state, which means, by definition, that you don't get the highest quality").

262. Carneal & Gallmetzer, *supra* note 95, at 283. *But see* HIRSH & WILCOX, *supra* note 8, at 48 (rejecting the concerns expressed by the Federal Trade Commission and disapproving the Texas legislature's rejection of "any willing provider" laws in 1993).

concerns, the National Association of Insurance Commissioners (drafters of the HMO Model Act) and the National Governors Association oppose such laws.²⁶³

Most importantly, lawmakers should reject "freedom of choice" initiatives that allow HMO enrollees the opportunity to obtain HMO coverage for care obtained outside the HMO's provider network.²⁶⁴ These laws permit enrollees to circumvent virtually all of the cost-containment mechanisms utilized by HMOs to hold down the costs of medical care. An HMO unable to limit patients to those physicians it has selected for their cost-conscious practice styles or to control enrollees' access to medical specialists cannot offer premiums substantially lower than those in a traditional fee-for-service health insurance plan.²⁶⁵

B. Democratizing HMO Regulation

Under the current regulatory scheme, HMOs too often deny the care their enrollees want most. Most notably, enrollees expect their HMOs to respect their own adherence to the Rule of Rescue, and not stand idly by where serious harm or a death might be prevented. If confronted with the question directly, a prospective enrollee choosing between coverage options might insist upon an HMO that will provide a bone marrow transplant should he ever need one; he may be willing either to pay a higher price for this coverage or to accept that other expensive therapies will not be available. Such an exercise in medical prioritizing requires an enrollee to exercise his judgment in a way that is deeply personal and that may well depend on his idiosyncratic preferences or knowledge of health risks. The reform proposals above work together toward furthering

263. See Carneal & Gallmetzer, *supra* note 95, at 283.

264. See, e.g., ME. REV. STAT. ANN. tit. 24A, § 4227 (West Supp. 1995) (requiring employers who offer an HMO to offer the option of selecting alternative benefits coverage as well).

265. Less ambitious "freedom of choice" statutes, such as those that merely allow enrollees and plan providers to obtain prescription drugs and medical supplies from any source, do not significantly affect either HMO costs or patient care. See, e.g., OR. REV. STAT. § 441.084 (1995) (requiring that patients in a licensed health care facility have a choice among prescription drug delivery systems); VA. CODE ANN. § 38.2-4312.1 (Michie Supp. 1996) (ensuring the right of HMO subscribers to unlimited selection of pharmacies).

medical decisionmaking that is faithful to patient preferences. Through these reforms, the law may more effectively compel HMOs to deliver the services considered essential by their own enrollees while leaving HMOs free to deny services that enrollees regard as wasteful.

Ensuring that prospective enrollees may choose from different health plans is an important first step toward health care decisions based on patient preferences. First, a patient's most basic medical judgments affect the number of dollars she is willing to spend on health care. Some buyers of health coverage may be willing and able to join an expensive plan covering any service a physician recommends.²⁶⁶ Another health care consumer, perhaps with less to spend on medical care and aware that aggressive medical interventions often do more harm than good,²⁶⁷ may well conclude that "the best use of his insurance dollar is to insure against only the least expensive acceptable course of treatment."²⁶⁸

Second, these basic judgments determine how a patient would allocate her health care dollars to buy coverage against different types of health risks. One enrollee might desire mostly to avoid pain and illness during the healthiest years of her life, figuring that no amount of coverage will provide tangible benefits in, for example, the final stages of terminal cancer. Another enrollee might take a different view, deciding that she can pay minor health care expenses out-of-pocket, but that she needs assurance that her health plan will cover any treatment, even at high cost, that may someday help her cope with a catastrophic illness.

If given the option, these two patients would surely join different HMOs. To do so, prospective enrollees must be free to contract for benefits they want while excluding others that they determine are not worth their costs. "Mandated benefits" laws restrict patient choice by preventing an enrollee from selecting an HMO that will not charge for unwanted coverages.²⁶⁹ Other laws, however, are necessary if enrollees' choices between HMOs are to be meaningful. In addition to the disclosures now mandated by law, HMOs should be required to reveal in marketing materials the financial incentives they offer to providers and an explanation of how these incentives

266. Cf. Hall & Anderson, *supra* note 164, at 1682.

267. See *supra* notes 47-50 and accompanying text.

268. Hall & Anderson, *supra* note 164, at 1682.

269. See *supra* Part IV.A.4.

reward doctors who cut costs.²⁷⁰ Armed with this information, a prospective enrollee may choose an HMO whose practices are consistent with his own notions of how health care dollars should be allocated.

Of course, a patient's choice of HMO leaves more specific questions unanswered. How should an HMO determine, for example, whether its enrollees consider "essential" expensive drug therapies that may extend the lives of people with cancer? Once the cancer is detected, it is of course too late; a patient who knows she is a candidate for these costly drugs cannot possibly weigh the benefits of the medicines to her against the costs to the HMO and the increased premiums that all enrollees will have to pay. Because such a patient cannot fairly fix an amount the HMO should pay for the care she needs, she cannot rank this care against other services competing for the limited resources of the HMO.

To circumvent this problem, enrollee preferences must be determined at the time of enrollment with the HMO, before health problems and the need for services arise. In Rawlsian terms, patient priorities must be expressed from behind a "veil of ignorance."²⁷¹ From this position, enrollees "do not know how the various alternatives will affect their own particular case."²⁷² Therefore, "they are obliged to evaluate principles solely on the basis of general considerations"²⁷³ instead of on the basis of what health care priorities will work to their advantage.

Unfortunately, no reliable method exists to ascertain a patient's priorities as of the date of enrollment. One simply cannot tell if a patient who enrolled in a top-of-the-line HMO thought he was purchasing coverage for high-cost drug therapies, for access to medical specialists, for any one of many expensive coverages, or even if he gave the question any thought at all. Researchers have found that despite sincere efforts, people generally cannot place a dollar amount on the value of reducing risks involving pain or death.

This phenomenon has been explored by Professor Thomas Schelling,²⁷⁴ who explains that ordinarily there are two methods

270. See *supra* Part IV.A.2.

271. See JOHN RAWLS, A THEORY OF JUSTICE 136 (1971).

272. *Id.*

273. *Id.* at 137.

274. Professor Schelling observes that "avoidance of a particular death—the death of a named individual—cannot be treated straightforwardly as a consumer choice. It involves anxiety and sentiment, guilt and awe, responsibility and religion." Thomas

of determining whether the benefits of a consumer choice exceed its costs. Of course, one can simply ask the consumer what the benefit is worth.²⁷⁵ Alternatively, one can observe his selections from options available in the market.²⁷⁶

Neither approach is entirely satisfactory in the health care purchasing context.²⁷⁷ Because "people are poor at answering hypothetical questions, especially about important events,"²⁷⁸ buyers of health care are rarely able to articulate their feelings about medical crises that may never arise. Nor can they predict what their needs might be in a crisis in order to form entirely rational purchasing decisions now; when considering possible future dilemmas "the mood and motive of actual choice are hard to simulate."²⁷⁹ These difficulties inevitably arise, Schelling explains, when conceptualizing "a minute probability of an awesome event."²⁸⁰ Thus, an enrollee's statements about which health care services and outcomes he values most highly may reveal more about the mood and circumstances under which the statements were made than about his underlying values.²⁸¹ For these reasons, while the information gleaned from a patient's choice among health plans may reveal his general stance toward high-cost medical care, it sheds little light on whether he would have found any particular service to be worth its costs. Because patients seem incapable of these types of decisions, an alternative is needed.

The best choice is to place these judgments in the hands of the primary-care physician.²⁸² First, no potential decisionmaker is better able to gain the patient-specific information needed in order to make care decisions that reflect a patient's medical priorities. Professor David Mechanic notes: "Patients vary

C. Schelling, *The Life You Save May Be Your Own*, in PROBLEMS IN PUBLIC EXPENDITURE ANALYSIS 127, 142 (Samuel B. Chase, Jr. ed., 1968).

275. *See id.* at 142.

276. *See id.*

277. *See* BARRY R. FURROW ET AL., THE HEALTH CARE ORGANIZATION AND FINANCE 326-27 (1991) (explaining that patients often cannot make rational health care purchasing decisions, resulting in "demand distortions" in the market).

278. Schelling, *supra* note 274, at 143.

279. *Id.*

280. *Id.* at 144.

281. *See id.* at 142-46.

282. *Cf.* Cohodes, *supra* note 56, at 102-03. Cohodes notes that managed-care doctors "are asked to make trade-offs between treatment costs and benefits," and concludes: "Physicians are ill-suited by training and inclination to undertake such responsibilities. Nonetheless, they have been placed in a position where they must." *Id.*

enormously in their willingness and ability to withstand pain and discomfort, to tolerate uncertainty, to fight to overcome illness, and even to stay alive."²⁸³ Compared to other possible health care decisionmakers, Professor Mechanic observes, a patient's physician is "more likely to understand the complexity of the patient's clinical condition, the social and familial consequences of the illness, patient and family preferences for conservative or aggressive care, and the value placed on possible future outcomes."²⁸⁴

Proximity to their patients alone is not sufficient for a physician to obtain this information; in addition, the doctor and patient must have an ongoing relationship built on trust. A patient may be unwilling to discuss candidly the above factors with his physician if he knows that his physician may have the final say in denying him care. Accordingly, patients should be aware at all stages of treatment that they have practical options to contest physicians' decisions both within and outside the HMO.²⁸⁵ In addition, patients should be told of the financial incentives offered to their physicians to avoid unfounded suspicions about a physician's loyalties based on news reports and fostered by an atmosphere of secrecy.²⁸⁶

Of course, no physician will understand perfectly how each of her patients perceives his own medical needs. However, doctors are best situated to supplement what they do know about each patient with an understanding of the needs patients generally encounter when they face medical problems. In contrast, HMO administrators generally lack recent clinical experience,²⁸⁷ and, like lawmakers, are removed from the clinical encounter.²⁸⁸

A primary care physician is also best positioned to make decisions faithfully reflecting her patients' preferences because she shares their goals for treatment. First, because of her proximity to her patients, a physician is likely to empathize with them, resisting modes of care that do not reflect enrollees' wishes. Psychologists have demonstrated that decisionmakers who are more removed from the subjects of their decisions are

283. Mechanic, *supra* note 92, at 1728.

284. *Id.* at 1727-28.

285. *See supra* Part IV.A.3.

286. *See supra* text accompanying note 213.

287. *See* Mechanic, *supra* note 92, at 1728.

288. *Cf. id.*

most willing to make decisions that will hurt them.²⁸⁹ Distant decisionmakers are accordingly more likely to impose losses that would be unacceptable to a patient, physician, or observer who will witness the consequences firsthand. This principle helps to explain why, when decisions are left to HMO administrators, HMOs sometimes exhibit a chilling disregard for enrollees' most urgent medical needs.²⁹⁰ Physicians are more inclined to heed the Rule of Rescue and to reject extreme cost-cutting measures that will lead to an avoidable loss.

Naturally, if physicians' decisions are to emulate the choices that would be made by a patient purchasing insurance—and not a patient actually facing a crisis—the physician must also have an opposing incentive to hold down costs. HMOs that offer their physicians moderate incentives or adopt reasonable withholding policies²⁹¹ may provide physicians with a motive to control costs that is roughly as powerful as a health care buyer's incentive to keep premiums low. An HMO physician should never be subject to incentives so coercive that they exceed the enrollees' own desire to cut costs, such as a system of pure capitation.²⁹²

Taking steps to align the interests of patient and physician will help to ensure that HMOs provide the care patients most want. Where feasible, HMO physicians would surely favor coverage for the types of care denied by HMOs in the horror stories. If a physician understands his patient's needs and is not swayed by overpowering financial incentives, it is unlikely that he would deny a breast cancer patient a necessary bone marrow transplant²⁹³ or insist that a prostate cancer patient undergo surgery when effective medicines are available.²⁹⁴

At the same time, where the impact of the Rule of Rescue must be limited, the clinical setting provides the best context for doing so. One might imagine that however urgently a patient about to undergo an internal X-ray may want his HMO to provide the expensive fluid with a lower risk of unforeseen complications, he would not have agreed upon enrollment to pay his share of the billion-dollar annual cost as part of his

289. *See id.* at 1728 & n.59 (citing STANLEY MILGRAM, *OBEDIENCE TO AUTHORITY* 32–43 (1969)).

290. *See supra* notes 2–6 and accompanying text.

291. *See supra* Part IV.A.1.

292. *See supra* Part IV.A.1.

293. *See supra* note 3 and accompanying text.

294. *See supra* note 4 and accompanying text.

premium. Likewise, physicians in an HMO governed by the four reform principles are likely to identify cases where the Rule of Rescue would lead to costs that the public would view as excessive.

This procedural approach is also the most palatable way to limit the Rule of Rescue, because patients are most likely to accept such decisions when they are made in the clinical setting. Patients are understandably wary of broad, inflexible edicts from health care administrators denying certain services despite their potential to save lives but are less disturbed when similar results are reached in case-by-case determinations involving a familiar physician.²⁹⁵ Thus, professional judgment is the tool best suited to the task of establishing rational criteria for determining the limits of medical insurance coverage while simultaneously satisfying patients' basic desire for insurance customized to their health needs.²⁹⁶

Patients must find allies in the health care system who will serve as reliable stand-ins to advocate expensive but vital services when appropriate and to explain HMOs' limited ability to provide some services where a genuine limit exists. Because in a managed care system patients have needs that are not purely medical, physicians in HMOs must supply more than medical expertise. They must also serve as "professional decision makers, who not only diagnose but decide for the consumer, because they decide with less pain, less regret, cooler nerves, and a mind less flooded with alternating hopes and fears."²⁹⁷ With legal measures in place to ensure that treatments selected by HMO enrollees and their physicians are both effective and cost-effective, the HMO decisionmaking process may be carried out "democratically, by letting the consumers decide for themselves"²⁹⁸ where possible, and in other cases by leaving detailed decisions to their physicians, whose preferences most nearly mimic their own.

295. See Mechanic, *supra* note 92, at 1745 (observing that "in the clinical setting, patients will be agreeable to physician decisions because they view them as medical rather than political") (citing Thomas Halper, *Who is the Odd Man Out? The Experience of Western Europe in Containing the Costs of Health Care*, 63 MILBANK MEMORIAL FUND Q. 52, 73-78 (1985)).

296. See Hall & Anderson, *supra* note 164, at 1672.

297. Schelling, *supra* note 274, at 147.

298. *Id.*

CONCLUSION

Frightened by "horror stories" about HMOs that refuse expensive but vital services to their sickest enrollees, patients no longer trust their HMOs to heed the Rule of Rescue and make medical decisions that respect the sanctity of life. Yet efforts to regulate HMOs have reinforced the routine, low-cost health care at which most HMOs already excel, instead of addressing patients' deepest concerns. State legislatures should enact safeguards that will both preserve HMOs' defining cost-reducing features and prevent HMOs from victimizing their most vulnerable enrollees. Reform measures may abate the concerns of anxious patients and restore their faith in managed care by improving the choices available in the health care market, empowering patients to contest HMO decisions, and placing more care decisions within the discretion of trusted primary-care physicians.