

Gagging Physicians: Is That What the Legislature Intended?

In 1996, the California legislature took steps to modify existing contractual relationships between physicians and managed care organizations (“MCOs”).¹ Legislative action was prompted by skyrocketing medical malpractice verdicts, cries from physicians about unfair treatment caused by new payment systems, and media hysteria. Regardless of which straw broke the proverbial camel’s back, the result was no fewer than four bills that promise to forever change health care in California.

I. HEALTH CARE TURMOIL

In California, health care turmoil grows from the interaction of many forces. California health care law, although extensive, did not explicitly address the pressures exerted on both doctors and patients by managed care organizations. The common law doctrine of informed consent clashes with the manner in which courts interpret health insurance contracts.² Moreover, uncertainty as to whether liability attaches to the actions of the physician or the MCO adds further confusion.³ Finally, extensive MCO penetration exacerbates these problems by permitting MCOs to exert a great deal of pressure on physicians by shifting both legal and financial risk to the physician.⁴

1. Managed care organizations are entities which arrange health care services by providing enrollees an incentive to use a network of providers working directly for, or under contract with, the MCO and providing services based on pre-determined compensation arrangements and monitored by a management system which ensures that the services provided are both medically necessary and cost efficient. James P. Freiburg, *The ABCs of MCOs: An Overview of Managed Care Organizations*, 81 ILL. B.J. 584, 585 (1993).

2. See *infra* notes 5-12 and accompanying text.

3. See *infra* notes 13-53 and accompanying text.

4. See *infra* notes 54-92 and accompanying text.

A. The Law

1. Informed Consent

In California, liability for medical malpractice stems from failure to possess and exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by other members of the profession.⁵ Additionally, physicians must receive informed consent from their patients prior to performing any procedures.⁶ Stringent disclosure requirements grow from a patient's need to rely upon the physician to learn of their health care needs.⁷ The scope of a physician's duty to disclose is measured by the amount of knowledge a reasonable patient requires to make informed health care decisions.⁸ When defining the physician's duty to disclose, the courts carefully avoid tying disclosure requirements to a standard set by the medical community.⁹ A physician-created standard would undermine a patient's right to obtain all necessary information. Under such a standard, the only information provided would be that which the physician felt is important,¹⁰ including any profit motive which the physician may possess.¹¹ Failure to obtain proper informed consent leaves the physician open to liability for negligence and/or battery.¹² More importantly, a physician's failure to obtain informed consent infringes on the patient's right to make truly informed health care decisions.

5. See *Landeros v. Flood*, 551 P.2d 389 (Cal. 1976). Rarely is the community standard of care based upon "careful thought or scientific reasoning." E. Haavi Morriem, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1731 (1987).

6. See *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972).

7. See *Truman v. Thomas*, 611 P.2d 902, 905-06 (Cal. 1980).

8. See *id.* at 905. Adequate informed consent requires disclosure of all that a reasonable patient may find material, including a physician's personal interests unrelated to a patient's health. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990).

9. See *Cobbs*, 502 P.2d at 9-10.

10. *Id.*

11. In making a decision to undergo treatment, a reasonable patient will want to know that his physician is free from profit motive. See *Moore*, 793 P.2d at 483 (citing *Magan Med. Clinic v. California State Bd. of Med. Exam'rs*, 57 Cal. Rptr. 256, 262 (1967)); but cf. Marc A. Rodwin, *Physicians' Conflicts of Interest, The Limitations of Disclosure*, 321 NEW ENG J. MED. 1405, 1406 (1989) (disclosure of financial interests is insufficient to inform most patients).

12. See *Cobbs*, 502 P.2d at 8. Failure of informed consent is governed under principles of negligence except in cases where there is clear deviation from the consent given by the patient.

2. *Contract Interpretation*

The California Supreme Court addressed the issue of interpreting health care insurance contracts in *Sarchett v. Blue Shield of California*.¹³ The court carefully examined defendant Blue Shield's contract language and retrospective utilization review policies.¹⁴ Plaintiff Sarchett first argued the contract was ambiguous because it did not explicitly state who would determine which health care services were covered.¹⁵ Following the lead of an Ohio court, the *Sarchett* court stated "[a] function, basic to the insurer, is the right ' . . . to determine whether . . . [a] claim should be allowed or rejected.'"¹⁶ The contract explicitly stated that a disinterested third party would decide which benefits were covered, so that the insurer provided a fair method to decide whether they should allow or reject a claim.¹⁷ Moreover, insurers have the right to challenge the medical necessity of physician recommended treatments in adjusting the claim.¹⁸

The court then reviewed the case under the doctrine of reasonable expectations.¹⁹ Insured parties "reasonably expect to be covered for hospitalization recommended by the treating physician."²⁰ They "reasonably expect" that any treatment recommended by their physician is in accord with good medical practice and is, therefore, covered by the insurance plan.²¹ A carefully fashioned holding stated insurance companies must construe insurance policy language liberally to meet these expectations.²² Insurers must construe contractual uncertainty in favor of coverage, although they may still review a physician's recommendations for reasonableness.²³ It will be the rare case in which

13. 729 P.2d 267 (Cal. 1987).

14. *See id.* In retrospective utilization review, the health management program reviews medical records and charts to determine if the treatment decision was appropriate. If not, payment may be denied. *See* MARC A. RODWIN, MEDICINE, MONEY, AND MORALS 112 (1993). Denial of payment creates incentive to only perform necessary services since the physician may not be compensated for those deemed unnecessary. *See id.*

15. *See Sarchett*, 729 P.2d at 270-71.

16. *Id.* at 273 (citing *Lockshin v. Blue Cross*, 434 N.E.2d 754, 756 (Ohio 1980)).

17. *See id.*

18. *See id.*

19. *See id.*

20. *Sarchett v. BlueShield*, 729 P.2d 267, 273 (1987).

21. *Id.*

22. *See id.*

23. *See id.*

the physician's judgment is so plainly unreasonable or contrary to medical practice to permit denial of coverage.²⁴

The court declined the invitation to declare retrospective review procedures violative of public policy.²⁵ Rather, the court noted Sarchett had been provided the option of enrolling in another health plan which would have covered all physician recommended treatments, but which required the insured to use pre-designated physicians.²⁶

To be sure, *Sarchett* provided notice to insurance companies and MCOs that the courts will take a strong stance against the denial of those benefits which insured parties reasonably expect to receive. This is especially true in instances when an insured's physician suggests a procedure will be covered. Thus, because the doctrine of informed consent requires disclosure of all that a patient may find material, often a physician's communications with a patient will create reasonable expectations of coverage.

3. *Where Should Liability Be Placed?*

a. *On the Physician?*

In *Wickline v. State*,²⁷ the California Court of Appeals analyzed the possibility of extending liability to MCOs when they make inappropriate medical decisions.²⁸ Because Ms. Wickline did not respond well to her medical treatment, her doctor arranged for vascular therapy.²⁹ After a series of complications relating to her circulatory system, Ms. Wickline's discharge date arrived.³⁰ Her treating physicians requested

24. *See id.* at 275. While Sarchett argued that retrospective review should be against public policy because it forces a patient to consent to a treatment that may later not be covered, retrospective review at least "finances" the operation during the interim period, allowing the patient to obtain treatment. Although a patient may later find that they must pay for services, they have, at least, been able to obtain medical care.

25. *See id.* at 274.

26. *See id.* By limiting physician selection in the program without retrospective utilization review, the health care provider controls the information given to a patient and thus limits the care which may be provided. *See* ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW 436 (1996).

27. 239 Cal. Rptr. 810 (1987).

28. *See id.* at 811. *Wickline* is factually different from *Sarchett* in that the plaintiff suffered actual injury resulting from denial of benefits. *See id.* at 811, 817. Prospective utilization review was used in *Wickline*. *See id.* at 811. Prospective review evaluates medical necessity in advance of treatment in order to screen out potentially unnecessary treatments. *See id.* at 812; *see also* Vernellia R. Randall, *Managed Care, Utilization Review and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 27 n.112 (1993).

29. *See Wickline*, 239 Cal. Rptr. at 812.

30. *See id.* at 813.

her hospital stay be extended by eight days.³¹ Unfortunately, a Medi-Cal decision based on factors unrelated to her circulatory problems allowed an extension by only four days.³² Following discharge, clotting restricted circulation in Ms. Wickline's leg.³³ Ms. Wickline's physicians readmitted her and attempted to save her leg.³⁴ However, the physician's efforts were unsuccessful and Ms. Wickline's leg was amputated below the knee.³⁵

Ms. Wickline filed a medical malpractice action alleging Medi-Cal negligently reviewed her medical situation.³⁶ The court denied Ms. Wickline recovery holding instead that liability attaches to the acts of physicians, not MCOs.³⁷ The physician's medical judgment, not the Medi-Cal decision, ultimately caused Ms. Wickline to be discharged.³⁸ Thus, the court stated in dicta that when a physician's medical determination is wrong, the physician may not avoid liability by merely pointing to the health care payor as a scapegoat, particularly in those circumstances where the physician fails to advocate on behalf of his patient.³⁹ However, the court also noted that a patient deprived of appropriate care may recover against "those responsible for the deprivation of such care, including, when appropriate, health care payors."⁴⁰ Accordingly, when a physician's appeal for medical benefits on behalf of a patient is "arbitrarily ignored, unreasonably disregarded or overridden," liability for any resultant injury may shift to the MCO.⁴¹

b. On the MCO?

In 1990, the California Court of Appeal, revisited the *Wickline* issues in *Wilson v. Blue Cross*.⁴² Mr. Wilson suffered from major depression, drug dependency, and anorexia.⁴³ Mr. Wilson's insurance company,

31. *See id.*

32. *See id.* at 814.

33. *See id.* at 816.

34. *See id.*

35. *See id.* at 817.

36. *See id.* at 811.

37. *See id.* at 819.

38. *See id.*

39. *See id.*

40. *Id.*

41. *Id.*

42. 271 Cal. Rptr. 876 (1990).

43. *See id.* at 877.

through a utilization review procedure, denied Mr. Wilson's request for four additional weeks of inpatient care.⁴⁴ Based on the utilization review findings, Mr. Wilson was discharged.⁴⁵ Shortly thereafter, Mr. Wilson committed suicide.⁴⁶

The trial court granted the defendant's motion for summary judgment which was premised on dicta in *Wickline* stating that a physician who fails to advocate for a patient is liable for any injury the patient suffers.⁴⁷ The Court of Appeal found a triable issue of fact as to whether the availability of an appeal by the physician would have proven "as a matter of law that his demise was unrelated to his denial of benefits" and subsequently overturned the summary judgment.⁴⁸

The Court of Appeal distinguished the facts in *Wilson* from those in *Wickline* on three grounds. First, the decision of the Medi-Cal review board in *Wickline* complied with the standard of care required of physicians.⁴⁹ Second, the parties' relationship in *Wickline* was based on statute, while the relationship of the parties in *Wilson* arose from contract.⁵⁰ Third, *Wickline* was not a case where cost control corrupted medical judgment.⁵¹

c. Possibilities

Unfortunately, the *Wilson* court did not state exactly when or how liability attaches to the third party payor. However, a broad reading of *Wilson* in conjunction with *Wickline* permits several inferences to be drawn about the placement of liability. Essentially, the MCO will be liable to the malpractice victim when: (1) it improperly or wrongfully denies benefits; (2) its decisions do not comport with the medically required standard of care; or (3) its decisions are motivated by cost control resulting in corrupted medical judgment.⁵²

When deciding *Wilson*, the Court of Appeal was apparently concerned that a truly negligent MCO could avoid liability by advancing the arguments contained in the *Wickline* dicta. The growth of managed care in the years between the decisions may account for the change in

44. See *id.* at 877-78.

45. See *id.* at 878.

46. See *id.*

47. See *id.*

48. *Id.* at 885.

49. See *id.* at 879.

50. See *id.*

51. See *id.*

52. See also, Kenneth R. Pedroza, Comment, *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 427 (1996) (suggesting that when an MCO's denial of care is a substantial factor in the resulting harm, liability should attach).

position articulated in *Wilson*. Unfortunately, since the decision in *Wilson*, the courts have published no further opinions discussing the placement of liability.⁵³

B. The Facts

1. Demographics

MCOs enroll approximately thirteen million of California's thirty-two million citizens.⁵⁴ In 1995, California MCO enrollment grew by 1,325,818 new members.⁵⁵ A 1995 study of six California medical groups showed the number of enrollees covered by capitated health plans grew by ninety-one percent between 1990 and 1994.⁵⁶ The number of Californians in managed care will continue to grow, possibly at an accelerated rate, as changes in Medicare force more elderly into MCOs.⁵⁷

California's five largest MCOs enroll approximately seventy-two percent of the MCO members (nine million MCO patients).⁵⁸ If two pending mergers are completed, the resulting three MCOs will enroll all these patients.⁵⁹ As a consequence of these mergers, the amount of

53. However, some commentators have suggested that *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156 (1982), which holds hospitals liable for injury to patients, should also apply to MCOs because of the similarity of relationship between hospital and patient and that between MCO and patient. See, e.g., Rex O'Neal, Note, *Safe Harbor for Health Care Cost Containment*, 43 STAN. L. REV. 399, 413-14 (1991).

54. See Vincent J. Schodolski, *Alleged HMO Abuses Spur California Ballot Issues*, CHI. TRIB., Aug. 13, 1996, at N1.

55. See *HMO Enrollment Up Despite Profit Decline*, MANAGED CARE OUTLOOK, Nov. 1, 1996, at 64.

56. See James C. Robinson & Lawrence P. Casalino, *The Growth of Medical Groups Paid Through Capitation in California*, 333 NEW ENG. J. MED. 1684, 1684 (1995). This is despite a California recession that resulted in a large loss of jobs and correspondingly health insurance. See *id.* at 1685.

57. See Robert A. Rosenblatt, *Big Increases in Medigap Premiums Expected in '97 Health Care*, L.A. TIMES, Oct. 25, 1996, at D1; cf. JOHN R. WOLFE, *THE COMING HEALTH CRISIS* 10-32 (1994) (discussing trends in which the elderly are becoming a larger portion of the population).

58. See David R. Olmos, *HMOs Shut Out of the Latest Trends in Health Care*, L.A. TIMES, Oct. 27, 1996, at A1; Robert E. Olsen, *Employers May Want to Look at Care Options*, BUS. INS., Jan. 27, 1997.

59. See Olmos, *supra* note 58, at A1. PacifiCare is to acquire FHP and Foundation Health is planning to merge with Health System's International. The third MCO is Kaiser Permanente. See *id.*

control MCOs will have over the patient market will ensure they will not need to meet either the physician's or the patient's expectations.⁶⁰

MCO profits fell during 1995.⁶¹ This trend is likely to persist as employers continue to search out the best value when providing employees with health care.⁶² Similarly, many patients shy away from plans that allow the greatest patient autonomy because of increased costs.⁶³ Along with declining MCO profits comes corresponding decreases in physicians' earnings. As early as 1992, physicians' earnings had fallen by between twenty percent and forty percent in California.⁶⁴ Exacerbating physician's troubles is a decline in demand for medical specialists.⁶⁵ Accordingly, physicians eager to obtain employment are willing to take on extra financial and legal risk. MCO manipulation creates a variety of problems ultimately affecting a party with potentially even less bargaining power than the physician—the patient.

2. Payment Mechanisms

Most of the concern surrounding health care reform arises from recent

60. See Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 355 (1996). Moreover, as the MCOs become larger, more powerful, and have access to a greater number of patients, they can exert force over doctors in designing their contractual arrangements. Cf. Mark Crane, *What's Holding Back Capitation*, MED. ECON., Jan. 27, 1997, at 162, 162 (small practices do not have the expertise to figure out if the capitation contract is a good or bad deal); cf. Marsha R. Gold, *A National Survey of the Arrangements Managed-Care Plans Make With Physicians*, 333 NEW ENG. J. MED. 1678, 1680 (1995) (finding that 84% of independent practice HMOs had some form of risk sharing with primary care physicians); Marilyn N. Nanzel, *Bound by Contract and 'Gagged' by Its Terms*, CHI. DAILY L. BULL., Feb. 6, 1997, at 6, 6 (physicians in areas with extreme MCO penetration are forced to enter plans with manipulative terms).

61. See *HMO Enrollment Up Despite Profit Decline*, *supra* note 55, at 64.

62. See Jay Greene, *Wondering Whether an HMO, PPO or POS is Right for You? Your Options May be Dwindling*, ORANGE COUNTY REG., Nov. 10, 1996, at K1 (some companies are switching to POS plans because they cost 20-40% less than PPOs); See also, Olmos, *supra* note 58, at A1.

63. See Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1319, 1343 (1996).

64. See Robert B. King & Ben Moore II, *Managed Care Past, Present, and Future*, 53 ARCH. NEURO. 851, 852 (1996). In New England, an area with lower MCO penetration, earnings fell by only ten to fifteen percent. See *id.* Physicians earned no more from capitated plans in 1996 than they did in 1995. See Crane, *supra* note 60, at 162.

65. See generally, Louis Goodman, *Managed Care's Role in Shaping the Physician Job Market*, 277 JAMA 72, 72 (1997) (contracting with primary physicians is increasing, but MCOs are becoming rather selective about contracting with specialists which has created a glut); Sarena D. Seifer, *et al.*, *Changes in Marketplace Demand for Physicians*, 276 JAMA 695, 695 (1996) (study showed the number of advertisements for specialists has decreased in recent years).

debate alleging that cost control measures affect the quality of health care.⁶⁶ Health care, however, has always been associated with financial incentives.

a. Fee-For-Service

In years past, health care was paid for on a fee-for-service basis.⁶⁷ Fee-for-service plans compensate a physician for each treatment provided.⁶⁸ Financial incentives in fee-for-service programs prompted physicians to provide patients with excessive levels of health care resulting in increased health care costs.⁶⁹ Patients rarely complained about excessive levels of medical care since they did not pay full price for the care they received.⁷⁰ One result of the heightened care was that physicians were subjected to very high community standards when treating patients.⁷¹

b. Capitation

Conversely, modern health care programs pay a great deal of attention to cost control.⁷² Health care service providers use financial incentives of varying degrees to control costs.⁷³ While bonuses and withhold

66. See, e.g., David Blumenthal, *The Origins of the Quality-of-Care Debate*, 335 NEW ENG. J. MED. 1146, 1146 (1996); Wendy K. Mariner, *Managed Care Gag Cheats the Patients*, NAT'L L. J., Feb. 5, 1996, at A19; Jeffrey L. Marxen, *Unethical Pay-by-the-Head HMOs Should Be Illegal*, SAN DIEGO BUS. J., Jan. 15, 1996, at 11.

67. See, e.g., Robert H. Brook, et al., *Health System Reform and Quality*, 276 JAMA 476, 476 (1996).

68. See Pedroza, *supra* note 52, at 401.

69. See Letter from Arthur Leibowitz, et al., to the Editor in 334 JAMA 1060 (1996); Malinowski, *supra* note 60, at 356.

70. See David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 161 (1996). Conversely, if care is withheld, the harm is physical and felt directly. See *id.* Moreover, patients sometimes seek out excess medical care because they do not pay the full cost. See WOLFE, *supra* note 57, at 84.

71. See Gary T. Schwartz, *Symposium: National Health Care Reform on Trial: A National Health Care Program: What its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1361 (1994); see also *supra* note 5.

72. See Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604, 604 (1995) (hereinafter Rodwin, *Managed Care*).

73. See Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330 (1996). Bonuses are often based on a physician's ability to decrease patient care expenditures. See *id.* at 331. "Withhold" arrangements hold a percentage of a physician's compensation until years end as a measure to cover any patient care budget shortages. See *id.*

arrangements may both effect a physician's judgment, capitation receives the lion's share of attention from the media and consumer groups.⁷⁴

Capitation arrangements pay a physician a predetermined sum for each patient in their care for a prescribed period.⁷⁵ This sum is a prediction of the cost of the patient's health care needs over that set period of time.⁷⁶ Capitation provides incentive by directly linking a physician's compensation to his treatment decisions.⁷⁷ Physicians will not profit if the cost of care provided during the contract period exceeds the capitation contract value during that same period.⁷⁸

c. Responses to Capitation

Physicians have reacted to capitation in many ways. Quality control programs now focus on identifying and limiting overused treatment modalities.⁷⁹ Physicians actively pursue measures to protect themselves from liability arising from the changing quality standards and financial risk.⁸⁰ An often-criticized method of risk avoidance is accepting only healthy individuals into a physician's practice.⁸¹ Other physicians increase potential revenue by accepting a larger number of patients into

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

75. See, e.g., *id.* ("Capitation means payment 'by-the-head'"); Thomas S. Bodenheimer & Kevin Grumbach, *Capitation or Decapitation*, 276 JAMA 25, 1025 (1996). Capitation agreements, like all contracts, may feature specialized terms such as including or excluding certain treatment programs. See *id.*; see also Thomas C. Rosenthal, *Medical Primary Care Services in New York State: Partial Capitation v. Full Capitation*, 42 J. FAM. PRAC. 362 (1997).

76. See Berwick, *supra* note 74, at 1227.

77. See *id.* "The problem with using incentives to shape physicians' behavior is the bluntness of the method." *Id.* at 1228.

78. See Tracy Griff, *Capitation Shifts Financial Risk from HMOS to Providers*, PREV. L. REP., Summer 1996, at 37 (hereinafter "Griff, *Capitation*").

79. See Eve A. Kerr, et. al., *Quality Assurance in Capitated Physician Groups, Where is the Emphasis*, 276 JAMA 1236, 1237 (1996); Rodwin, *Managed Care*, *supra* note 72, at 604. The most likely explanation is that incentive provided to reducing or eliminating unnecessary treatment. See Kerr, *supra* note 79, at 1237; Rodwin, *Managed Care*, *supra* note 72, at 604. However, in some instances a reduction in the care provided a patient actually results in a better quality of life. See Rodwin, *Managed Care*, *supra* note 72, at 604.

80. See, e.g., Griff, *Capitation*, *supra* note 79, at 26, 37. Physicians should understand the risks of capitation in order to avoid them, explain to enrollees how capitation works, follow-up on referrals, and bring the MCO into the case if the MCO policies contributed to the injury. See Tracy Griff, *Capitation: The Life-Threatening Secrets of Managed Care*, PREV. L. REP., Summer 1996, at 12 (hereinafter "Griff, *Secrets*").

81. See 1996 WILEY MED. MALPRACTICE UPDATE 239 (1996); *California Hospital Under Fire for Seeking Healthier Patients*, MOD. HEALTH CARE, Aug. 21, 1995, at 25. This practice eliminates the need to provide a patient with expensive medical treatment.

their practice.⁸² Others substitute outpatient visits in place of costly referrals and hospitalization.⁸³ Capitation proponents argue that any departure from current capitation payment arrangements will increase health care costs.⁸⁴ Similarly, they argue that capitation arrangements promote preventive care and thus better care.⁸⁵

3. Gag Orders

MCOs have also invaded medicine's ethical and legal arena. Tales of gag orders appearing in the contractual agreements between MCOs and physicians are legendary.⁸⁶ The use of gag orders casts doubt on the ability of physicians to disseminate ethically and legally required information to their patients.⁸⁷ In fact, some MCO gag orders prohibit disclosure of a proposed treatment until the MCO has approved the treatment for the patient⁸⁸ or expression of an opinion about the approval

82. See 1996 WILEY MEDICAL MALPRACTICE UPDATE, *supra* note 81, at 296. This also serves to eliminate some financial risk. However, it also results in limiting a physician's time with each of these patients and a corresponding increase in the use of nurse practitioners for individuals who are not particularly sick. *Id.* at 296.

83. See, e.g., Alan L. Hillman, et al., *How Do Financial Incentives Affect Physicians Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 89 (1989). Another interesting treatment supplement is the use of alternative treatments such as acupuncture and Indian healing techniques. See Susan Kelleher, *Hospital Prescribing Love, Medicine*, ORANGE COUNTY REG., Nov. 24, 1996, at B1.

84. See Griff, *Capitation*, *supra* note 78, at 37.

85. See, e.g., Harry Rosenfeld, *Laws are Needed on HMOs*, L.A. DAILY L.J., Jan. 3, 1996 at 6. However, many believe patients are not responsive to, or desirous of, preventive care. See Henry Scovern, *Hired Help: A Physician's Experiences in a For-Profit Staff Model HMO*, 319 NEW ENG. J. MED. 787, 787 (1988).

86. See Steffie Woolhandler & David U. Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706, 1706 (1995).

87. See Julie Forster, *California: Reflecting National Trend, Assembly Passes Bill to Restrict HMOs*, WEST'S LEG. NEWS, June 13, 1996; see also Marxen, *supra* note 66, at 11; Woolhandler & Himmelstein, *supra* note 86, at 1706. Contracts used by U.S. Healthcare, an MCO, contain the following language:

Physician shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in U.S. Healthcare of the quality of U.S. Healthcare coverage.

Physician shall keep Proprietary Information [payment rates, utilization review procedures, etc.] and this agreement strictly confidential.

Id.

88. See Mariner, *supra*, note 66, at A20. These provisions are designed to prevent the reasonable expectation of benefits recommended by a doctor as discussed in *Sarchett v. Blue Shield of Cal.*; see *supra* notes 13-24 and accompanying text.

or disapproval of a particular treatment.⁸⁹ Physicians in some MCOs may not suggest that a patient obtain services from a provider outside the network.⁹⁰ Additionally, MCOs enforce gag rules that prevent a physician from discussing their financial arrangement with patients.⁹¹ Gag orders limit expenses incurred by MCOs by reducing the volume of care provided to patients.⁹²

C. *The Reality*

Applying the facts of the California health care environment to the relevant law provides a picture of turmoil. The use of capitation and other financial incentives forces the physicians into risky ethical, financial and legal positions.

1. *Gag Orders*

Gag orders that prohibit discussion of non-covered treatments or referrals outside the provider's network are especially troubling for the physician. Failure to comply with these rules can result in a physician being terminated by the MCO.⁹³ Yet, failure to provide the necessary information violates a patient's right to informed consent thereby subjecting the physician to liability.⁹⁴

Physicians are not the only individuals affected by gag orders. Gag orders often prevent patients from learning about their health and health care needs.⁹⁵ While MCOs need only provide the services covered by their health care agreement, patients may wish to obtain necessary or desirable services that the MCO does not offer.⁹⁶ Consequently, failure to inform a patient of these needs compromises a patient's continued

89. *Physicians and Surgeons: Patient Advice: Hearings on SB 1847 Before the Senate Rules Comm.*, 1995-96 Reg. Sess. (1996).

90. *See id.*

91. *See* Forster, *supra* note 87; David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1695 (1996).

92. *See* Mariner, *supra* note 66, at A20; *cf.* Woolhandler & Himmelstein, *supra* note 86, at 1706 (most financial incentives are penalizing and a change in practice style is required to avoid the penalties).

93. *Cf.* Woolhandler & Himmelstein, *supra* note 86, at 1707 (co-author of article was terminated shortly after publication).

94. *See supra* notes 5-12 and accompanying text.

95. *See supra* notes 86-92 and accompanying text; Rodwin, *Managed Care*, *supra* note 72, at 605. Lay persons generally learn of their health problems from discussion with their physicians. *See id.* Obviously, patients cannot demand services they are not aware that they need.

96. *See* Rodwin, *Managed Care*, *supra* note 72, at 605.

good health.⁹⁷

2. Financial Incentives

Capitated plans provide incentive for physicians to choose only the healthiest patients.⁹⁸ By picking only patients that do not need expensive health care, physicians can limit their exposure to liability. One troubling aspect of this tactic is that patients with the greatest need for care are the ones denied health care.

Additionally, the level of care actually provided to patients is of lesser quality.⁹⁹ With the new inclination toward cost control, physicians' practice styles must adapt to the new cost saving mechanisms.¹⁰⁰ While it is possible that in some instance these new procedures will be better for the patient,¹⁰¹ many may be harmful. For example, as physicians withhold medical services on a regular basis, the community standard against which they are judged declines.¹⁰² Because medical custom is broader than health care affiliation, all members of society, whether or not a member of a cost -slashing MCO, will suffer. While these changes will not happen overnight, some physicians opine that even the current health care system has softened a decrease in the standard of health care

97. *See id.*

98. *See supra* note 81 and accompanying text.

99. *See* Marxen, *supra* note 66; *cf.* Woolhandler & Himmelstein, *supra* note 86, at 1706 ("most HMO managers believe that large incentives to physicians compromise the quality of care"); *see generally*, Mechanic & Schlesinger, *supra* note 91; Ellyn E. Spragins, *Beware Your HMO*, NEWSWEEK Oct. 23, 1995, at 54. The changing health care environment also is creating a "race to the bottom" with investigation into the consequences lagging far behind. *See* Woolhandler & Himmelstein, *supra* note 86, at 1706; *see also* Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 U. PITT. L. REV. 291, 308-09 (1994) (reports of diminished quality of care are commonplace); *cf.* Hillman, *supra* note 83, at 89 (capitation and salary compensation programs are associated with lower rates of hospitalization than fee-for-service plans).

100. *See, e.g.*, Sharon Safrin et. al., *Pyelonephritis in Adult Women: Inpatient versus Outpatient Care*, 85 AM. J. MED. 793, 793 (1988) (discussing the need to find better medical procedures to keep health care costs low).

101. For example, research into new methods to treat pylenopheritis resulted in reducing a patient's time away from work. *See id.*

102. Under fee-for-service contracts, physicians were motivated by the potential for great financial reward and the potential for allegations of malpractice. *See* E. Haavi Morriem, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1731 (1987). Thus, physicians provided heightened levels of care which led to a very high community standard. *See id.*

enjoyed by patients.¹⁰³

Clearly the health care environment in California is rapidly changing. MCOs are rapidly gaining power over both patients and physicians. Moreover, the lack of certainty in the law and changing health care standards indicate the existence of a large problem. Accordingly, the legislature, with the support of MCOs, took several steps to change the health care playing field.¹⁰⁴

II. EFFORTS TO REFORM THE HEALTH CARE SYSTEM

A. *The Bills*

1. *Gag Orders*

The legislature took a strong stance on gag orders contained in contracts between MCOs and physicians.¹⁰⁵ The legislature's efforts resulted in three bills.

103. See Marxen, *supra* note 66, at 11.

104. MCOs claim they support the new laws prohibiting gag orders. *Physicians and Surgeons: Patient Advice—Prohibiting Retaliation and Contractual 'Gag' Clauses: Hearings on SB 1847 Before the Senate Comm. on Bus. and Professions*, Cal. 1995-96 Reg. Sess. (Cal. 1996). However, it is most likely that MCOs wanted to shape the laws through lobbying and political process rather than leave these issues to the courts. The apparent change of judicial viewpoint between Wickline and Wilson strongly supports this theory. The lack of reported decisions since the Wilson case suggests that health care providers would prefer to settle cases rather than risk treacherous journeys into the appellate courts in the face of adverse precedent. The lack of case law development may also be tied to the use of arbitration agreements that are commonplace in insurance contracts. See generally, *Davis v. Blue Cross*, 600 P.2d 1060 (Cal. 1979); *Madden v. Kaiser Found. Hosp.*, 552 P.2d 1178 (Cal. 1976). Arbitration is strongly promoted by the courts. See *Madden*, 552 P.2d at 1185. Additionally, the Employee Retirement Income Security Act of 1974 ("ERISA") is often used by MCO's to force plaintiff's to bring suit against the physicians. See *How HMOs Have Hidden Behind ERISA*, MED. ECON., Aug. 12, 1996, at 200.

On the other hand, physicians have indicated the legislature's efforts may not be enough. See James D. Knight, M.D., Letter to the Editor, *SAN DIEGO UNION-TRIB.*, Dec. 15, 1996, at G3 (arguing that in capitated programs, physicians groups, not the HMO, make healthcare decisions, thus the HMO doesn't care if treatment is provided). This argument overlooks gag-orders which speak to a physician's ability to discuss alternate coverage arrangements or plan options which may prompt patients to seek better health care arrangements.

105. See, e.g., *Medical Malpractice, Informed Consent, Unconscionable Contracts: Hearings on SB 3013 Before the Comm. on Judiciary*, Cal. 1995-96 Reg. Sess. (Cal. July 9, 1996).

a. Assembly Bill 3013

As originally introduced, AB 3013 proposed that Business & Professions Code section 2056.1 should prohibit contracts limiting physicians' ethical and legal responsibilities to patients.¹⁰⁶ Several subsequent amendments substantially altered this rather simple legislation.

The first amendment allowed MCOs to impose limits on a physician's ability to steer patients into a different health care delivery plan solely for their own financial gain despite language allowing discussion of

106. As introduced, section 2056.1 of the Business & Professions Code stated: No health care service plan or its contracting entities shall enter into a contract with a physician and surgeon that limits the ethical and legal responsibility of the physician and surgeon to advise their patients fully about treatment options, alternative coverage arrangements, or other issues that affect the health care of patients, if the advice is consistent with the ethical and legal responsibilities of the physician and surgeon.

ASSEMBLY BILL 3013, 1995-96 Reg. Sess. (Cal. 1996) (as introduced Feb. 23, 1996). In the final version, section 2056.1 of the Business & Professions Code appeared as follows:

(a) The purpose of this section is to ensure that health care service plans and their contracting entities do not enter into contracts with physicians and surgeons or other licensed health care providers that interfere with any ethical responsibility or legal right of physicians and surgeons or other licensed health care providers to discuss with their patients information relevant to their patients' health care. It is the intent of the Legislature to guarantee that a physician and surgeon or other licensed health care provider can communicate freely with, and act as advocate for, his or her patient.

(b) Health care service plans and their contracting entities shall not include provisions in their contracts that interfere with the ability of a physician and surgeon or other licensed health care provider to communicate with a patient regarding his or her health care, including, but not limited to, communications regarding treatment options, alternative plans, or other coverage arrangements. Nothing in this section shall preclude a contract provision that provides that a physician and surgeon, or other licensed health care provider, may not solicit for alternative coverage arrangements for the primary purpose of securing financial gain.

(c) Any contractual provision inconsistent with this section shall be void and unenforceable.

(d) For purposes of this section, "licensed health care provider" means any person licensed or certified pursuant to this division or licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act.

(e) No communication regarding treatment options shall be represented or construed to expand or revise the scope of benefits or covered services under a health care service plan or insurance contract.

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

alternate health plan arrangements.¹⁰⁷ At first glance, this language seems to conflict with the stated legislative intent of prohibiting an MCO from interfering with a physician's ability to discuss alternative plans and coverage arrangements.¹⁰⁸ However, advocacy for personal financial gain is the more specific provision and as such must be honored.¹⁰⁹

A review of the legislative intent,¹¹⁰ which was to "guarantee that a physician and surgeon . . . *can communicate freely with*, and act as advocate for his or her patient" provides a glimpse of a much larger problem.¹¹¹ Whether or not a physician's communications with a patient embrace the physician's personal financial gain or merely represents the discharge of ethical and legal duties is a question of fact to be answered by a jury.¹¹² Physicians are placed between a "rock and a hard place." Disclosing better health care options to their patients may result in their being terminated from their MCO program while a failure to describe these very same programs may result in failure-to-inform liability.¹¹³

A subsequent amendment states that physician communications may not expand or revise the scope of plan benefits.¹¹⁴ This subsection also functions like a "gag clause." While the statute specifically states that a

107. See ASSEMBLY BILL 3013, 1995-96 Reg. Sess. (Cal. 1996) (as amended April 10, 1996). These changes were likely made in response to pressure by the California Association of Health Maintenance Organizations. See *Physicians and Surgeons: Patient Advice: Hearings on AB 3013 Before the Assembly Comm. on Ins.*, 1995-96 Reg. Sess. (Cal. 1996).

108. CAL. BUS. & PROF. CODE § 2056.1(b).

109. "[W]hen a general and particular provision are inconsistent, the latter is paramount to the former." CAL. CIV. PROC. CODE § 1859 (West 1983). It is not unreasonable to construe discussion for financial gain as being more specific than provisions promoting the general right to discuss coverage options.

110. "In the construction of a statute the intention of the legislature . . . is to be pursued if possible . . ." CAL. CIV. PROC. CODE § 1859. Statutes must be construed to conform to legislative purpose in light of the scheme of which it is part. See *Lambert Steel Co. v. Heller Fin., Inc.*, 20 Cal. Rptr.2d 453, 457 (1993).

111. CAL. BUS. & PROF. CODE § 2065.1 (West Supp. 1997) (emphasis added).

112. See *Medical Malpractice; Informed Consent; Unconscionable Contracts: Hearings on AB 3013 Before the Senate Judiciary Comm.*, 1995-96 Reg. Sess. (Cal. July 9, 1996).

113. For example, a physician may be terminated by his MCO when he seeks to inform a patient with special medical needs about a health care arrangement which will better address the patient's needs and which also has greater financial reward for the physician. If a physician sues the MCO as a result of the contract termination, this question of the physician's motive is left for the jury. One can envision a jury focusing on the increased profits to the physician, and determine that the jury was acting in his own self-interest. See, e.g., David Azevedo, *Did an HMO Doctor's Greed Kill Joyce Ching*, MED. ECON., Feb. 26, 1996, at 43. The jury was allowed to hear how physicians are paid. See *id.* at 50. After hearing how physicians were paid, some of the jurors stated they would no longer enroll in MCOs. See *id.* at 55.

114. See ASSEMBLY BILL 3013, 1995-96 Reg. Sess. (Cal. 1996) (as amended June 27, 1996).

physician's communications with a patient do not expand or revise the scope of benefits,¹¹⁵ those conversations may certainly create reasonable expectations of expanded benefits. By providing that benefits may not be expanded, the legislature has contradicted¹¹⁶ and has seemingly sought to overturn the *Sarchett* decision.¹¹⁷ Physicians must carefully tailor their discussions with patients. Discussion of a treatment plan which is not covered may mislead or frustrate the patient, cause the patient to lose trust in the physician, and possibly cause the patient to seek other health care options and providers.¹¹⁸ Accordingly, the physician must carefully discuss medical options to avoid these potential traps. Thus, this legislation is in direct conflict with its express purpose of *free communication* between patient and physician.¹¹⁹

Apparently, pressure by MCOs influenced the bill in a manner benefiting MCO interests, as opposed to those of the physician and patient. The physician must tread carefully to avoid tempting a patient into a more attractive health plan and must also be careful to avoid creating reasonable expectations of increased health care benefits. Thus, the physician has been gagged—he is better off financially if he discusses nothing with his patients. But this is not what the legislature intended, is it?

115. CAL. BUS. & PROF. CODE § 2056.1 (West Supp. 1997).

116. Courts assume that the legislature, when enacting a statute, is aware of existing related laws and intends to maintain a consistent body of laws. *See People v. Vessell*, 42 Cal. Rptr. 2d 241, 244 (1995). The legislature does not appear to have contemplated the *Sarchett* decision when drafting these new laws.

117. This clause has two potential problems. First, the patient in traditional plans may be forced to pay for coverage that was reasonably expected to be covered since these new laws do not change what a patient finds reasonable. Second, the physician in a capitation plan may be forced to cover the cost of treatment he reasonably believed was covered.

118. *Cf. Mechanic & Schlesinger, supra* note 91, at 1694 (discussing that patients lose trust in their physicians because of the use of financial incentives). Moreover, the California Supreme Court has recognized that parties purchase insurance not only for financial stability, but also to obtain peace of mind. *See Crisci v. Security Ins. Co.*, 426 P.2d 173 (Cal. 1967). A misled patient may transfer to another physician or health plan when they perceive their treatment to be compromised.

119. If the MCO is required to give a great deal of information about plan benefits and options at the time of enrollment, these provisions will not be so onerous since the patient will have no argument that the physician created reasonable expectations of increased benefits. *See JERRY, supra* note 26, at 147.

b. Senate Bill 1847

In its final version, Senate Bill 1847 adds teeth to California Business and Professions Code section 2056. In its prior version, Business and Professions Code section 2056 only suggested the “policy” of the “State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his patients.”¹²⁰ An amendment to section 2056 provides:

No person shall terminate, retaliate against, or otherwise penalize a physician and surgeon for that advocacy, nor shall any person prohibit, restrict, or in any way discourage a physician and surgeon from communicating to a patient information in furtherance of medically appropriate care.¹²¹

Before this amendment, section 2056 only stated that terminating a physician because he advocated on behalf of a patient, merely violated “public policy.”¹²²

Senate Bill 1847 underwent many changes before becoming the law of the state. The original version of Senate Bill 1847 proposed the addition of Business and Profession Code section 2056.3.¹²³ Section 2056.3 originally stated that no entity may limit a physician’s communications regarding 1) the nature of treatment, risks or alternatives, 2) the availability of other therapies, consultations or tests, 3) the decision of any plan to authorize or deny services, or 4) the process used to authorize or deny benefits.¹²⁴ This language was initially modified¹²⁵ before eventually being deleted altogether.¹²⁶

At first glance, the deletion of section 2056.3 seems troublesome. However, the language of section 2056.3 was, to a certain extent, both picked up by other statutory sections¹²⁷ and already covered by existing case law.¹²⁸ The resulting statute permits a great deal of communication

120. CAL. BUS. & PROF. CODE § 2056(b) (West Supp. 1997).

121. *Id.* § 2056(c).

122. *Id.* § 2056.

123. *See* SENATE BILL 1847, 1995-96 Reg. Sess. (Cal. 1996) (as introduced Feb. 22, 1996).

124. *See id.*

125. *See* ASSEMBLY BILL 3013, 1995-96 Reg. Sess. (Cal. 1996) (as amended Apr. 15, 1996).

126. *See* ASSEMBLY BILL 3013, 1995-96 Reg. Sess. (Cal. 1996) (as amended June 19, 1996).

127. Section 2056.1 of the California Business & Profession Code contains language which promotes discussion of the plan, including treatment options, alternative plans, and other coverage arrangements which replace the language of the proposed but omitted section 2056.3. *See* SENATE BILL 1847, 1995-96 Reg. Sess. (Cal. 1996) (as amended April 15, 1996).

128. Moreover, California law requires that physicians advocate for medically appropriate health care, including discussion of any factor material to a reasonable patient. By stating that a physician may advocate for medically appropriate care,

between a patient and his or her physician.

c. Senate Bill 1805

Senate Bill 1805 modified California Health & Safety Code section 1386 and added Insurance Code section 10120.5 which provides penalties for violation of California Business & Professions Code sections 510¹²⁹, 2056, or 2056.1.¹³⁰ A breach of any of these sections requires the MCO's license to be either suspended or revoked.¹³¹ Additionally, under Insurance Code section 10120.5, violation of sections 510, 2056, or 2056.1 is a violation of the Insurance Code.¹³²

Initially, Senate Bill 1805 also proposed the adoption of Health & Safety Code section 1366.16 in addition to Insurance Code Section 10120.5.¹³³ The language of Health & Safety Code section 1366.16 was similar to that of Business & Professions Code sections 2056 and 2056.1.¹³⁴ At the insistence of the Department of Corporations, the legislature dropped Health & Safety Code section 1366.16 to avoid potential conflict with similar "intent" language contained in the Business & Professions Code.¹³⁵ The Department of Corporations, however, recommended modification be made so that the penalty for violating the "intent" language would have some effect.¹³⁶ In its final form, Senate Bill 1805 met a good balance; it provided enforcement mechanisms for Business & Professions Code sections 510, 2056 and 2056.1, while avoiding potential conflict due to the redundancy.

contract provisions previously which resulted in gag orders have been abrogated. *See supra* notes 5-12 and accompanying text.

129. Section 510 of the Business & Professions Code provides that "[i]t is the public policy of the State of California that a health care practitioner be encouraged to advocate for his or her patients." CAL. BUS. & PROF. CODE § 510 (West Supp. 1997).

130. *See* SENATE BILL 1805, 1995-96 Reg. Sess. (Cal. 1996) (as amended Aug. 5, 1996).

131. CAL. HEALTH & SAFETY CODE § 1386 (West Supp. 1997).

132. CAL. INS. CODE § 10120.5 (West Supp. 1997).

133. *See* SENATE BILL 1805, 1995-96 Reg. Sess. (Cal. 1996) (as introduced Feb. 22, 1996).

134. *See id.*

135. *See Health Care Coverage: Hearings on SB 1805 Before the Assembly Comm. on Ins.*, Cal. 1995-96 Reg. Sess. (Cal. June 25, 1996).

136. *See id.*

2. Financial Incentives—Assembly Bill 2649

Chapter 1014 is the final version of Assembly Bill 2649.¹³⁷ This bill limits financial incentives that induce physicians “to deny, reduce, limit, or delay specific medically necessary and appropriate services.”¹³⁸ This language appears in the amended portion of Business and Professions Code section 511, Health and Safety Code section 1348.6, and Insurance Code section 10175.5.¹³⁹ These code sections contain language expressly permitting capitation arrangements which are not tied to specific medical decisions.¹⁴⁰ The final version of Health and Safety Code section 1367.1 requires every health plan to disclose 1) how participation may affect the person’s choice of a physician, hospital, or other health care providers, 2) the basic method of reimbursement, and 3) whether the plan uses financial incentives.¹⁴¹

When originally introduced by Assemblyman Thompson, Assembly Bill 2649 was a “get tough” proposition. The bill prohibited tying financial incentives to any inducement to deny or limit necessary

137. ASSEMBLY BILL 2649, 1995-96 Reg. Sess. (Cal. 1996) (enacted).

138. *Id.*

139. See generally, CAL. HEALTH & SAFETY CODE § 1348.6 (West Supp. 1997); CAL. INS. CODE § 10175.5 (West Supp. 1997); CAL. BUS. & PROF. CODE § 511 (West Supp. 1997). Section 511 of California Business & Professions Code appeared in its final form as follows:

Section 511: Proscription on payment to health care practitioner to deny, limit, or delay services

(a) No subcontract between a physician and surgeon, physician and surgeon group, or other licensed health care practitioner who contracts with a health care service plan or health insurance carrier, and another physician and surgeon, physician and surgeon group, or licensed health care practitioner, shall contain any incentive plan that includes a specific payment made, in any type or form, to a physician and surgeon, physician and surgeon group, or other licensed health care practitioner as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered under the contract with the health care service plan or health insurance carrier and provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

(b) Nothing in this section shall be construed to prohibit subcontracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are not tied to specific medical decisions involving specific enrollees or groups of enrollees with similar medical conditions.

CAL. BUS. & PROF. CODE § 511. Section 1348.6 of the Health and Safety Code is substantially similar to section 10175.5 of the Insurance Code and the operative language is the same in all three statutes. CAL. HEALTH & SAFETY CODE § 1348.6; CAL. INS. CODE § 10175.5.

140. See CAL. HEALTH & SAFETY CODE § 1348.6; CAL. INS. CODE § 10175.5; CAL. BUS. & PROF. CODE § 511. The trouble with this language is that capitation is still tied to reduction of care in a general sense.

141. See *supra* note 127.

services.¹⁴² At its introduction, Assembly Bill 2649 contained Health & Safety Code section 1348.7 which required health care service providers to report their compensation arrangements to the Commissioner of Corporations for review and approval.¹⁴³ Ultimately, the original proposal contained Health & Safety Code section 1348.8 which required that compensation arrangements 1) be based on actuarially sound data, which would be available to the physicians, 2) adjust to reflect severity of illness, 3) offer stop-loss coverage to all physicians, and 4) provide capitation payment to the first primary care physician that sees a patient dating back to the patient's enrollment date.¹⁴⁴ These provisions shift the financial risks of capitation arrangements back to the MCO.

Despite minor language changes, the bill left the Assembly in virtually the same form as it was born.¹⁴⁵ The Senate, however, substantially revised Assemblyman Thompson's bill. At the insistence of several opponents, the bill was stripped of both language requiring reporting to the Department of Corporations as well as all of the capitation control devices¹⁴⁶ before its August 15, 1996 presentation.¹⁴⁷ Before giving the bill final approval, the Senate eliminated all references to review and approval by the Department of Corporations and capitation agreements.¹⁴⁸ The result was a bill purporting to eliminate financial incentives, yet allowing MCOs to continue to exert strong influence over

142. See ASSEMBLY BILL 2649, 1995-96 Reg. Sess. (Cal. 1996) (as introduced Feb. 21, 1996).

143. See *id.*

144. See *id.* The purpose of this arrangement is to compensate the physician providing treatment for the capitation payments for the period in which the patient was a plan member but did not have a primary care physician.

145. See ASSEMBLY BILL 2649, 1995-96 Reg. Sess. (Cal. 1996) (as amended May 29, 1996).

146. See ASSEMBLY BILL 2649, 1995-96 Reg. Sess. (Cal. 1996) (as amended Aug. 15, 1996).

147. *Hearings on AB 2649 Before the Senate Comm. on Ins.*, 1995-96 Reg. Sess. (July 3, 1996); *Health Care Service Plan Contracts: Hearings on AB 2649 Before the Senate Comm. on Judiciary*, 1995-96 Reg. Sess. (Cal. Aug. 7, 1996) (committee reports indicate that the Department of Corporations, Department of Health Services, the California Association of Health Maintenance Organizations, and the Association of California Life and Health Insurance Companies all fought for removal of language restricting the manner in which capitation rates are calculated).

148. See ASSEMBLY BILL 2649, Reg. Sess. 1995-96, (1996) (as amended August 26, 1996). A possible reason that MCOs pushed for removal of all reporting requirements is that in late 1994 the California Department of Corporations issued a \$500,000 penalty to a MCO that denied a patient coverage for treatment. See David Azevedo, *Will the States Get Tough With HMOs?*, MED. ECON., Aug. 26, 1996, at 172, 184. That penalty is believed to be the largest ever levied against an MCO. See *id.*

physicians with restrictive capitation payment mechanisms. In fact, the legislature has not even required that capitation arrangements be actuarially sound.¹⁴⁹

B. *The Effects*

What is the result of legislative efforts to reform managed care in California? Not what one would hope it would be! Physicians essentially are now subject to gag orders written by the legislature instead of MCOs. Obviously then, MCOs need not even place gag clauses in contracts, for the legislature has taken care of that for them. Consequently, the MCOs cannot be found liable for the failure of a gagged physician to advocate on behalf of a patient.

Regardless of this consequence, prohibiting financial incentives to reduce or deny care is a step toward physician independence and patient benefit. By prohibiting financial incentives, the California legislature sought to remove the ability of an MCO to corrupt a physician's judgment through measures designed to control costs. By removing financial incentives, a physician's conduct is directed at patient care as opposed to cost control.

However, the legislature removed the opportunity for injured patients to argue both that the third party payor contributed to the injury by arbitrarily ignoring or overriding the doctor's appeal and that MCO cost control measures corrupted the medical decision. Physicians now make most of the final decisions regarding the care provided to patients. They cannot avoid liability by properly advocating to the MCO as suggested by *Wickline* because they, not the MCO utilization review board, now make the ultimate treatment decision.¹⁵⁰ Essentially, under current health care compensation arrangements, physicians have become the third party payor.¹⁵¹ Moreover, physicians are precluded from shifting liability to the MCO under arguments derived from *Wilson* and *Wickline*

149. From the final version of the bill, one can infer that the removal of requirements for actuarial soundness, stop-loss protections, etc. during the legislative process indicates a legislative intent not to require programs to be financially sound. Moreover, Medi-Cal recipients are covered by capitated health plans with provisions for determining capitation rates based on age, sex, and aid categories which are to be determined by actuaries or consulting groups. See CAL. WELF. & INST. CODE § 14301 (West Supp. 1997).

150. Cf. Pedroza, *supra* note 52, at 429 (discussing that liability should attach to the physician alone because the doctor is the party who makes the medical decision).

151. Third party payors, by shifting all medical decisions to the physician, have removed themselves from the group being charged with making care decisions. See James D. Knight, M.D., Letter to the Editor, SAN DIEGO UNION-TRIB., Dec. 15, 1996, at G3.

that the MCO denied their medical treatment.¹⁵² Whatever decision the physician makes, the MCO cannot be found to have caused the patient's injury even though the MCO corrupted the physician's medical judgment.¹⁵³ The physician is subject to considerable liability should the course of treatment go awry and also subject to the economic pinch of an unregulated capitation program. This point highlights the incredible conflict which is inherent.

III. RECOMMENDATIONS

The California legislative body needs to revisit its recent efforts at health care reform. Their primary goal should be promoting free communication. In addition, the legislature should endeavor to spread risk to those who best able to bear it and require disclosure of the important financial aspects by those best able to distribute that information—in both instances the MCOs.

A. Gag Orders

The three bills designed to prevent MCO contracts from containing gag orders or other constraints on a physician's ethical or legal obligation are a step in the right direction. However, the ambiguity in defining what constitutes a physician acting in his own financial interest is a major problem left unresolved by the legislature.

1. *Removing The Jury Question by Creating an Evidentiary Mechanism*

As enacted, Business & Professions Code section 2056.1 permits MCOs to continue exerting substantial control over physicians.¹⁵⁴ Physicians are trapped in the ominous situation of choosing to protect

152. See CAL. BUS. & PROF. CODE § 2056 (West Supp. 1997); *Wickline v. State*, 239 Cal. Rptr. 810 (stating in dicta that liability should attach to the person, including health care payors, who makes the decision to deny necessary care); see also, Griff, *Secrets*, *supra* note 80, at 13 (an unreported 1993 California jury verdict against an MCO awarded plaintiff \$89.3 million because the MCO refused to provide treatment.); *Pedroza*, *supra* note 52, at 429.

153. Attorney Mark Hiepler has presented arguments that the financial incentives of an MCO interfere with a physician's fiduciary duty to the patient. While the claim was dismissed, the changing health care environment may prompt courts to examine the propriety of shifting more liability to MCOs. See Griff, *Secrets supra* note 80, at 12.

154. See *supra* note 114-19 and accompanying text.

either their livelihood or their patients. By informing patients in a manner consistent with the patient's best interests, physicians risk termination.¹⁵⁵ Conversely, by failing to properly inform their patients, physicians risk liability for lack of informed consent.¹⁵⁶ Moreover, physicians' arguments that an MCO arbitrarily restricted dissemination of ethically and legally required information will now be less persuasive since the MCO is precluded from directly interfering with patient communication and the gag order has been placed by the legislature.¹⁵⁷ Furthermore, a jury is quite likely to believe an argument that a physician acted for profit motives.¹⁵⁸

To remedy this situation, the legislature should take a close look at the fine line between when a physician is properly advising a patient about their health and when a physician is acting for his own financial gain. Eliminating the question of fact aspect of the new law will remove the chilling effects of disclosing information that affects a patient's health care decisions. California law requires disclosure of all material information affecting a patient's decision to consent to a course of treatment, including personal economics. The new laws not only interfere with a physician's ability to discuss plan arrangements with patients but also conflict with their stated purpose.¹⁵⁹

A better alternative to leaving the question to a jury, would require a physician to prove that the patient was provided with complete disclosure regarding the physician's potential personal benefits as required by referral statutes.¹⁶⁰ Disclosure of financial considerations has previously been considered by both the courts¹⁶¹ and the legislature.¹⁶² A document should be prepared at the time of the physician's disclosure. The document would be signed by both physician and patient and would describe the subject matter of the conversations and the reasons for initiating the discussion. During trial, this document would create a rebuttable presumption that the physician acted in the patient's interest, and not his own, when making the disclosure.

Under this program, patients would receive a great deal of information about their health care. Moreover, costs would be kept under control

155. *See id.*

156. *See id.*

157. *See supra* notes 109-19, 149-52 and accompanying text.

158. *See supra* note 113.

159. *See supra* notes 110-19 and accompanying text.

160. *See, e.g.,* CAL. BUS. & PROF. CODE § 650.01(f) (West Supp. 1997) (permitting referrals only where the patient has received disclosure of the physician's financial interest in writing).

161. *See supra* notes 5-11 and accompanying text.

162. *See* CAL. BUS. & PROF. CODE § 650.01(f) (West Supp. 1997).

since the consumer would consider price in selecting an MCO.¹⁶³ In fact, the potential of losing the informed patient to more expensive programs or to another MCO would likely pressure MCOs to create more patient-friendly programs.

B. Capitation/Financial Incentives

The interaction of the new anti-gag order laws with capitation programs creates additional problems. Allowing an MCO to insulate itself from liability by forcing physicians to bear all the risks associated with a medical decision is flawed.¹⁶⁴ The physician has little control over his contractual agreement, and most physicians are in the business of patient care, not underwriting that care. The extent of MCO penetration in California requires affording some protection to the physicians and patients.¹⁶⁵ Contractual bargaining power is held nearly exclusively by the MCO. The MCOs force arrangements upon physicians which are often one sided and unduly place financial and legal risk on the physician. This is especially true since new capitation arrangements are not even required to be actuarially sound.

The legislature can remedy these problems by introducing laws that either decrease risk or shift the risk back to the MCO. Decreasing the risk in capitation plans may best be achieved by considering both the contents of the early version of Assembly Bill 2649 and physician recommendations. These include large patient pools, stop-loss provisions, and actuarial soundness.

163. "Patients' interests as both payers and recipients of medical care may conflict." Rodwin, *Managed Care*, *supra* note 72, at 604. In effect, this proposal would create a stratified health care system in which those willing to pay more would receive more. See Malinowski, *supra* note 59, at 352. At the same time physician advocacy in shifting patients would be kept in check by the "informed consent" requirement. Informed consent requirements may be carefully tailored to insure that patients are properly informed of the plan provisions which would be especially important in such a stratified system. See *id.* Finally, those physicians who do not wish to engage in the strict requirements of insurance information transfer can avoid them by referring patients to the insurance company for specific coverage questions. See *id.*

164. But see Pedroza, *supra* note 52, at 429 (because physicians make the decisions, they should bear the risk).

165. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. MED. 301 (1996).

1. Larger Physician/Patient Groups

Capitation arrangements should encourage physicians to work together. Pooling physicians' financial compensation furthers this end.¹⁶⁶ Pooling physicians' incomes will force physicians to seek measures which increase efficiency such as sharing information or developing synergistic treatment plans.¹⁶⁷ Increasing the number of patients in the capitation pools buffers the negative impact of the few who require expensive treatments.¹⁶⁸ Additionally, larger capitation pools will facilitate accurate determination of capitation contract rates.¹⁶⁹ A most interesting facet of this proposal is that while it would decrease physicians' legal and financial risk, risk to the MCO would also be minimized as a result of the diversification and increased efficiency.

2. Stop-Loss Protections

Physicians often advocate stop-loss provisions as a method of reducing the risk they bear.¹⁷⁰ Stop-loss provisions place only a predetermined percentage of a physician's compensation at risk.¹⁷¹ Because financial risk is limited and determined in advance, physicians need not worry about expensive treatments impacting their pocketbook.¹⁷² More importantly, the risk is shifted away from the provider and towards the MCO, the entity created to bear such risk.

Stop-loss plans have some potential negative aspects. First, MCOs often adjust contract terms to reflect the financial realities of stop-loss coverage.¹⁷³ Second, MCOs often require stop-loss provisions to be accompanied by stop-gain provisions.¹⁷⁴ Finally, in markets where

166. Cf. Dennis Murray, *Seven Ways to Prepare for Managed Care*, MED. ECON. Nov. 27, 1995 at 137, 137 (by working together, physicians can spread their "load").

167. See Berwick, *supra* note 74, at 1230.

168. See *id.* Large pools prevent a few patients from skewing costs. See Orentlicher, *supra* note 70, at 169.

169. See Ken Terry, *HMO Deals That Give You More Money for More Risk*, MED. ECON., Dec. 26, 1994, at 30, 31 (stating that 4,000-5,000 patients is not enough to take on full capitation risk); Philip H. Beard, *Make Sure You Won't Lose Big With Capitation*, MED. ECON., Mar. 25, 1996, at 50, 50 (for example, a group with 500,000 covered lives can predict the capitation rate with such accuracy that it can ensure a profitable rate).

170. See Beard, *supra* note 169, at 50.

171. See *id.*

172. See Berwick, *supra* note 74, at 1230. Most MCO managers feel it is appropriate to place fifteen percent of a physician's compensation at risk. See Orentlicher, *supra* note 70, at 167-68. Physicians may also view any compensation above the risk threshold as a bonus.

173. See Beard, *supra* note 169, at 55 (for example, the MCO will generally pay less per month when a stop-loss protection is in effect than otherwise); see also Bodenheimer & Grumbach, *supra* note 75, at 1028.

174. See Beard, *supra* note 169, at 55. Physicians, however, can still do well in

competition is fierce, MCOs will not offer stop-loss protections.¹⁷⁵ However, most of these negative aspects can be overcome by legislative action requiring MCOs to offer stop-loss protections.

For example, a recent Health Care Financing Administration (hereinafter "HCFA") regulation adopted stop-loss provisions for Medicare and Medicaid.¹⁷⁶ The HCFA implemented two methods for limiting physicians' financial risk. The first provision limits the at-risk portion of a physician's income to twenty-five percent; any loss exceeding that value is split at a ninety-ten ratio between the health plan and physician.¹⁷⁷ The second method imposes stop-loss protection by providing a maximum amount of loss on a per patient basis.¹⁷⁸

Other stop-loss protection plans extend not to individual patients, but to a physician's entire practice or to an entire hospital.¹⁷⁹ Accordingly, some advocate a stop-loss plan that is based on a percentage of the anticipated fee-for-service contract value.¹⁸⁰ Under these arrangements, stop-loss protections would be triggered when a physician's total reimbursement falls below what it would have been under a prior fee-for-service arrangement.¹⁸¹

contracts containing this income limitation because they can still earn the same amount of money that they would have under fee-for-service if they manage their work carefully. *See id.*

175. *See id.* at 51. One of these markets is Long Beach, California. *See id.*

176. *See* Marlene Cimon, *U.S. Acts to Ease HMOs' Cost Pressure on Doctors' Health*, L.A. TIMES, Dec. 26, 1996, at A1. HCFA spokesman Paul Cotton stated "[w]e want to ensure that managed care does not limit necessary care, and that patients are not injured in the process of curtailing costs." *Id.*

177. *See* Requirements for Physician Incentive Plans in Prepaid Health Organizations, 61 Fed. Reg. 13,430, 13,440 (1996) (to be codified at 42 C.F.R. pt. 417) (the 90/10 provision provides some incentive for the physician to continue careful regulation of services after the 25% level of loss has been met). *See generally* Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 425-29 (1996).

178. *See* Requirements for Physician Incentive Plans in Prepaid Health Organizations, 61 Fed. Reg. at 13,441. This type of stop-loss protection controls the potential amount of loss by stating a maximum amount of income to place at risk for a given pool of patients. *See id.* The amount of risk is adjusted to reflect the risk involved in different pool sizes taking into account that larger pools have decreased risk. *See id.*

179. *See* Beard, *supra* note 169, at 51.

180. *See id.*

181. *See id.* This system effectively creates a salary, the lower limit, and the opportunity to earn a large bonus by keeping health care costs in check. *See id.*

3. Shortened Capitation Periods

Short capitation periods are a very effective stop-loss mechanism.¹⁸² For example, standing capitation periods and rates may be divided into fourths. A two week flu epidemic bringing most of a physician's patients in for treatment might affect earnings during only one of the new shortened capitation periods. However, compensation for the three other shorter periods would not be affected. Conversely, under the same hypothetical, in the unmodified longer period, all of the monies paid to the physician under the capitation agreement might well be consumed during the short two week period of the flu epidemic. Thus, four times as much money was placed at risk of loss, and in this hypothetical, lost during that same two week period. Of course, a patient with serious long term illness would still negatively affect the physician's earnings.¹⁸³ Regardless, the physician will not feel a financial pinch and there will still be the same amount of money contributed by the MCO to patient care under either scenario. Accordingly, the financial risks will fall on the MCO rather than the physician.

4. Compensating the Physician From the Patient's Enrollment Date

When a patient enrolls in a health care program, he or she is generally given the opportunity to choose a primary care physician.¹⁸⁴ Once an MCO member chooses a physician, capitation payments begin flowing to that physician.¹⁸⁵ Often enrollees fail to choose a physician until they actually need medical care.¹⁸⁶ Consequently, the MCO, rather than the treating physician, possesses the funds which should be used to treat the patient.¹⁸⁷ The physician is thereby forced to provide medical care for which he has not been compensated.¹⁸⁸ To remedy this inequity, the

182. See Malinowski, *supra* note 60, at 354. Periods should be as short as one month. See *id.* The HCFA adjusts the amount a physician puts at risk based on the length of the capitation term. See Orentlicher, *supra* note 75, at 169.

183. While a patient with a major illness will still impact a physician's earnings, this situation is not so undesirable because physicians are still required to treat patients. Additionally, the impact that one sick individual has on a physician's earning capacity will encourage the physician to care for all of their patients in order to prevent even a single patient from having a costly severe illness.

184. See *Health Care Service Plan Contracts: Hearings on AB 2649 Before the Senate Comm. on Judiciary*, 1995-96 Reg. Sess. (Cal. Aug. 7, 1996).

185. See *id.* While it may seem that the doctor is getting something for nothing, in reality these payments establish a "pool" of funds from which a patient's medical needs are paid for in the event of an illness. See *id.*

186. See *id.*

187. See *id.*

188. See *id.* The California Medical Association argued that such a situation will protect the patient by providing funds from which they will be provided care and also

MCO should make retroactive capitation payments to the physician dating back to the patient's enrollment date as suggested by the early versions of Assembly Bill 2649.¹⁸⁹ Then, the money which is to be used for an enrollee's healthcare would be in the hands of the person actually paying for the care.

5. Actuarially Sound Programs

Finally, the most important aspect of capitation reform is the creation of actuarially sound programs. A physician practicing in an area requiring a great deal of medical care is at a severe financial disadvantage when compared to their counterparts practicing in other locales.¹⁹⁰ Similarly, some experienced physicians, or those with specialized knowledge, may attract those patients requiring more expensive health care.¹⁹¹

Studies demonstrating that health care costs are predictable suggest that sound programs are feasible.¹⁹² In fact, Medicare programs set capitated payment rates based on an average per capita cost which reflects age, sex, welfare status, institutionalization and geographic area.¹⁹³ Congress requires that federally qualified HMOs set rates in a way that reflects the needs of individuals or families.¹⁹⁴ Census data can be used to determine areas having patient populations with some distinct characteristics.¹⁹⁵ Capitation plans which minimize risk will reduce pressure on physicians to save costs by withholding both medical care and information they are legally and ethically required to disclose.

protect the physician from non-payment. *See id.*

189. *See* ASSEMBLY BILL 2649, 1995-96 Reg. Sess. (Cal. 1996) (as amended May 29, 1996).

190. *See* Woolhandler & Himmelstein, *supra* note 86, at 1706 (comparing the difference in a wealthy gay neighborhood from 1978 to 1987).

191. *See id.*

192. *See* Jinnat B. Fowles, *Taking Health Status into Account When Setting Capitation Rates: A Comparison of Risk Adjustment Methods*, 276 JAMA 1316 (1996) (finding that the ability to predict expenditures for groups is very good).

193. *See* 42 C.F.R. § 417.401 (1996); Kinney, *supra* note 165, at 315-16.

194. *See* 42 C.F.R. § 417.104(b) (1996). In classifying the groups, the HMO must use factors which predict differences in the use of health services. *See id.* § 417.104(b)(2)(ii). Factors which do not reasonably predict the use of health care will be disapproved. *See id.* § 417.104(b)(2)(iii).

195. A "crude" method for reflecting varying levels of patient risk is basing capitation rates on age-sex groupings. *See* Bodenheimer & Grumbacher, *supra* note 75, at 1028. Persons in certain age-sex groupings are more likely to use health care than other groups. *See id.*

Further, this system shifts some risk back to the MCO. Physicians will not put their earning potential at risk each and every time they consider an expensive or radical therapy plan.¹⁹⁶ Under this scenario, traditional medical malpractice doctrines will serve as a watchdog to influence a physician's medical judgment.

C. *The Next Step*

In addition to revamping the financial incentive legislation, the legislature needs to take at least one additional step. The legislature should require MCOs to disclose financial incentive arrangements and plan policies and procedures to prospective enrollees.¹⁹⁷ While the new Business and Professions Codes require this,¹⁹⁸ mechanisms which ensure strict compliance with the goals of the legislation should be developed.

1. *Placing the Burden on the Physician?*

California law requires that the physician explain to the patient many financial incentives.¹⁹⁹ A strong argument can be made that a physician is the party responsible for distributing information concerning his financial incentives, including capitation arrangements.²⁰⁰ First, the physician is the party that agreed to join the MCO and function at the mercy of the agreement.²⁰¹ Second, when the physician in a capitated plan makes a medical decision, arguably it is his decision alone, and not that of the MCO,²⁰² especially when the agreement is a fully-shifted risk arrangement.²⁰³ Finally, the doctrine of informed consent requires the physician to explain the medical aspects of the any proposed course of treatment, including the impact on the physician's personal economics.

196. See Berwick, *supra* note 74, at 1228.

197. While physicians who will gain financially should be required to provide complete information for any patient that switches plans, MCOs should be charged with that responsibility when the physician isn't seeking to influence a patient for personal financial gain. Requiring written disclosure of financial interests in the new health plan furthers evidentiary concerns regarding proper disclosure and may be used to indicate the physician's compliance with the appropriate requirements. Moreover, if true informed consent is given to the party seeking to charge a MCO or physician with creating reasonable expectations, the documents will memorialize the conversations and aid in the patient's ability to meet the strict pleading requirements of fraud.

198. See *supra* note 106 and accompanying text.

199. See *supra* notes 6-12 and accompanying text.

200. See Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients*, 83 GEO. L.J. 1821, 1839 (1995).

201. See *id.*

202. See *id.*

203. See Pedroza, *supra* note 52, at 429 n.321.

There are many problems with requiring physicians to disclose the financial incentives of their contracts. Physicians are not necessarily the best party to explain the various financial incentives. A physician's time is best spent treating patients, not learning and then teaching the intricacies of complicated health care programs to their patients. Finally, by providing information to a patient, a physician might create reasonable expectations of increased care or inadvertently influence a patient to switch health care service plans.

2. *Placing the Burden on the MCO?*

Requiring the MCO to explain the financial incentives at the time of enrollment will help ensure that patients learn how their insurance works before they require medical attention.²⁰⁴ Up front disclosure by the MCO permits the enrollee to make an informed decision about health care options.²⁰⁵ MCOs would educate health care consumers about the relationship between health care cost and benefits received before circumstances become exigent.²⁰⁶ Moreover, patients are generally in contact with their insurer well before they ever meet their physician.²⁰⁷

It is especially important that MCOs educate enrollees in situations where enrollees have access to more than one health care option or provider, or in those situations where stratified insurance options are present.²⁰⁸ This approach would require setting rigid guidelines²⁰⁹ to allow the consumer to "shop" the available plans. Furthermore, active disclosure of MCO rates might affect the movement of enrollees to MCOs appearing to afford the best care.²¹⁰ Additionally, active

204. A patient should not be forced to discover that their plan does not cover a needed service only at the time when the service is needed.

205. See Malinowski, *supra* note 60, at 351.

206. See *id.* at 352. For example, under an early disclosure system, patients would be informed of the need to purchase supplemental insurance before it becomes "too late." See *id.*

207. See *id.* Shifting the burden of disclosure to the MCO will also require special provisions so that the duty to inform does not rest with the employer, but instead with a well-versed agent. See *id.*

208. See *id.* Patients will understand that lower costs may come with decreased care, and may in fact be willing to bargain for such an arrangement. While the intricacies of such a stratified system are beyond the scope of this comment, it is worth noting that legislative reform efforts should contemplate and put the appropriate mechanisms in place to regulate such health care plans.

209. See *id.*

210. See Kinney, *supra* note 165, at 323-24.

disclosure would help to eliminate subsequent lawsuits based upon the theory that a physician inappropriately steered a patient into a more profitable health plan.²¹¹

IV. CONCLUSION

The California legislature has taken steps in the proper direction. Limiting financial incentives and prohibiting MCOs from using gag orders will help physicians provide quality health care to the citizens of California. The legislature, however, failed to achieve the best solution to the California health care turmoil. The Legislature should review its efforts. First, it should clear up the ambiguity surrounding both physician advocacy for patient's ability to change health plans and benefit non-expansion language and, thus, remove the gag order that it created. Additionally, the legislature should limit how much risk the doctors are forced to accept and require the MCO to comply with a strict disclosure requirement before member enrollment. Only then will the California patient be afforded appropriate health care.

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211. Since the MCO, as opposed to the physician, advised the insured of the policy provisions, there would be less room to argue that the physician manipulated the patient.