The Two Faces of Gag Provisions: Patients and Physicians in a Bind

Cynthia Herdrich felt a sharp, persistent pain in her abdomen.¹ She went to see her doctor, a physician who was a member of her health maintenance organization,² but Dr. Lori Pegram sent her home. Herdrich returned six days later. This time, the doctor found an inflamed six-by-eight centimeter mass in her abdomen. Instead of sending Herdrich immediately to an emergency ultrasound, the doctor scheduled the test eight days later. By the time Herdrich had her ultrasound, her appendix had ruptured and she was suffering from peritonitis, a potentially fatal internal infection. She required emergency surgery and a lengthy hospital stay.

Herdrich sued the health plan operators. She was lucky to have this option, because many plans now require enrollees to sign waivers giving up the right to sue in court for any alleged malpractice claims. Such waivers usually force disputants into binding arbitration, concealing wrongdoing from the public and limiting the range of grievances that patients can raise.³

Herdrich claimed that the doctors avoided recommending costly emergency treatment because they knew any savings to the plan would increase the size of their annual bonuses.⁴ She asserted that these incentives created a conflict of interest, violating the plan’s fiduciary duty to patient members and the federal law governing private employee benefit plans, the Employee Retirement Income Security Act of 1974 (ERISA).⁵ Her ERISA claim was dismissed by the trial court, but reinstated by a divided panel of the Seventh Circuit Court of Appeals.⁶ ERISA, however,

¹ The account of Herdrich’s case is taken from Herdrich v. Pegram, 154 F.3d 363, 365, 374 (7th Cir. 1998).
² Herdrich was enrolled in the plan through her husband’s employer. See id. at 366 n.3.
⁴ In Herdrich’s case, the plan ended up paying far more for Herdrich’s extended hospital stay than it would have if it had ordered an immediate ultrasound and discovered the infected appendix, a condition easily and inexpensively treated when caught in time. See Herdrich, 154 F.3d at 374.
⁵ ERISA, 29 U.S.C. §§ 1001-1461 (1994), provides that a “fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries.” 29 U.S.C. § 1104(a)(1) (1994); see also Herdrich, 154 F.3d at 374 n.8 (quoting this section of ERISA).
⁶ Although Judge Flaum agreed in his dissent with the trial court’s judgment that structural incentives for cost-cutting did not “suffice to make out a cause of action for breach of fiduciary duty under ERISA,” Herdrich, 154 F.3d at 381, the majority disagreed, reinstating her
severely limited her damages award, allowing recovery only for the cost of medical treatment. 7

The doctor-bonus policy attacked by Herdrich is one of several types of "gag rules" used by managed health care organizations. 8 Traditionally, gag rules have been thought of as clauses in a doctor's contract with a managed care organization that prevent the doctor from revealing alternative treatment options to her patients if those treatments are not covered by the plan. However, gag rules come in many forms, ranging from such explicit policies to implicit rules that silence doctors by financially penalizing them for ordering expensive emergency treatment or for referring patients elsewhere.

Managed care organizations have vastly transformed the patient-physician relationship in the latter half of this century. The primary goal of the managed care revolution in American health care delivery and financing was "to eliminate unnecessary and inappropriate care and to reduce costs" 9 associated with the traditional fee-for-service model. 10

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7. Herdrich was able to proceed to trial on her standard medical negligence claim against the operators of the plan. She won a $35,000 jury award for compensatory damages. See Herdrich, 154 F.3d at 367. ERISA limited Herdrich's medical negligence claim to recovery of the cost of medical treatment and barred collection of damages for lost wages, disability, pain and suffering, emotional distress, and punitive damages. See Robert Pear, Hands Tied, Judges Rue Law That Limits H.M.O. Liability, N.Y. TIMES, July 11, 1998, at A1; Robert Pear, H.M.O.'s Using Federal Law To Deflect Malpractice Suits, N.Y. TIMES, Nov. 17, 1996, at A24.

8. "Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care where a primary emphasis is on controlling costs to patients and third-party payers." Jennifer L. D'Isidori, Stop Gagging Physicians!, 7 HEALTH MATRİX 187, 192 (1997).


10. Under the fee-for-service model of health care delivery and financing, indemnity insurers reimburse doctors and hospitals for patient care. The fee-for-service model encouraged physicians and hospitals to overtreat patients because they were compensated for each and every medical procedure or service performed. This system offered little incentive for cost containment since the purchasers of health care services (insurers) were not themselves the consumers...
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Managed care organizations (MCOs) rely on cost containment mechanisms that regulate the type, volume, and manner in which health care is delivered to patient enrollees. Although the growth of managed care has helped curtail the rise in health care premiums, the new system has raised a new set of medical and legal concerns, because it encourages the rationing of care and discourages doctors from ordering necessary treatments. Rationing techniques, including utilization reviews, the payment of financial incentives to physicians, and gag provisions, all operate to constrain physician and patient control over health care decisions.

MCO gag provisions harm both doctors and patients. This Article explores the varying kinds of gag rules and the harms they cause, analyzes recent state legislation and proposed federal legislation, and suggests a recommendation for further reform.

The wide variety of forms in which gag provisions appear and are justified complicates the assessment of their nature and effects. Part I provides general background information about types of existing gag rules.

Part II discusses the ways in which gag provisions affect physicians. Because most MCO-affiliated doctors have employment-at-will arrangements with their MCOs, they may be dismissed without cause or with only a minimal showing of cause. Without an affiliate, such doctors may find their livelihood threatened, given the importance of MCOs to the medical profession in the United States. However, if a doctor fails to disclose certain information, she may violate the Hippocratic Oath or the

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11. Managed care organizations (MCOs) operate as a variety of business structures, including, but not limited to, health maintenance organizations (HMOs), independent practice associations (IPAs), and preferred provider organizations (PPOs). The most common MCO structure is the HMO, which offers basic and supplemental health care in exchange for a periodic, prepaid, per-capita premium. HMOs then reimburse health care providers through a negotiated, capitated payment made on behalf of each enrolled person or family unit. In addition, HMOs shift the risk and cost of health care delivery onto doctors. See D'Isidori, supra note 8, at 192. For a more substantial discussion of the differences among MCO structures, see, for example, Kwon, supra note 10, at 835-36.

12. See Kwon, supra note 10, at 831 ("The injection of managed care into the third-party payment system has helped arrest the rise in health care premiums, from double-digit inflation in previous years to just a two percent increase in 1995.").

13. Utilization reviews involve an evaluation of a patient's treatment, either before or after the fact, to determine the "necessity and appropriateness (and sometimes the quality) of medical care." Barry R. Furrow et al., Health Law 321-22 (West 1995); see Kwon, supra note 10, at 837; Picinic, supra note 9, at 576 ("Utilization review programs require providers to seek verification from the MCO for particular medical procedures, such as pre-admission approval of hospital admission, and prior approval for both referrals to specialists and certain treatments.").

14. MCOs generally provide financial incentives, such as capitated payments and bonus/withhold arrangements, to their providers as a means of holding physicians and other health care providers accountable for the care they provide. See Kwon, supra note 10, at 836-37; Picinic, supra note 9, at 576.
Part II will also discuss how MCO gag provisions create nondisclosable conflicts of interest by providing physicians a secret financial incentive that conflicts with the patient’s well-being. Regardless of the type, MCO gag rules place doctors in a double-bind.

Part III addresses the effect of gag rules on patients. It argues that gag provisions harm patients by preventing them from making informed decisions about medical treatments and that these provisions diminish a patient’s ability to select an MCO that best suits his needs because he has access to little, if any, information about covered treatments.

Finally, Part IV first analyzes one state’s statutory prohibition of gag rules and then proposed federal legislation. The Article then concludes with suggestions for legislation aimed at solving the problems caused by gag rules.

I. TYPES OF GAG RULES

MCOs have typically justified gag clauses on the grounds that they protect proprietary information and that they are necessary to protect the competitive managed care market. MCOs argue such clauses are necessary to prevent doctors from encouraging patients to switch to another plan that might better compensate the doctor. In effect, however, gag provisions operate to “prevent physicians from making all required disclosures to their patients or from referring patients to specialists.”

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16. See Kwon, supra note 10, at 845 (“MCOs assert that gag clauses are necessary to prohibit physicians from disparaging the MCOs... and denigrating the MCO[s] to their patients.... From the MCO’s perspective, gag clauses are necessary to compete effectively in an industry that is becoming increasingly aggressive.”); see also CALIFORNIA SENATE RULES COMMITTEE, COMMITTEE ANALYSIS OF SB 1805, at 4 (May 20, 1996), cited in Justin D. Harris, The Timely Demise of “Gag Orders” in Physicians' Contracts with Managed Care Providers, 28 PAC. L.J. 906, 912 (1997) (describing a “disparagement” clause that prohibits doctors from making any statements to the patient which might undermine the individual's confidence in the plan); D'Isidori, supra note 8, at 197-98 (discussing MCO justifications for “confidentiality clauses” which protect proprietary information from competitors); Pear, supra note 15, at A1 (discussing the concerns of MCOs about terminated physicians who will encourage patients to switch MCOs by disparaging one MCO in favor of another). In line with these justifications, some MCOs have defended the confidentiality clauses on the grounds that the provisions “encourage physicians to take their complaints to management rather than to their patients.” D’Isidori, supra note 8, at 198. Accordingly, patients are left out of economic disputes between doctors and MCOs. See id. Moreover, advocates of the provisions argue that unsatisfied physicians have the option of seeking redress from regulatory agencies if the MCO’s administration is not receptive. In short, MCOs often defend their position by asserting that the “confidentiality clauses” “merely provide a structured and insulated framework for grievances.” Id.

17. See Picinic, supra note 9, at 607.

18. Kwon, supra note 10, at 837, 846 (discussing the range of constraints created by gag provisions on physicians, such as the prohibition against discussing with patients the (i) benefits of a longer hospital stay beyond the time covered by the MCO, (ii) financial incentives doctors
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A. Express Gag Clauses

1. Discussion of Treatment Options

One type of gag rule explicitly prohibits doctors from discussing certain treatment options with patients.\(^9\) MCOs seek to enforce these provisions in order to prevent patients from seeking coverage elsewhere from another insurer. MCOs are also concerned that doctors with ulterior motives might encourage patients to seek coverage from another insurer by telling patients that their current insurer would not cover the best treatment options for their problems.\(^2\) Doctors affiliated with multiple MCOs might be tempted to offer such information because they hope to switch patients to health plans that provide more lucrative arrangements for the physicians. This type of gag rule, however, directly conflicts with the doctor’s duty to obtain informed consent; if noncovered treatment options are available and appropriate, the doctor must either inform patients of such options or face liability for battery.\(^2\) Thus, in order to shield themselves from liability to the patient, doctors must violate such provisions. Because of the conflicted position in which such gag clauses place doctors, most states have enacted legislation prohibiting these provisions.\(^2\) A recent federal act also prohibits MCOs that care for Medicare patients from using this type of gag clause in provider contracts.\(^2\)

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\(^9\) See Picinic, supra note 9, at 581.

\(^2\) See id. at 581 & n.69, 582 & n.70.

\(^2\) See Canterbury v. Spence, 464 F.2d 772, 781 (D.C. Cir. 1972) (stating that a physician may be duty-bound to “advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued”).

2. **Doctors’ Compensation Structure**

A second kind of gag clause restricts a doctor’s ability to disclose details about how she is compensated by the MCO or about the physician incentive structure the MCO uses to contain costs. MCOs have claimed that these clauses are necessary to protect proprietary information regarding the details of how the business is run. MCOs, the argument goes, labored intensively to negotiate the details of their contracts with participating providers, and competitors could use such information to gain a competitive advantage if they were obliged to disclose it.

Requiring doctors to withhold such information from patients, however, can again be seen to conflict with physicians’ duty to inform their patients of all information relevant to giving informed consent for treatment. From a doctor’s perspective, information on how an MCO compensates physicians is most useful for the patient when he is deciding which MCO plan to join, assuming he has a choice of plans. To be sure, a doctor may be reluctant to supply such information herself if she is concerned that such knowledge may jeopardize the trust the patient places in her to provide the best care possible. Nevertheless, many doctors prefer to have the right to disclose such information because they believe it may give their patients information relevant to making an informed decision about which MCO is appropriate for them.

The use of such incentives may well be a necessary cost-containment tool, but it can interfere with the doctor-patient relationship. As a result, those states that have legislated in this area have tended to place on MCOs the burden of providing information regarding compensation structures.

3. **Public Criticism**

The third category of gag rules, which includes anti-disparagement clauses, prohibits health care providers from criticizing the policies of the MCO to the general public or to patients. Such a gag provision contained in U.S. Healthcare’s provider contracts states:

Physicians shall agree not to take an action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in [the MCO] or the quality of [the MCO’s] coverage .... Physicians shall keep the Proprietary

24. See Picinic, *supra* note 9, at 582-83.
25. See id. at 608.
27. See Picinic, *supra* note 9, at 581-82.
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Information [payment rates, utilization review procedures, etc.] and this Agreement strictly confidential.  

Other gag provisions more explicitly discourage doctors from advising patients to seek plans that may better suit their particular medical needs. Consider, for example, the requirement that “[p]hysicians shall not, directly or indirectly, counsel or advise any Enrollee to disenroll from any Contracting Payor program or product or to access such program or product through any person or entity other than the IPA.”

If the doctors have legitimate complaints about a plan, many MCOs require that they be expressed to the MCO rather than to individual patients. Some physicians, however, argue that such clauses hinder their ability to fulfill the responsibility of informing patients about the quality of care their MCOs provide. Only a few states have protected physicians’ rights to criticize MCO policies to their patients.

B. Implied Gag Clauses

The vast majority of states have acted to prohibit certain types of gag clauses, especially those that explicitly interfere with the doctor’s duty to inform patients of all available treatment options. Nonetheless, implied gag rules, created by typical MCO incentive systems, can have as insidious an effect on the doctor-patient relationship. Implied gag rules are unwritten codes of conduct that MCOs enforce against their affiliated providers. Many provider-MCO affiliation contracts have at-will or no-cause termination clauses. MCOs can use such clauses to enforce implied gag rules by implicitly suggesting that providers who appeal denials of care or criticize the MCO’s policies too often—that is, providers who impose too many costs on the MCO by undertaking such actions—will be terminated. Currently, providers who are terminated under such provisions have virtually no recourse, because almost no regulation of at-will termination clauses exists in this context. Implied gag rules and their effect on doctors will be discussed further in Part II.

29. D’Isidori, supra note 8, at 196 (quoting American Medical Association, Background Information About “Gag” Clauses 2 (unpublished information provided by the AMA)) (emphasis added).
30. See id.
31. See Spielman, supra note 22, at 455.
32. See id. at 456; see also, e.g., CAL. BUS. & PROF. CODE § 2056.1 (West 1998); COLO. REV. STAT. ANN. § 10-16-121 (West 1998); MINN. STAT. ANN. § 62J.71 (West 1998).
II. EFFECTS OF MCO GAG PROVISIONS ON PHYSICIANS

This Part will discuss the effects of MCO gag provisions on physicians. While much has been written about the deleterious effects of the provisions on patients enrolled in MCO plans, comparatively little has been written about the effects on doctors who must face the competing directives of professionalism, tort liability avoidance, and employment necessity. This Part will argue that, because a large number of doctors must rely on MCO affiliation for their livelihood and because a large number of them are employees-at-will of the MCOs, doctors must often choose between the Scylla of losing their MCO affiliation and their livelihood for failing to abide by the gag provisions and the Charybdis of being held liable for malpractice for failing to inform their patients adequately.

As a practical matter, most doctors in the United States must be affiliated with an MCO in order to make a living. But most doctors have employment-at-will arrangements with MCOs. Employees-at-will may be dismissed from employment at any time, for any reason or for no reason at all. As a result, MCOs are generally allowed to release doctors on a minimal showing of cause and are entitled to terminate their contracts with doctors if the doctor provided care in a manner inconsistent with the MCO's policies. Physicians who disclose treatment options about which the MCO, for financial reasons, does not wish its members to know face dismissal and a serious threat to their livelihood. Furthermore, even if a physician is not explicitly bound by a written gag clause, because she is an


34. See D'Isidori, supra note 8, at 203-06 (noting that gag provisions create conflicts of interest for physicians); Julia A. Martin & Lisa K. Bjerknes, The Legal and Ethical Implications of Gag Clauses in Physician Contracts, 22 AM. J.L. & MED. 433, 458-61, 467-68 (1996) (discussing infringement of physicians' free speech rights imposed by gag provisions and consequences for violating ethical principles at the behest of MCOs).


37. See Payne v. Western & Atl. R.R., 81 Tenn. 507, 519-20 (1884) (applying the employment-at-will rule and holding that, under the rule, employees could legally be dismissed “for good cause, for no cause or even for cause morally wrong”).

38. See Jurgeleit, supra note 36, at 256.
employee-at-will, she may be dismissed for taking any action that the MCO deems subversive.

A. Contractual Remedies

Since gag provisions provide that physicians may not disclose certain information to their patients, contracts between MCOs and physicians that contain such provisions fall into the category of so-called “contracts of silence.” Neither the courts nor academics have adequately examined the legal status of “contracts of silence.” It is unclear whether gag clauses can be stricken by judges absent a statute, even though the clauses appear to be contrary to the public interest.

Blackmail involves contracts of silence, and it is illegal in every U.S. jurisdiction. One compelling reason for its illegality is that a significant class of those adversely affected by blackmail are nonparties to the transaction. For example, if one individual exacts payments from another individual on pain of publicizing the fact of an otherwise unsolved murder, both the murderer and the blackmailer arguably benefit from the transaction, whereas the victim’s family and the general public, nonparties to the transaction, suffer significant harm from it. Along similar lines, Alan Garfield argues that courts should regulate contracts of silence because they “threaten public access to information.” Garfield’s analysis, therefore, provides a patient-protection rationale for regulating gag provisions: Even if both parties to an agreement containing a gag clause were made better off by it, patients served by the MCO-affiliated doctors would be unacceptably harmed by it.

A compelling rationale from the physician’s perspective also exists. One could plausibly argue, for example, that a contract that potentially forces a physician to abandon her professional responsibilities could be stricken by a court because it is unconscionable. Courts void contracts for unconscionability when they result from a process marked by unequal bargaining power and when they contain substantively unfair terms. With respect to the former condition, it has been convincingly argued that physicians, having limited ability to negotiate, are effectively re-

40. See id. at 263 & nn.3-4.
41. Cf. D’Isidori, supra note 8, at 211-13 (discussing the inadequacy of the common law public policy exception to employment-at-will in protecting MCO-affiliated physicians).
43. See id. at 702-05.
44. Garfield, supra note 39, at 266.
required to accept the terms of employment provided in MCO form contracts. With respect to the latter condition, any provision that may require a physician to withhold information that she believes is relevant to her patients’ ability to give informed consent is tantamount to a contract to commit malpractice, because physicians owe a duty of informed consent to their patients.

B. Doctor’s Duty of Care to Patients and the Double-Bind

Some authorities have characterized the relationship between a physician and her patients as analogous to a fiduciary arrangement. Like a fiduciary, a physician is held to a high standard of care because her patients rely on her professional expertise in providing treatment advice and in advocating for their best interest. Doctors thus have a common law duty to inform their patients of all reasonable options before the patient is deemed to have granted informed consent for a given treatment protocol. Without informed consent, a physician may not treat an individual; if she does, she can be held liable for battery. In addition, the Hippocratic Oath and American Medical Association standards place an ethical and professional duty on physicians to provide the best care possible and to advocate on behalf of their patients.

In practice, however, a doctor-patient relationship differs from a typical fiduciary relationship, especially when the doctor is an MCO affiliate. For example, fiduciaries may not create conflicts of interest or promote their own self-interest. MCO-affiliated physicians, in contrast, are placed in a double-bind, forced to decide between taking into account the patient’s best interests and considering their own employment and financial incentives. Gag rules, whether express or implied, heighten the doctor’s dilemma.

46. See Little, supra note 35, at 1427-29.
47. See infra note 49 and accompanying text.
49. See Canterbury v. Spence, 464 F.2d 772, 787-88 (D.C. Cir. 1972) (holding that a patient must be informed of potential hazards of treatment, treatment alternatives, and likely results of refusing treatment before being deemed to have granted informed consent).
50. See id.
51. Doctors who take the Hippocratic Oath swear to follow the plan of treatment which they consider most beneficial to their patients. HIPPOCRATES, HIPPOCRATIC OATH (W.H. Jones trans., 1923), reprinted in MARC A. RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIANS’ CONFLICT OF INTEREST 268 (1993). This ancient standard of care has survived in contemporary statements of medical ethics. See AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS Principle II (1980), quoted in RODWIN, supra, at 269.
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1. *Implied Gag Rules*

As noted above, termination clauses in provider-MCO contracts often allow physicians to be terminated for no cause at all or on a minimal showing of cause based solely on economic factors. Such factors may include poor profit margins due to overutilization of health care resources by one doctor compared to the level of resource utilization by other physicians affiliated with the MCO. Such economic credentialing frequently fails to take into account the medical necessity of the increased resource utilization in individual cases. Thus, affiliated providers are forced to consider their own standing within the MCO when making decisions concerning patient care. Physicians know that, if they do not cooperate extensively with their MCOs, they may be dismissed and thereby lose a substantial portion of their livelihood.

Even if she has the ability to obtain prior authorization for resource utilization, a physician may be reluctant continuously to seek authorization for expensive treatments for fear that the MCO might terminate her for economic reasons. Similarly, a doctor may be reluctant to challenge or appeal an MCO’s decision to deny coverage for a specific treatment for fear of appearing uncooperative with the MCO. Thus, many doctors may opt not to order substantially useful treatment, at all. In addition, physicians may be disinclined to inform patients of treatment options not covered by their MCO if they think the patients might choose a different MCO in order to obtain such coverage. For the same reason, doctors avoid openly criticizing the MCO’s coverage policies and disclosing a system of physician incentives that discourages overutilization. If an MCO observed that a participating physician was losing enrollees or that a high number of that physician’s enrollees challenged the MCO’s denials of coverage, it could dismiss that provider, having only to show the decreased profitability of the provider’s affiliation or no cause at all.

When doctors have challenged their dismissal by an MCO, courts have generally upheld no-cause termination provisions as well as provisions that permit termination exclusively on economic grounds. For example, in *Knapp v. Palos Community Hospital*, the court upheld the defendant hospital’s decision to terminate the privileges of several physicians because they overutilized the hospital’s resources. The *Knapp*
court held that the hospital’s termination decisions were “not subject to judicial review,” as long as the hospital followed its own bylaws in making the decision to terminate the physicians, because the hospital was far better equipped than the court to make economic decisions for its business.  

A recent New Hampshire case provided some hope for physicians seeking to challenge termination under a no-cause agreement. The New Hampshire Supreme Court read a common law implied covenant of good faith and fair dealing into an at-will termination clause. The court held that a dismissed physician has a cause of action against an MCO if there is evidence that the at-will termination was the result of “malice or bad faith in retaliation for action taken or refused by the employee.” The court noted that public policy grounds for review of the termination could be invoked, because “the termination of [Harper’s] relationship with Healthsource affects more than just his own interest.” However, the court upheld the right of MCOs to use at-will provisions. Thus, the only precedent the case set in favor of physicians was a right to challenge a termination decision if the plaintiff believes the action was taken in bad faith or as a retaliatory measure. Such a high standard is often difficult to meet, especially if the MCO can point to economic factors that courts are reluctant to review.

New York has been one of the few states to enact legislation offering substantial protection to physicians terminated by an MCO. Under the New York law, MCOs must provide a written statement of reasons for a termination decision and must grant hearings at which the doctor may protest the decision. Furthermore, MCOs must provide the economic data that led to the decision to terminate and must give the terminated physician an opportunity to explain her higher rate of utilization. The physician may defend her record by proving, for example, that her patients had more ailments than average. This law also prohibits bad faith or retaliatory terminations. Thus, New York no longer permits its MCOs to terminate physicians without cause and now requires them to provide an economic justification for the termination decision in the context of the physician’s clinical profile.

57. Id. at 563.
59. Id. at 965.
60. Id. at 966.
61. See id.
63. See N.Y. INS. LAW § 4803 (McKinney 1998).
64. See id.
2. Legislative Remedies Currently Available to Physicians

As indicated above, in Subsection I.A.1, many states have acted to prohibit the most egregious examples of express gag provisions in order to allow doctors to perform their common law and ethical duty to obtain informed consent from their patients. However, at-will termination clauses still pose a significant threat to physicians. Such clauses permit the enforcement of implied gag rules, thus interfering with a physician's ability to act in her patient's best interest. Federal attempts to enact uniform legislation to protect doctors' advocacy for their patients have failed thus far. In addition, a number of courts have interpreted ERISA to preempt much state legislation that would otherwise regulate MCO-provider contracts. Thus, MCOs can continue to threaten physicians with termination, employing de facto gag clauses with virtual impunity.

A number of courts have interpreted ERISA to preempt state law claims brought by terminated physicians for breach of contract. For example, in Zuniga v. Blue Cross Blue Shield of Michigan, the court held that ERISA preempted the breach-of-contract claim of a doctor whose affiliation to the defendant was terminated for alleged overutilization. The court, applying the Supreme Court's interpretation of ERISA preemption established in Shaw v. Delta Air Lines, held that the federal act preempts any state law that relates to a company-funded employee benefits plan. Although a number of commentators have argued that Congress never intended to regulate MCO-provider contracts through ERISA, the Supreme Court has yet to resolve the issue.

III. Effects of MCO Gag Provisions on Patients

To the extent that gag provisions restrict complete disclosure to patients, the patient-physician relationship is impaired. First, the patient cannot give informed consent. Second, patients will not be aware of the content and extent of information withheld by the physician and, thus, will tend not to seek second opinions to acquire information they should have. "[I]nformation . . . is precisely what is being bought from most
In fact, a major concern in the business of managed care is that "health care consumers will not be able to formulate the preferences for which they wish to negotiate." Ultimately, the gag provisions undermine the firmly rooted contractual and fiduciary foundations of the patient-physician relationship.

The patient is, like the doctor, caught in a no-win situation. Most patients have little or no choice in their selection of a health plan, which is largely determined by their employers. Even if the physician offers a patient the opportunity to obtain treatment elsewhere, the patient may lack the financial means to do so, as the particular treatment may fall outside the range of employer-provided health care benefits. Furthermore, even for patients with financial means, alternative coverage is often denied, since the patient is already sick and unprofitable to other MCOs. While the resolutions to some of these problems require analysis beyond the scope of this Article, it is clear that the search for resolutions must begin with a critical examination of the nature and extent of the effects of gag provisions on patients.

A. Breach of Physician's Duty

The doctor's duty to her patient has at least three bases. First, the relationship between the doctor and patient has been recognized as a contract, which, express or implied, establishes the physician's duty to aid the patient who is, in essence, a person in peril.

Second, tort principles require that a physician be held liable for medical malpractice if she "fails to provide the care to a patient that a reasonable physician under the same circumstances would provide, even if the physician is prevented from providing reasonable care by limited resources." Physicians are also subject to tort liability for denying care solely (or largely) in order to increase their income.


74. Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 Am. Econ. Rev. 941, 946 (1963); see also Paul M. Schwartz, Privacy and the Economics of Personal Health Care Information, 76 Tex. L. Rev. 1, 48 (1997) ("A gag rule affects a medical service, namely information about treatment options, that plays a special role in health care." (emphasis added)).

75. Schwartz, supra note 74, at 48.

76. See, e.g., Lyons v. Grether, 239 S.E.2d 103, 105 (Va. 1977) (stating that the doctor-patient relationship "springs from a consensual transaction, a contract, express or implied, general or special").

77. D'Isidori, supra note 8, at 200; see also Wickline v. California, 228 Cal. Rptr. 661, 670-71 (Ct. App. 1986) (stating that a physician who complies without protest to limitations imposed by a third-party payor cannot avoid ultimate responsibility for patient's care if the care provided is unreasonable); Mehlman, supra note 48, at 352 (discussing the extent to which physicians are required to furnish access to health care regardless of resource constraints); Jonathan J. Frankel, Note, Medical Malpractice Law and Health Care Cost Containment: Lessons for Re-
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Third, most courts recognize the fiduciary law foundations of the patient-doctor relationship. Such fiduciary relationships involve the duty voluntarily undertaken by the physician, that of acting primarily for the patient’s benefit. The presumption that the physician possesses superior knowledge of medical diagnoses and services and that the patient accordingly places trust in the physician underlies the characterization of a doctor as a fiduciary.

B. Failure To Secure Patient’s Informed Consent

Closely aligned with the patient’s claim of breach of duty is the claim that the physician has violated the patient’s right to informed consent. In a medical context, the doctrine of informed consent rests on the notion of a patient’s right to individual autonomy and self-determination—that is, the right to exercise control over his own body and to determine whether or not to follow a particular course of medical therapy. Originating from the common law battery action, the doctrine of informed consent has expanded considerably in scope and has evolved into a negligence-based standard. This doctrine may be characterized today as, perhaps, the patient’s most formidable “guardian of individualism”.

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78. See Mehlmah, supra note 48, at 371. But see Madsen v. Park Nicollet Med.Ctr., 419 N.W.2d 511, 515 (Minn. Ct. App. 1988) (stating that it was proper to exclude evidence that could have adversely affected her doctor’s profits because the “evidence was only marginally relevant [to the malpractice claim] and potentially very prejudicial”), rev’d en banc on other grounds, 431 N.W.2d 855 (Minn.).


80. A fiduciary is a “person having a duty, created by his undertaking, to act primarily for another’s benefit in matters connected with such undertaking.” BLACK’S LAW DICTIONARY 625 (6th ed. 1990).

81. See Picinic, supra note 9, at 591 (“Informed consent originates from the theory that a health care provider cannot physically contact or treat a patient until the provider has given the patient an adequate amount of information regarding the proposed treatment with which the patient may then make an intelligent decision regarding that treatment.” (emphasis added)).

82. See id. at 592; see also Pratt v. Davis, 79 N.E. 562, 565 (III. 1906) (finding trespass to the patient where the doctor removed her ovaries without consent); Mohr v. Williams, 104 N.W. 12, 16 (Minn. 1905) (holding that a physician’s unauthorized treatment of a patient was “at least a technical assault and battery”); D’Isidori, supra note 8, at 206-07 (discussing the origins of the doctrine of informed consent).

83. See generally Alan Meisel & Lisa D. Kabnick, Informed Consent to Medical Treatment:
It protects the patient's right to determine his own destiny in medical matters; ... it guards against overreaching on the part of the physician; it protects his physical and psychic integrity and thus his privacy; and it compensates him both for affronts to his dignity and for the untoward consequences of medical care.  

Judge Cardozo, in Schloendorff v. Society of New York Hospital, articulated this view of patient self-determination, which ultimately rests on the disclosure and trust present in a fiduciary relationship. At the core of informed consent is disclosure—disclosure of the proposed treatment's risks and benefits, the probability of success, and alternative forms of treatment. The court in Cobbs v. Grant held that physicians are under a duty to disclose available medical treatment options and the dangers associated with each. In fact, a physician has a duty to disclose information about a type of treatment even if it is not readily available.

The informed consent rule is no less applicable in the managed care arena. The American Medical Association (AMA) guidelines state:

Physicians ... should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives ... is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all their treatment options, even those that may not be covered under the terms of the managed care plan.


D'Isidori, supra note 8, at 206.


105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body ... ."); see also Picinic, supra note 9, at 591-96 (discussing the doctrine of informed consent and patients' rights).

See Picinic, supra note 9, at 593-95 & nn.123-28. Picinic notes that:

Informed consent requires physicians to disclose many things such as: the nature and consequences of the procedure or treatment; the diagnosis; the risk of the procedure; the alternatives to the proposed treatment; the prognosis if there is no treatment; the prognosis with treatment; and the disclosure of success rates and outcomes for a particular procedure. In addition, physicians may be required to notify a patient of any existing conflict of interest.

Id. at 593-95 (footnotes omitted).

To obtain informed consent, a physician must "explain the proposed procedure to a patient and warn [the patient] of any material risks inherent in the treatment so that the patient can make an intelligent decision to undergo the procedure." D'Isidori, supra note 8, at 207. For judicial articulation of the informed consent rule, see, for example, Nishi v. Hartwell, 473 P.2d 116, 119 (Haw. 1970) (requiring physicians to inform patients of risks, benefits, outcomes, and alternatives for treatments).

8 Cal. 3d 229, 243 (1972).


Council on Ethical and Judicial Affairs, American Medical Association, Ethical Issues...
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Additionally, the AMA places upon MCOs the burden of "adher[ing] to informed consent" by giving patients "full disclosure of material information . . . [including] inform[ing] potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan." Upon enrollment, and at least annually thereafter, the AMA also requires MCOs to disclose "any incentives to limit care" offered to physicians employed or reimbursed by the managed care plans.

Despite issuing these guidelines, the AMA has failed to articulate a framework that would allow courts to effectively and consistently determine whether the physician's (and MCO's) duty to inform the patient has been breached. Courts typically use a two-step analysis when inquiring into violations of a patient's right to informed consent. The first question is whether the patient would have consented to the treatment had the physician adequately disclosed the material risks, benefits, and alternatives, and the second question is whether nondisclosure was the proximate cause of the patient's injury. This creates two potentially troublesome issues for litigants and patients' rights advocates. First, whether a particular gag provision in a physician's contract forced her to violate the duty of informed consent must be determined on a case-by-case basis. Second, and complicating the first issue, the plaintiff faces the burden of proof to establish that he would not have made particular treatment choices had there been full disclosure.

C. Holding Managed Care Organizations Liable

The debate on gag provisions turns on the relationship of the patient with his physician and with the managed-care organization. MCOs have minimal duties to solicit the informed consent of patients because the physician—not the MCO—intrudes upon the patient's right to self-determination. Nonetheless, MCOs can be held liable for the acts of employed physicians (including failure to obtain informed consent from patients) through the doctrines of ostensible agency and respondeat superior.

in Managed Care Guideline 2(f) (1994), quoted in D'Isidori, supra note 8, at 208 n.99.
92. Id. at Guideline 2(e), quoted in D'Isidori, supra note 8, at 209 n.102.
93. Id. at Guideline 3, quoted in D'Isidori, supra note 8, at 208 n.101.
94. See Terrion, supra note 90, at 500-01. The first step in the analysis may be resolved by applying one of three possible standards for disclosure: the medical professional standard, the reasonable patient standard, or the subjective standard. For further insight into this analysis, see id. at 502-06.
95. See id. at 500.
96. See Nancy M. King, Consent to Treatment, in HEALTH CARE FACILITIES LAW: CRITICAL ISSUES FOR HOSPITALS, HMOs AND EXTENDED CARE FACILITIES § 7.4, at 482.
97. See, e.g., Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988) (finding a material issue of fact as to the MCO's liability for the negligence of its physicians under the theory of agency because the MCO's advertisements indicated that there was an agency
A strong argument can be made that MCOs should be liable under either agency or respondeat superior theories when physicians abide by gag clauses that prohibit the disclosure of relevant information to patients. Additionally, MCOs may be liable under the theory of corporate negligence, ERISA, breach of contract, breach of warranty, and bad faith. The latter claims may be difficult, however, for the patient to argue in court.

First, since these claims rely on establishing direct corporate liability for a physician's action or failure to act, the patient must prove the physician liable on malpractice grounds. This will be difficult for the patient to establish, since the "reasonable physician" standard used to assess malpractice claims is much more difficult to meet than the standard in informed consent cases. To succeed in a malpractice claim, the patient "must prove that the physician's negligent performance resulted in injury." However, even if such injury exists, courts will probably not at

relationship between the doctor and the MCO); Picinic, supra note 9, at 598 & n.141.

For respondeat superior to apply, an employer-employee relationship must exist between the physician and the MCO. If the MCO exerts sufficient control over the physician-employee, the MCO may be found liable for the physician's acts. See Picinic, supra note 9, at 598 & n.142; see also Sloan v. Metropolitan Health Council, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987) ("[A] corporation may be held vicariously liable for malpractice for the acts of its employee-physicians."); Dunn v. Fraiss, 806 A.2d 862, 868-69 (N.J. Sup. Ct. App. Div. 1992) (finding an MCO liable under the theory of respondeat superior for the negligent acts of its physicians where the doctor was determined to be an actual agent of the MCO due to the level of control that the MCO exercised over the physician). But see Raglin v. HMO Illinois, Inc., 595 N.E.2d 155, 158 (Ill. App. Ct. 1992) (holding that an MCO was not liable under the theory of respondeat superior for negligent acts of its physicians when the physicians were considered independent contractors). Accordingly, to determine whether an MCO is liable for the acts of its providers, the relationship between the MCO and the physicians must be carefully evaluated.

Under the theory of corporate negligence, an MCO has the duty to exercise care in selecting, supervising, and controlling its medical staff. This duty extends to ensuring that patients receive high quality care. Accordingly, a patient may sue an MCO for "negligent interference with the patient's health care decisions" by employing gag clauses or utilization reviews. Picinic, supra note 9, at 598 n.145.

A patient may allege that the MCO breached its contract by failing to provide high quality medical services as promised in the enrollment contract. In order to recover, the patient must prove that the harm "arose in the usual course of events from the breach or that the harm could 'reasonably be supposed to have been in the contemplation of both parties, at the time they made the contract.'" Linda V. Tiano, The Legal Implications of HMO Cost Containment Measures, 14 SETON HALL LEGIS. J. 79, 90 (1990) (citing Hadley v. Baxendale, 156 Eng. Rep. 145, 151 (Ex. 1854)).

For instance, MCOs may be held liable for failing to conform to published statements in their subscriber contracts or promotional brochures.

A patient may argue that the MCO, in bad faith, enforced "restrictions on various medical procedures, medical treatment, and hospital stays as well as limitations on referrals to specialists and outside physicians." Picinic, supra note 9, at 600 & n.147 (quoting Diana Joseph Bearden & Bryan J. Maedgen, Emerging Theories of Liability in the Managed Health Care Industry, 47 BAYLOR L. REV. 285, 334-37 (1995)).

See Martin & Bjerknes, supra note 34, at 453.
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tribute it to the existence of gag provisions. A physician’s failure to disclose conflicts of interest will not result in malpractice liability because “the basis of malpractice liability is the deviation from the standard of care, not the presence of a hidden economic incentive.”

Second, an MCO will rarely be found liable on contract or breach of warranty principles for employing gag provisions. To prevail, the patient must prove that the MCO made specific promises of a particular level of care to its enrollees and that such level of care was not met. This construction may allow the rare patient to establish MCO liability if the MCO “clearly promise[d] a particular result” and if the patient “consented to an operation or other procedure in reliance” on such promise. In general, however, most patients will not prevail, largely because courts have found that an MCO’s literature claiming that it will provide “high standards” of medical care represents only “generalized promises of a good result,” not a guarantee. Thus, courts have effectively precluded liability for breach of warranty.

Accordingly, an MCO’s liability for imposing gag clauses is severely limited.

IV. PROPOSALS

Both doctors and patients suffer under a regime of gag clauses and have limited recourse to change it. Because such provisions are widespread throughout the managed care industry, and thus the health care industry as a whole, doctors cannot easily avoid express or implied gag clauses. Inside a restrictive work environment, doctors face termination

106. Id. at 457 (emphasis added).
108. Id.
110. Before the general outlawing of express gag clauses, such rules were a common component of MCO contracts. Indeed, gag clauses became a badge of shame only recently, when the number of MCO consumers dramatically increased. For instance, the provider contracts of Kaiser-Permanente, one of the country’s largest MCO providers, had overt gag clauses until 1995. Today, implied gag clauses are still widespread, and at-will employment contracts are the norm.
112. The fact that most doctors work for multiple providers creates only the semblance of discretion because it also fosters similarities between care providers. As a result, “most of today’s MCOs are not the differentiated delivery systems visualized in competition theory; instead, they are merely financing intermediaries all offering virtually the same product and differing from the third-party payers of the old paradigm only in their ability to demand lower prices . . . from providers.” Clark C. Havighurst, Making Health Plans Accountable for the Quality of Care, 31 GA. L. REV. 587, 630 (1997).
for tacitly or explicitly violating gag clauses. Notably, physicians may also fear for their job security even outside of the workplace. Under at-will termination, public critique or participation in an organized movement to reform the industry could cost a doctor her job.

Patients are, first, unable to exercise true informed consumer discretion when choosing plans and, later, limited in their ability to induce action through suit. Because MCOs function under a broad shield of liability protection established by ERISA, many of their customers are not entitled to sue them under state remedies. Moreover, with little mandated disclosure, MCOs are free to establish rules that keep valuable customer information away from the customer, on the grounds that such information is proprietary.

A. The State Legislation Solution

1. New York's Statute

In 1996, New York enacted a fairly comprehensive statute that effectively prevents MCOs from using implied gag rules to hold the threat of termination over a doctor's head. The legislation imposes minimum standard appeal procedures for physicians' challenges to contract terminations. In addition, the statute prohibits terminations as retribution "solely" because the doctor appealed a denial of care, advocated on behalf of her patients, or filed a complaint against the insurer. The appeal process must also give a doctor the opportunity to present evidence that her patients required a greater level of resource utilization than those treated by other similarly situated physicians under the plan.

The statute has certain gaps, however. First, the insurer appoints all three members of the appeals board that reviews a doctor's termination decision. Such unilateral appointment authority could compromise the


115. See id. § 4803.

116. See id. § 4803(e).

117. See id. § 4803(d) ("[E]ach health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the professional's [economic evaluation] profile and to work cooperatively with the insurer to improve performance.").

118. See id. § 4803(b)(3).
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impartiality of the appeals board. In addition, while the physician can provide evidence indicating a need for greater than average utilization, there is no provision indicating how heavily the appeals board must weigh such evidence in reviewing a decision to terminate. Moreover, while the statute mandates that termination may not be based "solely" on retributive reasons, the weak language still allows an MCO to use such reasons in a termination decision, provided it can articulate additional reasons for the decision. For example, an affiliated doctor might be terminated properly under the statute if the MCO were to cite increased costs imposed by the physician on the insurer due in part to the physician's filing of appeals of utilization denials. Finally, the statute explicitly provides that its provisions are not applicable to review procedures under a plan governed by ERISA, that is, self-funded benefit plans.

2. ERISA Preemption

State efforts to ban physician gag clauses may fail to protect most managed care consumers. More than eighty-six million Americans receive their health care coverage through private employer-sponsored plans. Most courts have held that many state-law causes of action are preempted by the broad reach of ERISA.

ERISA's provisions "shall supplant any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." The statute defines state law as "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." Most courts construe ERISA's preemptive power broadly—state law is preempted if it has a "connection with or reference to" an employee benefit plan. The "relates to" language has the effect of allowing ERISA preemption for state tort actions based on an MCO's negligence in denying necessary

119. See Little, supra note 35, at 1462-63.
120. See id. § 4803(d).
121. See id. § 4908; infra Subsection V.A.2.
122. This figure represents more than half of all privately insured Americans. See Martin & Bjerknes, supra note 34, at 465 (discussing the ERISA limitations on MCO liability for imposing gag clauses on physicians).
124. Id. § 1144(a).
125. Id. § 1144(c)(1).
Accordingly, ERISA preempts the majority of claims against MCOs, specifically those based on denial of coverage, misrepresentation as to plan benefits, financial incentives, disclosure requirements, and utilization review decisions. The courts have designated these elements as administrative decisions and, thus, have invoked ERISA preemption.

A number of state-law-based claims are not subject to ERISA preemption. First, ERISA does not preempt state regulation of the insurance business. Second, ERISA does not preempt state common law claims based on straightforward grounds of medical malpractice. The majority of claims challenging gag clauses, however, are not based on malpractice but rather seek to establish patient rights to particular medical coverage or treatment options. As a result, ERISA will preempt a majority of claims made by managed care patients—specifically the eighty-six million subscribers enrolled in ERISA plans—because “an HMO is likely to argue that the claim involves an administrative aspect of the plan in order to trigger ERISA’s preemption effect.”

The Supreme Court’s refusal to resolve the issue of whether ERISA preempts state-law-based tort claims against MCOs and the uncertain scope of its ruling in New York State Conference of Blue Cross & Blue

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127. See, e.g., Tolton v. American Biodyne, Inc., 48 F.3d 937, 943 (6th Cir. 1995) (dismissing a claim for wrongful death where an MCO denied psychiatric benefits and the patient subsequently committed suicide); Spain v. Aetna Life Ins. Co., 11 F.3d 129, 132 (9th Cir. 1993) (ruling that ERISA preempts a suit in which an MCO refused to authorize and later delayed approval for a bone marrow transplant); Kuhl v. Lincoln Nat’l Health Plan, 999 F.2d 298, 302 (8th Cir. 1993) (holding that ERISA preempts a wrongful death suit in which the MCO initially refused and then delayed approval for heart surgery). Several cases, however, hold that state tort claims are not preempted. See, e.g., Rice v. Panchal, 65 F.3d 637, 646 (7th Cir. 1995); Pacificare, Inc. v. Burrage, 59 F.3d 151, 155 (10th Cir. 1995), Dukes v. U.S. Healthcare, 57 F.3d 350, 351-52 (3d Cir. 1995); see also Herdrich v. Pegram, 154 F.3d 363, 365, 374 (7th Cir. 1998); supra text accompanying notes 1-6. For additional insight on judicial construction of ERISA preemptions of claims related to managed care, see Little, supra note 35, at 1464-68 and Susan O. Sheutzow, A Framework for Analysis of ERISA Preemption in Suits Against Health Plans and a Call for Reform, 11 J.L. & HEALTH 195 (1996-97).

128. See Picinic, supra note 9, at 614 & nn. 214-15.

129. See, e.g., Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992) (finding that even though the MCO made the medical decision, it was still considered an administrative decision regarding benefits made under the plan and, thus, was preempted by ERISA).


131. See, e.g., Pickett v. Cigna Healthplan, 742 F. Supp. 946 (S.D. Tex. 1990) (concluding that state, not federal, law should apply in a malpractice action because the MCO was not acting as an ERISA plan manager).

132. See Little, supra note 35, at 1464-68.

133. Picinic, supra note 9, at 615 (emphasis added).

134. See Cigna Healthplan v. Louisiana, 82 F.3d 642 (5th Cir.), cert. denied 117 S. Ct. 387 (1996); Little, supra note 35, at 1467; Linda Greenhouse, Supreme Court Roundup: Justices Reject Case on Whether Health Care Network Must Be Open to All Doctors, N.Y. TIMES, Nov. 5, 1996, at A16.
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*Shield Plans v. Travelers Insurance Co.*\(^{135}\) complicate the matter. Here, Travelers Insurance Company and the Health Insurance Association of America attempted to invalidate a New York statute that required hospitals to collect insurance surcharges from MCOs.\(^{136}\) The Supreme Court held that the New York statute did not "relate to" employee benefit plans within the meaning of ERISA's preemption clause, and further, that ERISA does not preempt state laws that have only an indirect effect on the relative cost of health insurance.\(^{137}\) The legal feasibility of a plaintiff allegation that a state law or state tort claim has only an indirect economic effect—as well as the relative success of such claims—is uncertain. Because the ERISA preemption has a broad scope and an uncertain future, the feasibility of filing anti-gag-clause claims under state law may be limited. The logical remedy is to secure federal legislation designed to protect all managed care patients.

**B. The Federal Solution**

Part I of this Article described how doctors and patients face a variety of problems when attempting to deliver and receive proper care in managed care systems today. No single solution can adequately address these difficulties; they demand a series of affirmative acts by MCOs and consumer discretion. But how can such reforms be achieved? Because MCOs are unlikely to self-regulate,\(^{138}\) government intervention in the form of federal and state regulations is necessary. Federal regulation is preferable, because state regulation leads to fragmented policies regarding standards of care,\(^{139}\) and because ERISA and pending federal legisla-

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\(^{135}\) 514 U.S. 645 (1995). Note that the uncertainty of the scope of the Court's ruling results largely from the difficulty of drawing a bright-line rule distinguishing the regulation of state insurance from ERISA regulation.

\(^{136}\) See id.

\(^{137}\) See id. at 661-62.

\(^{138}\) Historically, MCOs have sought to minimize the kinds of legislative reform for which this Article calls. See, e.g., *supra* notes 27-29 and accompanying text. This left open the option of self-regulation. Recently, however, MCOs have not lived up to past promises of this sort. See, e.g., Bruce Bryant-Friedland, *HMO Report Card: Incomplete*, JACSONVILLE TIMES-UNION, Oct. 16, 1998, at A1 (reporting that MCO industry promises to report performance to the National Committee for Quality Assurance dwindled in 1998, with 447 plans reporting performance information to the Committee, but 155 prohibiting the public disclosure of this information, up from 41 plans that refused public disclosure in 1997). In spite of such past performance, the threat of intrusive government regulation has motivated some MCOs to call for voluntary (rather than legislative) policies that foster greater informed decision-making by patients. See, e.g., Diddlebock, *supra* note 115.

\(^{139}\) According to the Health Policy Tracking Service of the National Conference of State Legislatures, over 1,000 bills relating to some aspect of managed care were introduced in legislatures throughout the country in 1997, and nearly as many in 1996. In 1997, 200 of those bills were passed and signed into law. See Milt Freedman, *Pioneering State for Managed Care Considers Change*, N.Y. TIMES, July 14, 1997, at A1; *Who's Regulating Managed Care?* People's Medical Society Newsletter 3:17, June 1998, at 5. These numbers suggest the variety of reforms
tion may preempt state regulations.\textsuperscript{140} An analysis of federal proposals dealing with gag clauses and of associated regulations is needed.\textsuperscript{141}

A number of federal bills have recently been introduced to confront the continuing problem of express and implied gag clauses in MCO-provider contracts. However, the managed care industry has strongly resisted any proposals that its members believe might threaten their cost containment strategies. In addition, partisan squabbling has prevented the enactment of bills currently before Congress. Furthermore, none of the current bills effectively addresses the issues at the core of the debate: (1) the market failure due to the lack of information available to consumers prior to enrollment in an MCO; and (2) the inability of patients to make informed health care decisions after enrollment.

Because states differ in the rigor of their regulation of managed care, it is difficult to provide a straightforward analysis of which states currently provide the best consumer protections. Generally speaking, states with little regulation, such as South Dakota, offer few consumer protections, and states with extensive regulation, such as New York, best protect consumers. See, e.g., FAMILIES USA FOUNDATION, HIT AND MISS, STATE MANAGED CARE LAWS 20-21 (July 1998); supra Subsection IV.A.1. In New York, state laws ensure that MCOs disclose treatment options to patients, that consumers have access to specialists as primary care providers, and that patients are granted standing referrals to specialists. FAMILIES USA FOUNDATION, supra, at 200.

\textsuperscript{140} See infra Section IV.B and accompanying text. MCOs should not, per se, fear federal legislation. While such legislation may expose them to tremendous liability, the crafting of these bills is an opportunity for the organizations to work with legislators to create a viable, truly competitive atmosphere for the future of managed care. In fact, some MCOs have recognized advantages of federal regulation. In 1997 Kaiser-Permanente, Group Health Cooperative of Puget Sound, and HIP Health Plans—three major not-for-profit health plans—joined forces with the American Association of Retired Persons and Families USA to promote federal regulations that would require health plans to follow 18 principles. Among these principles are:

5. Disclosure of information to consumers, including “procedures for utilization management” and “a description of the methodologies used to compensate physicians[;]”

\ldots

14. No limits on provider communication with patients.

15. Written standards for provider credentialing, barring discrimination against doctors who “treat a disproportionate number of patients with expensive or chronic medical conditions[;]”

16. No payment incentives that overtly encourage withholding necessary care; \textit{Would Federal Oversight in These 18 Areas Be a Cure Worse Than the Disease?}, MANAGED CARE (Oct. 1997) <www.managedcaremag.com/archiveMC9710/9710.legislator.shtml>. Each of these principles addresses a concern presented in this Article and provides a point of departure for addressing these concerns as they will be discussed in the analysis of the pending federal reform bills.

Developments in Policy

1. Patient Right To Know Act

The first bill, introduced by Rep. Greg Ganske (D-Iowa), a physician himself, and Rep. Edward Markey (D-Mass.) in February 1996, was entitled the Patient Right to Know Act of 1996. It would have prohibited health plan and provider contracts that “restrict or interfere with any medical communication,” a term defined broadly in the bill.142 The bill also would have prohibited a health plan from taking action against any doctor, such as termination of a contract, refusal to contract, or refusal to refer patients, in retaliation for the physician’s refusal to abide by a gag clause.143 It would have imposed civil damages for violations and preempted less restrictive state legislation.145 The bill, however, never cleared the Ways and Means Committee.

2. Patient Communications Protection Act of 1996

In the same year, Sen. Ron Wyden (D-Or.) introduced a bill that would have prohibited health plans from restricting communications between physicians and patients and imposed a fine for violations.146 The bill did not provide for civil penalties for violations based on oral, rather than written, communications “unless the communication is part of an [established] pattern [that is] demonstrated by a preponderance of the evidence.”147 Thus, this proposal did not prohibit implied gag rules enforced by at-will termination clauses. The bill failed after federalism concerns were raised, claiming that state laws already substantially regulated gag clauses.148 The record does not indicate, however, any concern about whether ERISA might preempt much of that state legislation.149

3. Revived Patient Right To Know Act

Representative Ganske revived the Patient Right to Know Act in February 1997 in similar form,150 and Sen. Jon Kyl (R-Ariz.) introduced

142. See H.R. 2976, 104th Cong. (1996). “Medical communication” is defined to include “any tests, consultations and treatment options,” id. § 2(b)(2)(A), “any risks or benefits associated with such tests, consultations and options,” id. § 2(b)(2)(B), and any “financial incentives or disincentives offered by [a health plan] entity to a health care provider that are based on service utilization,” id. § 2(b)(2)(F).
143. See id. § 2(a)(2).
144. See id. § 2(c).
145. See id. § 2(e).
147. See id. § 2(c)(i).
149. See id.
it in the Senate a month later. The bills would have nullified contractual provisions between MCOs and doctors that constrained oral communications between providers and their patients. However, MCOs would still have been able to enforce implied gag clauses through threats of termination under no-cause provisions or by decreasing particular physician referrals. Nonetheless, the bills explicitly covered ERISA-regulated plans and defined “medical communication” broadly, requiring the disclosure of all financial incentives that could affect patient care. Neither bill, however, made it to a floor vote.

4. Patient Access to Responsible Care Act

Representative Charlie Norwood (R-Okla.) introduced another bill in 1997, the Patient Access to Responsible Care Act (PARCA), which attempted to balance protection of patients and doctors with the need for health plans to contain costs. The bill would have permitted MCOs to maintain utilization management measures, while requiring physicians to oversee utilization review. PARCA would have prohibited restrictions on communications between providers and patients and mandated a timely review procedure to appeal denials of care. Significantly, the bill also sought to amend ERISA in order to permit wrongful death and personal injury suits against MCOs covered by ERISA. After the health care industry applied pressure, stating that permitting suits against MCOs would raise costs dramatically, Rep. Norwood offered a substitute for PARCA that eliminated the proposed broadening of legal exposure.

Representative Norwood’s bill also would have prohibited termination of provider contracts without cause and required MCOs to provide due process protections and to consider the medical necessity of increased utilization in determining whether to dismiss a provider. While many Democrats endorsed this bill, as well as a similar proposal based on the American Medical Association’s “Patients’ Bill of Rights,” the House Republican leadership refused to endorse it, relying upon estimates that the bill, if enacted, would force an increase in premiums by as much as

152. See id. § 2(a)(1); H.R. 586 § 2(a)(1).
153. See S. 449 § 3(3); H.R. 586 § 3(B)(3).
156. See id. § 2(a)(2).
157. See id.
158. See id.
159. See id. § 4(a).
161. See H.R. 1415 § 2(a)(2).
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23% on average and might cause an estimated 4.6 million individuals to lose their insurance. Nonetheless, 90 Republicans endorsed the bill after it was introduced.

5. Patients' Bill of Rights Act

The Patients' Bill of Rights Act of 1998 (PBRA), which included provisions similar to those in PARCA, was endorsed both by President Clinton and leading congressional Democrats. PBRA included a provision prohibiting "inappropriate financial incentives" as they had been defined under the Health Care Financing Administration Medicare regulations. In addition, PBRA would have protected doctors from retribution by the MCO for advocating for their patients in the appeals process. Finally, it would have amended ERISA to permit states to set up remedies for patients who were wrongfully denied or delayed in their receipt of treatment. While PBRA did not directly define "trade secrets" in the context of MCO information, it did include two requirements: MCOs must create firm written policies on all significant aspects of care authorization, and they must disclose extensive information on the scope of coverage, alternatives to coverage, and possible out-of-pocket expenses to consumers.

New estimates supplied by the Congressional Budget Office suggested that the Democrats' proposal, if enacted in its entirety, would only have increased individual premiums by an average of two dollars per month. Nonetheless, PBRA failed to pass the House.

165. See id. § 151(b)(4). The United States Department of Health and Human Services previously enacted a federal initiative that prohibited MCOs that serve Medicare patients from stifling doctor-patient discourse regarding care. In December 1996 for Medicare patients and in February 1997 for Medicaid patients, the agency restricted, according to its director of the office of managed care, Bruce Merlin Fried, "any contractual provisions, including . . . gag rules, that restrict a health care provider's ability to advise patients about medically necessary treatment options . . ." Robert Pear, Clinton Prohibits H.M.O. Limit on Advice to Medicaid Patients, N.Y. TIMES, Feb. 21, 1997, at A22.
166. See H.R. 3605 § 144(a).
167. See id. § 115(b). The bill also would have mandated disclosure of these policies to the government but would have required individual access to information on utilization reviews "only to the extent it is necessary to perform the utilization review activity involved." Id. § 115(c)(5).
168. See id. § 121(b)-(c).
170. The bill failed by five votes on the same day that the competing Republican bill passed by a narrow margin.
6. **The Patient Protection Act**

In response to PBRA, the Republican leadership introduced a weaker bill, the Patient Protection Act of 1998. The bill passed the House on July 24, 1998, by a vote of 216 to 210, but has not yet been submitted for a vote in the Senate. This bill lacked the provisions protecting physicians from retribution for advocating on the behalf of their patients. It also failed to include substantial regulation of financial incentives and did not amend ERISA, thereby perpetuating the limited nature of remedies available to patients injured by their MCO's misconduct.

**C. Analysis of the Current Proposed Legislation**

Although legislators have submitted numerous proposals, Congress has not enacted any of them. It is highly unlikely that any legislation will pass until well into the next Congress, because none of the bills has received broad bipartisan acceptance.

While unfortunate, this provides time for reflection on the content of the proposed bills and allows for dialogue about which aspects, if any, the pending legislation lacks. For purposes of our discussion, it allows for an assessment of whether protections effectively barring implied gag clauses have been proposed.

The most promising of all pending bills is PBRA. As noted, this bill would prohibit inappropriate physician financial incentives, shield physician advocacy on behalf of patients' medical care, and uphold state law remedies for wrongfully denied or inappropriately delayed care.

The Patient Protection Act, on the other hand, does not properly address the concerns voiced in this Article. The most significant disadvantage of the bill is that, although it would forbid outright prohibitions on doctor-patient communications, it would not address other restrictions of these communications. Not only would the plan fail to establish a clear

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174. Under this plan, remedies are limited to the value of the benefit. Under certain circumstances, civil monetary penalties are available, but these are capped at $100,000. See H.R. 4250 § 1197 (a)(3). For general information on the limits of the plan see Cohn, *supra* note 163, at 16.
175. H.R. 3605, 105th Cong. § 142(b) (1998).
176. *See id.* § 144(b).
177. *See id.* § 302.
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ban on implied gag clauses, it would fail to address improper financial incentives and obstacles to patient-advocacy.

While both plans provide for the release of specific information to subscribers, PBRA is more demanding, requiring the collection of information related to quality of care. This requirement includes the collection of data on aggregate utilization, patient satisfaction, voluntary withdrawal, and grievances. The sum of this information is needed for truly informed decision-making.

D. Suggested Modifications to PBRA

While comprehensive, PBRA does not address the central issue of the entire gag clause debate: the free flow of information to consumers. Only under a system of broadly disclosed information will MCO subscribers be able to navigate the free market of managed care. Although PBRA would outlaw physician incentives and give consumers access to information about the extent of their care, PBRA would allow the withholding of a sum of information invaluable to informed decision-making.

1. Strengthen the Prohibition on Physician Incentives That May Impair Patient Care

Requiring the disclosure of physician payment plans to consumers will ensure that physician incentives to restrict patient care are truly eliminated. While PBRA does prohibit physician incentive plans, it does so in an ambiguous fashion that may leave room for explicit and implicit exceptions. One alternative to the present statute would make its language more robust, expressly prohibiting both implicit and explicit incentive plans. Alternatively, payment schemes could be made public. This would discourage MCOs from establishing indirect or covert incentive structures and would restore patient confidence in MCO physician advice.

178. See id. § 112.
179. Rhode Island provides a model template for such language and is an exception to the general rule of poorly written state prohibitions against physician incentives. The Rhode Island law forbids MCO plans "from making specific payments directly or indirectly to the provider as an inducement or incentive to reduce or limit service, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient. . . ." FAMILIES USA FOUNDATION, HIT AND MISS, STATE MANAGED CARE LAWS 17 (1998) (quoting R.I. GEN. LAWS § 23-17.13-3(B)(8) (1997) (footnote omitted)).
180. This information should be revealed before the consumer subscribes to the plan and should also be available, by request, in a boilerplate form that a patient can request from a doctor at the time of care. Physician Incentive data should be written in plain language and, in order to be effective, must be accompanied by any supplemental data (such as the cost of given procedures) necessary for the consumer to make use of the information.
181. While it is assumed doctors would prefer to practice in a regime without such incen-
2. Publicize Standards for Denial of Coverage

In order to allow a patient to determine whether a doctor or MCO is acting out of self-interest or in the patient's interest, patients should be made aware of the standards for denial of coverage and the appeal procedures within the MCO for challenging a denial of coverage. Although PBRA establishes necessary protections for doctor advocacy and protects the patient and doctor from the threat of termination for aggressive pursuit of care, the patient should be fully informed of the MCO utilization procedures. The consumer should be entitled to know the identity of the decision-maker or decision-making body, the basis for the decision, the doctor's recommendation, and the details of the grievance process.\textsuperscript{182}

Comprehensive disclosure of this information, coupled with PBRA's requirement that the possible limitations of care be divulged at the time of subscription, will create a greater sense of justice in the event that care is denied. The consumer will be aware that care may be refused and will know under what circumstances this may occur. Moreover, disclosure of the out-of-pocket costs at the time of subscription may encourage MCOs to offer a greater number of supplemental coverage options to accommodate risk-averse customers.\textsuperscript{183}

3. Establish Standardized Procedures for Dismissing Doctors

MCOs should establish standardized procedures for physicians' appeals of their dismissals that would require an MCO to consider the medical necessity of increased utilization before terminating contracts with providers. At-will termination should be eliminated, or at least prohibited when it occurs on the basis of economics without regard to clinical considerations.\textsuperscript{184}

This recommendation provides greater protection than the proposed PBRA rules, because PBRA would simply mandate a procedure for no-

\textsuperscript{182} PBRA does establish subscriber access to information surrounding grievance procedures. See H.R. 3605 § 121(b)(8). This would expedite the process of the grievance by making it less mysterious. It would not help the patient, however, if his petition were denied. A better rule would require disclosure of such details when the patient is in a position to choose between plans so that consumers could comparison shop for the aspects of plans that best suited their expectations and desires.

\textsuperscript{183} For an in-depth development of economic informed consent, see generally Mark A. Hall, \textit{A Theory of Economic Informed Consent}, 31 GA. L. REV. 511, 630 (1997).

\textsuperscript{184} Unlike most employment situations, doctors and care providers are necessarily economic adversaries. Excluding savings attributable to preventative medicine, the better a doctor does her job, the more she costs her employer.
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tice and review of decisions regarding employment. Without standardized procedures for dismissal, the associated protections of the bill, such as those surrounding vigorous patient advocacy by physicians, would have little effect. Under the threat of at-will termination, doctors can never be free of the express, implied, or simply feared threats of providing optimal health care.

V. CONCLUSION

Gag clauses are a simple method of cost containment. By eliminating recommendations for care or providing other incentives to discourage comprehensive medical treatment, MCOs perform a vital function both for their own survival and for that of affordable healthcare in America. What we propose is not reverting to a pre-managed-care system where insurers funded treatment without appropriate controls. Rather, we endorse a structure of free flowing information that would allow for better patient decisions about coverage and treatment. Managed care subscribers could choose at the outset the type and extent of care for which they desire coverage, knowing in advance its potential limits.

With appropriate institutional safeguards, the proposed system would increase the efficiency of care. Patients would receive open assessment of treatment options, knowing physician incentives were prohibited. Protecting patient advocacy and publicizing physician-compensation schemes would ensure the integrity of physician recommendations. Patients would also know the limits of their insurance and have access to fair and open grievance procedures. Such a system would lend itself to increased variety in coverage options and would more effectively incorporate individual risk assessment into managed care.

The foregoing amendments to the pending federal legislation would help establish this system. These important improvements seek to liberate doctors from unreasonably restrictive care-giving and patients from the burdens of uninformed decision-making. Only when these proposals or other similar reforms are effected will doctors and patients benefit from physicians' ability to live up to the solemn oath upon which their profession is founded:

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is

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185. H.R. 3605 § 143(a).
deleterious and mischievous. . . . Into whatever houses I enter, I will go into them for the benefit of the sick.\textsuperscript{186}

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\textsuperscript{186} HIPPOCRATES, \textit{supra} note 51.
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