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SYMPOSIUM ARTICLES

INTRODUCTION

ADAPTING OLD RULES FOR A NEW PARADIGM

Thomas A. Eaton[*]

This Symposium brings together prominent practitioners and academic commentators in the field of health law. They are the authors of leading casebooks, treatises, and articles, and they craft the agreements that make "managed care" a practical reality. Collectively these authors explore a variety of cutting edge legal issues as our health system moves from a "fee-for-service" paradigm to one of managed care. These articles address such issues as tort liability for negligent care, fraud and abuse, disclosure of economic incentives to control costs, and antitrust. These seemingly disparate topics are united by a common theme: the need to adapt legal doctrines formulated under the fee-for-service paradigm to the new realities of managed care. Before describing the individual articles some background information may be useful.

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[*] J. Alton Hosch Professor of Law, University of Georgia. Many thanks to Juliana Rowland, Senior Articles Editor in charge of this issue, whose hard work and unflagging good humor made this Symposium a reality.

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For most of the twentieth centure, health care was provided by independent physicians who were paid for their services by the patient or her insurer. Under this fee-for-service model, individual patients selected the physician of their choice. Physicians determined what procedures or treatments were medically appropriate for particular patients and how much to charge for those services. Hospitals served as the location where services were rendered but were generally not considered providers themselves. Legal doctrine developed under this paradigm largely assumed that hospitals, doctors, patients, and insurers were independent actors.

Over the past two decades, the country has rapidly moved towards a managed care system of health care delivery. Today, more than half the nation's privately insured individuals are enrolled in some form of managed care system. The same is true for more than twenty-five percent of those who receive medical care through publicly financed Medicaid programs. The primary motivation for the shift from fee-for-service to managed care is a desire to control costs. While there are different types of managed care organizations (MCOs), they share the common characteristic of integrating to some extent the payment and provider functions. Costs are controlled through a complex web of agreements among payers, providers, and patients. These agreements tend to advance the cost containment objective by limiting the patient's choice of physicians and hospitals, limiting provider compensation for services, and establishing financial incentives that discourage the use of expensive technologies and specialists. Thus, the managed care paradigm is one of vertical and horizontal integration rather than one of independent actors.

By most accounts, managed care has succeeded in reducing the rate of increase in the cost of medical care. It is perhaps ironic, though not surprising, that this success has given rise to new concerns about quality, accountability, and access to needed care. These consumer-oriented issues lie at the heart of most of the articles in this Symposium.

Professor Furrow's article focuses on MCO liability for patient injury. He surveys the medical literature and concludes that managed care appears to have succeeded in reducing the rate of increase in health care costs without compromising quality of care. However, he identifies several types of patient claims that are

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likely to arise from the integrated nature of MCOs. These include disputes over coverage; selection and retention of providers; limitations on access to drugs, specialists, or hospitals; and the effect on treatment decisions of economic incentives in MCO agreements with doctors. Professor Furrow offers a comprehensive overview of how existing law and various reform proposals might resolve these types of claims. He argues persuasively that neither market forces nor government regulation will sufficiently deter preventable treatment-related injuries. In the end, Professor Furrow concludes that a tort liability system that targets the MCO is a socially useful strategy for reducing iatrogenic injury.

Professor Havighurst also examines tort liability issues pertaining to managed care. Although Professor Havighurst hails the growth of managed care as a desirable component of a market-oriented national health policy, he argues that injury liability issues are not adequately addressed under existing legal doctrine. For example, principles of vicarious liability that evolved under an assumption that providers and payers were truly independent actors do not reflect sound policy in a world of integrated health care delivery. He endorses a regime of enterprise liability under which the MCO would be legally responsible for treatment-related injuries. Enterprise liability would integrate legal responsibility for both cost and quality in the same hands. Such integration is more consistent with the integration of payment and provider functions of managed care. Enterprise liability would offer needed economic incentives for MCOs to concern themselves with quality as well as cost. Perhaps more importantly, in Professor Havighurst's view, enterprise liability would enhance the political legitimacy of the private rationing of services provided by MCOs and reduce the demand for government regulation.

Professor Hall addresses some of the most controversial aspects of managed care—cost-based constraints on access to care and physician financial incentives. Professor Hall recognizes that these features of managed care are essential to achieve the cost containment objectives. They are legitimate, however, only if consented to by a fully informed patient. To this end, Professor Hall proposes a theory of "economic informed consent" as the ethical basis for enforcing cost-based constraints on patient access to marginally beneficial but expensive treatment. Under his theory, patients

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would be bound by decisions they make at the time they enroll in a managed care program. The article advocates a "global disclosure" of cost containment incentives, rules, and mechanisms at the time of enrollment. However, disclosure alone is not sufficient to support consent. Professor Hall maintains that consumers must be given an adequate range of choices—either within a plan or among various plans—for consent to be meaningful. Professor Hall's article goes beyond the theoretical and offers a practical blueprint of the type of disclosure and choices needed to support a claim of binding consent. Professor Hall maintains that if such conditions were satisfied, it would be ethically permissible to hold patients to their managed care agreements denying them access to expensive but marginally beneficial treatment.

Professors Davies and Jost discuss how the shift to managed care requires a change in how the legal system attempts to police fraud and abuse. Under a fee-for-services system in which most payments are made by insurers, doctors and other providers have an economic incentive to overutilize medical services. Patients have little incentive or ability to question whether such services are needed or cost-effective. Indeed, it is the separation of provider, patient, and payer that contributes to the increase in medical care costs in a fee-for-service system. Professors Davies and Jost describe the types of fraud and abuse found in a fee-for-service system. These include charging for services not provided, ordering expensive—but only marginally beneficial—diagnostic tests, receiving kick-backs from referrals to specialists, and making referrals to entities in which the doctor has an economic interest.

Managed care has an entirely different incentive structure. The primary danger in a managed care system is *under*utilization of expensive but appropriate care. Professors Davies and Jost identify the types of fraud and abuse most likely to occur under a system of managed care. These include false or misleading statements by an MCO to consumers to induce them to join a plan, false or misleading statements by an MCO to providers to induce them to join a plan, and inappropriate limitations on access to specialists or other expensive, but medically needed, treatment.

Existing state and federal laws address the problems of excessive cost and unnecessary care through a system of civil and administrative penalties and qui tam actions. This structure does not fit

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well when the primary fraud and abuse problems relate to denial of access—not overpayment. Professors Davies and Jost propose a variety of statutory amendments and changes in management and enforcement strategies to deal with the new fraud and abuse dangers.

Kim Roeder offers a practitioner's perspective on the application of antitrust laws to managed care and places particular emphasis on provider networks. Ms. Roeder explains that to avoid being relegated to the status of minor players in the new world of managed care, an increasing number of doctors and sometimes hospitals have formed networks to provide health care services to MCOs. This collective action by providers raises antitrust issues. The Supreme Court has made it clear that the medical profession is not immune from antitrust laws. Ms. Roeder describes how the Supreme Court in its 1982 decision in *Arizona v. Maricopa County Medical Society* set the stage for current antitrust issues by ruling that the maximum fee schedule adopted by a medical society constituted illegal price fixing—a per se violation of the Sherman Act. The Court suggested, however, that provider groups could integrate their operations to form bona fide joint ventures under certain circumstances. Following *Maricopa*, practitioners representing provider networks were faced with the challenge of structuring bona fide joint ventures among providers without running afoul of the per se prohibition against price fixing. The Department of Justice and the Federal Trade Commission offer informal guidance in the form of enforcement policy statements commonly referred to as "Joint Statements." Ms. Roeder describes these various Joint Statements (including the one issued in 1996) and identifies issues they help clarify and issues that remain uncertain as the health care industry continues to undergo rapid change.

As the delivery of health care services continues to evolve, so must the relevant legal doctrine. The articles in this Symposium demonstrate that many rules adopted under a fee-for-service paradigm may not be appropriate for a world of managed care. The ideas and recommendations contained in these articles will provide the framework for academic, legislative, and judicial discussions in the years to come.

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