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## Patient Advocacy and Termination from Managed Care Organizations: Do State Laws Protecting Health Care Professional Advocacy Make Any Difference?

Linda C. Fentiman

*Elisabeth Haub School of Law at Pace University*

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# Patient Advocacy and Termination From Managed Care Organizations. Do State Laws Protecting Health Care Professional Advocacy Make Any Difference?

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- \* Linda C. Fentiman is Professor of Law at Pace University School of Law and former Director of its Health Law and Policy Program. She holds a B.S. from Cornell University, a J.D. from S.U.N.Y. at Buffalo Law School, and an L.L.M. from Harvard University Law School. She is grateful for the advice of many colleagues, including MaryAnn Baily, Sandra Fentiman, Gretchen Flint, Joshua Greenberg, Jill Gross, Chris Stern Hyman, Patrick Kasperitis, Tom McDonnell, John Blum, James Brown, Elena Cohen, Edward Cooper, Henry Fenton, Michael Mushlin, Leonard Nelson, Robert Oshell, Michael J. Fleck, Joseph V. Sedita, and Stanton Tefft, and for the help of Pace University Law School students and graduates Rowena De Leon, Lorraine Girolamo, Lauren Maaier, Caitlyn Venskus, and Gail Wilder, M.D. Preliminary versions of this article were delivered in October 2002 at the Hastings Center in Garrison, New York, where the author was a North American Visiting Scholar and at the ALI-ABA Healthcare Law and Litigation Conference in Washington, D.C.

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*"Charlie, you were my bruddah. You shoulda looked out for me a little bit. I coulda had class, I coulda been a contendah. . ."*

Marlon Brando, playing Terry Malloy in *ON THE WATERFRONT* (Columbia 1954).<sup>1</sup>

## I. INTRODUCTION

This article examines the impact of state laws designed to protect the role of health care professionals as advocates for their patients on American health care delivery during the last decade. During the 1990's managed care spread rapidly, largely replacing the fee for service health care system,<sup>2</sup> and changing both the practice and the perception of providing health care services in America. As horror stories circulated of risk-sharing arrangements that lead to denial of medically necessary care,<sup>3</sup> Draconian utilization review,<sup>4</sup> "gagging" of physicians in their communications with patients,<sup>5</sup> and as many patients began to have more impersonal and transient relationships with their doctors, there was an inevitable backlash against managed care's goals of cost containment and the more active and effective manage-

1. In this scene, Rod Steiger plays the part of Charlie, a mob boss, and Marlon Brando plays his younger brother, Terry. Terry confronts his brother for his failure to keep an eye out for Terry's interests, rather than the mob's. Terry's sorrowful complaint, "Charlie, you were my bruddah. You shoulda looked out for me a little bit," identifies the essence of fiduciary duty – a fiduciary is a person who looks out for the little guy he is supposed to protect. This article examines fiduciary obligations in another context – that of the health care professional who must look out for the patient's interests in gaining access to medically necessary health care.
2. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 369-70 (2002) (describing the evolution of health care in the United States over the last decade and the trend away from indemnity insurance toward managed care as the predominant mode of health care financing).
3. See, e.g., Steffie Woolhandler & David U. Himmelstein, "Extreme Risk – The New Corporate Proposition for Physicians," 333 *NEW ENG. J. MED.* 1706 (1995); see also Michael A. Hiltzik & David R. Olmos, *Pressure is Mounting for Better Oversight of HMOS*, L.A. TIMES, Aug. 31, 1995, at A1 (discussing proposed solutions to the oversight of cost reduction practices by HMOs).
4. See, e.g., *Corcoran v. United Healthcare*, 965 F.2d 1321 (5th Cir. 1992) (holding that a state law negligence claim for improper utilization review decisionmaking leading to the death of plaintiffs' fetus was preempted under ERISA § 514(a), 29 U.S.C. §§ 1144(a), because it "relate[d] to" an employee benefit plan, even while recognizing that this decision left the plaintiffs without a remedy for their loss).
5. See, e.g., GENERAL ACCOUNTING OFFICE REPORT, *MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERNS REMAIN 1* (GAO/HEHS 97-175 August 1997) (hereinafter GAO GAG CLAUSE REPORT). The GAO GAG CLAUSE REPORT found no explicit gag clause in any of more than a thousand managed care provider contracts, but did find some clauses that could be interpreted by health care providers as limiting their ability to freely discuss all treatment options with their patients. *Id.* at 2-3.

ment of patient care.<sup>6</sup> As part of this backlash, many states enacted statutes to protect health care professionals (HCPs) who advocated on behalf of their patients, declaring that HCPs could not be terminated from a managed care organization (MCO) or otherwise penalized because of their advocacy.<sup>7</sup>

Now that we are several years into this counterattack on managed care, it is appropriate to consider whether these state advocacy protection laws have made any difference, either for health care professionals or for the patients on whose behalf they are advocating.<sup>8</sup> A broad range of possibilities is apparent. One could view advocacy protection laws as a cheap and meretricious political fix, adopted by politicians anxious to demonstrate their concern to the electorate without really doing anything about systemic problems with managed care. One could decide that these laws are largely irrelevant, since changes in the healthcare marketplace and the enormous wave of public opinion against managed care have already caused managed care organizations to eliminate their most offensive cost-containment strategies.<sup>9</sup> Or one could conceive of these laws as scripts for modern "morality plays," providing updated versions of frontier dramas in the tradition of the shoot-out at the OK Corral.<sup>10</sup> Pursuing the metaphor further,

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6. Passions run high on this subject and, of course, "managed care" is an umbrella term, embracing a broad spectrum of approaches to health care delivery and financing. Like the elephant that is examined by three blind persons, managed care's appearance and impact depends on the context and the audience. In this article, I have tried to adopt a value-neutral description of managed care's goals.

7. Since 1993, seventeen states have adopted statutes explicitly protecting patient advocacy by health care professionals. Many more states adopted statutes which implicitly protected such advocacy, including many laws prohibiting "gag clauses" in health care professionals' contracts with managed care organizations. These laws will be discussed in detail in Part III *infra*.

8. In undertaking this evaluation, it is important to consider both formal legal authority (published opinions, statutes, and regulations) and informal sources of law (including negotiated settlements, individual jury verdicts, and the practical experience of working lawyers). Paying attention to these nontraditional, informal sources of legal authority is essential when one recognizes that over 95% of all civil cases are settled before trial. Hope Viner Samborn, *The Vanishing Trial*, 88 A.B.A. J. 24, 26 (2002); see also THEODORE Y. BLUMHOF, MARGARET Z. JOHNS, EDWARD J. IMWINKELRIED, *PRETRIAL DISCOVERY: THE DEVELOPMENT OF PROFESSIONAL JUDGMENT* 11 (1993) (emphasizing the significance of discovery in light of the fact that most cases are settled prior to trial). Indeed, many cases are resolved without resort to litigation at all. BLUMHOF et al., at 11. For further development of the argument that to be effective, lawyers need to consider both formal and informal sources of the law, see Thomas M. McDonnell, *Playing Beyond the Rules: A Realist and Rhetoric-Based Approach to Researching the Law and Solving Legal Problems*, 67 U.M.K.C. L. REV. 285, 286-89 (1998).

9. This view has been suggested by Professors Gail Agriwal and Mark Hall.

10. This concept was used by Clark C. Havighurst, with compelling frontier references, to describe consumer class actions, most notably those suits brought against managed care organizations, in *Consumers Versus Managed Care: The New Class Actions*, 20 HEALTH AFF. 8, 10 (2001).

one could envision these statutes functioning as “the equalizer,” altering the power balance between MCOs, HCPs, and their patients, to ensure that HCPs will effectively protest denials of medically necessary and appropriate care, and thus fulfill their fiduciary obligation to act on the patient’s behalf, without giving in to economic pressures to comply with MCO rules. In this scenario, advocacy protection laws would both vindicate the rights of individual HCPs who have been terminated and serve as a powerful deterrent to inappropriate MCO cost containment strategies, by encouraging HCPs to be forceful advocates for necessary patient care, knowing that their conduct will be protected.

## II. A ROAD MAP

This article will explore the history, implementation, and impact of state advocacy protection statutes. The article is in four major parts. The first Part provides an introduction to the concept of advocacy, both as it was understood at common law, and as it is presently interpreted by HCPs and MCOs. The article will also examine the phenomenon of HCPs’ “deselection,” that is, the termination or non-renewal of their contracts with MCOs. In this context, the article will highlight the distinction between anecdote and data and emphasize the paucity of hard evidence to support either side’s version of the truth about these HCP-MCO interactions.

The second part will survey the legislative and common law landscape surrounding HCP advocacy. The article will look first at state statutes that explicitly protect HCP advocacy on behalf of patients, and then consider the large group of statutes that provide supplemental support for such advocacy. These include laws that implicitly protect such advocacy, by providing other “Managed Care Bill of Rights” protections for patients, providing procedural due process protections for HCPs who are deselected from an MCO, or otherwise attempting to rein in cost containment efforts by MCOs. The article will also consider other federal and state statutes that could be used by HCPs as part of their arsenal in suits against MCOs. Finally, the article will address common law protections for HCP advocacy, examining the cases that have been brought by HCPs to challenge their deselection by an MCO, as well as additional common law theories that might be used creatively on behalf of deselected HCPs.

The third part will review the implementation of state advocacy protection statutes. Federal preemption is an important potential hurdle to litigants, as both ERISA<sup>11</sup> and the Medicare program<sup>12</sup> have arguably carved out a significant regulatory domain free from state

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11. ERISA is the acronym for the Employee Retirement and Income Security Act of 1974, codified at 29 U.S.C. §§ 1001-1461 (2003).

incursion. In addition, there are state law interpretation problems for an HCP litigant, as well as burden of proof and discovery issues that may make it difficult for deselected HCPs to prevail against MCOs that no longer want their services.

The fourth part will consider whether state advocacy protection laws make any difference for HCPs or their patients. This paper will evaluate the efficacy of these laws, and conclude that they have a limited *in terrorem* effect, making it somewhat harder for MCOs to terminate HCPs who advocate for their patients. After concluding that current legal rules are inadequate to ensure that health care professionals will vigorously advocate for their patients, I suggest alternative means to encourage and support patient advocacy, which will improve the resolution of disputes among managed care organizations, health care professionals, and patients, and will enhance the quality of health care delivery.

### III. WHAT IS ADVOCACY?

#### A. Fiduciary Duty

Defining the concept of advocacy is critical to exploring the relationship between health care professionals and their patients. An advocacy definition is also needed to understand the dynamic underpinnings of the struggle between HCPs and MCOs over who should determine the care a particular patient needs and will receive. Organized American medicine has long believed that no outsider should interfere with the physician's relationship to the patient.<sup>13</sup> In part this reflects ancient notions of a physician's special, fiduciary obligations to the patient,<sup>14</sup> which Hans Jonas has described as a "sa-

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12. Medicare is the federal health insurance entitlement program providing health insurance coverage to persons over 65, those suffering from end-stage renal disease, and, in certain circumstances, people with disabilities. It is governed by Title XVIII of the Social Security Act, 42 U.S.C. § 1395-1395ggg (2003). In 1997, Congress created Medicare+Choice (or M+C) managed care programs, which are available to Medicare beneficiaries who choose a managed care delivery model for their health care services. 42 U.S.C. § 1395w-21 (2003). The Medicare+Choice program is governed by extensive regulations, found in 42 C.F.R. Part 422 (2003).
  13. See, e.g., Paul Starr, *WHITHER HEALTH CARE? THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 27 (1982); GEORGE J. ANNAS, SYLVIA A. LAW, RAND E. ROSENBLATT & KENNETH R. WING, *AMERICAN HEALTH LAW* 15-16 (1990).
  14. The Hippocratic Oath, which has been part of medical training for more than 2500 years, provides in part: "I will apply . . . measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. . . . Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice . . ." MARSHA GARRISON AND CARL E. SCHNEIDER, *THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION* 7 (2003); JUDITH AREEN, PATRICIA A. KING, STEVEN GOLDBERG, & ALEXANDER MORGAN CAPRON, *LAW, SCIENCE, & MEDICINE* 273 (1984); see also ROBERT M. VEACH, *A THEORY OF MEDICAL ETHICS* 21-25 (1981).

cred trust.”<sup>15</sup> In part, the notion of a unique, confidential physician-patient relationship reflects organized medicine’s long-standing opposition to third party involvement in the delivery of care, whether the third party is an indemnity insurer, a governmental regulator or payor, or, more recently, a managed care organization.<sup>16</sup>

The concept of a fiduciary involves two key elements: superior knowledge, skill, and experience by one party, and the obligation of that party to use that expertise for the benefit of the other on whose behalf the fiduciary is acting, and not act out of self-interest.<sup>17</sup> All definitions of fiduciary also recognize that the relationship is founded on the trust that one party places on the other, and that the fiduciary must act with good faith and candor.<sup>18</sup> Classic examples of fiduciary obligations include the physician-patient, attorney-client, guardian and ward, executor and heir, and trustee and beneficiary relationships.<sup>19</sup> Statutes employing the concept of fiduciary have built on its common law definition, leading to very specialized rules of fiduciary obligation for particular statutes.<sup>20</sup>

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15. Jonas writes:

In the course of treatment, the physician is obligated to the patient and to no one else. He is not the agent of society, nor of the interests of medical science, nor of the patient’s family. . . . The physician is bound not to let any other interest interfere with that of the patient in being cured. . . . We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.

HANS JONAS, *Philosophical Reflections on Experimenting with Human Subjects*, in CONTEMPORARY ISSUES IN BIOETHICS 432, 438 (Tom L. Beauchamp & LeRoy Walters eds., 3d ed. 1978), cited by William M. Sage, *Physicians as Advocates*, 35 HOUSTON L. REV. 1529, 1531 (1999).

16. For early statements of this viewpoint, see American Medical Association (AMA), *Sickness Insurance Problems in the United States*, June 30, 1934 (adopted in response to the 1932 report of the Committee on the Costs of Medical Care, organized by the Carnegie Foundation to evaluate health and medical services in the United States), cited in ANNAS ET AL., *supra* note 13, at 16-17. The principles announced by the AMA in its report include the following:

Second: No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession. . . . Fourth: The method of giving the service must retain a permanent, confidential relation between the patient and a “family physician.” This relation must be the fundamental and dominating feature of any system. . . . Tenth: There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

17. See, e.g., the interchange between Marlon Brando and Rod Steiger in Elia Kazan’s movie, *ON THE WATERFRONT*, *supra* note 1.

18. *Id.*

19. BLACK’S LAW DICTIONARY (4th ed. 1951).

20. See, e.g., ERISA § 4402, 29 U.S.C. § 1461 (2003), in which the obligations of an ERISA plan fiduciary have undergone continuing revision in Supreme Court decisions, such as *Variety Corp. v. Howe*, 516 U.S. 489 (1996) and *Pegram v. Herdrich*, 530 U.S. 211 (2000).



## B. Health Care Professionals' Viewpoint

The American Medical Association (AMA) has embraced this concept of fiduciary obligation in several official pronouncements.<sup>21</sup> First, in a set of principles focusing on the "Fundamental Elements of the Patient-Physician Relationship," the AMA emphasizes that physicians can contribute to a collaborative, "mutually respectful [physician-patient relationship] . . . by serving as their patients' advocates."<sup>22</sup> In an Opinion of its Council on Ethical and Judicial Affairs directed explicitly at managed care, the AMA declares that, "The duty of patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the system of health care delivery. Physicians must continue to place the interests of their patients first."<sup>23</sup> The Opinion requires physicians to act as advocates for their patients, both in individual cases and in the development of broad allocation and clinical practice guidelines. In regard to individual treatment decisions, physicians are adjured to act as a patient advocate to challenge a denial of care that the physician believes will materially benefit the patient,<sup>24</sup> and are even mandated to initiate appeals on behalf of their patients in certain circumstances.<sup>25</sup> The Opin-

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21. Other health care professions also recognize an ethical obligation to advocate for patients. See, e.g., CODE OF ETHICS FOR NURSES WITH INTERPRETATIVE STATEMENTS 3 (American Nurses Association 2001) (providing that "[t]he nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient").

22. AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics: Ethical Opinion E-10.01 (July 31, 2002), *available at* <http://www.ama-assn.org/ama/pub/category/2498.html>. The Council on Ethical and Judicial Affairs (CEJA) maintains and updates the 155-year-old AMA Code of Medical Ethics, *available at* <http://www.ama-assn.org>, which is considered by many to be a comprehensive ethics guide for physicians. The CEJA renders opinions concerning the interpretation or application of the constitution, bylaws, rules, or principles of medical ethics of the American Medical Association. *Available at* <http://www.ama-assn.org/ama/pub/article/4325-4427.html>.

23. AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics: Ethical Opinion E-8.13(1) (June 2002) (Managed Care), *available at* <http://www.ama-assn.org/ama/pub/category/2498.html>.

24. For instance, *id.* at section (2) provides: "When health care plans place restrictions on the care that physicians in the plan may provide to their patients, [the] following principles should be followed: . . . (b) Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients."

25. Specifically, *id.* at section (2)(d) provides:

Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician chal-

ion also emphasizes the need for physicians to work with managed care plans to develop broad resource allocation guidelines that will be “sensitive to differences among patients,” so that physicians will not have to “engage in bedside rationing.”<sup>26</sup> At the same time, in recognition of the potential distorting effect of the financial incentives provided by different reimbursement mechanisms, the AMA stresses that physicians’ first obligations are to their individual patients.<sup>27</sup>

### C. Common Law Views on Health Care Professionals’ Duty to Advocate

The cases are few and far between. Some cases recognize that physicians and other health care providers have a fiduciary duty to their patients that includes advocating for medically necessary care and emphasize that the physician (or other HCP with primary patient responsibilities) is the only person who can effectively perform this function. In *Wickline v. California*,<sup>28</sup> a landmark case decided in 1986,<sup>29</sup>

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lenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operations. In such cases, the physician’s duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan’s policy-making level to seek an elimination or modification of the guideline. Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient’s best interests.

26. Again, *id.* at sections (2)(a) and (c) provide:

(a) Any broad allocation guidelines that restrict care and choices – which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities – should be established at a policy making level so that individual physicians are not asked to engage in bedside rationing.

....  
(c) Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Health care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan’s development of allocation guidelines.

27. See, e.g., AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics: Ethical Opinion E-8.054 (June 2002) (Financial Incentives and the Practice of Medicine), available at <http://www.ama-assn.org/ama/pub/category/2498.html>. Specifically, *id.* provides:

In order to achieve the necessary goals of patient care and to protect the role of physicians as advocates for individual patients, the following statement is offered for the guidance of physicians: (1) Although physicians have an obligation to consider the needs of broader patient populations within the context of the patient-physician relationship, their first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician’s clinical practice.

28. 239 Cal. Rptr. 810 (Cal. App. 1986).

an indigent patient, Lois Wickline, claimed that Medi-Cal, the California Medicaid program, employed an oppressive prospective utilization review process that led to severe injuries when she was discharged prematurely from the hospital following surgery to relieve arteriosclerosis in her leg. Due to infection and loss of circulation in Wickline's leg that the doctors had not been able to observe because she was not in the hospital, her leg became gangrenous and had to be amputated. Wickline argued that Medi-Cal was responsible for the amputation, because her doctors had been intimidated by Medi-Cal's prospective utilization review process and therefore did not contest the discharge decreed by Medi-Cal. The California Court of Appeals disagreed on the facts, finding that Medi-Cal was not liable because Mrs. Wickline's physicians had not fulfilled *their* duty to adequately communicate the reasons why a longer hospitalization was necessary, which would have put Medi-Cal on notice about their concerns and permitted them to authorize a further stay. The court observed, "[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care[.]"<sup>30</sup> but, importantly, the court emphasized that "cost limitation programs [should] not be permitted to corrupt medical judgment."<sup>31</sup>

The California Supreme Court did later explicitly recognize physicians' fiduciary duties to their patients. In *Moore v. Regents of the University of California*,<sup>32</sup> the Court considered a suit based on the alleged removal of a patient's spleen for economic gain. John Moore's physician removed his spleen, ostensibly to treat Moore's leukemia. However, Moore alleged that the physician's goal in moving the spleen was to obtain its potentially valuable "cell line," and that the doctor had failed to disclose his financial interest to the patient. The California Supreme Court rejected Moore's suit for conversion, but found that he did state a cause of action for breach of fiduciary duty and lack of informed consent, holding that:

a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment; and (2) a physician's failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.<sup>33</sup>

This duty to disclose conflicts of interest is relevant to the duty to advocate in the managed care context. Under a fee for service health care system, there is a financial incentive to over-treat, because health

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29. Wickline was cited by the California Legislature in its advocacy protection statute, discussed *infra* in Part IV.

30. 239 Cal. Rptr. at 819.

31. *Id.* at 820.

32. 271 Cal. Rptr. 146 (1990).

33. *Id.* at 150.

care professionals are paid on a per-procedure basis.<sup>34</sup> Under a managed care system, the physician is given incentives to “manage” care<sup>35</sup> carefully, by making sure that only medically necessary care is provided.<sup>36</sup> Primary care physicians serve as “gatekeepers” through their ability to refer patients for appropriate services with hospitals, diagnostic tests, and other health care professionals. Capitation, withholds, and other financial incentives in the HCPs’ contracts are designed to induce them to only offer care that is clearly medically indicated, and there is thus the potential for under-treatment.<sup>37</sup> The duty to disclose potential financial conflicts of interest has been recognized by other courts as well,<sup>38</sup> although there is not universal agreement on who must do the disclosing.<sup>39</sup> Indeed, some commentators

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34. *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000); *see also* AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics: Ethical Opinion E-8.054 (June 2002) (Financial Incentives and the Practice of Medicine) (addressing the incentive to overtreat created by fee for service medicine), available at <http://www.ama-assn.org/ama/pub/category/2498.html>.
35. Most managed care plans emphasize the provision of preventative care, including immunizations and age-appropriate screening tests. MCO physicians also arrange for diagnostic, acute, and chronic care services for their patients.
36. Indeed, in the 1990’s managed care plans moved from reliance on utilization review as the primary mode of cost containment to a strategy of providing incentives to HCPs for cost containment that “moved rationing responsibilities from the health plan to the health provider. . . .” BARRY FURROW ET AL., *HEALTH LAW* 496-97 (2d ed. 2000).
37. *Pegram*, 530 U.S. at 219 (2000). These incentives can often be quite complicated. For example, “[I]n multiple-tier arrangements, the health plan reimburses the physician group in one way and the physician group reimburses the physician with incentives that may be entirely different.” Tracy E. Miller & Carol R. Horowitz, *Disclosing Doctors’ Incentives: Will Consumers Understand and Value the Information?* 19 *HEALTH AFF.* 149, 150 (2000) [hereinafter *Disclosing Doctors’ Incentives*]. Significantly, it has been found that MCO financial incentives to HCPs and utilization review processes had a greater impact on treatment availability than did contractually based coverage denials. FURROW ET AL., *supra* note 36, at 437 n.10 (citing Peter D. Jacobsen et al., *Defining and Implementing Medical Necessity in Washington State and Oregon*, 34 *INQUIRY* 143, 148 (1997)).
38. *See, e.g.*, *Shea v. Esensten*, 208 F.3d 712 (8th Cir. 2000) (permitting plaintiff to go forward with a claim of negligent misrepresentation based on a treating physician’s failure to disclose to a patient that the doctor’s payment arrangements with a MCO gave him a financial incentive not to refer patients to specialists).
39. Thus, in *Neade v. Portes*, 739 N.E.2d 496 (Ill. 2000), the Illinois Supreme Court held that a plaintiff could not bring causes of action for both medical malpractice, based on a failure to diagnose the plaintiff’s husband’s coronary condition (a diagnosis that might have been made had the physician referred the husband for an angiogram) and for breach of fiduciary duty, based on the physician’s failure to disclose his financial incentives to limit diagnostic and medical procedures (including angiograms) as part of his arrangement with the MCO. The court observed that because an Illinois statute provided that health maintenance organizations (HMOs) must disclose their financial incentives structure to enrolled patients, the Illinois legislature had decided that physicians did not have an independent duty to disclose their financial arrangements.

have suggested that consumers have a hard time understanding physician incentives, and thus, that even though disclosure is appropriate, it may lead to consumers' confusion and a decrease in their trust for physicians.<sup>40</sup>

Courts outside of California have also endorsed the principle that health care professionals have a fiduciary duty to advocate for patients in their interactions with insurers and managed care organizations. In *Nealy v. U.S. Healthcare Versalite Plus HMO*,<sup>41</sup> the New York Court of Appeals implicitly recognized that physicians have a fiduciary duty to advocate for their patients by expeditiously referring them to a specialist when their symptoms warrant it. In that case, a patient was forced to switch managed care plans when his employer changed plans. He spent several weeks pursuing appointments with his new primary care physician, and further weeks seeking a referral to a cardiac specialist. Ultimately, the patient died of a massive heart attack the morning of his scheduled appointment with the specialist. The Court of Appeals held that the plaintiff's medical malpractice and breach of fiduciary duty claims against a primary care physician were not preempted by ERISA, and thus let the claim for breach of fiduciary duty go forward. In *Murphy v. Godwin*,<sup>42</sup> the Delaware Superior Court ruled that plaintiffs could proceed in their claim against a physician for failing to fill out the short form necessary to obtain insurance, holding that when "a doctor-patient relationship is shown to exist, it must . . . [give] rise to a duty of reasonable care [in regard to filling out the form]."<sup>43</sup>

However, not all courts have agreed that health care professionals have a fiduciary duty to advocate for patients. In *Pryzbowski v. U.S. Healthcare Inc.*,<sup>44</sup> the Third Circuit Court of Appeals found that New Jersey state courts had not recognized the fiduciary duty to advocate on behalf of patients to an HMO for the timely approval of benefits.<sup>45</sup>

#### D. Advocacy – A Problem of Definitions

The question of what is meant by the term "patient advocacy" is critical to understanding the clinical and legal impact of state advocacy protection laws. The question of HCP advocacy arises primarily in a managed care context, in which concurrent and prospective utili-

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40. *Disclosing Doctors' Incentives*, *supra* note 37.

41. 711 N.E.2d 621 (N.Y. 1999).

42. 303 A.2d 668 (Del. Super. Ct. 1973).

43. *Id.* at 674 (ruling on a motion for summary judgment).

44. 245 F.3d 266 (3d Cir. 2001).

45. Interestingly, the Medical Society of New Jersey had submitted an amicus brief urging the court not to find such a duty. *Id.* at 281-82. This submission was, of course, at odds with the AMA's position that patient advocacy is an essential part of the physician's obligations to the patient. See AMA Opinion 8.13, *supra* note 23.

zation review, as well as HCP incentives, can result in denial of care.<sup>46</sup> A variety of scenarios can be envisioned in which health care professionals may believe that they are ethically obligated to fight for a particular treatment, while a managed care organization may view such conduct as "obstructionism," an unwillingness to "get with the program" of managed care, or the health professional's acting out of a vested personal or financial interest. The following scenarios indicate the range of potentially disputed activity:

(1) A health care professional treats a potentially suicidal patient in a hospital emergency room and determines that the person needs to be admitted to the hospital. Is it protected patient advocacy to argue with the patient's MCO that immediate admission to the hospital is medically necessary and appropriate?<sup>47</sup>

(2) When an emergency room physician determines that a patient needs an emergency diagnostic procedure, which can best be provided at a specialized tertiary care center which is not part of the MCO network, and the MCO denies pre-authorization to be transferred to the recommended tertiary care center, is the physician who argues with the HMO engaging in protected patient advocacy? If so, how long must the physician continue to argue with the MCO before the fiduciary obligation to the patient is satisfied?<sup>48</sup>

(3)(a) Is it protected patient advocacy or an unwillingness to accept the basic premise of managed care for a primary care physician to insist on making a referral to an out-of-network specialist whom she believes can best evaluate and treat the patient's symptoms? How rare or serious does the suspected

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46. See, e.g., *Wickline v. California*, 239 Cal. Rptr. 810, 810 (Cal. App. 1986); *AMA Opinion 8.13*, *supra* note 23; *FURROW ET AL.*, *supra* note 36. In contrast, under a fee-for-service system, HCPs are not generally called upon to engage in advocacy, because the health care payor, usually an indemnity insurance company, will reimburse patients for all "medically necessary" services recommended or performed by the HCP. In addition, in many fee-for service systems, health care services are first provided to the patients and disputes about medical necessity arise only after the fact. See, e.g., *Sarchett v. Blue Shield*, 233 Cal. Rptr. 76 (Cal. 1987).

47. See, e.g., *Wagner v. Magellan Health Servs., Inc.*, 121 F. Supp. 2d 673 (N.D. Ill. 2000); *Wagner v. Magellan Health Servs., Inc.*, 125 F. Supp. 2d 302 (N.D. Ill. 2000); see also *Wagner v. Magellan Health Servs., Inc.*, Case No. 01 L225 (Cir. Ct. for 19th Judic Cir., Lake County, Ill.) (currently pending).

48. Cf. *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001) (*Pappas II*) (affirming its original decision in *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998) (*Pappas I*) (holding that ERISA did not preempt state law malpractice claim against HMO physicians where consultation with HMO caused an inordinate delay that resulted in harm to patient)). The Pennsylvania Supreme Court decided *Pappas II* on remand from the Supreme Court's grant of certiorari, *sub nom* *U.S. Healthcare System of Pennsylvania, Inc. v. Pennsylvania Hospital Insurance Co.*, 530 U.S. 1241 (2000), which simultaneously granted certiorari, vacated the judgment, and remanded the case to the Pennsylvania Supreme Court for further consideration in light of *Pegram v. Herdrich*, 530 U.S. 211 (2000), decided the previous week. See also *Miller v. HealthAmerica Pa. Inc.*, 50 Pa. D. & C.4th 1 (2000) (overruling HMO's objection that plaintiff's claim was preempted by ERISA where hospital imposed such heavy workloads on physicians that they were unable to properly monitor patients).

disease or condition have to be? What if the MCO has contracts with at least half of the "best" specialists within the area?

(3)(b) Is it protected patient advocacy for a pediatrician to decline to send a two week old infant with a high fever to an off-premises clinical laboratory that is under contract with the infant's MCO, when sending the child there will delay diagnosis, and therefore treatment, by more than a day and the pediatrician could perform the test in the office and get the results back within several hours?

(4) Is it protected patient advocacy when a patient presents with symptoms indicating possible coronary problems for the HCP to urge the patient's MCO to put the patient at the head of the queue, because of the urgent nature of his condition? How much time/effort must the HCP expend to satisfy this fiduciary obligation?<sup>49</sup>

(5) Is it protected patient advocacy for a HCP to argue with the patient's MCO to continue to authorize hospitalization after a patient has been in the hospital longer than the time normally expected for the particular medical condition/DRG, if the HCP can demonstrate that a longer hospitalization is necessary and appropriate?<sup>50</sup>

(6) Is it protected patient advocacy for a physician to write to the MCO complaining that its reimbursement rates were less than the costs of providing care and suggesting that the MCO was systematically limiting patient access to timely and appropriate care? Or, is the MCO justified in terminating the physician on the ground that dissatisfied providers do not provide good patient care?<sup>51</sup>

(7) Is it protected patient advocacy for an anesthesiologist who believes that a patient scheduled for surgery is medically unstable to refuse to administer anesthesia, thus precluding the surgery?<sup>52</sup>

(8) Is it protected patient advocacy for an orthopedic surgeon to argue that the patient's back pain should be treated by orthopedic surgery rather than the neurosurgery recommended by the patient's MCO's medical director?<sup>53</sup> What if the doctor and the hospital would require the patient to sign an informed consent form acknowledging that the surgery is experimental in order to obtain the surgery?<sup>54</sup>

49. *Nealy v. U.S. Healthcare Versalite Plus HMO*, 711 N.E.2d 621, 621 (N.Y. 1999).

50. *See, e.g., Wickline v. California*, 239 Cal. Rptr. 810, 810 (Cal. App. 1986).

51. *See* David R. Olmos & Michael A. Hiltzik, *Doctors' Authority, Pay Dwindles Under HMO*, L.A. TIMES, Aug. 29, 1995, at A1; *see also* Woolhandler, *supra* note 3 (stating that a doctor who complained publicly that his HMO's risk-sharing and financial incentive arrangements lead directly to a lower quality of care for patients was terminated without cause).

52. *Khajavi v. Feather River Anesthesia Med. Group*, 100 Cal. Rptr. 2d 627 (Ct. App. 2000).

53. *Cf. Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (holding that state statute requiring HMOs to provide independent medical review of disputes between primary care physician and HMO and to cover services deemed medically necessary by independent reviewer was not preempted by ERISA), *with* *Lewis v. Individual Practice Ass'n, Inc.*, 723 N.Y.S.2d 845 (Sup. Ct. 2001) (authorizing discovery into whether physician's employment contract was not renewed because he had participated in patient advocacy).

54. *See* *Bradley v. Empire Blue Cross & Blue Shield*, 562 N.Y.S.2d 908 (Sup. Ct. 1990) (granting terminally ill plaintiff's motion to enjoin his insurer from refusing to cover procedure because it was excluded from coverage as "experimental or investigative").

These scenarios, drawn largely from actual cases, sketch the landscape where the current argument over the meaning and limits of legally protected patient advocacy is being played out. Next, we turn to the data.

### **E. How Common Is Health Care Professional Deselection?**

There is considerable disagreement about the extent to which managed care organizations terminate or fail to renew their contractual relationships with health care professionals because of these professionals' advocacy. There are many reasons why an HCP's contract with an MCO might not be renewed, some appropriate and some not. Appropriate reasons include concerns about an HCP's professional competence, including issues of board certification, pending disciplinary or malpractice actions, as well as sexual harassment or other improper conduct. MCOs have a substantial incentive to make sure that the records of participating HCPs are "squeaky-clean," as more and more courts are holding MCOs vicariously liable for the negligence of network HCPs,<sup>55</sup> and MCOs are increasingly seen as "deep pocket" defendants. Apart from liability concerns, MCOs also have important business and economic grounds for parting company with HCPs, including the use of more primary care and fewer specialist physicians as part of their "gatekeeping" strategy.<sup>56</sup> In addition, broad changes in national and local health care markets, such as the evolving medical needs of MCO enrollees and the need to reconfigure relationships with hospitals, can lead MCOs to deselect HCPs who no longer meet their needs. One gray area which has emerged is whether it is appropriate to deselect HCPs due to their overutilization of diagnostic, specialist, and inpatient resources, particularly if these services are provided out of network. Questions about whether certain procedures are medically necessary and appropriate frequently arise.<sup>57</sup> Although an MCO's motive in questioning the necessity of certain procedures may be to cut costs, it is also true that many patients receive medically unnecessary care, which can be merely unhelpful or actively harmful, with innovative medical treatment providing a classic case in point.<sup>58</sup> On the other hand, some HCPs and their lawyers charge that MCOs deselect HCPs not for negligent or otherwise inappropriate care, but because the HCPs push too hard for care for their patients or challenge MCO policies, particularly in public.

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55. In the 1990s, MCOs are increasingly taking on the role that hospitals had in an earlier era, in terms of credentialing and otherwise vouching for the quality of care provided by their physicians.

56. See, e.g., Olmos & Hiltzik, *supra* note 51.

57. See *Foong v. Empire Blue Cross & Blue Shield*, 2003 WL 21234956 (N.Y. App. Div. 2003).

58. See *Bradley*, 562 N.Y.S.2d at 908.



In part, the disparity of views between HCPs and MCOs can be attributed to terminology. As noted in the scenarios posited above, one person's patient advocacy may be another person's not "getting with the program" of managed care, or making a recommendation that is medically unsound or acting out of a vested financial self-interest.<sup>59</sup> But beyond this obvious opportunity for different perceptions about what constitutes appropriate patient advocacy, there appears to be a powerful disconnect between the experiences reported by managed care officials compared to those of health care professionals. For example, one lawyer for a large managed care entity has stated that HCPs were almost never terminated from that MCO because of advocacy, since the MCO's contract with its physicians affirmatively encouraged them to advocate on their patients' behalf.<sup>60</sup>

In contrast, media accounts are replete with stories of physicians who were terminated from MCOs, either because they complained generally about lowered quality of patient care or because they made too many out-of-network referrals.<sup>61</sup> Lawyers for physicians who have been deselected from MCOs have frequently stated that their clients' contracts with an MCO were terminated or not renewed after protracted wrangling with the MCO over either patient-specific or broader patient care issues.<sup>62</sup> These included MCO refusals to authorize recommended procedures for their patients (including emergency hospital admissions), MCO failures to collaborate with physicians in establishing clinical practice guidelines, or MCO insis-

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59. As Bill Sage has observed, "[j]ust because one physician desires to provide treatment to a patient does not automatically confer legitimacy on that physician as advocate to the exclusion of others." William M. Sage, *Physicians as Advocates*, 35 Hous. L. Rev. 1529, 1569 (1999).

60. The contract for physician specialists at one large MCO provides, in pertinent part:

Nothing in this Agreement or the Policies should be construed to prohibit, limit or restrict you from advocating on behalf of your patients or providing information, letters of support to, or assistance consistent with the health care needs of your patients and your professional responsibility, conscience, medical knowledge, license and applicable law. In fact, we encourage you to discuss with your patients all pertinent details regarding their condition and all care alternatives, including potential risks and benefits, even if a care option is not covered. We also encourage you to discuss your compensation arrangements hereunder with your patients. Nothing in this Agreement or the Policies should be construed to create any right of Company or any Payor to intervene in the manner, methods or means by which you render health care services to your patients.

Physician Specialist Contract (copy on file with the author).

61. See, e.g., Olmos & Hiltzik, *supra* note 51; Glenn Singer, *HMO Action Draws Inquiry, State Studies Termination of Pediatrician*, S. FLA. SUN-SENTINEL, July 24, 2001, at 1D.

62. Although no specific date is available, this information has been gathered over several conversations with the author.

tence on cost-containment procedures which the physicians believed put their patients at risk.<sup>63</sup> These attorneys also related stories about other HCPs whom they said were afraid to confront MCOs over such issues as utilization review, denials of necessary care, pressures to limit prescriptions for expensive pharmaceuticals, and a variety of other cost-containment measures, and suggested that at least some MCOs used the threat of contract termination to keep HCPs in check.

The economic pressure on physicians to comply with MCO cost containment and utilization review policies has been well documented. In *Potvin v. Metropolitan Life Insurance Co.*,<sup>64</sup> the California Supreme Court discussed the large number of articles and authorities asserting that managed care organizations operating in California held “substantial economic power” over both physicians and patients in that state, which made “access to provider panels a ‘practical prerequisite’ to any effective practice as a health care provider.”<sup>65</sup> While the authors of the 1997 GAO Gag Clause Report<sup>66</sup> found no explicit gag clause in any of the more than 1,100 managed care contracts they reviewed, they did find that “non-disparagement clauses” were widely used by the MCOs to “protect a plan’s business interests by requiring that physicians dissatisfied with an HMO complain to the HMO and

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63. This last category is, of course, huge and open-ended, since it encompasses most, if not all, of the clinical and ideological disagreements between physicians and MCOs. In one litigated case, a physician claimed that he was terminated by his MCO after challenging the MCO’s proposed new policy of requiring physicians to transfer care of their hospitalized patients to an MCO physician who lacked any previous relationship with the patient, but who presumably would adhere more readily to the MCO’s discharge guidelines. A jury awarded him \$4 million in compensatory damages and \$15 million in punitive damages. Guy H. Lawrence, *Jury Awards \$15 Million in Punitive Damages to Local Physician Visit . . .*, CALLER-TIMES (Corpus Christi, Tex.), Nov. 18, 2000, at B1; see also Singer, *supra* note 61.

64. 95 Cal. Rptr. 2d 496 (Cal. 2000).

65. *Id.* at 504-05.

66. See GAO GAG CLAUSE REPORT, *supra* note 5. The Report concluded:

Many physicians and attorneys believe that the most powerful incentive for a physician to cooperate with HMO policies on physician-patient communication is the possibility that his or her contract could be canceled. Of the contracts that we reviewed for this study, nearly all were initially written for a period of 1 year or less, and were renewable for 1-year periods. To the extent that the plan threatens the economic well-being of those ignoring its contract provisions, physicians may feel forced to be more compliant. One means HMOs have for enforcing physician adherence to plan policies, procedures, and utilization management guidelines is the “without cause” or “at-will” termination clause, which we found in 72 percent of the HMO contracts we reviewed. . . . Physicians also told us that the termination clause becomes especially important in regions where the health care marketplace is dominated by a few large managed care plans. In this situation, physicians may be less willing to challenge HMO policies because they view their participation in managed care plans as essential to sustain their practice.

*Id.* at 14-15.

not to the patient.”<sup>67</sup> The Report observed that physicians could interpret these clauses as limiting or precluding communications with patients about treatment options, financial incentives, or other MCO cost containment mechanisms, although they expressed some doubt that many physicians actually read their contracts carefully enough to be intimidated by these clauses. However, the Report noted that for many physicians, the threat of termination or nonrenewal of their contract was a powerful inducement for them to comply with the policies and practices of the MCO, whether written or unwritten. Thus, the *in terrorem* impact of MCO contracts, with their short terms and the possibility of terminations “at-will” or “without cause,” likely has a profound effect on the way HCPs deliver health care and advocate for their patients, despite contracts which are formally neutral, or even supportive of patient advocacy.

#### F. National Health Care Professional Data Banks

Yet acknowledging the psychological and economic power of MCOs<sup>68</sup> *vis á vis* HCPs and patients is only the first step toward understanding the reality of HCP-MCO relations. There are very limited data available, apart from news stories or individual anecdotes, to indicate the frequency of HCP deselection from MCOs, either for advocacy or other reasons. Although there are two major national information sources for actions taken against physicians and other health care professionals - the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB)<sup>69</sup> - neither data bank provides much information about MCO

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67. *Id.* at 6.

68. Of course, whether or not an MCO has the upper hand in negotiating and enforcing a contract with HCPs depends considerably on the concentration and power of that MCO and MCOs generally in a particular geographic health care marketplace. *Id.* at 14-15.

69. Congress established these two entities with the goal of creating a nationwide data base concerning all HCPs who have had their professional competence or honesty called into question, so that state licensing boards, hospitals, and health plans, among others, can make better disciplinary and credentialing decisions. Both data banks are authorized to collect and release data concerning health care professional performance. These data are available to the public only in aggregate form, which precludes the public (and research scholars) from knowing what actions have been taken against individual HCPs, and why the actions were taken. The NPDB was established as part of the Health Care Quality Improvement Act of 1986 (HCQIA), Title IV of Pub. L. 99-660, codified at 42 U.S.C. §§ 11131-11137 (2000), a multi-faceted effort to improve the quality of health care. By providing antitrust immunity for physicians who participate in peer review activities, the HCQIA encourages them to engage in peer review and other disciplinary actions against incompetent or negligent health care professionals. In addition, the HCQIA established the NPDB, a national clearinghouse for information about incompetent HCPs, thus limiting these HCPs' ability to move from state to state and continue to practice their profession even after disciplinary

terminations of HCPs. Health plans<sup>70</sup> reported 410 contract terminations of HCPs, primarily physicians and dentists, to the HIPDB, covering the period from August 1996 through the end of 2000.<sup>71</sup>

The significance of these contract terminations is unclear, because of an inadequate context in which to interpret the meaning of the data. One can speculate that all these cases involved providers deemed so problematic by their health plans that it was felt necessary to terminate their contract before the end of its term, usually a year or less.<sup>72</sup> It is impossible to know why the HCPs were terminated by the health plans, since no reason need be given in the report. Since the only terminations that must be reported are those in which due process procedures were utilized, we do know that in every one of these cases, the providers objected to their termination and challenged it through an adversarial due process proceeding.<sup>73</sup> What we do not

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action has been taken against them in another state. Actions that must be reported to the NPDB include state disciplinary actions against physicians or dentists relating to that person's professional competence or conduct; adverse HCP clinical privileges decisions made by hospitals and other health care entities, including HMOs and professional societies; exclusions of HCPs from the Medicare and Medicaid programs; Drug Enforcement Administration (DEA) actions to revoke the registration of a HCP (i.e. the ability to write prescriptions), and; all medical malpractice awards paid by anyone other than the HCP himself (i.e., a malpractice insurer, medical group, or hospital). *See generally* NATIONAL PRACTITIONER DATA BANK, 2000 ANNUAL REPORT 2-6 (2000), available at <http://www.npdb-hipdb.com/annualrpt.html>.

Congress authorized the Healthcare Integrity and Protection Data Bank (HIPDB) in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as part of a massive federal initiative to combat health care fraud and abuse. HIPDB's goal is to "flag" HCPs who have engaged in fraudulent or improper billing for health care services, so that "queriers" may know whether a particular HCP has allegedly engaged in fraudulent activity. Among the "adjudicated actions or decisions" which must be reported to the HIPDB are: state and federal licensing and certification decisions; health care-related civil judgments and criminal convictions; injunctions related to the delivery of a health care item or service, exclusions from participation in Medicare, Medicaid, and other state or federal health care programs; and any other adverse action taken by a private entity, including contract terminations made by health plans. HEALTHCARE INTEGRITY AND PROTECTION DATA BANK, 2000 ANNUAL REPORT 1 (2000).

70. Health plans include MCOs and insurers.

71. This apparent time anomaly is due to the requirements of HIPAA, the statute which authorized the formation of the HIPDB. Although the HIPDB did not become operational until November 1999, HIPAA requires that all reporters communicate "adverse events" and other mandated actions dating back to August 21, 1996, the date the statute was enacted. HEALTHCARE INTEGRITY AND PROTECTION DATA BANK, 2000 ANNUAL REPORT, *supra* note 69, at 1-2, 8.

72. *See* GAO GAG CLAUSE REPORT, *supra* note 5, at 14-15.

73. There is some anecdotal evidence from health care lawyers working in this area that health plans and other entities may be underreporting the adverse actions they have taken against health care professionals, because of a lack of information or understanding about which procedures meet these due process standards, and thus must be reported.

know is how many health plans decided to wait until the HCP's contract expired at the end of its term, and simply chose not to renew it.

Finally, we have no estimate of the costs, to individual health care professionals and their patients (through a loss of continuity of care), of the deselection of those HCPs from an MCO. In *Potvin v. Metropolitan Life Insurance Co.*,<sup>74</sup> a physician who was terminated from a HMO's preferred provider network alleged that because he was obligated to report Met Life's termination of his contract, other HMO's also terminated their contractual agreements with him, leading to a loss of patient referrals, and therefore income. Specialists, like the obstetrician-gynecologist Dr. Potvin, are particularly vulnerable to deselection, since most MCOs rely on a gatekeeping system, in which all patient treatment is funneled through a single primary care physician who coordinates care through referrals.<sup>75</sup>

#### IV. STATUTORY AND COMMON LAW PROTECTIONS FOR HEALTH CARE PROFESSIONALS WHO ADVOCATE FOR THEIR PATIENTS

##### A. Legislative Action

###### 1. *Explicit Protection of Advocacy*

Seventeen states have adopted laws explicitly protecting health care professionals against retaliation due to their advocacy on behalf of patients. In 1993, California launched this trend, as it has done so many other times in health care, enacting a statute that broadly promotes patient advocacy. The statutory preamble<sup>76</sup> declares that phy-

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74. 95 Cal. Rptr. 2d 496 (2000).

75. Olmos & Hiltzik, *supra* note 51. Indeed, the need for a MCO to be able to effectively "manage" care, by choosing only those HCPs who understand its philosophy of rationalizing care and expenditures, is one reason that MCOs object so strenuously to Any Willing Provider Laws, discussed in text accompanying notes 123-26 *infra*.

76. CAL BUS. & PROF. CODE § 2056 (West 2003) provides "protection against retaliation for physicians who advocate for medically appropriate health care" and declares that:

(a) The purpose of this section is to provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients pursuant to *Wickline v. California*, 192 Cal. App. 3d 1630.  
(b) It is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. For purposes of this section, "to advocate for medically appropriate health care" means to appeal a payor's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the

sicians who engage in advocacy *a la Wickline*<sup>77</sup> are protected from retaliation, and announces that it is the public policy of California that “physician[s] and surgeon[s] . . . be encouraged to advocate for medically appropriate health care for . . . [their] patients.”<sup>78</sup>

Over the next ten years, sixteen more states followed California’s lead. Alaska, Arizona, Colorado, Connecticut, Illinois, Indiana, Louisiana, Maine, Missouri, New Hampshire, New York, North Dakota, Oregon, Pennsylvania, and Tennessee have each enacted laws that explicitly protect health care professionals from retaliation due to patient advocacy<sup>79</sup> by a managed care organization or other payor.<sup>80</sup> These laws vary widely in their definitions of protected advocacy, the scope of their coverage, and the form that the statutory mandate takes. None of the statutes spells out precisely what will happen if an HCP is penalized for engaging in protected advocacy.<sup>81</sup>

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physician’s ability to provide medically appropriate health care to his or her patients.

(c) The application and rendering by any person of a decision to terminate an employment or other contractual relationship with, or otherwise penalize, a physician and surgeon principally for advocating for medically appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care violates the public policy of this state. No person shall terminate, retaliate against, or otherwise penalize a physician and surgeon for that advocacy, nor shall any person prohibit, restrict, or in any way discourage a physician and surgeon from communicating to a patient information in furtherance of medically appropriate health care.

77. *Wickline v. California*, 239 Cal. Rptr. 810, 810 (App. 1986).

78. CAL BUS. & PROF. CODE §2056(b) (West 2003). Under California law, courts are limited to finding a public policy in statutes and constitutional provisions.

79. ALASKA STAT. § 21.07.010(a)(5) (2002); ARIZ. REV. STAT. § 20-827(B) (2003); COLO. REV. STAT. § 10-16-121 (2002); CONN. GEN. STAT. §§ 38a-478(c) (1999) and 38a-503d(b) (1997); 215 ILL. COMP. STAT. 134/35 (2001); IND. CODE ANN. §§ 27-13-10-11 and 27-8-28-18 (Ind. 1999 Replacement & 2000 Supp.); LA. REV. STAT. § 22:215.18 (2003 Supp.); ME REV. STAT. ANN. tit. 24-A § 4303 (2000); MO. REV. STAT. § 354.609 (2001); N.H. REV. STAT. ANN. § 420-J: 8 VIII (2000); N.Y. PUB. HEALTH LAW § 4406-d(5) (McKinney 2003); N.D. CENT. CODE § 26.1-04-03(18) (2003); OR. REV. STAT. § 743.803(f) (2001); 40 PA. CONS. STAT. ANN. § 991.2113(c) (2001); TENN. CODE ANN. § 56-32-230 (2001). While most of these statutes protect all health care professionals, California protects only physicians. See CAL BUS. & PROF. CODE § 2056 (1996).

80. Most statutes direct their sanctions against HMOs or MCOs, but some include insurance companies as well. The California statute is even broader, granting physicians protection against retaliation by any “person.” CAL BUS. & PROF. CODE § 2056(c).

81. Of course, a failure to articulate a precise sanction for noncompliance is not uncommon. However, it does raise the question, discussed *infra* in Part V, about what enforcement mechanisms are available to HCPs who seek to challenge their deselection from an MCO on advocacy grounds.

Several statutes provide protection for advocacy without defining that term,<sup>82</sup> while other statutes specify those actions that constitute protected advocacy. Maine, for example, prohibits carriers offering managed care plans from "terminat[ing] or otherwise disciplin[ing] a participating provider because the provider advocates for medically appropriate health care."<sup>83</sup> The statute then offers a definition of advocacy:

[T]o advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established grievance or appeal procedure; or to protest a decision, policy or practice that the provider . . . reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients.<sup>84</sup>

Some states seek to protect health care professionals' advocacy by mandating advocacy protection provisions in all contracts between HCPs and MCOs, while other states explicitly prohibit retaliation against an HCP because of advocacy. Alaska takes the former approach, requiring that:

[All] contract[s] between a participating health care provider and a managed care entity . . . must contain a provision that . . . a health care provider may not be penalized or the health care provider's contract terminated by the managed care entity because the health care provider acts as an advocate for a

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82. See, e.g., ALASKA REV. STAT. § 21.07.010 (Patient and Health Care Provider Protection) (providing in (a)(5) that "[a] contract between a participating health care provider and a managed care entity that offers a group managed care plan must contain a provision that . . . states that a health care provider may not be penalized or the health care provider's contract terminated by the managed care entity *because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary health care services*" (emphasis added)).

83. ME REV. STAT. ANN. tit. 24-A § 4303(3).

84. *Id.* at § 4303(3)(A). For another example of a statutory definition of advocacy, see ARIZ. REV. STAT. § 20-827(B), which provides that hospital, medical, dental, and optometric service corporations [which arrange for delivery of health care services to subscribers] shall not:

2. Terminate a contract with or refuse to renew a contract with a health care professional solely because the professional in good faith does any of the following:

- (a) Advocates in private or in public on behalf of a patient.
- (b) Assists a patient in seeking reconsideration of a decision made by the [health plan]. . . to deny coverage for a health care service.
- (c) Reports a violation of law to an appropriate authority.

See also MO. REV. STAT. § 354.609, which provides that:

5. No health carrier shall terminate a contract or employment solely or in part because a health care provider in good faith:

- (1) Advocates on behalf of an enrollee;
- (2) Files a complaint against the health carrier;
- (3) Appeals a decision of the health carrier;
- (4) Provides information or files a report with the department of insurance;
- (5) Requests a hearing or review pursuant to this section.

covered person in seeking appropriate, medically necessary health care services.”<sup>85</sup>

Arizona takes the alternative approach, expressly prohibiting retaliation against HCPs who engage in protected advocacy.<sup>86</sup> The choice between procedural and substantive contract protections is classic in American jurisprudence. Depending on one’s ideological perspective, one either believes that parties to a deal can best achieve the bargain they want and be protected against overreaching by knowing all the details of the transaction in advance, or by having substantive limits placed on the terms of that transaction.<sup>87</sup> In the case of advocacy protection laws, the very limited number of lawsuits brought by HCPs who have been deselected from an MCO makes it extremely difficult to say that one method of protecting advocacy is superior to any other.

Another difference among advocacy protection laws is that some statutes enumerate those activities which constitute prohibited retaliation against an HCP, while other statutes speak more generally of not “penalizing” or “retaliating against” an HCP who engages in advocacy on behalf of patients.<sup>88</sup> The North Dakota statute is an example of the former approach, providing a broad array of *verboden* actions:

An entity may not take any of the following actions against a health care provider solely because the provider, in good faith, reports to state or federal authorities an act or practice by the entity that jeopardizes patient health or welfare, or advocates on behalf of a patient in a utilization review program or grievance procedure:

- a. Refusal to contract with the health care provider;
- b. Termination of or refusal to renew a contract with a health care provider;
- c. Refusal to refer patients to or allow others to refer patients to the health care provider; or
- d. Refusal to compensate the health care provider for covered services that are medically necessary.<sup>89</sup>

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85. ALASKA STAT. REV. § 21.07.010(a)(5). The Oregon statute takes a similar approach. OR. REV. STAT. § 743.803(2)(f) (1999). Whether or not such a mandatory contract term would be preempted by ERISA, since it “relates to” the structure and administration of an employee benefit plan or would be “saved” from ERISA preemption by the insurance “savings clause” will be explored in Part V *infra*.

86. See, e.g., ARIZ. REV. STAT. § 20-827(B).

87. A similar debate took place among courts and commentators about whether unconscionable consumer contracts are better conceptualized as a problem of substantive or procedural unconscionability. See, e.g., Arthur Leff, *Unconscionability and the Code – The Emperor’s New Clause*, 115 U. PA. L. REV. 485, 487 (1967).

88. See, e.g., CONN. GEN. STAT. § 38a-478h(c) (2000) (providing that: “No managed care organization shall take or threaten to take any action against any provider in retaliation for such provider’s assistance to an enrollee under the provisions of subsection (e) of section 38a-226c [participation in expedited utilization review in urgent health circumstances] or section 38a-478n [appeal to Insurance Commissioner taken after enrollee has exhausted the MCO’s internal grievance procedure]”).

89. N.D. CENT CODE § 26.1-04-03(18) (2002).



Further, there are some advocacy protection laws that, while they look good on paper, may have only a minimal impact on HCPs and the patients they serve, due to the limited scope of the statute. For example, the Kentucky law, which declares that the HCPs shall not be penalized or have their contract with a health plan terminated because they have discussed treatment options and information with the patient or other persons, applies only to "Limited Health Service Benefit Plans." These are plans such as vision plans or dental plans, which encompass a narrow range of health care services.<sup>90</sup> There are no comparable provisions protecting HCP advocacy which apply to the much larger number of traditional, full service MCOs that operate in Kentucky.

Many of the statutes address incompletely a problem inherent in protecting individuals from retaliation: how can we know whether the MCO terminated or "non-renewed" its contract with the HCP because of advocacy or for other reasons? What recourse should an MCO have against an HCP who, in addition to being an advocate for patients, is also a bad diagnostician or a careless surgeon, the possessor of an abrasive personality, an "outlier" in the use of services, or simply one of a number of specialists whom the MCO no longer needs to retain in its network, either due to market changes or to a change in organization or focus of the MCO? Seven statutes limit their protection to those HCPs who are terminated "solely" because of their advocacy,<sup>91</sup> but do not articulate any mechanism for determining when advocacy is the "sole" motivation for the HCP's deselection from the MCO.<sup>92</sup> The ten other statutes are silent on this point. Many statutes are also deficient in failing to define or "operationalize" advocacy,<sup>93</sup> because, as the scenarios postulated in Section D above indicate, advocacy has different meanings to different people and under diverse circumstances. Part V will address the consequences of the failure to clearly articulate and operationalize the concept of patient advocacy on the statutes' ultimate effectiveness.

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90. KY. REV. STAT. ANN. § 304.17C-010(5) (Cum. Supp. 2003).

91. ARIZ. REV. STAT. § 20-827(B); IND. CODE ANN. §§ 27-13-10-11 and 27-8-28-18; LA. REV. STAT. § 22:215.18; MO. REV. STAT. § 354.609; N.Y. PUB. HEALTH LAW § 4406-d (5); N.D. CENT. CODE § 26.1-04-03(18); OR. REV. STAT. § 743.803(2)(f).

92. Of course, courts are experts in allocating burdens of production and persuasion in order to achieve a statute's goals, and it may not be necessary to explicitly lay out all these steps in a statute. The response of at least one court to a statutory lacuna will be explored in the Part V discussion of *Lewis v. Individual Practice Association of Western New York, Inc.*, 723 N.Y.S.2d 845 (Sup. Ct. 2001).

93. See ALASKA REV. STAT. § 21.07.010(a)(5); OR. REV. STAT. § 743.803(2)(f).

## 2. *Implicit Protection of Advocacy*

### a. *By Statutes*

In addition to the explicit protection of advocacy, a number of states have enacted statutes that can offer additional support for health care professionals who advocate on behalf of their patients. These statutes fall into four main groups: 1) statutes declaring that HCPs cannot be terminated for rendering statutorily mandated health care services, 2) so-called anti-gag clause provisions, that is, statutes that declare that HCPs cannot be retaliated against for providing information to patients or other relevant individuals about available treatment options, 3) laws mandating procedural protections for HCPs in connection with termination or non-renewal of their contracts, and 4) statutes imposing limits on MCOs' ability to use financial incentives or other cost-containment measures that could interfere with HCPs' exercise of their professional judgment. Just as with statutes providing explicit protection for HCPs' patient advocacy, the question which must be answered in regard to supplemental support statutes is how effective they are in protecting HCPs who act as advocates and fiduciaries for their patients.

#### i. *Prohibition of Retaliation Based on Rendering Mandated Services*

Several states have adopted statutes that prohibit the punishment of HCPs who provide health care services that are mandated by another statute, thus implicitly protecting the most basic type of advocacy – the actual provision of patient services. In most instances, these mandated services laws were enacted in response to a public concern that health insurers and MCOs were imposing unduly narrow utilization review or benefit eligibility criteria and denying medically necessary and appropriate services. For example, many states and Congress<sup>94</sup> adopted laws in the mid-1990s in response to a concern that health plans were routinely mandating such short hospital stays for a newborn child and its mother that they could be characterized as “drive-through deliveries.”<sup>95</sup> These laws were enacted despite the lack of clear evidence that requiring mothers and their newborns to stay in the hospital at least 48 hours after a normal vaginal delivery

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94. The Newborns' and Mothers' Health Protection Act of 1996 is found at 29 U.S.C. § 1185 (1996).

95. Declerq & Simmes, *The Politics of "Drive-through Deliveries": Putting Early Postpartum Discharge on the Legislative Agenda*, 75 MILBANK Q. 175 (1997); David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N.C. L. REV. 5 (1999); see also CLARK C. HAVIGHURST, JAMES E. BLUMSTEIN, AND TROYEN A. BRENNAN, *HEALTH CARE LAW AND POLICY* 19-20 (2d ed. 1998).

was clinically necessary or good preventative health care.<sup>96</sup> To give these laws more teeth, a number of states adopted laws that specifically prohibited MCOs, health plans, and insurers from retaliating against an HCP who provided the mandated services. For example, Alabama enacted a law providing:

No health benefit plan subject to the provisions of this chapter [governing mandatory maternity and newborn care] shall terminate the services, reduce capitation payment, or otherwise penalize an attending . . . [HCP] who orders medical care consistent with this chapter. No health benefit plan shall provide, directly or indirectly, any financial incentive or disincentive . . . to any person to encourage or cause early discharge of a hospital patient from postpartum care . . . .<sup>97</sup>

Connecticut and Florida have adopted similar laws in regard to out-patient mastectomies, which had become a cause célèbre at the time.<sup>98</sup> Indiana enacted a law proscribing punishment against health care professionals who prescribed “nonformulary,” typically more expensive, drugs to their patients.<sup>99</sup> Rhode Island has enacted a law that precludes “discrimination” against health care providers who “treat[ ] a substantial number of patients who require expensive or uncompensated medical care.”<sup>100</sup>

96. Hyman, *supra* note 95.

97. ALA. CODE § 27-48-3 (1998); *see also* FLA. STAT. ch. 641.31(18)(f)(3), (4) (2003).

98. CONN. GEN. STAT. § 38a-503d(b) provides:

No individual health insurance carrier may terminate the services of, require additional documentation from, require additional utilization review, reduce payments or otherwise penalize or provide financial disincentives to any attending health care provider on the basis that the provider orders care consistent with the provisions of this section [mandating at least 48 hours of inpatient care following a mastectomy or lymph node dissection, or longer if recommended by physician, and forbidding insurance policy from requiring outpatient surgery].

Chapter 641.31(31)(a) of the Florida statutes states that an HMO that provides services for breast cancer treatment shall not limit inpatient services to a period less than determined by treating provider to be medically necessary. The statute further declares that an HMO may not:

(b)(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to a covered patient under this subsection; [or]

(b)(4) Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to a covered patient in a manner inconsistent with this subsection.

99. Section 27-13-38-1 parts (a) and (b) of the Indiana statutes mandate certain operations for HMOs' drug formularies and require that HMOs have procedures for enrollees to obtain nonformulary drugs without incurring additional costs. Part (c) declares that:

A health maintenance organization may not:

(1) void a contract; or

(2) refuse to renew a contract between the HMO and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary drug or device as provided in subsection (b)(2).

100. R. I. Gen. Laws § 23-17.13-3(c)(8) (2001).

*ii. Statutes Prohibiting "Gag Clauses"*

The most common form of implicit HCP advocacy protection is found in the so-called "anti-gag clause" statutes. A majority of states enacted such laws in the mid-1990s, following widely circulating horror stories about physicians and other HCPs who were precluded from disclosing MCO incentive arrangements to their patients, or discussing the full range of treatment options available, because of "gag clause" provisions in the HCPs' contracts with MCOs.<sup>101</sup> Although, as noted above, the 1997 GAO Gag Clause Report failed to find any explicit bans on HCP-patient communication in the more than 500 managed care contracts that were reviewed, the concern that managed care was intruding into the sanctity of the HCP-patient relationship struck a powerful chord with American citizens and their legislators. The Delaware statute is typical:

An insurer shall not refuse to contract with or compensate for covered services a participating or contracting healthcare provider solely because that provider has in good faith communicated with 1 or more of the provider's current, former or prospective patients regarding the provisions, terms, or requirements of the insurer's products or services as they relate to the needs of that provider's patients.<sup>102</sup>

Some statutes protect not only communications between the HCP and the patient, but also between the HCP and others who may be involved in delivering or paying for the patient's care.<sup>103</sup> Thus, the

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101. See Steffie Woolhandler & David U. Himmelstein, *Extreme Risk – The New Corporate Proposition for Physicians*, 333 N.E. J. MED. 1706 (1995).

102. DEL. CODE ANN. tit. 18 § 3339 (2001). Congress also enacted a law regarding gag clauses that applies to Medicare managed care plans, although it was careful to limit the effect of the law so as not to conflict with the disclosure requirements of ERISA or state law. 42 U.S.C. § 1395w-22(j) provides, *inter alia*, that:

a Medicare + Choice organization . . . shall not prohibit or otherwise restrict a covered health professional . . . from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

103. LA. REV. STAT. § 22:215:18 provides that:

B. In a contract with a health care provider, a managed care organization shall not include provisions that interfere with the ability of a health care provider to communicate with a patient regarding his or her health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangement.

C. No managed care organization shall refuse to contract, renew, cancel, restrict, or otherwise terminate a contract with a health care provider solely on the basis of a medical communication. No managed care organization shall refuse to refer patients or to allow others to refer patients to the health care provider, refuse to compensate the health care provider for covered services, or take other retaliatory action against the health care provider. As used in this Subsection "medical communication" shall

Louisiana statute noted below<sup>104</sup> not only utilizes a broad definition of "medical communication," but also explicitly prohibits a broad array of retaliatory actions by MCOs, something not present in all anti-gag clause statutes. Other statutes are more circumscribed in their scope, in that they reject gag clause provisions in contracts between MCOs and HCPs, but do not provide any sanction for a failure to comply with the law.<sup>105</sup>

*iii. Statutes Establishing Procedural Due Process for Health Care Professionals*

Another major way in which states have provided protection to health care professionals who engage in advocacy for their patients is by mandating government oversight and procedural due process protections for HCPs who are terminated or non-renewed by managed care organizations. States require a wide variety of procedural due process protections in order to ensure at least a basic level of fairness in MCO-HCP relations. These include the requirements that MCOs provide a minimum period of notice to HCPs whose contracts they are terminating or not renewing, guaranteeing HCPs a hearing prior to such termination or nonrenewal, mandating an additional appeals process for HCPs who are dissatisfied with the hearing results, and requiring that MCOs disclose their credentialing, profiling, and utili-

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mean information regarding the mental or physical health care needs or the treatment of a patient.

The Texas law is similar, although not quite as broad, declaring that:

(a) a health maintenance organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(b) a health maintenance organization may not in any way penalize, terminate, or refuse to compensate for covered services, a physician, dentist, or provider for communicating with a current, prospective, or former patient, or a party designated by a patient, in any manner protected by this section.

TEX. INS. CODE art. 20A.18A (2002) (repealed 2003).

104. LA. REV. STAT. § 22:215:18.

105. See VA. CODE ANN. § 38.2-3407.10(H) (2001) (providing that "[n]o contract between a carrier and a provider shall prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider"). Likewise, FLA. STAT. ch. 641.315(5) (Supp. 2003) declares that:

A contract [between an HMO and a provider] shall not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

zation review criteria to HCPs. Taken together, these procedural due process statutes may provide enhanced protection to HCPs who become "undesirable" members of an MCO network due to their advocacy by giving HCPs remedies additional to those available at common law to challenge their deselection from the MCO. At the same time, however, these statutes may have unintended and not necessarily desirable side effects. First, any HCP contract termination accompanied by procedural due process becomes a reportable event to the Healthcare Integrity and Protection Data Bank.<sup>106</sup> Second, a court may decide that a legislature's enactment of certain procedural protections forecloses the recognition of other, implicit public policies as well.<sup>107</sup>

Many states require minimum notice of termination or nonrenewal of a contract, a requirement which is binding upon both MCOs and HCPs.<sup>108</sup> Frequently these statutes provide exceptions to the notice requirement based on a threat to patient health or safety, pending disciplinary action, or provider fraud.<sup>109</sup> One problem that can arise is to determine what the relationship is between mandatory notice requirements and statutes that protect HCPs against retaliation due to advocacy. In the only case to directly address this issue, *Lewis v. Individual Practice Association of Western New York, Inc.*,<sup>110</sup> an HMO gave a participating provider 60 days notice that it was not renewing his contract with the HMO. The applicable New York statute provided a number of procedural protections for HCPs, including a 60 day minimum notice requirement as well as a provision that prohibited

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106. See discussion in text accompanying notes 71-75 *supra*.

107. In *Grossman v. Columbine Medical Group, Inc.*, 12 P.3d 269 (Colo. Ct. App. 1999), the Colorado Court of Appeals upheld the termination of a physician from a medical group that provided services to a MCO. The physician argued that both the implied covenant of good faith and fair dealing and the public policy interest in ensuring continuity of care for patients justified requiring the defendants (a medical group and MCO) to provide him with a hearing prior to termination. The court disagreed, holding that since his contract permitted termination without cause, the implied covenant of good faith and fair dealing should not be used "to circumvent terms for which . . . [the physician] expressly bargained." *Id.* at 271. The court also rejected the argument that there was a public policy interest in maintaining the stability of the physician-patient relationship that required the defendants to provide the physician with a hearing. The court declared that the legislature had already articulated the public policy on this point when it enacted two statutes, not yet effective, which, taken together, permitted MCOs to terminate health care providers without cause if they gave sixty days notice, declaring, "It is not for the courts to enunciate the public policy of the state if, as here, the General Assembly has spoken on the issue." *Id.* This case illustrates the irony in the fact that the procedural protections intended to help HCPs can end up hurting them, by limiting the remedies that a sympathetic judiciary might otherwise have made available.

108. See, e.g., CONN. GEN. STAT. § 38a-478(h) (1997) (mandating that both parties to the contract give sixty days notice prior to termination).

109. *Id.*; see also MO. REV. STAT. § 354.609(2)(1) (2001).

110. 723 N.Y.S.2d 845 (Sup. Ct. 2001).

termination or nonrenewal of a contract due “solely” to the HCP’s advocacy. The New York trial court ruled that while the HMO’s compliance with the minimum notice requirement of the statute meant that the HCP was not entitled to a hearing or other procedural remedies provided by the statute, nonetheless the HCP was entitled to litigate the question of whether his nonrenewal was based on his patient advocacy. The court observed that any other interpretation of the statute would render the patient advocacy provisions of the statute unenforceable, and pointed to an extensive legislative history showing that the governor and legislature intended the statute to protect HCPs who engaged in advocacy on behalf of their patients.<sup>111</sup>

A second important procedural protection for providers is the requirement that HCPs be given a hearing or other meaningful opportunity to challenge the MCO’s decision to terminate their contracts. The New York statute is fairly typical, requiring that HCPs receive: 1) written explanation of the reasons for the proposed termination,<sup>112</sup> 2) notice that they are entitled to request a hearing or review by a panel appointed by the health care plan,<sup>113</sup> 3) a hearing before that panel, a third of whose members must be clinicians in the same specialty as the HCP under review,<sup>114</sup> 4) written notice of the panel’s decision,<sup>115</sup> and 5) time limits for action which are short enough to ensure that the process does not drag out interminably but long enough to permit a provider to prepare and present a case.<sup>116</sup> Exceptions to the statute are provided for cases involving imminent harm to patient care, fraud, or a final disciplinary action by a government agency that “impairs the HCP’s ability to practice.”<sup>117</sup> Other states provide lesser protections. Delaware, for example, requires insurers to give written notice of the reasons for termination or nonrenewal of a contract only if the HCP requests such notice within twenty days,<sup>118</sup> and requires only “administrative review” of the challenged contract action, without specifying the parameters of that review.<sup>119</sup> In contrast, Maine’s statute is even more protective than New York’s, as the enumerated procedural protections apply to HCPs whose contracts are not renewed as well as those whose contract is terminated, and the law also applies to HCPs who are terminated “without cause.”<sup>120</sup> The Maine statute also requires that the MCO’s notice of termination or nonrenewal include

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111. *Id.* at 848-850.

112. N.Y. PUB. HEALTH LAW §4406-d(2)(a) and (b)(9)(i).

113. *Id.* at § 4406-d(2)(b)(ii).

114. *Id.* at § 4406-d(2)(c).

115. *Id.* at § 4406-d(2)(d).

116. *Id.* at § 4406-d(2)(b)(iii), (iv) and (e).

117. *Id.* at § 4406-d(2)(a).

118. DEL. CODE ANN. tit. 18, § 3339(c) (2001).

119. *Id.*

120. ME. REV. STAT. ANN. tit. 24-A, § 4303(3-B) (2002 Supp.).

"[r]eference to the evidence or documentation underlying the carrier's decision . . . ." <sup>121</sup> Finally, the statute provides that "[a] carrier shall permit a provider to review this evidence and documentation upon request," <sup>122</sup> thus making it much easier for an HCP to challenge his or her termination or nonrenewal, and putting the MCO to its proof.

Yet another vehicle for protecting HCPs from contract termination or nonrenewal are statutes that mandate that MCOs and insurers disclose their credentialing and/or utilization review criteria, so that HCPs can know in advance the factors which will be used to evaluate their performance in the MCO, and are also more able to challenge their deselection for an alleged shortfall in their performance. Kentucky adopted such a statute as part of its "Any Willing Provider" law, <sup>123</sup> which was reviewed by the Supreme Court. <sup>124</sup> The Kentucky law provides that "[i]nsurers shall establish relevant, objective standards for initial consideration of providers and for providers to continue as a participating provider . . . ." <sup>125</sup> The statute further requires the standards be adjusted to take into account the "case mix, severity of illness, patient age" and other factors that could affect the HCP's cost of providing care, and that "[a]ll data profiling or other data analysis pertaining to participating providers shall be done in a manner which is valid and reasonable." <sup>126</sup> New York has taken a similar ap-

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121. *Id.* at § 4303(3-A)(A)(2).

122. *Id.*

123. KY. REV. STAT. ANN. § 304.17A-525 (2002). An "Any Willing Provider" (AWP) law mandates that a health plan, MCO, or insurer permit any willing HCP who meets the minimum credentialing requirements of that entity to treat its members or enrollees. Physician groups have lobbied for such laws in a number of states, claiming that they are necessary to ensure that physicians can continue to practice their profession in a geographic area where managed care has heavily penetrated. MCOs, on the other hand, generally oppose AWP laws, because they make it much harder for the MCO to achieve efficiency and use the kinds of cost containment measures which are essential to its success. Complying with an AWP law means, for example, that an MCO will have to permit all one hundred of the ophthalmologists in a particular area to be participating providers, rather than choosing twenty whom it believes are both clinically qualified and understand the basic premises of managed care. Supervising these one hundred physicians will require the MCO to engage in more contracting, more paperwork, and other kinds of oversight, while the MCO simultaneously can exercise less control over each physician, as physicians can belong to many MCOs and will be less likely to be beholden to any one health plan. AWP laws also deny insureds the ability to seek health care coverage "from a closed network of health-care providers in exchange for a lower premium." *Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 Sup. Ct. 1471, 1478 (2003).

124. In *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 Sup. Ct. 1471 (2003), the Supreme Court upheld Kentucky's AWP law against a claim of ERISA preemption, finding that although it "relate[d] to" employee benefit plans, it was "saved" from preemption as a "law . . . which regulates insurance." *Id.* at 1479.

125. KY. REV. STAT. ANN. § 304.17A-525(1).

126. *Id.*



proach, requiring MCOs to 1) develop "methodologies to collect and analyze health care professional profiling data" in consultation with HCPs, 2) use the data to evaluate HCPs against objective, agreed upon criteria and to compare HCPs who treat comparable patient populations, 3) have policies and procedures to ensure that HCPs are informed of information which is used to evaluate their performance, 4) disclose these data periodically to HCPs, and 5) provide them with an opportunity to respond to the MCO's assessment of their performance, including clarifying the nature of their patient population, and working cooperatively with the MCO to improve their performance.<sup>127</sup> These laws can provide essential ammunition for litigation by HCPs who assert that they were deselected by an MCO due to their patient advocacy, because they provide relatively objective criteria, chosen in advance by the MCO, by which the HCP's satisfaction of their contract requirements can be measured.

At least two states appear to sharply limit the utility of their credentialing and profiling statutes, by declaring that the statute or the information provided under it cannot be used to provide a private right of action. The Delaware statute, which we have already noted offers somewhat rudimentary procedural protections for HCPs in other respects, nonetheless requires that insurers who collect and use "professional profiling data" in evaluating an HCP's performance must disclose the data to the HCP and discuss it during the administrative review process.<sup>128</sup> However, the statute also provides a significant caveat: "This section shall not be deemed to create a private cause of action as a result of an insurer's termination or nonrenewal of a provider's contract. This section shall not abrogate any cause of action or remedy to which a provider may have a right pursuant to contract."<sup>129</sup> Thus, one is left wondering what the effect of the statutory mandate to disclose professional profiling data really is. It seems likely that the result of this proviso will be to ensure that all contracts governing MCO-HCP relations in Delaware will include language expressly denying an HCP any other ground on which to sue for termination or nonrenewal. Similarly, in Maryland, the applicable statute appears to protect HCPs by mandating that "practice profile"<sup>130</sup> data be provided to all HCPs who contract with HMOs. The profiling criteria must be disclosed at the commencement of their contractual rela-

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127. N.Y. PUB. HEALTH LAW § 4406-d(4) (2002).

128. DEL. CODE ANN. tit. 18, § 3339(e) (2001).

129. *Id.* at § 3339(h).

130. MD. CODE ANN., INS. § 19-710(s)(1) (2002 Replacement) provides that 'practice profile' means a profile, summary, economic analysis, or other analysis of data concerning services rendered or utilized by a provider under contract with or employed by a health maintenance organization for the provision of health care services by the provider to enrollees or subscribers of the health maintenance organization.

tionship and annually thereafter if the HCP requests it, along with information concerning the “manner in which the practice profile is used to evaluate” the HCP.<sup>131</sup> Unfortunately, the benefits of receiving these data are significantly undercut by the statute’s pronouncement that “[t]he information provided under this subsection may not be used to create a cause of action.”<sup>132</sup> Although it is possible that the Maryland Department of Insurance will vigorously enforce the law governing practice profiling by HMOs, it would appear far more useful to give HCPs a direct means of challenging the termination or nonrenewal of their contract with an HMO. As all law students learn early in their career, “There is no right without a remedy.”<sup>133</sup>

*iv. Statutes Prohibiting Financial Incentives to Control Costs*

Finally, a small number of states have provided general support for HCPs who advocate on their patients’ behalf by enacting laws that seek to limit MCOs’ use of cost-containment measures which could compromise clinical care. The New Hampshire statute is typical:

No contract between a health carrier and a participating provider shall contain any payment or reimbursement provision the terms of which creates [sic] an inducement for the provider to not provide medically necessary care to covered persons. Nothing in this section shall be construed to prohibit the use of payment arrangements between a health carrier and a participating provider or provider group, which involve capitation, withholds or other arrangements.<sup>134</sup>

Maine has adopted a similar statute, which spells out in some detail the precise form that cost-control measures are permitted to take.<sup>135</sup> Under this statute, managed care plans may offer general inducements to limit care such as capitation or risk-sharing that apply to groups of enrollees and groups of providers, but “may not offer or pay any type of material inducement, bonus, or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary health care services covered under the plan to an enrollee.”<sup>136</sup>

Two states, New Mexico and North Carolina, have adopted statutes that combine a condemnation of MCO financial incentives that would induce HCPs “to provide less than medically necessary services

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131. *Id.* at (s)(2).

132. *Id.* at (s)(3).

133. *See, e.g.,* *Ashby v. White*, 2 Ld. Raym. 938, 953 (1703) (Holt, C.J.) (“It is a vain thing to imagine a right without a remedy; for want of right and want of remedy are reciprocal”); *see also* *The Western Maid v. Thompson*, 257 U.S. 419, 433 (1922) (Holmes, J.) (“Legal obligations that exist but cannot be enforced are ghosts that are seen in the law but that are elusive to the grasp.”).

134. N.H. REV. STAT. ANN. § 420-J: 8 (VIII) (2000).

135. ME. REV. STAT. ANN. tit. 24-A, § 4303 (3-B) (2003).

136. *Id.*

to an enrollee<sup>137</sup> with a concern that HCPs should not be required to violate their fiduciary duties to their patients, including the duty of full disclosure of all available treatments, thus bringing us back to the most common form of implicit advocacy protection law, the “anti-gag clause” statute. The North Carolina law prohibits financial incentives in much the same way as New Hampshire and Maine,<sup>138</sup> and also declares that while providers must “comply with the quality assurance programs of the HMO . . . [t]he quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider’s ability to provide information or assistance to the patient.”<sup>139</sup> Similarly, New Mexico law provides succinctly that:

No managed health care plan may:

- (1) adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with an enrollee . . . ;
- (2) include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to an enrollee; or
- (3) require a health care provider to violate any recognized fiduciary duty of his profession or place his license in jeopardy.<sup>140</sup>

While these laws may be rather grandly written, particularly in regard to their injunction against MCO inducement of HCPs to violate their professional ethics, they provide a statement of public policy that could prove useful to an HCP who asserts wrongful termination from an MCO because of patient advocacy.

#### *b. Other Statutory Protections for Advocacy*

Finally, creative attorneys have used other statutes to challenge MCOs who have penalized those HCPs advocating on behalf of patients. Lawyers for aggrieved HCPs have invoked the Sherman Antitrust Act,<sup>141</sup> RICO,<sup>142</sup> and a variety of state statutes such as deceptive business practices laws, in an attempt to gain relief for their clients. However, these efforts have met with mixed success. Courts have denied the claims of HCPs that MCOs conspired with hospitals to pressure HCPs to comply with managed care policies, both written and unwritten, threatening a hospital with the loss of its contract with an MCO unless the hospital persuades the HCP to go along with the

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137. N.M. STAT. ANN. § 59A-57-6(A)(2) (Cum. Supp. 2002).

138. N.C. GEN. STAT. § 58-3-265 (2001).

139. *Id.* at § 58-67-88(H)(2). This law is designed to ensure continuity of care for patients with certain acute, chronic, or terminal illnesses, even though the HMO or the provider may have terminated its contractual relationship or the patient’s health coverage has changed.

140. N.M. STAT. ANN. § 59A-57-6.

141. 15 U.S.C. §§ 1-7 (1997).

142. RICO is the Racketeer Influenced Corrupt Organizations Act, 18 U.S.C. §§ 1961-1968 (2003).

MCO policy, implicitly rejecting the HCPs' arguments that the MCOs are either capable of using, or have used, significant market power to get their way.<sup>143</sup> Courts have dismissed RICO claims because the HCP failed to allege the requisite predicate criminal act.<sup>144</sup> But the Connecticut Supreme Court permitted a suit for wrongful termination of physicians' contracts to go forward based, *inter alia*, on claims that the Connecticut Unfair Trade Practices Act and the Connecticut Unfair Insurance Practices Act were violated when the defendant insurance company made misleading statements about the physicians' qualifications and status under the insurer's health plan.<sup>145</sup>

## B. Common Law Protection for Advocacy

Apart from statutes which provide explicit and implicit support for HCPs' patient advocacy, there is also common law that supports HCPs who advocate for patients, although there is significant variation among the states. These cases include decisions that physicians have a fiduciary duty to advocate for their patients, discussed in Part III. above,<sup>146</sup> opinions considering whether contracts between HCPs and MCOs should be interpreted to include an implied covenant of good faith and fair dealing, and cases involving the tort of the right to fair procedure, the right to be free from tortious interference with a contract, and other common law torts.

### 1. Fiduciary Duty to Advocate

The case law is mixed as to whether HCPs have a common law fiduciary duty to advocate on behalf of their patients. The majority of cases that have found that there is a duty to advocate emphasizes the fiduciary role that physicians and other HCPs have with their patients, the importance of the trust that patients place in their HCPs, and the reality that if the patient's treating health professional does

143. See *Finkelstein v. Aetna Health Plans, Inc.*, 1997 WL 419211, \*5 (S.D.N.Y. 1997) (relying on *Kartell v. Blue Shield*, 749 F.2d 922, 926 (1st Cir. 1984) for the proposition that "in the complex context of health insurance contracts, no antitrust liability lies where an insurer 'pays the bill and seeks to set the amount [and the terms] for the charge'"). For example, see *Wagner v. Magellan Health Services, Inc.*, 121 F. Supp. 2d 673 (N.D. Ill. 2000) (dismissing the plaintiffs antitrust action, which grew out of the facts discussed in *Wagner v. Magellan Health Services, Inc.*, Cause No. 01 L225 (Cir. Ct for 19th Judic. Cir., Lake County, Ill.) (currently pending)), discussed *infra* in section IV.B., because under the *Copperweld* doctrine a corporation cannot conspire with its own employees.

144. See, e.g., *Wagner v. Magellan Health Servs., Inc.*, 125 F. Supp. 2d 302 (N.D. Ill. 2000) (dismissing the plaintiffs RICO action, based on the facts discussed in *Wagner v. Magellan Health Servs., Inc.*, Cause No. 01-L225 (Cir. Ct for 19th Judic. Cir., Lake County, Ill.) (currently pending), discussed *infra* in section IV.B.

145. *Napoletano v. Cigna Healthcare, Inc.*, 680 A.2d 127 (Conn. 1996) discussed *infra* in text accompanying notes 256-259.

146. See discussion in section III.C. *supra*.

not advocate, it is unlikely that anyone else will, or that the patient will even know that there is something to advocate about.<sup>147</sup> In the one case that declined to find a duty to advocate by physicians, *Pryzbowski v. U.S. Healthcare, Inc.*,<sup>148</sup> the court relied on the *amicus* brief of a state medical society urging it not to impose such a duty.<sup>149</sup> In contrast, the AMA has recognized that because of the conflicts inherent in managed health care, in which physicians are given financial incentives to under-treat their patients, physicians must act as advocates for their patients, both by participating at the macro level in research and policymaking about what types of diagnostic and treatment procedures should be performed under specified clinical circumstances, and by arguing for the treatment of particular patients when their individual medical condition merits it, regardless of whether the patients meet standardized clinical parameters.<sup>150</sup> Thus, courts that impose a duty to advocate for patients on health care professionals are simply restating a public policy position of long-standing, that the association between health care professionals and their patients creates a fiduciary relationship, which requires protective judicial action.

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147. These cases have recognized a duty to advocate in a variety of circumstances, finding that physicians have a duty to inform a third party payor of the facts which justify extended treatment or hospitalization, *Wickline v. California*, 239 Cal. Rptr. 810 (App. 1986); to fill out forms necessary to obtain health insurance coverage, *Murphy v. Godwin*, 303 A.2d 668, 674 (Del. Super. Ct. 1973); and to make it clear to the payor that urgent medical treatment is necessary, *Nealy v. U.S. Healthcare*, 711 N.E.2d 621 (N.Y. 1999); see also *Pa. Psychiatric Soc'y v. Magellan Health Servs., Inc.*, 280 F.3d 278 (3d Cir. 2002) (noting a series of cases that recognized that physicians are able to effectively advocate on behalf of their patients, in the context of ruling that psychiatrists may have standing to assert the interests of their mentally ill patients who had been denied treatment by the defendant MCO); *Shea v. Esenstein*, 208 F.3d 712 (8th Cir. 2000) (finding that a physician has a duty to disclose potential conflicts of interest that might lead him not to recommend a referral to a specialist).

148. 245 F.3d 266 (3d Cir. 2001).

149. See discussion *supra* in text accompanying note 44. The basis for the medical society's position was not stated in *Pryzbowski*, but it appears that many physicians are uncomfortable with having a court impose such a fiduciary duty because they lack power to effectively challenge a MCO. Alternatively, physicians may believe it is wrong to hold them responsible when it is really the third party payor that is making medical treatment decisions in the guise of utilization review and payment decisions. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). Indeed, one court has so held, finding that a medical director for an HMO was practicing medicine (and was therefore subject to state disciplinary review) when he denied approval for proposed surgery. *Murphy v. Board of Medical Examiners*, 949 P.2d 530 (Ariz. App. 1997).

150. See discussion at text accompanying notes 21 - 27 *supra*.

## 2. *Implied Covenant of Good Faith and Fair Dealing*

The nature of the physician-patient relationship is at the heart of decisions which have interpreted the nature of the contract between MCOs and HCPs. In the landmark case of *Harper v. Healthsource New Hampshire, Inc.*,<sup>151</sup> the New Hampshire Supreme Court construed the contract between an HMO, Healthsource New Hampshire, and a participating physician, Dr. Harper, to include an implied covenant of good faith and fair dealing. The implied covenant meant that the physician was entitled to a hearing at which he could challenge his termination from the HMO and the purported reasons for that termination. During Harper's ten year affiliation with Healthsource, its patients had come to account for thirty to forty percent of his patient population. Harper complained to the HMO that it was "manipulating" his patients' records, apparently to change the reimbursement due him under a contractual withhold provision. Immediately after this charge, the HMO announced that it was terminating Harper "for cause," allegedly because he had not met the HMO's "recredentialing" criteria, even though the HMO had no concerns about his quality of care.<sup>152</sup> When Harper sought to challenge his termination through the HMO's internal appeals process, he was repeatedly denied access to the documentation that the HMO said it had relied on in making its decision. Ultimately, the HMO terminated Harper "without cause."

Harper argued that this termination, made without a meaningful hearing, violated public policy. The court agreed, finding that although Harper's contract with the HMO permitted him to be terminated with or without cause, the public policy interests in the physician-patient relationship and access to health care in the managed care setting required that the contract be interpreted in light of the implied covenant of good faith and fair dealing imposed upon each party to a contract.<sup>153</sup> The court stressed that "[g]ood faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party; it excludes a variety of types of conduct characterized as involving 'bad faith' because they violate community standards of decency, fairness or reasonableness."<sup>154</sup> The court went on to hold that:

A terminated physician is entitled to review of the termination decision under . . . [the standard of good faith and fair dealing], whether the termination was for cause, or without cause. This rule does not eliminate a health maintenance organization's contractual right to terminate its relationship with a physician without cause . . . . If a physician's relationship, however, is termi-

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151. 674 A.2d 962 (N.H. 1996).

152. *Id.* at 963.

153. *Id.* at 965 (citing RESTATEMENT (SECOND) OF CONTRACTS § 205 (1979)).

154. *Id.* (citing cmt. a to § 205).

nated without cause and the physician believes that the decision to terminate was, in truth, made in bad faith or based upon some factor that would render the decision contrary to public policy, then the physician is entitled to review of the decision.<sup>155</sup>

The *Harper* court thus spoke very broadly, relying on the public policy interest in protecting the physician-patient relationship and the legislative wish that “preferred provider agreements must be ‘fair and in the public interest’”<sup>156</sup> to effectively grant a physician who is terminated from an HMO the right to a hearing whenever the physician disagrees with the decision of the HMO, or whenever there is a colorable case that there was a hidden, impermissible reason for the termination.<sup>157</sup>

In contrast to *Harper*, in *Sammarco v. Anthem Insurance Cos.*<sup>158</sup> and *Grossman v. Columbine Medical Group, Inc.*<sup>159</sup> two mid-level state courts rejected physicians’ efforts to challenge their termination from a health plan based on an implied covenant of good faith and fair dealing. These courts declined to consider the MCO’s obligations to the contracting physician in light of the changed physician-patient relationship wrought by managed care, or to recognize a public policy need to ensure continuity of care for patients. Instead, the courts focused on the “strictly business” relationship between physicians and MCOs, concluding that because they had equal bargaining power in the contract negotiation process, it would therefore be inappropriate to construe the contracts between them to include an implied covenant of good faith and fair dealing.

In *Sammarco*, an insurance company terminated the contracts of some physicians after a merger of several insurance companies left the merged entity with a provider surplus. The physicians sued for wrongful termination, claiming that they had been misled about the nature of the merger, had not been told that the merger would convert a not-for-profit company to a for-profit, and had been unfairly treated by this surprise termination.<sup>160</sup> The physicians asserted that several important public policy interests (the need to protect the public interest in adequate access to health care recognized in several Ohio constitutional and statutory provisions, the fiduciary duty physicians owe to their patients, and the physicians’ interest in practicing their profession “in any manner [they see] fit”) required that the contract between the insurance company and the physicians be construed to require

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155. *Id.* at 966 (citation omitted).

156. *Id.* (citing N.H. Rev. Stat. Ann. § 420-C:1).

157. On remand, *Harper* and Healthsource conducted a seven week trial, which was settled by the parties during jury deliberations. Personal communication with Stanton Tefft, counsel for *Harper*.

158. 723 N.E.2d 128 (Ohio Ct. App. 1998).

159. 12 P.3d 269 (Colo. Ct. App. 1999).

160. 723 N.E.2d 128, 131, 137-39.

both parties to act in accordance with a covenant of good faith and fair dealing.<sup>161</sup> The court rejected this argument, noting that the contract permitted termination of physicians "without cause," that physicians and insurance companies stood on an equal economic footing (in contrast to relationship between insureds and insurance companies), and that insurance companies were allowed to make decisions (such as cutting the size of provider panels) based on economic considerations and the profit motive.<sup>162</sup>

Similarly, in *Grossman*, the Colorado Court of Appeals upheld the termination of a physician from a medical group that provided services to an MCO.<sup>163</sup> The court declined to infer a covenant of good faith and fair dealing into a contract for which the physician had "expressly bargained."<sup>164</sup> The court also rejected a plea to use non-statutory "public policy" justifications to reach a different result, where the legislature had already provided certain procedural protections to physicians, and thus had already "spoken on the issue."<sup>165</sup>

### 3. Common Law Right to Fair Procedure

In *Potvin v. Metropolitan Life Insurance Co.*,<sup>166</sup> the California Supreme Court used the common law tort of fair procedure to hold that Dr. Potvin, a physician who was "delisted" from a health insurer's preferred provider list, was entitled to a hearing in which he could challenge the grounds for termination, notwithstanding a contract which permitted termination "without cause."<sup>167</sup> The court noted that the tort of fair procedure had been used for more than one hundred years to protect individuals against the arbitrary exercise of private power, where a private entity's action had major economic consequences for the affected individual.<sup>168</sup> Dr. Potvin, an obstetrician-gynecologist, claimed that the MetLife patients constituted a significant fraction of

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161. *Id.* at 133-36.

162. *Id.* at 133-35. The court also turned down the physicians' claim that the insurance companies had tortiously interfered with the physicians' relationship with their patients, finding first that it was the patients who had terminated the contract with their doctors (after finding out that the doctors had been terminated from their health plan) and also that the insurance companies had not precluded the patients from seeing their doctors, but had only declined to pay for the visits. *Id.* at 136.

163. 12 P.3d 269.

164. *Id.* at 271.

165. *Id.*

166. 997 P.2d 1153 (Cal. 2000).

167. *Id.* at 1162. Dr. Potvin was terminated allegedly because he did not meet the current malpractice selection and retention standards, even though there had been were no new malpractice cases brought against him since he had first entered into a contract with Metropolitan Life. *Id.* at 1155-56. The case was settled after remand. Personal interview with Henry Fenton, attorney for Dr. Potvin.

168. *Id.* at 1157.



his practice, and also asserted that MetLife's action had a significant economic domino effect, since he was obligated to reveal his termination by MetLife to other insurers and MCOs, leading to his removal from their preferred provider lists and a decrease in referrals from other physicians.<sup>169</sup>

The California Supreme Court also emphasized the important public interest in protecting access to health care in a managed care era in determining that Potvin must receive a hearing. The court cited *Harper v. Healthsource New Hampshire, Inc.* and noted the "great [ ] public interest . . . at stake when . . . medical services are provided through the unique tripartite relationship among an insurance company, its insureds, and the physicians who participate in the preferred provider network."<sup>170</sup> Thus, the court declined to enforce the contract provision that permitted termination "without cause," because to do so would effectively eviscerate the common law right to fair procedure.<sup>171</sup>

#### 4. Additional Common Law Theories

Other common law theories may also be advanced by creative plaintiffs' counsel. As these causes of action have not yet been successfully invoked, I will sketch them only briefly. One is for breach of contract in violation of a public policy interest grounded in professional ethics and the second is for tortious interference with contract or a business relationship. The former category of claims has been recognized increasingly, although not universally, during the last three decades.<sup>172</sup>

In *Pierce v. Ortho Pharmaceutical Corp.*,<sup>173</sup> for example, the New Jersey Supreme Court held that a professional code of ethics could form the basis for a non-statutory public policy exception to the doctrine of employment at-will. Dr. Grace Pierce claimed that she was, in effect, fired from her research position at Ortho Pharmaceutical after she decided she could not ethically continue to pursue re-

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169. *Id.* at 1156.

170. The court noted:

Our conclusion that the relationship between insurers and their preferred provider physicians significantly affects the public interest does not necessarily mean that every insurer wishing to remove a doctor from one of its preferred provider lists must comply with the common law right to fair procedure. The obligation to do so arises only when the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest.

*Id.* at 1160.

171. *Id.* at 1162.

172. See, e.g., *Pierce v. Ortho Pharm. Corp.*, 417 A.2d 505 (N.J. 1980), and cases cited therein.

173. 417 A.2d 505 (N.J. 1980).

search to develop loperamide, a drug for infants and children, because it contained a high dosage of saccharin, which had caused cancer in some laboratory animals and whose safety was the subject of ongoing scientific controversy. While the court accepted that, in general, the Hippocratic Oath and AMA Code of Medical Ethics could support a public policy exception to the doctrine of employment at-will, it also found that the facts did not support a conclusion that Dr. Pierce's professional, as opposed to personal, ethics were the basis for her refusal to work on the project.<sup>174</sup>

*Pierce* has been cited with approval by numerous other courts, including the Colorado Supreme Court in its decision in *Rocky Mountain Hospital & Medical Service v. Mariani*.<sup>175</sup> The court there found that "[a] professional employee forced to choose between violating his or her ethical obligations or being terminated is placed in an intolerable position."<sup>176</sup> The test for whether a nonstatutory code of ethics can be used as the source of public policy is whether the "ethical provision . . . [is] designed to serve the interests of the public rather than the interests of the profession."<sup>177</sup> In an important pre-*Enron* decision, the court held that the Colorado State Board of Accountancy Rules of Professional Conduct constituted an appropriate expression of public policy because they had an "important public purpose[:] [to] ensure the accurate reporting of financial information to the public . . . [and] to allow the public and the business community to rely with confidence on financial reporting."<sup>178</sup> The court therefore permitted Diana Mariani, a CPA employed by Blue Cross and Blue Shield, to proceed to trial on her claim of retaliatory discharge for refusing to falsify accounting information prepared in support of a proposed merger among several Blue Cross and Blue Shield organizations.<sup>179</sup>

Building on decisions such as *Pierce* and *Mariani*, it appears that health care professionals who have been terminated due to their advocacy on behalf of their patients can also make a compelling case that the termination or nonrenewal of their contract with an insurer or MCO is a violation of public policy, because their professional codes of ethics demand that they engage in such advocacy.<sup>180</sup> Further, in

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174. *Id.* at 514.

175. 916 P.2d 519 (Colo. 1996).

176. *Id.* at 525.

177. *Id.*

178. *Id.* at 526.

179. *Id.* at 521-22, 527.

180. See the AMERICAN MEDICAL ASSOCIATION and AMERICAN NURSING ASSOCIATION CODES OF ETHICS, discussed in section II.B, *supra* notes 21-22. Physicians, nurses, and other health care professionals should argue that the code of ethics provisions requiring advocacy on behalf of patients are designed to benefit the public, not the health professionals themselves, and should demonstrate how their advocacy actions are mandated by the code, and do not simply reflect a personal, idiosyncratic view of health care ethics.

states which do not provide explicit statutory protection for patient advocacy, an HCP who alleges wrongful termination due to patient advocacy can argue that a termination "without cause" or minimal notice provision should not be enforced. To this end, as the Supreme Courts of California and New Hampshire declared in *Potvin* and *Harper*, respectively, that a termination without cause provision was unenforceable as against public policy, in light of the need to protect patient-physician relationships and to ensure adequate access to quality health care in the managed care context. Under these circumstances, a court should find that a terminated HCP must be given a hearing. Even in a state like Ohio, where the *Sammarco* court declined to read an implied covenant of good faith and fair dealing into what it saw as an "arms length" business contract between a physician and an insurance company,<sup>181</sup> a court should still be willing to enforce a clear mandate of public policy, based on national codes of professional ethics that should be recognized in virtually every state and declare that health professionals should not be "forced to choose between violating his or her ethical obligations or being terminated. . . ."<sup>182</sup>

A second promising common law remedy is the cause of action for tortious interference with a contract. This tort holds a defendant liable for damages caused by intentional actions in inducing the breach of, or otherwise interfering with, a contractual relationship between the plaintiff and a third party.<sup>183</sup> The traditional rule is that once a plaintiff makes a preliminary showing that his contract with a third party was interfered with by the defendant, the burden shifts to the defendant to show that this interference was justified,<sup>184</sup> although some more recent cases, following the position of the Second Restatement of Torts, have held that the plaintiff must initially establish the wrongfulness of the interference.<sup>185</sup> To succeed a plaintiff need not prove that the contract was breached in its entirety, but may simply show that the contract has become more onerous to perform or rendered less valuable.<sup>186</sup>

In the patient advocacy context, this means that if an HCP can show that due to advocacy on behalf of patients the MCO interfered with his contract with a third party, he can successfully bring an ac-

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181. *Sammarco*, 723 N.E.2d at 133-36.

182. *Rocky Mountain Hosp. & Med. Serv. v. Mariani*, 916 P.2d 519, 525 (Colo. 1996).

183. See generally PROSSER AND KEETON ON THE LAW OF TORTS § 129 (5th ed. 1984); DAN B. DOBBS, THE LAW OF TORTS §§ 445-446 (2000).

184. PROSSER, *supra* note 183, at § 129.

185. See, e.g., *Wagenseller v. Scottsdale Mem'l Hosp.*, 710 P.2d 1025, 1042-43 (Ariz. 1985) (citing RESTATEMENT (SECOND) OF TORTS § 766); *Mason v. Wal-Mart Stores, Inc.*, 969 S.W.2d 160, 162-66 (Ark. 1998); DOBBS, *supra* note 183, at 1260.

186. *Herman v. Endriss*, 446 A.2d 9, 10 (Conn. 1982); DOBBS, *supra* note 183, at 1267-68.

tion for tortious interference with a contract. For example, in *Wagner v. Magellan Health Services, Inc.*,<sup>187</sup> Dr. Wagner, a psychiatrist, alleged that Magellan, a “behavioral health” MCO, penalized him for advocating for necessary inpatient treatment of seriously ill and unstable individuals by refusing to permit him to be the attending physician for any Magellan patient. Wagner alleged a series of events in which he and Magellan disagreed about the necessity of hospitalizing particular patients and described his virtual blacklisting by the MCO. He further alleged that Magellan exerted pressure on Good Shepherd Hospital, where Wagner had staff privileges, by threatening to terminate the hospital’s contract with Magellan as a participating provider. Wagner alleged that these actions constituted intentional interference with his staff privileges contract with Good Shepherd Hospital. While this case is still awaiting trial, the use of this cause of action for tortious interference with contract may prove to be a good strategic choice.

## V. BARRIERS TO ENFORCEMENT OF ADVOCACY PROTECTION LAWS

We now turn to the key question of enforceability; that is, whether or not state statutes that seek to protect health care professionals from retaliation for patient advocacy can be successfully invoked by HCPs. There are three major groups of enforcement issues, which range from the complex and highly sophisticated to the practical and mundane aspects of pursuing litigation. The first group raises complex questions of federalism as well as difficult substantive law issues, specifically whether two federal laws – ERISA and the Social Security Act, which governs Medicare<sup>188</sup> – preempt state advocacy protection statutes and thus preclude state legislative efforts to affect the quality and structure of health care delivery. The second involves procedural matters, including questions about allocating the burdens of proof for retaliation by an MCO, as well as determining the proper scope of discovery. The third involves the practical costs of litigation, which may deter or prevent many deselected HCPs from attaining legal redress.

### A. Federalism

#### 1. ERISA Preemption

In the ongoing saga of federalism and the quest to identify appropriate and complementary roles for state and federal government, few areas have gained more attention recently than the continuing ten-

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187. Cause No. 01-L225 (Cir. Ct for 19th Judic. Cir., Lake County, Ill.) (currently pending).

188. Medicare is governed by Title XVIII of the Social Security Act, which is codified at 42 U.S.C. § 1395-1395ggg (2000).

sions between providing a uniform, national set of rules for health care delivery and preserving the states' role in expanding access to, and improving the quality of, the health care that their citizens receive. For many years, ERISA has been viewed as a significant impediment to state efforts at health care reform because of its powerful preemptive effect.<sup>189</sup> ERISA was enacted to protect employees' interest in their "employee benefit plans" (EBPs), including pension plans and "welfare plans" (which provide health care and disability coverage) from the actions of unscrupulous employers or union leaders, which had led to many workers' loss of their retirement benefits after years of work.<sup>190</sup> Congress' goal was also to provide a uniform federal law of fiduciary obligation for EBPs, to make it easier for corporations operating in multiple states to do business, without having to comply with the competing laws of different states. However, an unintended consequence of ERISA has been to make it difficult for states to enact laws regulating health care delivery, because of the preemptive effect of ERISA § 514(a), the so-called "relate to" clause.<sup>191</sup> This provision states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan . . .".<sup>192</sup> In effect, this means that ERISA acts like a giant eraser, sweeping across the United States and rubbing out any state statute or common law remedy that "relate[s] to" an employee benefit plan, which includes most Americans' health care, disability, and pension plans.<sup>193</sup> Further, since ERISA provides only procedural safeguards for the reporting, disclosure, and fiduciary obligations which govern employee benefit plans, without regulating their substantive content,<sup>194</sup> in many cases the "relate to" clause's practical effect has been to deprive litigants of recourse to state law remedies without providing any alternative federal remedy in their place.<sup>195</sup>

189. FURROW ET AL., *supra* note 36; see also Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. LEGISL. 35, 38 (1996); Mary Ann Chirba-Martin and Troyen Brennan, *The Critical Role of ERISA in State Health Reform*, 1 HEALTH AFFAIRS 144 (1994).

190. FURROW ET AL., *supra* note 36, at 419.

191. ERISA § 514(a) is codified at 29 U.S.C. §1144(a) (2000).

192. *Id.* (emphasis added).

193. Most Americans receive their health care and disability coverage through a family member's employment, although this percentage is declining as such coverage becomes increasingly burdensome, with premiums rising and employers paying a smaller share of those premiums. FURROW ET AL., *supra* note 36, at 466-68.

194. *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985). For example, the Department of Labor, which administers ERISA, has only recently promulgated regulations governing the process by which beneficiaries of EBPs may appeal the denial of health care coverage under group health plans, filling a gap which had previously left many persons aggrieved by a denial of care remediless. In addition, see 65 Fed. Reg. 70,246, providing an overview of the regulations found at 29 C.F.R. pt. 2560.503-1, which became effective on January 1, 2002.

195. See, e.g., *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

The meaning of the “relate to” clause has evolved over time. Initially, the Supreme Court read the clause quite expansively, finding that Congress intended to preempt state laws that had any “connection with or reference to” an employee benefit plan.<sup>196</sup> In the 1987 case of *Pilot Life Insurance Co. v. Dedeaux*,<sup>197</sup> the Court declared that the plaintiff’s common law tort suit for bad faith breach of contract against a disability insurer was preempted by ERISA, since the insurance company’s conduct in processing the plaintiff’s claim for disability benefits “relate[d] to” the employee benefit plan at issue.<sup>198</sup> However, in 1995, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,<sup>199</sup> the Supreme Court took a new, narrower view of ERISA preemption. The Court considered a challenge to a New York law designed to equalize the costs of different types of health care coverage by imposing differential surcharges for hospital care on commercial insurance companies, Blue Cross and Blue Shield plans, and HMOs. The Supreme Court acknowledged that, read literally, the “relate to” clause had no limits, because “if ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for ‘really, universally, relations stop nowhere.’”<sup>200</sup> Rejecting such a broad interpretation, the Court began with the presumption that Congress did not intend to preempt state law without making a clear and manifest statement of intent,<sup>201</sup> cautioning that “nothing in the language of [ERISA] or in the context of its passage indicate[d] that Congress chose to displace general health care regulation, which historically has been a matter of local concern.”<sup>202</sup> The Court then held that the New York surcharge law, which had only an indirect effect on the costs of providing an employee benefit plan, did not “relate to” the employee benefit plan, because it “[did] not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself.”<sup>203</sup> The Court contrasted the surcharge law with laws that “mandated employee benefit structures or their administration,” which were clearly preempted by ERISA.<sup>204</sup> The *Travelers*

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196. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

197. 481 U.S. 41 (1987).

198. *Id.* at 48. The Court also ruled that the cause of action was not saved from preemption by the insurance “savings clause,” because the common law tort was not “specifically directed toward [the insurance] industry,” but had a much broader scope and provided remedies additional to those permitted under ERISA. *Id.* at 50-52.

199. 514 U.S. 645 (1995).

200. *Id.* at 655 (citations omitted).

201. *Id.*

202. *Id.* at 661.

203. *Id.* at 659.

204. *Id.* at 658.

decision began a trend of judicial cutbacks on ERISA preemption that continues to the present.<sup>205</sup>

It is also important to recognize that state laws that “relate to” an employee benefit plan are “saved” from ERISA preemption if they “regulate insurance,”<sup>206</sup> reflecting the balance that Congress struck in ERISA between providing uniform national rules to govern employee benefit plans and the need to accommodate the traditional interests of the states in regulating the terms and conditions of insurance policies. The effect of this Congressional compromise was seen in operation in *Metropolitan Life Insurance Co. v. Massachusetts*,<sup>207</sup> in which the Supreme Court held that a Massachusetts statute mandating that all insurance policies sold within the state provide minimum mental health benefits was saved from ERISA preemption by the insurance “savings clause.” Consequently, the Massachusetts statute applied to all insurance policies purchased for employee benefit plans by Massachusetts employers.<sup>208</sup>

Since ERISA’s enactment, the question of whether a state statute regulates insurance has often been hotly contested.<sup>209</sup> Moreover, courts have become experts in applying, not to say manipulating, several factors which were developed to answer this question when it arose in the context of antitrust litigation.<sup>210</sup> This issue first arose in

205. See, e.g., *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355 (2002); *Ky. Ass’n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471 (2003); *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003); *Napoletano v. Cigna Healthcare Inc.*, 680 A.2d 127 (Conn. 1996).

206. Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A) (2000), provides that with one exception, nothing in ERISA “shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”

207. 471 U.S. 724 (1985).

208. Of course, as the Court noted, this mandated benefits law would not apply to Massachusetts employers who “self-insured;” that is, undertook the financial risk of providing health care coverage to their employees themselves, rather than by purchasing insurance. *Id.* at 747 n.25. Today about one-third of Americans receive health care coverage through employers which have self-funded or self-insured, and thus cannot rely on state laws designed to promote citizens’ access to high quality health care through the regulation of insurance. FURROW ET AL., *supra* note 36, at 468-69.

209. See Final Rule on Group Health Plan Claims Processing, 65 Fed. Reg. 70,246, 70,254 n.32.

210. The Supreme Court and lower courts have long struggled over how to identify when a state law “regulates insurance.” For many years, the Supreme Court relied on the analytical factors used in antitrust law to determine whether a law regulates “the business of insurance” under the McCarran-Ferguson Act, 15 U.S.C. § 1011-15. See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 742-47 (1985). However, the Court’s analysis has not always been a model of clarity. Acknowledging this analytical weakness in *Kentucky Association of Health Plans, Inc. v. Miller*, the Supreme Court announced “a clean break from the McCarran-Ferguson factors.” *Id.* at 1479. The Court held that in order for a state law to be saved from ERISA

the 1980's over the question of whether a state could mandate minimum insurance benefits<sup>211</sup> and then came to a head in the late 1990s, as many states rushed to protect their citizens from what were seen as unfair denials of care by insurers and MCOs. These states enacted laws mandating internal and external appeals processes, which permitted patients/consumers to challenge an MCO's or insurer's refusal to provide or pay for care. Because these laws "relate[d] to" the structure and administration of an employee benefit plan, they were obvious candidates for ERISA preemption, unless they were exempted by the insurance "savings clause."

In *Rush Prudential HMO, Inc. v. Moran*,<sup>212</sup> the Supreme Court addressed the question of whether the Illinois independent review law was preempted by ERISA § 514. Debra Moran sought to compel her HMO, Rush Prudential, to submit a dispute over the medical necessity of proposed surgery to treat her severe shoulder pain to the independent review process dictated by Illinois law. Under the Illinois HMO Act, in the event of a dispute over medical necessity of a particular procedure,

Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the [HMO], jointly selected by the patient . . . , primary care physician, and the [HMO]. . . . In the event that the reviewing physician determines the covered service to be medically necessary, the [HMO] shall provide the covered service.<sup>213</sup>

Rush Prudential refused to consent to the independent medical review, and Moran chose to have the surgery performed at her own expense. She then filed suit to compel independent review and an independent review was ordered by the state court. The independent reviewer determined that the surgery was medically necessary, but Rush Prudential refused to pay for it. Moran then sued for reimbursement under the HMO Act in state court. Rush Prudential removed the case to federal court, claiming that the state cause of action was preempted by a different section of ERISA, § 502(a)(1)(B), which provides litigants with a remedy for denial of benefits due under their employee benefit plan: either injunctive relief or the monetary value of those benefits. The United States District Court for the Northern District of Illinois held that Moran's state law claim was preempted, but

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preemption as a "law . . . which regulates insurance" . . . [it] must be specifically directed toward entities engaged in insurance . . . [and] substantially affect the risk pooling arrangement between insurer and the insured." *Id.*

211. In *Metropolitan Life*, the Court held that while a Massachusetts law mandating minimum mental health benefits certainly "relate[d] to" an ERISA-governed plan, it was saved because it was a law regulating "the business of insurance." 471 U.S. at 743-44.

212. 536 U.S. 355, 361 (2002).

213. 215 ILL. COMP. STAT. 125/4-10 (2000). There was a parallel provision governing Illinois insurance companies.



the Court of Appeals for the Seventh Circuit reversed.<sup>214</sup> The stage was set for Supreme Court review.

The Supreme Court reduced an extraordinarily complex issue to apparently simple terms. The Court agreed that the Illinois HMO Act “relate[d] to” an employee benefit plan,<sup>215</sup> in this case the health coverage received by Moran through her husband’s employer. Yet, the Court held that the Illinois HMO Act was not preempted by ERISA because the statute was “saved” as a law regulating insurance. Rejecting Rush Prudential’s argument that a law governing HMOs could not be a law that regulates insurance, the Supreme Court ruled that just because HMOs provided care in addition to paying for it did not mean that the Illinois law was not a law regulating insurance, since HMOs still operated with insurance-like features, particularly “spreading and underwriting of a policyholder’s risk.”<sup>216</sup> The Court stated: “The answer to Rush is, of course, that an HMO is both: it provides health care, and it does so as insurer. Nothing in the savings clause requires an either-or choice between health care and insurance in deciding a preemption question . . . .”<sup>217</sup> The Court emphasized that Congress had understood this hybrid quality of HMOs — as both health care provider and risk spreader — when the HMO Act of 1973 was passed,<sup>218</sup> just one year before ERISA was enacted.<sup>219</sup> Further, the Court held that requiring HMOs to comply with the state law mandate of an independent external review would only have an indirect effect on employee benefit plans, comparable to the indirect impact of the hospital surcharge statute that the Court found acceptable in *Travelers*.<sup>220</sup> Finally, the Court found that the independent review requirement did not create an “alternative remedy” for beneficiaries of employee benefit plans (EBPs), which *would* have supplanted the ER-

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214. 230 F.3d 959, 972-73.

215. 536 U.S. at 365.

216. *Id.* at 366. It appears that this result is consistent within the Court’s reasoning in *Miller*, as discussed in note 210 *supra*.

217. *Id.* at 367.

218. Health Maintenance Organization Act of 1973, 87 Stat. 914, amended by 42 U.S.C. § 300e(c) (1994).

219. *Rush Prudential*, 536 U.S. at 368-369. Applying this understanding to the Illinois HMO Act, the Court declared:

[P]rior to ERISA’s passage, Congress demonstrated an awareness of HMOs as risk-bearing organizations subject to state insurance regulation, the [Illinois] state Act defines HMOs by reference to risk bearing, HMOs have taken over much business formerly performed by traditional indemnity insurers, and they are almost universally regulated as insurers under state law. That HMOs are not traditional “indemnity” insurers is no matter; “we would not undertake to freeze the concept of ‘insurance’ . . . into the mold they fitted when these Federal Acts were passed.”

*Id.* at 372-73 (citation omitted).

220. *Id.*

ISA remedies available<sup>221</sup> and thus argued for preemption despite the exception provided by the "savings clause." The Court held that the independent review law was more akin to the requirement of a medical second opinion than the provision of an additional method for obtaining relief, such as the use of arbitration, which could run afoul of the Congressional goal expressed in ERISA of having uniform national remedies for its violation.<sup>222</sup>

The result in *Rush Prudential* is entirely consistent with that the Department of Labor's recently promulgated regulations, which prescribe minimum standards for the processing of claims by group health plans.<sup>223</sup> The regulations' goal is to achieve more expeditious claims processing and to ensure that claimants who are dissatisfied with their health plans' response are able to have quick access to the courts or available administrative remedies, including state mandated external review processes.<sup>224</sup> The regulations also explicitly provide that where a patient needs urgent care and therefore seeks a prompt review of a decision to deny care, the health plan must permit a patient's treating health care professional to serve as the patient's authorized representative in this appeal,<sup>225</sup> recognizing the key role that health care professionals may play in advocating for their patient's interests. The new regulations explicitly address the preemption question, and take a lenient approach to state laws, tilting decidedly against preemption. The regulations declare:

(k)(1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

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221. ERISA § 510(a), 29 U.S.C. § 1132(a) (2002) enumerates available civil enforcement mechanisms.

222. *Rush Prudential*, 536 U.S. at 376-84 (distinguishing *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987)).

223. Interestingly, the Court did not mention these regulations, despite the fact that they had been promulgated a year and half before the Court's decision, and specifically addressed the preemption question. The regulations were a long time in the making. They were initially proposed on September 9, 1998. Then, after the Department of Labor held public hearings and received extensive comments, the regulations were promulgated in final form on November 21, 2000, taking effect on January 1, 2002. Employee Retirement Income Security Act of 1974, 65 Fed. Reg. 70,246 (November 21, 2000) (codified at 29 C.F.R. pt. 2560).

224. *Id.* at 70,246-56. ERISA § 503, 29 U.S.C. § 1133 (2000), provides:

In accordance with regulations of the Secretary, every employee benefit plan shall —

(1) provide adequate notice in writing to every participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

225. 29 C.F.R. § 2560.503-1(b)(4) (2003).

(2)(i) For purposes of paragraph (k)(1) . . . a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, [or their employees or agents].

(ii) [C]laimants . . . need not exhaust such State law procedures prior to bringing suit under section 502(a) of [ERISA].<sup>226</sup>

As explained in the commentary to the regulations, the Department of Labor's view is that state laws designed to assist consumers in challenging a denial of care under their health plan escape preemption in two significant ways. First, as provided in paragraph (k)(1) of the regulations, if the state law concerns the *internal* HMO or insurance grievance process it will be preempted *only* if it is not possible to comply with the state law as well as the Department of Labor regulations.<sup>227</sup> Second, under paragraph (k)(2), if the state law mandates an external appeal (*i.e.*, one that is not administered by the insurer, health plan, or employer), it will also not be preempted because it provides a remedy that is supplemental to the ERISA plan grievance procedure and will not preclude a claimant from bringing suit under ERISA § 502(a).<sup>228</sup> This, of course, is the interpretation given by the Supreme Court to the Illinois independent medical review at issue in *Rush Prudential*. Thus, the Supreme Court and the Department of Labor agree that state internal and external review laws are to be construed whenever possible to permit individuals aggrieved by a decision of their insurer or health care plan to challenge those decisions expeditiously and in multiple venues.

Viewed against this background, it appears likely that a state statute prohibiting MCOs and insurers from retaliating against HCPs who advocate for their patients would survive a challenge based on ERISA preemption.<sup>229</sup> For illustrative purposes, I will discuss the

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226. 29 C.F.R. § 2560.503-1(k)

227. This very generous approach is captured by the following hypothetical from the commentary to the regulations: "[A] State may have a law requiring insurers to allow oral appeals of all claims or to decide claims within shorter periods of time. These laws would not prevent the application of the regulation because plans could comply with both the regulation and the State laws." Employee Retirement Income Security Act of 1974, 65 Fed. Reg. 70,246, 70,254 (November 21, 2000) (codified at 29 C.F.R. pt. 2560).

228. See *Moran*, 536 U.S. at 377-84; Employee Retirement Income Security Act of 1974, 65 Fed. Reg. 70,246, 70,254 (November 21, 2000) (codified at 29 C.F.R. pt. 2560).

229. An MCO defendant could argue that ERISA preempted the state advocacy protection law if health care through the MCO was provided as part of an employee benefit plan, at least for the patients on whose behalf the HCP had advocated. If, on the other hand, the protected advocacy was provided to patients who had purchased coverage as an insurance policy, outside of an employment relationship, ERISA would have no conceivable application.

Maine advocacy protection law.<sup>230</sup> This law, part of a detailed statute enumerating the “plan requirements” for health plans, is in the Maine Insurance Code.<sup>231</sup> The statute prohibits managed care plans from “terminat[ing] or otherwise disciplin[ing] a participating provider because the provider advocates for medically appropriate health care”<sup>232</sup> and also prohibits plans from limiting HCPs’ discussions with their patients concerning treatment alternatives.<sup>233</sup>

First, the Maine advocacy protection statute is likely to survive an ERISA preemption challenge because the law focuses on the relationship between MCOs and the HCPs who provide care under a health plan and is, therefore does not “relate to” the terms of the plan itself. Second, even if the “relate to” clause is implicated, the law is saved from preemption by the insurance savings clause.<sup>234</sup> In analyzing the hospital surcharge statute at issue in *Travelers*, the Supreme Court ruled that while the statute might have an “indirect” economic impact on the costs of administering an employee benefit plan, because it could increase the costs of providing services to enrollees depending on the type of plan involved, that impact was too remote for the statute to be seen as “relat[ing] to” an employee benefit plan.<sup>235</sup> Here too, I suggest that a statute that limits an MCO’s ability to retaliate against a participating HCP has too tenuous and indirect an impact to be considered to “relate to” an EBP, even though the statute might make it more expensive for MCOs to provide services if they could not use the threat (or the reality) of retaliation against HCPs to reduce the overall costs of providing health care services to their enrollees.<sup>236</sup>

But even if an advocacy protection statute were found to “relate to” an EBP because of its effects on the structure and administration of that plan, the statute should be saved from preemption by the insurance “savings clause,” because the statute clearly regulates insurance under the test announced in *Kentucky Association of Health Plans*.<sup>237</sup>

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230. ME. REV. STAT. ANN. tit. 24-A, § 4303.

231. See text accompanying notes 79-80.

232. ME. REV. STAT. ANN. tit. 24-A, § 4303(3).

233. The statute also mandates additional requirements for health plans, including provisions regarding enrollee rights and remedies, HCP credentialing rules, procedural due process protections for HCPs whose contracts may be terminated or not renewed, and restrictions on financial incentives to HCPs to limit medically necessary care. *Id.*

234. ERISA § 514, 29 U.S.C. § 1144 (2000).

235. *Travelers*, 514 U.S. at 645.

236. *But see* Ky. Ass’n of Health Plans v. Miller, 123 Sup. Ct. 1473, 1478 (2003) (discussing the economic consequences of Kentucky’s AWP laws – to increase the costs of healthcare coverage to consumers – but concluding that because the “AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer it is saved from ERISA preemption by the insurance savings clause.”)

237. *Id.* at 1479.

First, the law is “specifically directed toward entities engaged in insurance, as if it applies to “carrier[s] offering a health plan in this state,” and is part of the Maine Insurance Code.<sup>238</sup> Second, the statute includes multiple provisions about the spreading and underwriting of risk, which, as explained by the Court in *Kentucky Association of Health Plans*, “substantially affect the risk pooling arrangement between the insurer and the insured.”<sup>239</sup> These include rules about the adequacy of the managed care network to ensure reasonable access to health care,<sup>240</sup> prohibitions on certain financial incentives,<sup>241</sup> grievance procedures for enrollees,<sup>242</sup> provisions regarding standing referrals to specialists for enrollees with chronic conditions,<sup>243</sup> and provisions to ensure continuity of care.<sup>244</sup> Importantly, all these provisions are either risk-spreading or risk-underwriting, thereby meeting the requirements of the insurance savings clause.

Further, holding that state advocacy protection laws are not preempted by ERISA is consistent with the Department of Labor’s internal appeal regulations, which recognize that a treating HCP is often in the best position to advocate for her patients, and must be permitted to serve as the patient’s representative where the patient’s medical condition requires urgent treatment.<sup>245</sup> The central purpose of these regulations is to guarantee compliance with the mandate of ERISA section 503 and ensure that claims of denials of care due under employee benefit plans are resolved accurately and expeditiously.<sup>246</sup> It therefore makes eminent sense to uphold state laws that effectuate the spirit of these regulations, by forbidding MCO punishment of HCPs for doing what is mandated by professional ethics and common law.

A contrary holding would also be inconsistent with the rationale of the Supreme Court’s decision in *Pegram v. Herdrich*, the first Supreme Court decision to consider ERISA’s implications for managed care.<sup>247</sup> While *Pegram* was not addressing a question of ERISA preemption, the Court nonetheless explained its view that in enacting ERISA, Congress had drawn a distinction between quality of care issues, which were reserved to the states, and quantity of care (or adequacy of benefits) issues, for which Congress sought to provide a

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238. ME. REV. STAT. ANN. tit 24-A, § 4303.

239. *Rush Prudential HMO, Inc.*, 536 U.S. 355, 355 (2002).

240. ME. REV. STAT. ANN. tit. 24-A, § 4303(1).

241. *Id.* at § 4303(3-B).

242. *Id.* at § 4303(4).

243. *Id.* at § 4303(6).

244. *Id.* at § 4303(7).

245. 29 C.F.R. § 2560.503-1(b)(4) (2001).

246. Employee Retirement Income Security Act of 1974, 65 Fed. Reg. 70,246, 70,246-56 (November 21, 2000) (codified at 29 C.F.R. pt. 2560).

247. 531 U.S. 211 (2000).

uniform federal remedy under ERISA § 502. In *Pegram*, a plaintiff sued her physician (and the HMO of which the doctor was part-owner), alleging that the physician was a “plan administrator” under ERISA and thus had a fiduciary duty to patients/plan enrollees under ERISA § 404.<sup>248</sup> The plaintiff’s appendix had burst while she was awaiting an appointment for an ultrasound. She alleged that the physician had delayed appropriate diagnostic procedures because she had a financial incentive to have the procedures performed in-network, and that this incentive scheme had caused the physician to breach her ERISA fiduciary duty of undivided loyalty to the plaintiff, an EBP enrollee.<sup>249</sup> The Supreme Court rejected this argument, holding that, in contrast to “traditional trustees,” whose business usually involve financial accountability, physicians who allocate diagnostic and treatment resources to particular patients under an HMO plan are not acting as ERISA fiduciaries under § 404.<sup>250</sup> Instead, the Court found that such physicians are making “mixed [benefits] eligibility and treatment decisions.”<sup>251</sup> The Court suggested that an alternative holding would be impossible, since the only way an HMO physician could defend against a breach of fiduciary duty claim would be to argue that she had not erred in her diagnosis or treatment decisions, and this, of course, would involve the domain of state medical malpractice law, with which Congress and the federal judiciary were loath to interfere.<sup>252</sup> The Court found that Congress could not have intended such a result, since the federal HMO Act, designed to promote the development of HMOs, was enacted only a few months before ERISA.<sup>253</sup>

This reasoning was recently invoked by the Second Circuit in its decision in *Cicio v. Does*.<sup>254</sup> There the majority held that the plaintiff’s state law claim that the medical director of an HMO had engaged in medical malpractice when he rejected the course of treatment requested by an HMO enrollee’s physician was not preempted by ERISA, since the physician’s actions in deciding what medical care was appropriate for the patient/enrollee were precisely the type of “mixed eligibility and treatment decision” involved in *Pegram*.<sup>255</sup>

Several state courts have also taken the view that Congress did not intend broad ERISA preemption of state laws that regulate the prac-

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248. *Id.*

249. *Id.*

250. *Id.*

251. *Id.* at 228-32.

252. *Id.* at 235-37.

253. *Id.* at 232-330.

254. 321 F.3d 83 (2d Cir. 2003).

255. *Id.* at 104. Judge Calabresi dissented in part, arguing that while the court may have done justice for the injured plaintiff, its reasoning could not be squared with Supreme Court precedent and the ERISA preemption framework. *Id.* at 106.

tice of medicine and the delivery of health care services, including MCO-HCP relations. In *Napoletano v. Cigna Healthcare of Connecticut, Inc.*,<sup>256</sup> the Connecticut Supreme Court considered a suit brought by physicians who had been terminated by a “preferred provider” health plan, allegedly in violation of Connecticut statutory and common law.<sup>257</sup> The court rejected the defendant’s contention that the physicians’ claims were preempted by ERISA because they all “relate[d] to” an employee benefit plan.<sup>258</sup> Citing *Travelers*, the court held that “because the claims raised by the plaintiffs do not affect or prescribe the establishment, administration, regulation or maintenance of an employee benefit plan, but, rather, merely seek to enforce the plan that CIGNA has chosen to create and administer, the claims do not ‘relate to’ employee benefit plans. . . .”<sup>259</sup>

Similarly, in *Nealy v. U.S. Healthcare HMO*, the New York Court of Appeals held that the plaintiff’s claims for medical malpractice, breach of fiduciary duty, and breach of contract against her husband’s physician, based on alleged misdiagnosis and failure to promptly refer him to a specialist, were not preempted by ERISA.<sup>260</sup> The physician defended against these claims on the ground that because he was acting under contract to an HMO, his actions were mandated by the rules of the employee’s benefit plan, and therefore governed by ERISA rather than state law. The Court of Appeals disagreed, invoking the Supreme Court’s presumption in *Travelers* “that Congress does not intend to supplant State law,” particularly in fields of traditional state regulation.<sup>261</sup> The court held that the mere fact that the physician had to comply with the HMO’s administrative rules in fulfilling his patient obligations did not transform alleged “violations of . . . [his] duty of care into claims that ‘relate to’ ERISA plan administration.”<sup>262</sup> Thus, the plaintiff’s claims were not preempted.<sup>263</sup>

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256. 680 A.2d 127 (Conn. 1996). The plaintiffs brought claims under breach of contract, breach of the implied covenant of good faith and fair dealing, tortious interference with business expectancies, and violations of the Connecticut Unfair Trade Practices Act (CUTPA) and a recently enacted Act Concerning Managed Care. The suit was a companion to one filed by the physicians’ patients, who brought suit based on alleged misrepresentations by CIGNA and the lack of continuity of care in treatment occasioned by the physicians’ termination from the health plan. *Id.* at 131-32.

257. *Id.* at 133.

258. *Id.* at 136.

259. *Id.*

260. 711 N.E.2d 621, 623 (N.Y. 1999).

261. *Id.* at 624 (citing to N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654-55).

262. *Id.* at 625.

263. *Id.* at 625-26.

Most recently, in *Pappas v. Asbel*,<sup>264</sup> the Supreme Court of Pennsylvania relied on *Pegram* to hold that a suit challenging an HMO physician's decision to deny plaintiff emergency transfer to an academic medical center involved precisely the sort of "mixed eligibility and treatment decision" that *Pegram* suggested would *not* be preempted by ERISA.<sup>265</sup> The court held that the plaintiff's claim for medical negligence could go forward.<sup>266</sup>

Applying these precedents to the case of an HCP who is deselected from an MCO, I suggest that if a physician's decisions about resource allocation (e.g., referral for diagnosis and treatment) are not preempted by ERISA, then surely an HCP's actions in advocating for a patient to receive such resources, i.e. necessary medical care, should likewise not be preempted. Since the regulation of medicine and other health care professions has long been in the domain of state law, a statute that explicitly protects the common law fiduciary duty to advocate should not be preempted by ERISA.

## 2. Medicare Managed Care Preemption

In addition to facing the hurdle of ERISA preemption, health care professionals who treat Medicare patients in a managed care setting may also meet a defense of preemption under the regulations governing "Medicare + C" or "Medicare Choice" plans. While these regulations are generally supportive of HCPs' advocacy, the remedies they provide are not as extensive as those of some state advocacy protection laws. In addition, HCPs who treat both Medicare Choice patients and other patients could be compelled to pursue both a state statutory cause of action and Medicare administrative relief simultaneously.<sup>267</sup>

Following a Congressional mandate,<sup>268</sup> the Medicare Choice regulations require many procedural protections for HCPs who participate

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264. *Pappas II*, 768 A.2d 1089 (Pa. 2001) (affirming its original decision in *Pappas I*, 724 A.2d 889 (Pa. 1998)). The Pennsylvania Supreme Court rendered its decision in *Pappas II* on remand from the Supreme Court's granting of certiorari, *sub nom. U.S. Healthcare System of Pennsylvania, Inc. v. Pennsylvania Hospital Insurance Co.*, 530 U.S. 1241 (2000), in which the Court granted certiorari, vacated the judgment, and remanded the case for further consideration in light of *Pegram v. Herdrich*, 530 U.S. 211 (2000).

265. *Pappas II*, 768 A.2d at 1096.

266. *Id.*

267. A third wrinkle is also possible. Some persons enrolled in a Medicare Choice plan also receive benefits under an ERISA plan, pursuant to a separate arrangement between the Medicare Choice organization and an employer or employee organization. Claims for denial of these benefits would have to be pursued under ERISA rules (which might permit resort to state law, as discussed above), rather than the Medicare Choice regulations. U.S. DEPT OF LABOR, FREQUENTLY ASKED QUESTIONS ABOUT THE BENEFIT CLAIMS PROCEDURE REGULATION A-2, at [http://www.dol.gov/ebsa/faqs\\_claims\\_proc\\_reg.html](http://www.dol.gov/ebsa/faqs_claims_proc_reg.html) (last visited July 18, 2003).

268. 42 U.S.C. § 1395(w)(21) – (27) (2002).



in a Medicare Choice plan, including rules for HCP credentialing,<sup>269</sup> a process for appealing adverse participation decisions,<sup>270</sup> notice and hearing prior to suspension or termination,<sup>271</sup> and a formal mechanism for MCO-physician consultation about clinical and management issues.<sup>272</sup> The regulations also mandate extensive appeal and grievance procedures for MCO enrollees (patients) who want to challenge a denial of care.<sup>273</sup> As with many state managed care statutes, the regulations also place limits on permissible financial incentives for HCPs.<sup>274</sup> The regulations further provide that MCOs may not prohibit or restrict an HCP from advising or advocating on behalf of enrollees.<sup>275</sup> However, the regulations do not provide a direct remedy for an HCP who is terminated or suspended because of such advocacy.<sup>276</sup>

Thus, a deselected HCP invoking a state advocacy protection statute might well face a defense by the MCO that the law is preempted by Medicare Choice regulations. The answer provided by the regulations is not particularly helpful. The regulations first state a general preemption rubric: that the rules supersede otherwise applicable state laws "only to the extent that such State laws are inconsistent with the standards established under this part."<sup>277</sup> However, the regulations also carve out certain areas for explicit preemption, including "[r]equirements relating to [the] inclusion or treatment of providers and suppliers."<sup>278</sup> Looking just at the general preemption provision, one might argue that it should be interpreted similarly to the Department of Labor external appeal regulations, which permit state reme-

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269. 42 C.F.R. § 422.204 (2002).

270. 42 C.F.R. § 422.202(a) (2002).

271. *Id.* at § 422.202(d).

272. *Id.* at § 422.202(b).

273. If an enrollee is dissatisfied with the results of his appeal, he may seek review by an administrative law judge if the amount in controversy is greater than \$100. Under certain circumstances, the administrative law judge's decision may be reviewed by a Departmental Appeals Board and, ultimately, a federal court. 42 C.F.R. §§ 422.600-.616 (2002). Medicare Choice regulations have recently been promulgated to permit enrollees to expeditiously challenge a Medicare managed care organization's decision to terminate provider services. Improvements to the Medicare+Choice Appeal and Grievance Procedures; Final Rule, 68 Fed. Reg. 16,652, 16,667 (Apr. 4, 2003) (codified as 42 C.F.R. Parts 422 and 489).

274. 42 C.F.R. § 422.210 (2002).

275. 42 C.F.R. § 422.206 (2002).

276. Of course, the Centers for Medicare and Medicaid Services (CMS) always have the power to exclude a MCO from the Medicare Choice program, if its violations of Medicare regulations are serious and frequent enough. 42 C.F.R. §§ 422.206, .750-.758 (2002).

277. 42 C.F.R. § 422.402(a) (2002).

278. *Id.* at § 422.402(b). In addition, these rules are not to be interpreted to affect the impact of any other law that might have preemptive effect, presumably a reference to ERISA. *Id.* at § 422.402(c).

dies to co-exist with the Department's regulations, if there is no direct conflict.<sup>279</sup> However, the second, specific preemption rule appears dispositive, as it clearly states that relations between the MCO and its providers and suppliers are to be governed by the regulations alone.

### 3. *Procedural Enforcement Obstacles*

#### a. *Does the Statute Create a Private Cause of Action?*

The first question that may be faced by a deselected HCP is whether a state advocacy protection statute creates a private right of action.<sup>280</sup> While all of the explicit advocacy protection statutes are silent on this point, in every case in which a statute has been invoked, the courts have found that the statute *does* create a private right of action. In one case in which physicians challenged their termination from a managed care plan for non-advocacy reasons, a state court has also held that the provider protection statute created a private right of action.<sup>281</sup> In regard to state statutes which provide supplemental support for health care professional advocacy, the record is mixed. One state, New Mexico, explicitly provides a private right of action for any person who is injured by "[the] violation of a right protected pursuant to . . . the Patient Protection Act."<sup>282</sup> However, provider protection statutes in two states, Delaware and Maryland, expressly declare that they do not create a private right of action.<sup>283</sup>

In several recent decisions, courts have been emphatic that state laws protecting health care professional advocacy, or protecting HCPs in a managed care arena more generally, must be interpreted to give HCPs a private cause of action, so that they may have a meaningful opportunity to be heard. In *Lewis v. Individual Practice Ass'n of Western New York, Inc.*,<sup>284</sup> a New York trial court held that a physician who asserted that his contract with an HMO was not renewed because of patient advocacy could seek judicial relief based on a New York advocacy protection statute.<sup>285</sup> Pointing to a legislative intent to

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279. See text accompanying notes 226-28 *supra*.

280. Without a private right of action, a deselected HCP has much less power, having been compelled to rely on a complex and often overburdened bureaucracy for vindication.

281. *Napoletano v. Cigna Healthcare, Inc.*, 680 A.2d 127, 146 (Conn. 1996).

282. N.M. STAT. ANN. § 59A-57-9 (2001).

283. Delaware and Maryland are the only states that explicitly disclaim creating a cause of action for individual litigants based on the health care professional protections they provide. DEL. CODE ANN. tit. 18 § 3339(h); MD. CODE ANN. § 19-710(s)(3).

284. 723 N.Y.S.2d 845 (N.Y. Sup. Ct. 2001).

285. *Id.* at 847-48 (quoting N.Y. Pub. Health Law § 4406-d(5) (McKinney 2002)). That statute provides:

No health care plan shall terminate a contract or employment, or refuse to renew a contract, solely because a health care provider has:

“remed[y] . . . the termination or non-renewal of health care providers for advocating on behalf of their patients,”<sup>286</sup> the court held that it must interpret the statute generously.

*Lewis*’ reasoning was found persuasive in *Foong v. Empire Blue Cross & Blue Shield*,<sup>287</sup> which involved a different section of the same New York provider protection statute.<sup>288</sup> Dr. Foong, who was terminated from Empire’s managed care network due to an alleged threat of “imminent harm” to patients, challenged his termination. Foong argued that Empire had terminated him due to a billing dispute over the medical necessity of certain procedures, and, rather than giving him a chance to respond, had mislead the state insurance department into dropping its administrative review of the case.<sup>289</sup> The court concluded that “providing a private right of action in this case . . . is necessary to give substance to . . . [the statute].”<sup>290</sup> The court observed:

[T]he Legislature . . . sought to afford health care providers the ability to challenge the decisions of HMOs to terminate their contracts. . . . [The statute] will become meaningless if Empire is able to strip away the due process protections given to health care providers terminated from its plan. Empire’s decision to terminate Foong from its plan without following the steps delineated in the statute and its subsequent action, preventing Foong from seeking administrative relief, opened the door for the courts to enter.<sup>291</sup>

In *Khajavi v. Feather River Anesthesia Medical Group*, a California appellate court gave that state’s advocacy protection statute an expansive interpretation to ensure that the legislature’s purpose in enacting the statute was given effect.<sup>292</sup> Khajavi was an anesthesiologist who became embroiled in a dispute with a surgeon over the appropriateness of administering anesthesia to a patient whom Khajavi deemed unstable. The surgeon’s brother was a partner in the medical group which employed Khajavi, and the group terminated Khajavi’s employment shortly after the incident. Khajavi brought suit under the Cali-

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- (a) advocated on behalf of an enrollee;
  - (b) filed a complaint against the health care plan;
  - (c) appealed a decision of the health care plan;
  - (d) provided information or filed a report pursuant to . . . [the N.Y. external appeals procedure]; or
  - (e) requested a hearing or review pursuant to this section.

286. *Lewis*, 723 N.Y.S.2d at 849.

287. N.Y. First Judicial District, Justice Ramos, Oct. 9, 2002, N.Y.L.J. Oct. 11, 2002, p.29, *aff’d* *Foong v. Empire Blue Cross & Blue Shield*, 762 N.Y.S.2d 348 (N.Y. App. Div. 2003).

288. N.Y. Pub. Health L. § 4406-d.

289. *Foong*, 762 N.Y.S.2d at 348.

290. *Id.* Although the court was no doubt influenced by Empire’s alleged deliberate misrepresentations to the state insurance department, the court’s ruling acknowledged the central truth that if the legislation were not interpreted to permit individual litigants to sue, the statute would be rendered ineffectual.

291. *Id.*

292. 100 Cal. Rptr. 2d 627, 673-41 (Cal. Ct. App. 2000).

for California advocacy protection statute.<sup>293</sup> The defendants claimed that Khajavi's actions were not the sort of advocacy the Legislature had envisioned in passing the law, citing the statute's explicit reference to *Wickline*,<sup>294</sup> which had addressed the duty to advocate against a third party payor that tried to limit care.<sup>295</sup> The appellate court disagreed, holding that the statute's application was not limited to the context of *Wickline*.<sup>296</sup> The court found that the statute's goal was to encourage physicians "to advocate for medically appropriate health care"<sup>297</sup> in two settings: "(1) an appeal from a payor's decision to deny payment, and (2) a protest of a decision, policy, or practice that the physician reasonably believes impairs his or her ability to provide medically [necessary] care."<sup>298</sup> The court ruled that Khajavi's cause of action, which fell squarely within this second advocacy context, permitted his suit to proceed.

In *Napoletano v. Cigna Healthcare of Connecticut, Inc.*, the Connecticut Supreme Court held that a state law establishing procedural safeguards for physicians in MCOs must be construed to create a private cause of action, despite the statute's silence on the question.<sup>299</sup> The physician plaintiffs claimed that they were improperly terminated from a health care network and a group of patient plaintiffs separately claimed that they had been harmed by the lack of continuity of care when their physicians were terminated from the network. The court used the criteria announced by the Supreme Court in *Cort v. Ash* to determine whether a private remedy should be implied in a statute that did not address the question.<sup>300</sup> Three factors were deemed pertinent:

First, is the plaintiff one of the class for whose . . . benefit the statute was enacted . . . ? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? . . . Third, is it consis-

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293. *Id.* at 635 (quoting CAL. BUS. & PROF. CODE § 2056 (West 2003)).

294. *Id.* at 639 (citing CAL. BUS. & PROF. CODE §2056(a) (West 2003)). Section 2056(a) provides that: "The purpose of this section is to provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients pursuant to *Wickline v. State of California*, 192 Cal. App. 3d 1630."

295. See text accompanying notes 28-31 *supra*, discussing the facts and holding of *Wickline*.

296. The court relied on the statutory bill analyses, which made "clear that the bill's reference to *Wickline* was only intended to refer to the *responsibility* of physicians to advocate for medically appropriate health care for their patients, not to limit the statute's protections to the facts of *Wickline*." *Khajavi*, 100 Cal. Rptr. 2d at 640.

297. CAL. BUS. & PROF. CODE §2056(b) (West 2003).

298. *Khajavi*, 100 Cal. Rptr. 2d. at 638.

299. 680 A.2d 127, 145-46 (Conn. 1996).

300. *Id.* at 145 (citing *Cort v. Ash*, 422 U.S. 66, 78 (1975)).

tent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?<sup>301</sup>

Here, the court held that the statute was indeed enacted for the benefit of physicians and patients, permitting the former to determine whether they met the plan's credentialing criteria and the latter to decide whether or not to enroll in the plan. Although the statute was silent on the question of a private right of action, the court found that it was consistent with the statutory purpose of protecting physicians and patients to permit a private cause of action.<sup>302</sup> As in *Lewis and Foong*, the court found that a contrary interpretation would leave the injured parties without redress and would render the statute useless.

It thus appears that courts are likely to construe state advocacy protection laws to permit private causes of action, even where the statutes are not artfully drafted or do not address the issue. Although there has been a trend among federal courts to be more hesitant to infer a private cause of action,<sup>303</sup> state courts are still likely to find that their legislatures meant to protect patients and HCPs from overreaching by insurers and MCOs and will permit aggrieved health care professionals their day in court.

## B. Burdens of Production and Persuasion

The next sections will address the issues of how the HCP will make its case: what must he prove, and how will he prove it? In deciding how an HCP might demonstrate that he was deselected by an MCO because of patient advocacy, one of the most difficult issues is the allocation of the burdens of production and persuasion. The only case to directly address this point is *Lewis v. Individual Practice Ass'n of Western New York*.<sup>304</sup> The plaintiff surgeon, who had a ten year relationship with the defendants, a physician practice association and the HMO with which it was affiliated, sued after the defendants chose not to renew his contract. Under the New York health care provider protection statute, health care plans<sup>305</sup> must provide HCPs with procedu-

301. *Id.* at 145. The Connecticut Supreme Court determined that the fourth *Cort v. Ash* factor, "whether the cause of action [is] one traditionally relegated to state law . . . so that it would be inappropriate to infer a cause of action based solely on federal law?" was inapposite. *Id.* at 145 n.23 (alteration in original) (quoting *Cort*, 422 U.S. at 78).

302. *Napoleitano v. Cigna Healthcare, Inc.*, 680 A.2d 127, 146 (Conn. 1996).

303. See ERWIN CHEMERINSKY, *FEDERAL JURISDICTION* 358 (2d ed. 1994) (finding a trend "for the Supreme Court to be less willing to create private rights of action"); Donald H. Zeigler, *Rights, Rights of Action and Remedies: An Integrated Approach*, 76 WASH. L. REV. 67, 90-91 (2001) (discussing the Supreme Court's increasingly restrictive criteria for creating a private right of action).

304. 723 N.Y.S.2d 845, 850-51 (N.Y. Sup. Ct. 2001).

305. The statute defines health care plans to include HMOs and independent practice associations. N.Y. PUB. HEALTH LAW § 4406-d(8) (McKinney 2002).

ral due process protections, including notice of the health plan's credentialing and profiling criteria,<sup>306</sup> and notice and an opportunity for a hearing prior to termination,<sup>307</sup> and are prohibited from penalizing HCPs for their advocacy. The statute provides that "[n]o health care plan shall terminate a contract . . . or refuse to renew a contract, *solely* because a health care provider has (a) advocated on behalf of an enrollee."<sup>308</sup> In this case, the defendants claimed that once they gave plaintiff the required sixty days' notice that his contract would not be renewed, they had satisfied their statutory obligations, since the statute provided explicitly that a "non-renewal shall not constitute a termination for purposes of this section."<sup>309</sup> The defendants also argued that even if some hearing was required, once a health plan offered some reason for not renewing the HCP's contract other than advocacy, no further challenge was possible.<sup>310</sup>

The court disagreed. It found that the only way to effectuate the statute's purpose - to prohibit "managed care entities from preventing providers from advocating on behalf of patients or disclosing to patients appropriate information concerning their care"<sup>311</sup> - was to provide deselected HCPs with a meaningful opportunity to demonstrate that their advocacy activities played a role in the health plan's decision not to renew the contract. The court rejected the defendants' argument that the statute's use of the term "solely" meant that the statute could be violated only if "patient advocacy [was] the one and only reason for non-renewal."<sup>312</sup> The court held that the Legislature had not intended "to allow HMOs to avoid compliance with the patient advocacy provision by simply pointing to other provider deficiencies, whether real or fabricated, significant or insignificant, as a pretense for punishing a provider through termination or non-renewal for engaging in a protected activity."<sup>313</sup>

Drawing upon New York employment discrimination law for an analogy, the court ruled that a plaintiff HCP carries the initial burden

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306. *Id.* at § 4406-d(1), (4).

307. *Id.* at § 4406-d(2).

308. *Id.* § 4406-d(5) (emphasis added). In addition to its general protection of HCPs who "advocated on behalf of an enrollee," the statute also protects those who:

- (b) filed a complaint against the health care plan,
- (c) appealed a decision of the health care plan;
- (d) provided information or filed a report pursuant to . . . [the New York external review process]; or
- (e) requested a hearing or review pursuant to this section.

*Id.*

309. *Lewis*, 723 N.Y.S.2d at 847 (quoting N.Y. PUB. HEALTH LAW § 4406-d(3) (McKinney 2002)).

310. *Id.* at 848.

311. *Id.* at 849 (quoting N.Y. State Educ. Dep't recommendation of the Act).

312. *Id.* at 848.

313. *Id.* at 849.

of production, as he “must show that he engaged in the protected activity of patient advocacy and that his contract was not renewed.”<sup>314</sup> If he does this, “the burden shifts to the defendant to show other valid reasons for the non-renewal.”<sup>315</sup> Finally, once the defendant does this, the burden shifts back to the plaintiff,

[who] must show that the reasons given were simply a pretense for not renewing the contract based on patient advocacy and that the reasons given would not alone or in combination have led to non-renewal such that patient advocacy became the sole determining factor in the decision not to renew the contract. As evidence . . . the plaintiff can demonstrate that others who were similarly situated and who did not engage in the protected activity were treated differently, i.e., their contracts were renewed.<sup>316</sup>

In order to evaluate whether the reasons given for nonrenewal are real or pretextual, the plaintiff can rely on the HCP profiling criteria which the statute requires the health plan to disclose as part of its ongoing relationships with its health care providers, to permit the plaintiff to compare his performance under the plan’s criteria with those of other HCPs. Ultimately, the burden of persuading the trier of fact “that patient advocacy was the determining factor in a non-renewal decision” rests with the plaintiff.<sup>317</sup>

The court’s decision in *Lewis* is significant in seeing the relationship between an HCP and an MCO as more than a business relationship because of the important public interest in ensuring that HCPs act as fiduciaries for their patients. The decision follows the lead of the California Supreme Court’s decision in *Potvin v. Metropolitan Life Insurance Co.*<sup>318</sup> and the New Hampshire Supreme Court’s decision in *Harper v. Healthsource New Hampshire, Inc.*,<sup>319</sup> both of which insisted that deselected HCPs be given a meaningful opportunity to challenge the grounds for the health plan’s decision. Second, *Lewis* recognizes the elusive and complex nature of the truth about why a health plan might choose to terminate an HCP, including the reality that an HCP might be a strong patient advocate *and* a poor clinician, or a person who refuses to accept the basic principles of cost-containment, or a person who makes referrals out of vested personal or financial interest. The court does not consider protected patient advocacy to be the trump card for all HCPs whose relationship with an MCO is ended, but establishes a thoughtful mechanism for each party to a dispute to shed light on the reasons for the break-up. Third, the court connects its analysis of the burdens of production and persuasion with the discovery process, recognizing that if a plaintiff is denied access to

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314. *Id.* at 850.

315. *Id.*

316. *Id.* at 851.

317. *Id.* at 850-51.

318. 997 P.2d 1153, 1159-61 (Cal. 2000).

319. 674 A.2d 962, 966-67 (N.H. 1996).

information that is critical to making his case, he will not be able to go forward.<sup>320</sup>

### C. Discovery

In order to prevail on a claim that the HCP was terminated or non-renewed because of patient advocacy, the lawyer will first have to gather background information about the MCO's credentialing, recredentialing, and utilization review criteria for all HCPs belonging to the MCO's network or health plan, looking at the criteria used when the HCP first entered a contractual relationship with the MCO and when the HCP was deselected. The credentialing and recredentialing criteria establish important minimum standards. The utilization review, practice guidelines, and/or practice profile data used by the MCO in evaluating its participating HCPs set a baseline for evaluating the performance of the HCP client compared to other similarly situated HCPs in this MCO. Industry, trade group, and relevant accrediting association standards for credentialing and practice profiling should also be requested. Throughout the discovery process, the plaintiff's requests should focus on the standards and internal plan mechanisms applicable to the HCP's clinical specialty. While the MCO may resist disclosure of much of this information on the ground that it constitutes confidential business or proprietary information, in many states, this data is required to be disclosed, either by the advocacy protection statute itself,<sup>321</sup> or by other statutes establishing procedural safeguards for HCPs.<sup>322</sup> In *Lewis*, for example, the court noted the defendants' "insistence that the statute did not intend to invade the daily business decisions of the HMOs,"<sup>323</sup> but ruled that "the patient advocacy protections clearly carve out one specific exception to this general laissez-faire rule. Without reliance on the objective criteria for provider performance in Public Health Law Section 4406-d(4), the protections contained in the patient advocacy section of the law become virtually unenforceable."<sup>324</sup> Further protection may be provided by insisting that confidential information be disclosed in an *in camera* proceeding, or by limiting the attorneys to whom disclosure may be made.

In addition, the HCP's lawyer should seek to discover all information that would give a complete picture of how the MCO and its subcontractors interact with HCPs that are part of its network. This includes information that might suggest bias in utilization review or

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320. *Lewis*, 723 N.Y.S.2d at 851.

321. *See, e.g.*, N.Y. PUB. HEALTH LAW § 4406-d (4) (McKinney 2002).

322. *See, e.g.*, ME. REV. STAT. ANN. tit. 24-A § 4303 (2002 Supp.) and statutes discussed *supra* in section IV.A.

323. 723 N.Y.S.2d at 851.

324. *Id.*



HCP profiling, such as information concerning the structure of payments made by the MCO to utilization review personnel and others who evaluate the performance of individual HCPs, to learn the incentives that may influence non-providers in making utilization review decisions and evaluating HCPs. In order to avoid being blindsided later, the lawyer should also request information concerning any procedures the MCO has in place to assist HCPs to be more efficient and to achieve greater compliance with the MCO's practice guidelines. In all aspects of this background discovery, the lawyer should strive to identify relevant decisionmakers – those who developed and/or implemented criteria and their enforcement mechanisms – and the meetings at which such decisions were made, so that the decisionmakers can be deposed and documents requested.

The second aspect of discovery focuses on the special circumstances of the plaintiff HCP. Here, the plaintiff's lawyer will seek to discover evidence of any conduct by the plaintiff that might constitute protected patient advocacy, such as records of letters written and phone calls made by the HCP to challenge an MCO decision to limit or delay care.<sup>325</sup> Further, the plaintiff should request copies of communications regarding the HCP between the MCO and regulatory agencies or government prosecutors, in order to understand fully the reasons why he was deselected. The lawyer should also request individual utilization review and practice profile data for the plaintiff and other HCPs who may be similarly situated. These would include information such as case mix, efficiency index, per capita patient costs, financial performance, withhold calculations, referral data, and other professional profile and resource utilization data. Although it is likely that the MCO will resist providing any of this data, citing its own business needs and the confidentiality interests of the other HCPs, the plaintiff might ask that the data be transmitted in the aggregate, without any individual provider identifiers, since the goal is simply to establish whether or not the HCP is an "outlier" in clinical practice, to determine if deselection was based on advocacy as opposed to other, permissible reasons. Again, the *Lewis* court endorses a pragmatic approach to discovery, recognizing that this request is the only way that a deselected physician can meet the burden of proof.<sup>326</sup> The plaintiff may also request the names of other deselected HCPs and the reasons for their deselection, but this information is less likely to be provided because of the confidentiality concerns noted. In regard to each type of information sought, the plaintiff should seek all underlying statistical data, as well as memoranda, meeting dates and notes, the identity of all people involved, and any other written and oral communications.

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325. Of course, what constitutes protected advocacy will vary with the terms of the advocacy protection statute.

326. 723 N.Y.S.2d at 851.

### 1. *Practical Burdens of Litigation*

Simply to articulate the potential avenues of discovery make it clear that a deselected HCP seeking to challenge the actions of an MCO faces an expensive uphill battle. It is therefore critical for the lawyer representing an HCP to have a clear understanding of the client's goals, which undoubtedly reflect a complex mix of personal, professional, and economic concerns on the client's part. The client could be seeking reinstatement, declaratory or injunctive relief, as well as money damages.

A health care professional has a strong incentive to fight a deselection decision, because of its enormous long-term consequences for the HCP's income, ego, and reputation. An MCO's action in ending its relationship with an HCP can often have a crippling economic domino effect. As the MCO's decision becomes known to state or federal regulatory bodies as well as other insurers or health plans, an HCP, particularly one who is a specialist, can quickly face a sharp fall-off in referrals from other HCPs.<sup>327</sup> In other cases, an HCP's hospital staff privileges can be threatened.<sup>328</sup> Without referrals and privileges, the HCP's income may be slashed drastically. In addition, some lawyers for HCPs have suggested that statutes designed to ensure due process for HCPs may have unintended negative consequences, since by forcing an MCO to provide procedural due process, the termination of an HCP's contract becomes an adverse action, reportable to a state licensing board or a national health practitioner data banks if it raises a concern about the HCP's competency or integrity.<sup>329</sup>

At the same time, although one should not automatically view every dispute between a deselected HCP and an MCO as a David and Goliath struggle, rather than a dispute between two evenly matched business entities, in many cases it is likely that the MCO commands significantly greater resources than an individual HCP and can afford to wage a war of attrition, thus making it extremely difficult for an HCP to prevail. Individual litigants may have a particularly difficult time, while class actions or other suits challenging the systemic as-

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327. *But see* Potvin v. Metro. Life Ins. Co., 997 P.2d 1153, 1160-61 (Cal. 2000) (recognizing that elimination from a plan can significantly impair a provider's ability to practice medicine in a specific locale).

328. *See, e.g.,* Wagner v. Magellan Health Servs., Inc., 121 F. Supp. 2d 673, 677-79 (N.D. Ill. 2000).

329. Indeed, some lawyers have suggested that statutes mandating due process may, in a close case, push a MCO into describing a HCP's deselection as being based on quality of care or competency concerns, in an effort to ensure that the MCO meets its reporting obligations. Other lawyers disagree, suggesting that most MCOs would rather wait until a HCP's contract term expires, and simply not renew the contract, rather than initiate what could be a protracted administrative or judicial battle. *See* text accompanying notes 66-73 *supra*.

pects of an MCO may be more successful.<sup>330</sup> A defendant MCO can exert tremendous leverage by prolonging the discovery process: making its own discovery requests, seeking a protective order, and/or possibly engaging in dilatory tactics in regard to the plaintiff's discovery requests. The client is of course handicapped by the very fact of his injury – he would probably not be suing if he had not just lost a substantial fraction of his income because of the MCO's decision not to continue his contract, but that unpleasant economic reality renders it harder to prosecute the case, unless he has significant capital available from an earlier, more successful time in his career. This also puts enormous pressure on HCPs to settle, whatever the merits of their case, because the stakes are so high.

#### VI. HOW EFFECTIVE ARE ADVOCACY PROTECTION LAWS – IS MORE NEEDED?

If we view one function of law as telling stories, then the recently enacted advocacy protection laws and the cases in which they have been invoked by deselected HCPs may serve as important morality plays, illuminating changes in the legal landscape for providing health care services. Three cases have been decided in the last two years under state laws protecting HCPs in the managed care setting: *Lewis*, *Foong*, and *Khajavi*. The *Lewis* case is particularly significant because of the court's careful effort to make the New York advocacy protection statute operational, both in terms of articulating the shifting burdens of production and persuasion, and in addressing concrete issues in discovery, which are likely to be outcome determinative. These cases may be seen as part of a larger trend toward providing deselected HCPs with their day in court.<sup>331</sup> State court judges are acknowledging that the relationship between HCPs and MCOs is both

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330. It is important to note that an increasing number of suits challenging the systemic actions of MCOs against patients and health care professionals have been brought, with some success. See, e.g., *Napoletano v. Cigna Healthcare, Inc.*, 680 A.2d 127 (Conn. 1996) (holding that doctors' and patients' claims for violation of state laws governing MCOs are not preempted by ERISA and may go forward); see also *In re Humana Inc. Managed Care Litig.*, 285 F.3d 971 (11th Cir. 2002) (permitting class action suits brought by physicians and state medical societies challenging MCO reimbursement schemes to go forward and rejecting the application of mandatory arbitration provisions) *rev'd on other grounds sub nom.* *Pacificare Health Sys. Inc. v. Book*, 123 S. Ct. 1531 (2003) (holding that it was premature to conclude that arbitration clauses would preclude the awarding of treble damages under RICO, and that therefore, the proper course was to compel arbitration); *Penn. Psychiatric Soc'y v. Green Spring Health Servs., Inc.*, 280 F.3d 278 (3d Cir. 2002) (holding that psychiatrists might be able to establish third-party standing on behalf of their patients to challenge alleged denials of care by defendant MCOs).

331. The plaintiffs in the *Harper*, *Napoletano*, *Potvin*, and *Schulze* cases were also successful in getting a trial or other meaningful opportunity to challenge either the process or the criteria by which they were terminated, even though they did

unequal and freighted with a public trust, and are trying to create a more level playing field on which to adjudicate problems in that relationship.<sup>332</sup>

At the same time, if we truly want health care professionals to be able to fulfill their fiduciary duty to their patients, and advocate for them to receive medically necessary and appropriate care in a timely fashion, both federal and state governments must make it easier for HCPs to challenge denials or delays in care. An ideal first step would be to amend ERISA to provide an expanded administrative review process that would work, consistent with the recently promulgated internal appeals regulations, to permit HCPs to be the designated representative of patients in all challenged denials of care, rather than the current narrow limitation for urgent care situations.

In addition, since less than half of Americans receive their health care through ERISA-governed plans, it is necessary to push for expanded state laws that define protected patient advocacy in clear terms, while providing express protections for HCPs who engage in such advocacy, including explicit provisions to make it possible to challenge MCOs who penalize HCPs for engaging in patient advocacy. Both administrative and judicial remedies should be provided. Simplified administrative procedures would make it easier and less costly for HCPs to contest actions by an MCO that the HCPs believe is in retaliation for advocacy, and would also permit a state department of insurance or managed care to observe, and then address, systemic patterns of MCO overreaching that develop. Most important, statutes should explicitly provide for a private cause of action for aggrieved HCPs, to ensure that HCPs can be heard and not have their case derailed by unfair tactics on the part of MCOs. Given the Supreme Court's recent decision in *Rush Prudential HMO, Inc. v. Moran* and *Kentucky Ass'n of Health Plans v. Miller*, these state laws would not run afoul of ERISA, since they would not be deemed to affect the operation of an employee benefit plan, but would only have an indirect economic effect on it. Even if they did, they would be saved by the insurance savings clause, as were the state laws at issue in *Rush Prudential* and *Kentucky Ass'n of Health Plans*.

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not always have a specific HCP protection statute on which to rely. The plaintiffs in *Grossman*, *Sammarco*, and *Wagner* have not yet been successful.

332. At the same time, the paucity of lawsuits that have been brought, in comparison to the number of HCPs terminated from health plans and the larger number of HCPs whose contracts are simply not renewed, suggests that advocacy protection laws cannot be viewed as the best or only remedy for aggrieved HCPs. Such a conclusion follows because of the high costs of litigation and the practical difficulty of making a case, given the shifting burdens of production and persuasion and the hurdles posed by discovery, which may make it difficult for a HCP to show that he or she was terminated or non-renewed solely because of patient advocacy.