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Ethical and Legal Considerations in Managed Care

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Summary: By rationing health care resources, managed care organizations have raised ethical and legal issues not commonly found under previous financing structures. This session addresses these issues.

Mr. Dennis J. Hulet: My copresenter is Mr. Gerald L. Coe. He is an attorney and has a very nice managed care background. He is currently involved in his own consulting firm and actively consults with managed care organizations and providers. He was a managed care executive for 20 years, and for the last several years has been a chief executive officer (CEO) of Providence Health Plans in Seattle, Washington. Prior to that he was with Group Health Cooperative as a senior executive assisting with its expansion across the state into other locations where it did a great deal of primary care models. He's been on numerous boards of national and local health organizations. He served the Group Health Association of America (GHAA) and other such organizations in his managed care career, so he has a great deal of practical knowledge of the industry and where the problems lie. We'll try to address some of those legal issues that we all have to deal with as managed care actuaries or others working in the managed care industry.

Ethics is something that has been on the minds of many professionals over the last several years. There have been a number of professional organizations that have

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seen their members get into various difficulties because of the lack of attention to ethical issues. I don't know that we have experienced any problems as an actuarial organization on such issues in managed care, but there certainly is a great deal of potential depending on the individuals that you are advising as to actions to take in managed care. We will not try to answer many questions, but we'll try to point out some of the questions that you ought to be thinking about. The determination of whether something is ethical or not ethical often depends on your own personal value, and so you have to recognize the value system anytime you're making judgments as to what is ethical and what is not. There are certain things that everyone would agree are unethical or way over the line. There are many things in the gray area, though that could be interpreted by some to be unethical, yet in other segments they'll just be termed as good business things. So we need to think about those and how we, as actuaries, can influence those decisions and those players in the managed care industry so that we can avoid some of those problems.

My experience in managed care goes quite a ways back. I was with Pacific Mutual and was there when it first started dealing with PPOs. I remember an SOA meeting in San Diego that took place in 1980 where someone from PacifiCare gave a presentation about what it was doing in managed care, how it was negotiating favorable prices with the hospitals and physicians, how it was taking some responsibility for looking at the delivery of services and providing input into the utilization management process. At that time, I was dealing with group representatives in the San Diego area who were calling me daily and telling me how uncompetitive the insurance rates were for San Diego as compared to what PacifiCare was able to offer. I thought about the situation and wrote a memo to my boss and told him that I could only see two ways that we, as an indemnity company, could compete with the HMOs. One was to negotiate with physician groups for favorable prices and some involvement in the utilization management process. The second was to own and operate hospitals so we can control that segment of delivery cost. I thought that I had thought this out well enough, so I gave it to my boss. He read it, kind of chuckled, tossed it in the garbage can, and said it will never happen.

It was probably about three years later when he came into my office very excited one day. He had just been in a meeting with some of the senior managers of the insurance company and an organization called CAPP Care. CAPP Care was asking Pacific Mutual to be its pilot insurance company and to have a preferred provider product. I went to my file and pulled out the memo I'd written three years earlier and put it in front of him. I said, "Well, I guess it happened. Never wasn't very long." That was when my experience started in managed care. The issues surrounding managed care are no different than insurance. We just have to

recognize that the processes are different and make sure we apply our actuarial skills to those processes correctly.

We're not going to try to give you many answers. We're going to try to bring up some questions that will get you thinking. If you think about our managed care delivery systems, many people are asking questions about what is taking place, and we very often don't give them good answers. They're left in a quandary.

EIGHTEENTH CENTURY HEALTH CARE

I would like you to think for a moment about how health care used to be. I have a premise about health care in the eighteenth century. It probably is a premise that was true until we started to get the third-party insurance involved. Basically, the premise is that you may or may not have had access to health care in that environment. If you lived out on a farm away from other people, you may have had no choice but to treat yourself. So the patient decided on his or her health care, and if there was a physician available then maybe that doctor would be involved. A doctor would make a weekly round or a monthly round to see how you're doing and maybe prescribe some medicine for you periodically to take care of the flu or colds or whatever you might have, but most of it was individually applied health care. You had grandma's remedy and what your sister may have told you and other things like that. Resources, other than things you probably had in your home, probably weren't available. The cost was very negotiable. You could have paid with pigs and chickens or flour or wheat or something like that. Payment was not the big issue. Most physicians, at that time, were not in the profession for the money. They were in it because they wanted to serve the needs of those patients who were on their route or in their area.

The main attitude of the patient was, I should be able to take care of myself, and if I get a little help from a physician, that's great. We changed that so that the traditional premise that I think most of us grew up with was that everyone should have access to health care. It became the national expectation. It's the expectation of most other countries that have been industrialized. Some of the countries that are still in that process of getting industrialization may not feel this way about it yet. They know that the resources are not available, so they may not assume everybody should have access to health care. The patient and doctor relationship was very sacred, and together they decided, and most of the time it was a physician that decided, what care was needed, because patients looked at them as having all the answers. So there was no reason why we should ask questions, we just follow their advice.

RESOURCES SHOULD BE MADE AVAILABLE

We had a big push to get more hospitals built. We had a big push to get more physicians trained so, to meet the attitude that everyone should have access to health care, we had to develop the infrastructure to provide the resources for that care.

Now we all felt like someone should pay and it should not necessarily be us. When we got the employer involved and insurance companies involved then that removed us as patients a little bit away from that financial relationship that we needed to have with our physician in making decisions. It became one where the financial aspect was not part of the decision because we were immunized from that. Of course, we all developed the attitude that I deserve the best, and it should be available to me.

The managed care premise has changed that just a little bit. It's now the members who should have access to health care. In other words, you don't find many managed care organizations that say, "Yes, we're going to throw in an extra 10% to cover the uninsured." They want to cover their members. They are collecting premiums for those members and want to arrange for the care for those members. The managed care organization and the doctor are the ones that make the most of the decisions about what care is to be provided. Individuals have less say in that determination. We still believe resources should be made available and, basically, put it on the managed care organizations to ensure that they are available. Most of the contracts that are approved by regulators in states where they are regulated require that the HMOs take responsibility for the provisions of care even if they have subcontracts to physician groups, hospitals, and other organizations. Someone should pay the full cost. The employer is paying a large part if it. Managed care generally has small co-payments. The contribution structure that employers put onto their employees varies a great deal from employer to employer and area to area. Therefore, we have to recognize that people believe the costs should be paid for, but we still look to the employers to pay a great deal of that cost. Of course, we still have the theory that each of us deserves the best.

Now if we look at what's emerging as we move risk down the line to the providers, we're finding that we have broadened the group of people who should get care to those who are funded. When we look at the uninsured, those who are in the Medicaid programs and others, there is a sentiment out there that maybe they don't deserve the same care as somebody who can pay for it. So we look at the experiment in Oregon, for example, where they said here are the things that we'll pay for and if those things don't have enough value in our opinion, we're not going to pay for those who can't afford it themselves. The doctor decides on care and is financially responsible for care. That puts a different kind of pressure on the decision-making process for physicians than when we just ask them to try to

determine what the best care is. Now we're saying not only do you have to think about what the outcome of the care will be, but, also, what is the most cost-efficient way to deliver care, because we're going to keep track of that, and we're going to slap your hands if you seem to be using technology that is overpriced for what it accomplishes.

THE RESOURCES SHOULD BE AVAILABLE

We say somewhere you are seeing the development of centers of excellence and things like that where people are being flown across the country to get to a facility that does it well and does it cost effectively. I think there will continue to be that kind of sentiment in the managed care industry where they try to identify who can do it the best for the least cost. If the condition is such that you can be moved, they'll move you to another location, whether it be across the city or across the country.

There are funding differences that will emerge down the line. I believe that in the next ten years we will see defined contribution as the major way health care is paid for by employers. I think the lack of control that the employers have in cost will change that scenario so we will no longer have defined-benefit health care. We have defined-contribution health care. We now often say that you deserve what you can afford. That's much like the system that they have created in Canada, if you can't wait the necessary time. If you can afford to go across the border into the U.S. and pay for the care, then you get care that you could not receive in Canada. We may see more and more of that in the U.S. as we become more picky about what we, as a society, are willing to pay for.

FUTURE OF MANAGED CARE

I believe that physicians will regain their influence and broker the care to others. So those that have been primary sites for care, like the hospitals, will obtain their patients through a physician relationship. So if they don't develop that relationship with the physician, then they're going to have too few patients to fill their beds and the consequence is that they won't be able to stay in business.

Quality measures will become available and meaningful. There's much talk about quality measures. There are some that the National Committee for Quality Assurance (NCQA) and others have tried to put together but, as yet, I don't believe they have anything that is truly meaningful in terms of clinical quality. We talked a little bit at another session about how to measure managed care effectiveness. Patients don't necessarily know how to do that and so we need others involved in the discussion. Employers are trying to figure out how to measure it so they can decide who the best plans are to negotiate with. We have the commissions themselves that are looking at it, trying to decide what is high quality and what is

not. As that emerges, we will have a way to collect the information, a way to measure it, and a way to report it.

The Internet gives us a great opportunity to provide information to consumers. I believe the number of those who will be electronically connected will continue to increase so that there will be ways to do it even if you don't have it in your home, so that you can connect and find out whether this physician has a good reputation, whether his or her quality measures are good, or whether the hospital seems to be high quality and efficient.

Cost control will continue to be a focus because of those who pay the bills. They don't want to open up their checkbooks and continue writing the checks. Healthy behaviors will be rewarded. If we can reward healthy behaviors, then maybe we can truly have a health care system instead of just a sick care system. We always call it the health care system. We call HMOs health *maintenance* organizations, and yet what we really want to do is maintain current health status, but also *improve* it wherever it's possible. So that will become a focus as we move into the future.

FIVE PRINCIPLES OF HIGHLY EFFICIENT CARE

The First Principle

I've put together a number of principles that I believe are necessary for highly efficient care, and when we look at these, we find that they present some ethical dilemmas. The first one says: *The services provided must not include any services that are not medically necessary or more intense than medically necessary.* So somebody needs to make that judgment call about when it is medically necessary, and when it is not. I've added a caveat to that which creates more of an ethical dilemma: To produce the improvement in health status that a patient has the right to expect. We, as a society, have this attitude that our health care professionals should be able to solve any health problem we have. We should be able to be returned to whatever our condition was before we had the injury, before we had the illness, and before the chronic condition came upon us. We know that's not true, but that doesn't change the expectation we have.

Somewhere along the line, we have to build into our a system a way to convey to individual patients what they should expect and what they should not expect. I remember a situation, maybe it was three or four years ago, where there was an individual in the Midwest who had his arm chewed off in some kind of a farm accident. It took about two hours before they could get him to the hospital. They reattached the arm. I would think the best you could hope for is that he would maybe have a little movement of the arm. But, as it turned out, he got almost full function back to the arm. It's great that he did, and I would say that's a modern day

miracle, but we should not expect that would happen. I think we sometimes have to tell patients who have serious or chronic conditions, like cancer or diabetes, what the realistic expectations will be.

The Second Principle

The care should not be provided by a provider with a greater level of expertise than is medically necessary to provide the medically appropriate care. It does not make sense to have somebody who is trained as a neurosurgeon giving an immunization. They are qualified to give immunizations, but why would we want to pay for all that expertise when it is not needed? So if the nurse practitioner can do an adequate job of delivering immunizations, that's the kind of expertise we should pay for. We should not be paying for the neurosurgeon. A caveat that goes along with this principle is: the provider should agree to provide care at a cost that is equivalent to the cost a provider having the appropriate level of expertise would charge. So if the neurosurgeon is willing to accept the same payment for giving the immunization as the nurse practitioner would, no problem. But our expectations, at least the expectations that have been built among the provider community, is that the neurosurgeons must be paid more because of the extensive training that they have had to go through. So we need to align the expertise and what we're going to pay for that expertise.

The Third Principle

The care should not be delivered in a setting that is more intense or costly than is medically necessary. We don't want to put somebody in the acute facility in a hospital bed when we can do it on an outpatient basis or do it in the home. As home care technology continues to improve, we'll find many of the types of patients that used to be in our acute care facilities being handled at home. So if we can put them in an environment that is much more secluded, where there aren't so many germs as there are at the hospital, it is better health care. So we need to look at the environment. The caveat that goes along with this one is: Recognize that there are nonclinical factors that may make a more intense setting necessary. The best example I have here is for somebody who needs dialysis. Home dialysis may be appropriate, but if the patient is homeless, that option is not possible. So you have to determine whether there are some other factors that would play into that equation. Somebody has to make this judgment each time a patient is seen.

The Fourth Principle

The prices for health care resources should be directly correlated to the appropriate level of provider expertise intensity of the services and setting. We do not want to pay more for outpatient surgery than we do to put somebody in a hospital bed for a day and perform the surgery. That is because we know that less resources are required to just put them in, do the surgery, and get them out, than to keep them in

a bed and utilize all the ancillary services that go along with that. Many of the managed care contracts out there will end up having an outpatient surgery charge that is greater than the one-day per diem. That is not a rational way to price, so we have to bring some rationality into the way we price things.

Now the caveat here is: The prices should also be competitive with other contracts offered by providers in the marketplace. That is a very difficult business decision for many to make, so in most markets, you see people jumping into contracts that will never be financially successful; but they do it as a defensive measure because they feel that if they don't do it, somebody else will, then they'll lose the business and soon be out of business. I would maintain that if they take these financially adverse contracts, they're going to be out of business anyway. So it may be better to educate the consumers and those who are negotiating the contracts about what the real cost of care is and what the benefits are that they get by paying the proper price for that care.

The Fifth Principle

The fifth principle is more of an insurance principle. *The administrative cost, added by those who provide financial and delivery management services, should not be excessive.* This is one of the issues that many of the regulators jump on. I remember being in a meeting in Oregon where they said that there could be enough savings in administrative costs to cover all the uninsured in the states. I think somebody did their math wrong, but, nonetheless, the attitude that was coming through was that the insurance companies (the Blue Cross plans) were so outrageous in what they were charging for administrative services that, if the state took it over, they could reduce the administrative costs to the point where there would be much more money to pay for services. So we need to keep this in mind and not overcharge for those services.

In the Medicare risk contracts, we have people who will take out an exorbitant amount on the administrative fees before they pass the money onto the providers. At some point, that's going to blow up in their face, because providers will learn that they are not earning that portion that they're taking. The caveat that goes along with this principle is: administrative cost must be minimized and directly correlated to the value added by those services. So if you do have a utilization management function in your insurance organization, in your managed care organization (MCO), then you need to make sure that they are adding enough value that it's worked well paying that organization to be part of your greater organization. If you cannot prove that the value is there then you'd better rethink having that capability in the first place. So those are things that I think need to take place to have an efficient system. There are many systems that are moving in that direction, but some of the dilemmas

we have, which mean we have to make a determination that some things are needed and some things are not, are causing much discomfort.

The following is a list of some experimental treatments for breast cancer and factors related to it:

- bone marrow transplant
- Stem cell transplants
- High dosage chemotherapy
- $100,000 or more per patient
- Primarily desperation after failure of other procedures to positively impact later stages of disease

What I want you to notice about this is that we're talking about an experimental treatment that is very costly. Physicians who work for our company view these treatments as primarily desperate measures when other things don't work. Do we want to pay for those desperate measures? If the patient is my wife, my daughter, or my mother, the answer is yes. If it's yours, I'm not sure. So those are the kinds of things that we, as a society, have to get a handle on so that we can make the right decisions and make them consistently.

Let's talk about screening for breast cancer, particularly genetic testing. Unless there's a high probability that somebody is going to have breast cancer, genetic testing really isn't justified because of the cost and complications that it may cause. But if you do genetic testing and find out that somebody has the right genes for being prone to breast cancer, what do you do with that information besides help the patient manage their own health? What happens if the employer gets their hands on it? Does that mean that employee will be terminated for one reason or another so that the employer will not have to incur the cost of treatment once breast cancer does emerge? What does it mean in terms of life insurance? Genetic testing has some benefit, but, on the other hand, if it is put into the hands of the wrong people, it could have some very devastating effects to the individual who was tested.

In the same vein we have some suggested criteria for outcome measures. If we're able to get these outcome measures reported, and they're available to us so that we can report them to the health plan, or the physicians or the patient, what action can we take based on those measures? If somebody doesn't shape up and get in sync with everybody else so that its measures are consistent, what kind of action can we take? Mr. Coe is going to talk a little bit about the selection of physicians and that will certainly come into play in deciding what criteria we are going to use for selecting a physician.

One of our physicians made a presentation at the Society meeting last year on the ethics of medical care and managed care. He said that we have different members of the delivery system advocating different positions. The health plans are not going to advocate anything that's wrong, but they may look at the cost consequences in making the determination. Perhaps there is something they want to try first.

There is always a choice between what is satisfactory and what is best. If you're the physician, you may recommend X. You may know that the health plan will approve and pay for Y. Then you'll leave it up to the patient to decide what he or she wants. Does the patient want what will be paid for or what the doctor thinks should be done? If that kind of a situation occurs, and the patient is unhappy with the outcome, guess where the patient will go for resolution? The courts. In a number of cases, I think it has been true that health plans have a tough time proving that the physician should not have followed their own opinions if the outcome is adverse and they followed the health plan's recommendation. So we have to be very careful about what we recommend if we are in a management position versus what we accept from the provider if we are overseeing their decision.

Confidentiality is a big issue when you get into ethical discussions. Once again, with genetic testing, who gets that information? It can have a disastrous effect to an individual's life if the wrong people get hold of that information. There are certain things that must be disclosed. The federal government and state government in Medicaid and workers' compensation require that you report everything. Now where does that go? Can you get your hands on it as an actuary to do some evaluations? If so, what is done to protect the identity of the patient? In most cases they try to encrypt the patient code, whether that be a social security number or something else. But if you really wanted to, you could probably put enough things together to determine who that patient is in many of the environments that we work in as actuaries. So we have to be careful that we don't violate confidentiality requirements when we do our work.

In HMOs, the patient is required to sign a waiver so the HMO can get the information. That could come from hospitals or it could come from physicians, but nonetheless, the patient is not involved in the decision of who gets that information. The same principle applies to life insurance. There are certain requirements to get the coverage that you have to disclose to certain people, and there are not necessarily limitations on what happens after the information is obtained. So those are the things that we have to be cognizant of as actuaries because it does hit us in our day-to-day activities, regardless of what kind of a role we play in the system. I'll have Mr. Coe give his comments, and then I will throw out some more questions so that we can get your reactions to them.

Mr. Gerald L. Coe: As Mr. Hulet said, I'm both a lawyer and a manager. I started my career too many years ago, back in about 1974, with an organization called Group Health Cooperative, one of the oldest HMOs in the country. In those days it probably covered about 70,000 lives. Back then, you could count the number of HMOs on two hands, and all combined, they covered about three million lives.

Prior to that I had been an attorney with the University of Washington, representing the Health Sciences Complex, working with the medical school defending discrimination suits in admissions and then reversing discrimination suits. You might remember that happened back in the early 1970s. The dean of the school of medicine and the vice president for health affairs told me not to go to work for Group Health Cooperative, "a socialist outfit up on the Hill." It was the type of medicine that has no place in this country and has no future, and I chose to go with it. Today Group Health has probably about 600,000 lives, a billion dollars in revenue, and, as I'll talk about later, managed care, as it is called today, has become mainstream in America. It is how Americans are receiving health insurance today. So the dean of the medical school is still there doing research and the vice president for health affairs is still there doing research. I like to recall those statistics for them because they told me not to go to work for Group Health Cooperative. I was able to spend about 12 years with Group Health and learned a great deal. I started as a lawyer and ended up as a manager in developing, at least in the State of Washington, the first primary care community-based kinds of arrangements with physicians.

Group Health is a big staff model. When it moved from Seattle, it really built community models of health care based through primary care physicians; and, we'd literally go out and organize these physicians into pods. We would pay about $5,000 (in those days) for a consultant. It costs much more today to hire a consultant to come in and organize them into a legal corporation, so we could deal with them and pay them on a capitation basis. Those models that we built for Group Health Cooperative are still in place today. When I became a CEO of a health plan, I could not get into some of those markets. I still can't get into them today because of the relationship that Group Health has built with those physicians and how it has partnered and integrated with them in really meaningful ways. In each one of those markets today Group Health is clearly the dominant HMO or health insurance plan. So this stuff works. I'm kind of a believer in it.

What I want to do though is put on more of a legal hat and talk to you from a legal perspective, because one of the things I believe that we need in this business is to integrate the financial end and the insurance end with the delivery end. As we integrate, the complexities in those relationships (among the plan, the physician, and the provider) become more significant and have significant legal, and in many

ways, ethical implications. These literally create dilemmas for the health plan and the physicians.

I want to start off talking a bit more about at a high level of what's going on. I want to relate to how this translates into a legal dilemma in selecting and what I call deselecting physicians. My wife said, "Deselecting isn't a word. You can't use deselecting." So I'll talk about termination. I really want to focus on termination and many of the legal and ethical issues that are starting to emerge for MCOs as they build these relationships with doctors. Many of these were analogous to what happened to hospitals in the late 1970s and early 1980s when professional liability and malpractice liability just exploded. We had a malpractice crisis, and we had major malpractice reform in the middle 1980s, all of which was attributable to the attempt to try to get some control of this issue. We're starting to see it happen with MCOs, and I think there are several causes for it.

One of the things Mr. Hulet did in one of his slides on the traditional premise of health care is define that everyone should have access to health care, that patients and doctors should decide on the care, resources should be available, and someone should pay the full cost. And I, the consumer, deserve the best. Mr. Hulet went on to show the future models and where we are and where we're going. And I agree with all of that from a health plan perspective. I agree with all of it from a provider perspective and from a purchaser perspective. I don't agree with it from a consumer perspective. I think the consumer is still back in this traditional mode. The consumer wants the best. When you get health care services, you want the best. You want somebody else to pay for it. That's still the mind-set. It's changing. As Mr. Hulet said, from the purchaser's perspective, we're moving to a defined-contribution model. The purchaser is saying, "Here are the services I want from your health plan." And the doctors are saying, "Here is what I'm willing to pay. Here is the budget that you have to work with; you figure out how to do it." But the individual consumer still wants the best care, timely access, his or her own physician, and somebody else to pay for it. That creates a dilemma as we really integrate these health plans and these physicians.

We try to reduce cost using data that actuaries and others are able to accumulate and feed back to us. We try to reduce variability and process and make outcomes more predictable. The kinds of cancer screening guidelines that Mr. Hulet referenced create expectations in the consumers' minds, and they want those expectations met. I learned years ago, as a young lawyer, that the reason people sue usually is because they had an expectation going in, but what they came out with was different from their expectation. They were surprised, they didn't like the result, and they sued. Regardless of whether there was negligence involved they

sued. It is a premise today of why people sue. It creates a great deal of tension in the physician-patient or physician-health plan relationship.

Toss that on top of what is going on in this national environment. I said earlier that managed care is becoming the national health insurance—the way people in this country are getting health insurance today. It has replaced indemnity insurance. Again, when I started three million people were covered. How many tens of millions of people today are getting their care through MCOs? The government clearly is pushing it all there, because its trust funds and its resources are disappearing. It doesn't have the answers. It's taking itself out of the risk-sharing role and the reimbursement role. It's giving money to the health plans and the providers and saying, "You figure it out and then we'll police you in terms of fraud, abuse, and quality."

In Washington state, Boeing took a strike from its employees in order to move to managed care. It had a huge, giant self-funded plan with a big Blue Cross PPO wrapped around it with the Blue's administering it. The company was losing a great deal of money. It took a strike in order to move all of those people into four managed care plans. It even paid the employees the first year $600 per person to move. The next year they were paid $400 per person to move. Last year they were paid $300 per person to move and it's virtually moving them all in. There is a great deal of dissatisfaction and unhappiness. All of a sudden, they are in a system where prior authorizations are required. Nonetheless, Boeing is moving them and that's the seriousness, that's the focus of the country. Managed care really is becoming the health insurance for the people of this country.

You'll see this criticism growing among consumers. Again, their expectation is for the best. The want somebody else to pay for it, they want it now and they want it from their own doctor. States are responding to this by mandating 48-hour newborn stays. You don't have a choice. Consumers want point-of-service (POS) guarantees. New York now requires health plans to offer a POS product and many other states are going to follow. You have rationing. Complaints mount over access to specialists. Many people like to go to their own specialist. You can't easily do that in a managed environment. You can do it but you have to pay for it. That's what they don't like.

I just received a notice in the mail that I didn't get prior authorization on my last referral. It's going to cost me $75. Believe me, I'll get it on the next one. Physician protection.

States are legislating any willing providers. In some states like Washington you have a law that requires you to include all licensed providers in your network.

There is credentialling for massage therapists and social workers through physicians. You have to include every licensed category of provider. Many states are moving that way. Now the physicians are saying, "I can't get left out of this; I have to participate in managed care." All of this is resulting in an increase in malpractice suits. Again, I talked about the malpractice crisis of the 1970s and 1980s for hospitals. We're now seeing it emerge in health plans; there aren't many staff models left in the country today. There's usually a contractual relationship. The health plan contracts with a physician. The physician is an independent contractor. The physician has to follow all the rules and policies and procedures of the health plan. The physician has to comply with the plan's referral management policy and with its utilization management policies. They must have care available 24 hours, seven days a week, etc., so there is an arm's-length relationship.

The courts are redefining that relationship, and there are basically three theories that they are using to hold the health plans liable for the actions of the physician. Why do they want to hold the health plan liable? It's because of the deep pocket—it has the money. It's the same reason they went after hospitals back in the 1970s and 1980s. It's where the money is. Physicians have liability insurance too; but if you really want the big bucks, you go to the source—the health plan.

They are using three legal theories and the oldest one is *respondeat superior*. I learned that in law school. It means employer-employee relationship. You think, from what I described, there's no employer-employee relationship here. This is an independent contractor. The courts say, "No, look at their contract." Look at how this relationship is integrated and look at the degree of control the plan has over the physician's action. When the courts see that level of control, they say that's analogous to controlling that relationship. The employer is liable for the acts of its employees as long as the acts are performed within the scope of the contract; therefore, the patients can sue not only the doctor, but they can also sue the health plan. Newer cases are starting to reach that kind of conclusion.

The most likely analogy, or legal theory, that you will run into is called ostensible or apparent agency. We publish provider network directories. We say to the person who joins, "Here are your physicians." In doing that, we imply that these are quality physicians qualified to provide the services the health plan says it will provide because the people are choosing them to do it. So the health plan represents the physicians, which is an apparent relationship. Based on that relationship, the courts reach over and extend liability vicariously; they impute it over to this health plan, the MCO. So that's another way the patient can sue both the doctor and the health plan.

I don't know how many of you remember a case back in 1966. It was called the *Darling* case, and it was an Illinois case involving a hospital. For the first time, the court said the hospital not only has a standard in terms of employer-employee or apparent agency, it also has a higher duty to the patient to ensure that the physician who treats that patient is qualified to provide the services that he or she is providing to that patient. This case created a higher duty. The courts have never said that hospitals have that kind of higher duty before. And if you can show, through their privileging process in hospitals, that doctors somehow did not meet that duty, (perhaps they were not aware and should have been aware that they were not practicing at a level they should have been practicing at, whatever the standard of care is or however it's defined), they are liable.

There was a case decided in 1989 called *Harrow* v. *Total Health Care*. That's our *Darling* case in MCOs. We are now held to the standard of assuring the patients that the physicians we credential in a health plan are qualified to provide the services they are credentialed for to our enrolled population. It's a very high standard. So this standard places a great deal of burden on the plan in this credentialling process. Once the physician is approved to participate in the plan's network, the plan has a greater burden and a real dilemma if it decides to terminate the physician.

THE DILEMMA

To be a competitive MCO you have to offer a network of physicians. What are you without physicians? You're nothing. You can't provide a product. In doing that you have to meet expectations. I've already talked about the first set, the consumer expectation in terms of choice, access, and quality. In terms of access, the consumers are demanding we have everybody in it. They want to see their chiropractor. They want their midwife in the plan. They want their massage therapist, and we have to credential all of them to the same standards relative to their licensure, relative to their practice. You can't treat any of them differently.

We also have purchaser expectations in terms of cost effectiveness, outcome, and quality of care, and many of these purchaser expectations have been translated into accreditation standards for health plans. Many of you know about the NCQA. It started in the mid-1980s with the national trade association GHAA and the Washington, D.C. Employers Purchasers Association. The purchasers wanted to develop a set of standards that they could use to measure apples to apples for these health plans that were starting to emerge. How do you measure it? How do you determine whether one is better than the other? They wanted standards. It is similar to the Joint Commission on Accreditation for Hospital Organizations (JCAHO), which has been around for a long time with regard to hospitals. They

wanted them with regard to health plans. JCAHO also has its own separate standards for health plans, so there are two bodies that you can go to.

The dominant body, in terms of setting the standards for health plans, is NCQA accreditation; in other words, it is our good housekeeping seal. You have to get it in your market. If you don't have it, other plans can't say you don't have it, but they can say that they do. Employers have come to believe that NCQA accreditation is becoming a critical criteria when choosing a health plan to offer to their employees. You need to have NCQA accreditation. Once again, this evolved out of a purchaser demand of common standards to evaluate plans and compare levels of quality and access for their employees. So you have NCQA standards and purchaser expectations. All of that combined with all of the managed care bashing and the expectations of the consumer makes for increased liability exposure to the health plans.

COST

Some health plans are big enough to self-fund malpractice. Others have to buy it. It's not cheap to buy. But that increased exposure results in an increased burden on the MCO in first selecting and, then what I call, deselecting physicians.

I'd like to focus on deselecting (terminating) doctors. Most of us take the easy way out. We credential all of them and let them all in, so we have large networks. As we move down the road, we become very integrated with the physicians and want to develop smaller networks. We come up with very creative ways to get rid of physicians, and I'm going to talk about those.

One of those is For Cause, and it is competency related. Another is economic credentialling and economic termination. We're facing some very ethical and legal dilemmas of how to use both of those.

FOR CAUSE STANDARDS

NCQA has a standard that plans have to meet for purposes of accreditation. It basically says in terms of any reduction, suspension, or termination for reasons related to quality of care, competence, or professional conduct, you are required to give a provider (including all categories of providers that you have credentialed) an appeals process. If, as a result of the appeals process, a decision to terminate is upheld, then you have to report it back to the national practitioner data bank, your state licensing agencies, and medical disciplinary boards, etc.

This appeals process sounds simple. You'd think that if you came up with your reasons for termination and mailed a letter to the provider, everything would go along easily. It really doesn't. A basic requirement of an appeals process is giving

prior written notice. In law school, this is what we all called due process. You must give prior written notice. You must give them a right to a hearing, and it has to be before an unbiased and fair adjudicator. It is not an easy thing to find in the medical profession. Doctors all know each other, I don't care how big a plan is or how big a community it is. You also have to bring physicians in who have the same specialties and skills or providers with the same specialties and skills, and they all know each other. If you are in Washington state, for example, you can find unbiased people in California. You find somebody and fly them up. It's a big expense. Due process is very time consuming. You must get lawyers involved and go through discovery, even though there's nothing that requires it. It becomes just like a legal trial. It can be a very time-consuming, costly process. People are reluctant to give their time to participate in it because it's time consuming and because of some other reasons I'll talk about in a minute.

The key to this whole thing is that the plan follows the NCQA standard and adopts its own policies and procedures. It then follows those policies and procedures. A court will be reluctant to overturn the decision of a plan if it has followed its own policies and procedures. That's legal principle 101 that we tell to our clients. On the other hand, it will overturn it if you have violated a fundamental constitutional right of the individual, such as discrimination based on race or sex, but there is a heavy burden that the individual physician must prove.

For all intents and purposes, you're going to win it or lose it at this appeal level, so it's a very important process. You have to build a record very carefully to ensure that you have adequate proof and, most importantly, that you followed your procedures. If you missed one step in your procedures, you'll lose the case. The court will reverse your decision. It holds you to what you said you will do. The appeal process isn't just one hearing. There are layers of appeal that, ultimately, go up to the board of the organization. So there are layers in the process that the physician can go through.

In the old days when there were many physicians and health plans let everybody participate, it was not much of an issue. Today, as physician panels shrink, as we try to steer more to the really cost-effective physicians who work the way we want them to work, it becomes very threatening to the individual provider that is not in the network and increases the likelihood that if you terminate an individual provider from the network he or she is going to sue. And remember when we started in this business, the idea was to put everybody in. Now we have to take them out and start to narrow panels down. As we do that you generate an increased amount of legal challenges from these professionals who are very threatened. Their economic viability is threatened because they're not able to participate in this plan. You may have 20% or 30% of their patients. That's significant to them.

Now I talked a lot about a requirement of prior notice. There certainly are obvious exceptions to that. If a physician loses hospital privileges as a surgeon, he or she is terminated immediately. If physicians are convicted or if there are even allegations of an assault of some kind on a patient, they're out immediately. If they lose their license or are suspended, or put on probation to practice, they're out immediately. You still have to go back and provide them all this due process. You just do it after the fact as opposed to before the fact. Unless a physician loses his or her license, it's not an easy decision to make. If someone alleges a physician assaulted a patient, do you believe the physician or do you believe the patient, and how do you act on that?

Again, you're talking about the reputation and economic viability of an individual. It's a huge ethical and legal dilemma. The decision is always made by the CEOs, I can guarantee you. The medical director doesn't want to deal with it, so where does it end up? With the lawyers and the CEO. And if the CEO happens to be a lawyer, that's even more reason to have these issues end up on his or her desk. Some of the toughest decisions you're going to deal with as a CEO in this business are these decisions. They're not easy, because, again, they have significant implications for the individual if the allegation is not true.

I remember a case at Group Health where we had a black obstetrician in the state capitol who was alleged to have taken sexual improprieties with one of his female patients. He was an upstanding, reputable physician. This occurred in the days when we were really getting sued for discrimination. What do you do? The doctors and the medical directors all run in and say, "Get rid of him." Well, the medical director is a white male standing there telling me to get rid of this black obstetrician. It's not that easy. Have there been any other allegations? They say, "Oh, we all know he's that kind of a physician." Well, where is the documentation?

We pull out his file and find that he has been recredentialled every two years as he's supposed to. He has good recommendations, excellent skills, and is board certified, etc. Do I take the patient's word? Do I put more emphasis on this physician's long history and reputation with the organization? What do I do? In that case, some other women started coming forward. My belief is where there's smoke there's fire. Once I get two or three complaints, even though they haven't been proven, I'll act on them. But I can't act on one complaint. You're balancing a professional reputation against a complaint from one individual. You need more than that. The complaints are not clear cut, they're hard to deal with, they're usually nasty when you get into them, and they're not easy to resolve. There is a fairly rigorous appeals process and a fairly personal decision that you end up making in terms of how it affects an individual's career.

You also have another law that's involved called the Health Care Quality Improvement Act of 1986 (HCQI). It was really adopted to help deal with the malpractice hospital crisis that I was talking about earlier. One of the primary reasons it was adopted was to protect individual professionals participating in suspension or termination hearings, granting immunity to such participants. Inherent in this whole process of when you're dealing with a provider, particularly a physician, is unbiased peer review. When the hospitals were all getting these huge $10 million judgments against them, they couldn't find physicians to participate because the physicians were getting sued in the process. As a result, Congress and many states enacted this law to provide immunity from liability to physicians who participate in this peer review process if they don't do anything that evidences they are not an unbiased individual. There are caveats to all of that, but the law was not intended to protect them. The law was intended to ensure due process when a provider is terminated along the lines of what I describe. It was also intended to ensure immunity. There were reporting requirements. It created this national provider data bank, and today it's an online resource to instantly find out if there has been any malpractice claim or judgments that have been entered against a provider, or any adverse impact on that provider's credentials. It's a highly useful resource to have.

This law was created in 1986, but it really came out of the whole hospital crisis and not managed care. It does include, though, in its definition of health care entity, HMOs. The problem is it doesn't include other entities in the broad spectrum of MCOs that we have today. Each state defines them differently. Each state has different definitions for health insurers, so the lawyers like to play the game of asking whether they are included in the revisions of the law applicable to them or not applicable to them. Courts aren't letting them do that. There's a broad definition of a health care entity: it's one that provides health care services and engages in a professional peer review process. The courts are, in general, holding MCOs responsible under that law.

Now let's turn very quickly and look at economic credentialling and economic termination. Keep in mind when I talk about this contractual relationship between the plan and the provider, we execute a contract with them. That contract has termination provisions in it and usually those termination provisions are that it's automatically renewable at the end of each year unless the plan gives the physician 30, 60, or 90 days prior written notice. It doesn't say what has to be in that notice. It says we can terminate the physician if we give you notice. So it's a contractual relationship with termination provisions in it. Also, NCQA requires that the plans recredential physicians every two years. Once you credential them, you have to go back and recredential these providers. So those requirements provide easy ways

out, particularly in the old days, for a health plan to get out of this relationship; it just doesn't renew the contract.

The courts aren't letting you do that anymore. The courts are coming back and saying that's economic credentialling. You're terminating your contractual relationship with this provider. We want to distinguish that from terminations based on competency or quality of care. Examples of economic terminations would be the contracts having all these requirements of complying with a health plan's policies and requirements and regulations with regard to utilization management, referral authorization, committed hour schedules in your office, collection of co-payments and deductibles, etc. If the physical audit doesn't do those things and the plan has documented it through medical management audits, then you have a basis to terminate that contract. Without those kinds of basis even your ability to terminate that contractual relationship is now challengeable in the eyes of the courts. They'll make you go back through that same kind of appeals process I talked about.

Let me tell you that in the old days when we had a tough case, and we didn't feel we had enough proof, but the medical director felt strongly that the physician was not qualified, we just terminated the contract at the end of the year. We gave 60 days notice. If the physicians would ask, "Why?," we'd say we just terminated the contract. It was an easy out. There isn't an easy out anymore as the courts start to develop a body of case law that starts to put limits on how we can use those contractual provisions. So you end up in a real conflict when you get in a nasty case and your documentation of competency and quality issues isn't great. You'll find your medical leadership pointing to the contract and saying, "Terminate!" This is not as easy to do anymore.

So the question, "Is due process required?" has divided the courts, but I think that the trend is clearly moving towards requiring you to go through the same kind of process. Why? Again, managed care is becoming the health insurance of this country and, from an economic perspective, physicians are becoming more and more concerned about where they will get most of their patients. When you cut them off, there's a severe economic impact on them. It can even carry implications in terms of their reputation in the community and their ability to attract patients. One of the first questions patients ask their doctor is, "What plans are you on?" They don't say "What do you practice?" or "How long have you been in practice?" They say, "What plans are you signed up with?" There's a very severe potential economic consequence if a doctor is discharged or terminated or a contract is severed, particularly in terms of the patients' relationships with a plan.

As lawyers have a way of generating work for themselves, there are even more hurdles being tossed. I call them emerging legal hurdles in this whole physician and health plan relationship. Antitrust is a big one. It has been around for a long time, again, with hospitals and peer review processes. The argument started back in the mid-1980s when it was noted that everyone knew everyone in small, one-hospital towns. You would see a peer review group either reduce, suspend, or take away privileges of a physician competitor in town. One of the questions was always: was it truly for competency and quality of care reasons, or was it just a conspiracy on the part of these physicians in the peer group to economically impair the practice of this physician over on the other side of town?

There are some great cases. There's a case in Oregon where the terminated physician was able to come back and show that the physicians in the peer review process were economically motivated to terminate him because he was a competitor. The kicker in all of this is that they were able to show an antitrust violation; they brought in a Ph.D. in economics and he said there was the loss of income that could have been realized by this professional over this normal life span. It's usually big dollars. An antitrust violation can triple the damages. It has a huge chilling effect against individual providers who participate in a peer review process. The very real chilling effect of getting physicians to participate in this peer review process is they could be sued personally and loose their own personal estate.

They're taking these same theories that they have worked hospitals over with and the result is this quality improvement act I talked about earlier. You're starting to see these legal challenges arise when a physician is terminated. Even when the plan has followed the process, they're saying there was an antitrust violation. They point to an old law that has been around a long time, the Sherman Act. It was enacted back in the 1930s. It prohibits (and this is legal language) "every contract combination in the form of trust or otherwise, or conspiracy in the restraint of trade or commerce among the several states." Interstate commerce is easy to show because any health plan today buys goods and services in interstate commerce. It sounds technical, but it's not. The issue is the conspiracy.

The plaintiff in that case, the harmed physician or harmed provider, has to prove that there is more than just an adverse economic consequence to himself or herself. The plaintiff has to show that the market has changed by the action of the peer group or entity, either from the perspective of the consumer (consumers won't sign up with this physician anymore) or other providers with the same or similar services. Those providers won't work with this provider anymore. They won't refer patient to this provider anymore. You have to show that kind of an impact. You

just can't show that you're not making as much money. You have to show that you have truly been harmed in the marketplace.

So this is a whole other area of legal concern, that is, again, creating a real crisis between the health plans and physicians as they integrate and come closer and closer together. It gets to be a more difficult relationship. If they follow the rules, there certainly is immunity protection, just as I described under For Cause cases.

Another law that's coming into play is the Americans with Disabilities Act (ADA). This basically prohibits employers from discriminating against qualified individuals with disabilities. Health plans are not necessarily the employers of the doctors, but the courts overlook that. They look at the control the plan has over the physicians and they say the employer relationship exists, so the requirements of the law apply. The issue isn't with disabilities as you and I think of them. Someone who can't see has an obvious handicap. Disabilities include alcoholism and drug addiction. Those are the areas in which you end up making tough decisions. Do we terminate this physician so that the physician or the provider can come back and file a disability claim under the ADA?

Another thing we have to look at is any termination for a past or present disability without a determination about whether the provider can perform the job. This automatically triggers one of these claims today. Lawyers know this stuff and they'll state every cause of action they can. They'll automatically trigger a claim here. So it's becoming a very complex world.

You know I believe very strongly that we have to figure out how to integrate this financing insurance arm with the delivery arm. There is no doubt in my mind about that. As you move closer together and as, again, we work together with providers to reduce variability, improve outcomes, provide earlier intervention, and really improve the health status of the individual whom we serve, we create more legal complexity and more legal and ethical dilemmas for ourselves in these relationships. One can't work without the other. I know that many providers think they can be insurers. Insurance business is very complex. It's not that simple and providers find out the hard way that it is a complex business. Likewise, insurance companies need providers and they need delivery capability. As you integrate these kinds of relationships, complexities and legal implications make them difficult, at best, and always increase the cost. None of this stuff is easy.

When I started in this business as a health lawyer, I helped found an organization called the National Health Lawyers Association, the biggest association of health lawyers in the country today. I held and went to our first seminar. We had 100 people. About ten of them were lawyers. The rest were management. Now there

are thousands of attendees. That just shows you what has happened to this field. It's fruit for lawyers. There are many careers being made and that just complicates these kinds of relationships even more. I believe in the right of individuals to sue and all of that, but it just makes for a more complex world.

In the long run, it's not going to be easy. Success is still about taking care of patients, providing the right care at the right place, the right cost, and the right provider. I tried to follow the same criteria that Mr. Hulet used because I think the criteria of the principles that he put up here are the correct principles. The name of the game is about getting the right care, at the right place, for the right cost, at the right provider. And the obligation on both the physician, the provider, the hospitals, and the whole delivery system and the health plan working together is to ensure the provision of both value and quality for the care received. That's what the purchaser wants, and that's what the member wants, but it's still not easy.

Mr. Hulet: The issues that we have brought up so far are ones that are affecting us in real life. They probably don't do a good job of necessarily anticipating what those concerns are going to be in the future. We need to try to think ahead and identify some of the areas that will affect the way we do our business. To the extent that we can affect the decisions about what is ethical and what is not ethical in those areas, we should let our voices be heard.

ELECTRONIC MEDICAL RECORDS

I'm sure you've all heard about electronic medical records. I was working with a physician in Canada who was working with a group to install electronic medical records that would be used by the physicians and the hospital in delivering care. The question came up about who should have access to those records. What if an individual comes into the emergency room? The primary care physician who provides most of the care for that patient won't be there. Who decides what the emergency room (ER) doctor can and can't see? Once we put it all in electronic form we have to be able to have some kind of screening criteria to determine who can see what. The same kinds of issues arise with genetic testing and other things where we get into privacy. So, Mr. Coe, I'll put you on the spot. Do you have any feeling about what legal protections we can put on an electronic medical record?

Mr. Coe: I think you can put in all the legal protections you want. The reality is that it's hard to control those data. In my experience I've seen claims processors looking at full copies of medical records. You could say that what appears on your screen is only what you need to know. It is a big dilemma. It's easier said than done. All we can try to do is really educate the consumers in terms of the issues, in terms of how the information is going to be needed or used, so that they have a realistic expectation and they're not shocked when they come into a health plan to

file a member complaint when somebody pulls out a file on them or pulls a screen up and there's information there that they consider confidential. There is not an easy answer, and we're a long way off from a true electronic medical record. Many organizations are doing a great deal of work on it today and we are progressing. Eventually, we do need that record, which tracks everything from the physician's office right back through all the claims information, and eligibility coverage information on the patient. There is no easy answer.

Mr. Hulet: Information is particularly important to actuaries to be able to perform their jobs, but when do we have too much information?

We have all heard about provider report cards. We probably think they're a good idea for us as consumers so that we have a better idea of the kind of provider that is delivering services to us. But what effect does a provider report card and, generally, a bad report card, have in terms of malpractice?

Mr. Coe: How do you develop criteria to really objectively evaluate one provider versus another? You're into the practice of medicine. Much of it is subjective. You know that a specialist's or a physician's record, in terms of death rates and C-section rates, can vary depending upon the particular mix of patients they get. How do you make judgments about that stuff and then issue a report card? It's not hard to base it on some pure financial information, but it is difficult to base it on quality and competency. I think you can do it in terms of simple things like appointment wait times. You can do consumer surveys about the friendliness of receptionists. How were you treated when you walked into the physician's office? How long did you have to wait in an exam room? There are some fairly simple things you can identify. You can certainly disclose charges that physicians levy, although they are more often controlled from the health plan perspective as we move into capitation. Co-payments and deductibles are set. Most states say the doctor can't balance the bill. So the old fee schedule, as we knew it, has probably gone out the door. Assuming you still have that, you can certainly publish that kind of information. What do you publish and how do you judge who's good and who isn't?

Mr. Hulet: As actuaries, we do actual-to-expected studies all the time. In order to have a report card you really need something to compare against. If you set the basis for comparison as some average, that means somebody's going to come up looking negative. If you look negative, it can then have a very bad impact on your economic life if patients are privy to that information and act on it. There's a question in the back.

From the Floor: This is just an observation. I work with a large pension fund and we do most—about three-quarters—of our business with a large carrier in the East

and it's hoping to look now to work with professional medical associations to come up with best practices. It's working with the American Diabetes Association and the American Cancer Association to really look at best practices for physicians. It is going to be looking at a comparison of them in spite of differences in case mix. There are organizations that have developed or are working on some fairly sophisticated case mix adjustments to really do fair comparisons. It is true that doctors will say I have a thicker population. Often, when it's really evaluated, they don't really have that much difference in their population.

Mr. Coe: If you have a physician who has a significant malpractice judgment against him or her, should that physician be included in a grading? Should that be made public in terms of information?

From the Floor: I don't know, but that's a good question. There is a law in Massachusetts that allows consumers to have access to information on physicians. I was wondering how that was going.

Mr. Coe: I don't know. I can't answer that off the top of my head, but my experience says that just because there's a large malpractice judgment entered against a physician, it doesn't mean that the physician is a bad one. Often the best surgeons are the ones who take the toughest cases and end up getting sued. Many times the least qualified physician is the most personable one. He or she is the one who the patient likes and, therefore, doesn't sue. Anybody who has worked in malpractice will tell you that. If you publish a malpractice decision, and make it public (even though it is public anyway), people just don't know how to find it. You must go down to a courthouse and nobody wants to go to a courthouse. So nobody is aware of it. A very good physician's career could be severely impacted with a bad malpractice judgment. As we move towards these published guidelines, I think there is a strong argument that the courts will look at them as standards of care. What if, as a physician, you deviate from published guidelines? Perhaps, in your judgment as a professional, you gave the best care in that given situation. It is highly subjective. If you put yourself in a physician's position, you can see why you would be concerned if there were a published ranking of providers.

Mr. Hulet: Let me just read the rest of the list of the questions, and you can take them home and think about them. If you have any responses on them go ahead and make them public. You can contact the media, and I'm sure they'll be glad to hear what you have to say. What should the employer know?

We have too many physicians in some specialities in particular. We have too many hospital beds, so who makes the decision of what we close down? How much of the managed care savings should go back to providers? They are the ones who are

providing all of the labor. Or should the savings go to the senior management of the managed care organizations?

Can you be a provider and an insurer and not have conflicting priorities?

Mr. Coe: That's a really important one because you are seeing increasing numbers of providers move into this insurance business and that's why you have a great deal of loss, fraud, and abuse. They're really limiting the extent to which physicians can own the labs and the radiology units and all the services they refer to. That's really a tough one. It's the "fox guarding the house" theory.

Mr. Hulet: This is more of a traditional question. Is underwriting ethical? I mean is it ethical to try to exclude everybody who's going to have a problem? Insurance is supposed to be aggregate protection so they can spread it out over a large base.

Mr. Coe: The insurance companies would be dead without it though. That's the name of the game. That's how you protect against adverse selection.

Mr. Hulet: Can a provider delay needed care until he or she is no longer responsible for that patient? Can the provider transfer responsibility from one period to another?

Mr. Coe: I'd say no. I think the courts have answered that. They call it abandonment and the provider is liable. I don't think you can do that.

Mr. Hulet: How long can providers accept less than the cost of providing services before they are bankrupt? Who should pay for education? How much of the managed care negotiated price is for the providers? Also, the same thing applies to research. Who's going to pay for the new research? I don't see many managed care plans building in an extra payment to providers to cover those things.

Who decides whether experimental treatment is justified? When can you have that $100,000 procedure? Who gets available organs? That's one issue we've been dealing with for a while. You may remember a report a while back about a baseball player who received an organ. Reports were that he was moved up in line because of his notoriety. That seems to be a fairly important ethical consideration that we need to worry about.

Those questions should give you something to think about as you go home. It is certainly not an exhaustive list, but they were questions that came to me as I was thinking about this issue recently. Hopefully, you will find that your job doesn't require you to make decisions that have ethical implications. Hopefully, you can

just do business as usual. However, I think we are often put in a position when we have to make those judgments. Physicians have been making those judgments for a long time, and we've accepted their judgments. Whether or not people will accept our judgment as actuaries remains to be seen, but we certainly need to be in a position to build our case. You can't build a case if you haven't thought it through.