

Part II

Business Aspects of Medical Practice

Chapter 6

Health Care Provider Contracts

Stephanie Rifkinson-Mann, MD, JD, FCLM

Managed Health Care Goals: Effect on Contracting
Health Care Providers
Contracting and Reimbursement: Health Care Provider

Contracts
Contract Analysis
Conclusion

Physicians once labored under gentlemen's agreements to provide medical care to patients. Such promises, inferred from the physicians' actions, became binding as contracts implied in fact.¹ With the advent of the modern health care industry, safeguarding the exchange of medical services along with cost-containment measures became a priority, for which reason managed care contracts were developed. Managed care organizations (MCOs), single entities coordinating the finance and delivery of health care services,² offered "boilerplate" contracts with uniform terms. These standardized terms enhanced the calculation of risks for health care companies, eliminated uncertainties, and reduced costs for the MCO.³

Boilerplate contracts are important to understand because they afford the physician little or no opportunity to shop around for better terms since most of the MCOs offer very similar things. This chapter outlines the concerns that the physician should have in contracting with a health care company. The following section briefly outlines the goals of managed care. Contracting issues of importance for the health care provider are reviewed and the ways in which contract conditions may affect reimbursement for physician services are discussed. Finally, details of health care contracts that the physician should be aware of before signing any agreement with an MCO are reviewed.

MANAGED HEALTH CARE GOALS: EFFECT ON CONTRACTING HEALTH CARE PROVIDERS

With traditional indemnity plans, patients had no incentive to choose "economically efficient providers." Physicians

did not need to control the number of services rendered since under the cost-based payment systems, reimbursements for services were based on "customary, usual and reasonable" charges and payment was guaranteed. Costs were of no consequence to the patient because a third party (such as the employer) was footing the bill. This resulted in overutilization of medical technology, highly specialized physicians, in-hospital care, and surgical procedures. Managed care was developed as a response to the skyrocketing cost of health care.⁴

MCOs offer financial incentives and management controls to deter patients from unnecessarily consulting physicians and to prevent health care providers from overutilizing health care services.⁵ Quality assurance (QA) controls are implemented to assure "appropriate" care. Primary care physician gatekeepers regulate the use of specialty and ancillary services.⁶ Utilization management evaluates the "medical necessity" of services for which claims are made (while "medical necessity" is understood to mean that a medical procedure or service must be performed only for the treatment of an accident, injury, or illness and not be considered experimental, investigational, or cosmetic, there is no consensus in the courts as to the meaning of the term).⁷ Concurrent ("pre-certification" or "pre-authorization" of services to determine whether or not the costs will be covered by the health care plan) and prospective review (potential costs of treatment are reviewed to determine whether or not a health care plan will cover the service) is conducted.⁸

MCO cost-containment policies require that members obtain their health care from a restricted list of "participating" providers, who agree to accept lower compensation rates in exchange for a larger patient base.⁹ The MCO controls the selection of participating providers, utilizing strict physician credentialing requirements, including "physician profiles," financial analyses of physicians' practice patterns conducted

36 Health Care Provider Contracts

so as to identify physicians who use health services efficiently and less expensively. Managed care forces the physician to reconcile his or her medical decisions with the MCO's cost-containment policies. If he or she provides medically indicated treatments that are costly to the MCO, his or her compensation may be diminished. If he or she does not fit the profile the MCO seeks, he or she may not be included on the MCO's preferred provider list. If he or she has already signed a contract with termination clauses and flexible terms that change with time, and his or her practice patterns are not economically efficient from the MCO's perspective, the contract may be terminated without explanation (the MCO's right to terminate a physician "without cause" has been upheld by the courts and may be treated by the courts as a matter of public policy).¹⁰

Financial incentives offered to health care providers with less costly practice styles include a "withhold" (whereby the health care plan retains a portion of the provider's reimbursement as a reserve to cover unexpected expenses; if utilization of services does not exceed the MCO's budget, some or all of the withhold is returned to the physician) or a "variant-risk withhold" (where a physician who does an above-average job of managing health care utilization receives the full withhold in addition to a bonus payment). Both types of withholds may be construed as "bribes" and subject to criminal penalties since they encourage the provider to implement fewer services.¹¹

Participating providers function as independent contractors (a person who is hired to complete a specific project but who is left to do the assigned work and to choose the method for accomplishing it; he does not, upon committing a wrong while carrying out the work, create vicarious liability for the employer who did not authorize the wrongful act). Most jurisdictions view MCO provider agreements as contracts between independent parties.¹² The will of the employer is represented by the result of the work and not the means by which it is accomplished. In the case of an MCO, that work entails delivery of health care services, although the method by which that health care is supplied presumably is under the control of the physician. The significance of being considered an independent contractor for the physician is that he or she—rather than the MCO—can be held liable for the manner in which he or she carries out their work. Also, their participation in the plan can be considered terminable at the will of the MCO.¹³

CONTRACTING AND REIMBURSEMENT: HEALTH CARE PROVIDER CONTRACTS

Physician income has decreased in recent years as MCOs increasingly control the marketplace.¹⁴ The threat implicit in managed care contracts is that, if the physician does not offer a discount acceptable to the plan, the plan will shift its enrollees to a different health care provider.¹⁵ Contracting with MCOs may result in loss of the physician's

professional independence since his or her medical judgment may be directed by HMO payment decisions, especially denials of payment.¹⁶ The MCO is in a position to enforce its cost-containment decisions under the guise of QA. The provider can be penalized financially or their participation with the plan terminated when the MCO simply does not credential him or her or it "deselects" him or her from its provider list. Some deselection components have included shifting requirements from board eligibility to board certification; barring certain specialties based upon alleged reduced utilization; patient satisfaction; and so-called physician "performance factors," including use of ancillary services, number of hospitalizations, specialty referrals, and number of services provided per health care plan member as compared to other physicians in the same specialty in the same or a similar community.¹⁷

Negotiation regarding termination clauses should specify termination both with and without cause, especially since a health care plan may offer termination clauses that are not fair to both parties. Such wording might appear as follows: "This Agreement may be terminated (a) by MCO at any time with or without cause upon thirty (30) days written notice; and (b) by Physician at any time with or without cause upon ninety (90) days advance written notice." This type of provision allows the plan to dispense quickly with a physician, disrupting their cash flow abruptly as opposed to the plan's far longer (90-day) allowance to adjust to the change, although the physician still has obligations post termination for continuity of care of patients until transition of their care to another provider (this period of time may be as short as a few weeks or as long as a year; may require that the physician continue care until a patient is discharged from the hospital or until treatment is completed; or until the insurer assigns the patient to another participating provider).¹⁸

There are several other contract issues of concern for physicians. The physician must pay for his or her own malpractice insurance.¹⁹ Typical wording for this type of contract condition may appear as: "Physician shall provide and maintain malpractice insurance subject to the approval of MCO, and shall not be less than \$1,000,000 per claim and \$3,000,000 per year;" or "Physician at his sole expense shall procure and maintain policies of general and professional liability and other insurance as is necessary to insure him and his employees against any claim for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of services hereunder in connection with this agreement." Provisions such as exculpatory or indemnification clauses ("hold harmless" clauses by which the physician indemnifies the health care plan, thereby exposing themselves to the risk of liability for actions of other physicians or MCO policies that directly affect how a patient's care is managed) expose the physician to an uninsured risk since their malpractice policy will not cover for such possibilities²⁰ and may prevent a physician's malpractice attorney from bringing an HMO into the claim even where the facts support HMO negligence. The physician should be aware that even if a current contract does not

contain an indemnification clause, an older version of the same contract may contain such language. If the physician contracted under that older version, he or she may be bound by the indemnification clause even if the new contract does not contain it.²¹

In past years, some MCO contracts included a clause forbidding the physician from recommending medical procedures to patients not covered by the plan, or forbidding them from discussing the financial aspects of their relationship with the MCO, such as financial incentives to withhold care, etc. Such a “gag rule” might be worded as follows: “Physician agrees not to make any communication or take any action which undermines the confidence of enrollees.”²²

Term renewal and exclusivity of contract also should be of concern to the contracting physician. Though most health care contracts typically provide for automatic renewal at the end of a particular period (often one year), some contracts may not provide for renegotiation of the terms. While the health care plan may contract exclusively with a physician or physician group, any agreement by a physician to contract exclusively with only one health care plan calls for their giving up the right to participate in other managed care business, which could be detrimental to their practice. Another important point is that the contract should not be assignable to any other party without the physician’s prior written approval. The contracting physician also needs to be aware that the MCO may not allow him or her to arrange practice coverage with other physicians unless they also have contracted with the same plan.²³

The payment structure of the contract generally involves one of two arrangements. One is the modified fee-for-service for specialists (where the provider is reimbursed for each service provided), a variation of which is the “discounted fee-for-service” (a straight discount on charges or a discount based on volume or a sliding scale). Other variations on fee-for-service include flat, global, or case rates. The “flat rate” is a single fee paid for a procedure regardless of how much time and effort the physician expends providing service. A “global fee” is a flat rate encompassing more than a single type of service (e.g., postoperative care and follow-up office visits included in a single surgical reimbursement fee). Note that surgical subspecialties most commonly use a relative value scale, such as the resource-based relative value scale (RBRVS) or a fee allowance schedule, where each procedure is assigned a relative value, which is then multiplied by a conversion factor so as to arrive at a payment. The fees in a fee allowance schedule are explicitly defined in the contract. “Case rates” are single reimbursements that combine both institutional and professional charges into one lump sum.²⁴

The other type of arrangement is the capitation fee (a fixed payment to a physician to cover a specified set of services, regardless of the actual number of services provided to each patient).²⁵ It is this type of contract that MCOs typically will offer physicians in primary care fields. Plans often will select providers caring for healthy populations unlikely to require costly medical attention, such as

pediatricians, internists, and family practitioners, since preventive care is encouraged in these fields.²⁶ Doctors are considered cost-effective if they perform fewer procedures, hospitalize fewer HMO subscriber patients, order fewer diagnostic tests, write drug prescriptions in an effort to avoid hospitalization, and minimize referrals to costly specialists. “Carve-outs” refer to medical services that are separated from a contract and paid under a different arrangement.²⁷

Utilizing some of these methods, MCOs can demand that providers partly subsidize their state-funded benefits plans. Specialists often are asked to assume a portion of the economic responsibility of caring for certain populations by furnishing services on a discounted fee-for-service basis.²⁸ Typical wording for such contract conditions might be exemplified by the following: “Member Physician authorizes MCO to withhold from any fees payable to the Member Physician such amounts as are deemed necessary by MCO to allow Member Physician to share the risk of costs and utilization in the state-funded Health Benefit Plan.” Other contracts may call for physician payments consisting of a percentage of the premium dollars collected from insured population groups, thereby shifting risks onto the provider.²⁹ The best time for the physician to get concessions regarding reimbursement is when the MCO is looking to expand its network of providers, since it is at that point that the physician is in a better position to negotiate (e.g., physicians can compare reimbursement rates offered by different health care plans and then choose a set number of CPT codes, suggesting the fees they would find acceptable).³⁰

CONTRACT ANALYSIS

Signing a Standard Health Care Contract

The typical physician practice reportedly has at least fifteen or more managed care contracts, with a significant proportion of its income derived from the agreements it has with MCOs.³¹ Yet, in most contracts, MCOs retain complete control over reimbursement rates, payment adjustments, and determination of the medical necessity of all services provided.

The MCO can determine at any time whether it considers a service “medically necessary” and what criteria it will implement in order to reimburse the provider. Requirements stipulate that the physician is obligated to care for any member enrolled in the plan and that he or she is required to accept whatever reimbursement rate the MCO designates as “appropriate.”³² Plans receiving state funds offer lower reimbursement fees for services rendered to certain populations. These fees range from 30% to 75% of private market prices, the upper range going to less expensive primary care services.³³ For providers participating in plans that include “underprivileged” populations insured through state-provided funds, the provider’s obligation to serve those populations at significantly reduced fees may not have been what he or she originally agreed to but may be included in the health care plan’s fee schedules.

38 Health Care Provider Contracts

Rates of reimbursement also vary from state to state and between specialties. The most costly care is the least reimbursed, such as surgical and medical subspecialties, which may not cover the physician's expenses in maintaining a medical practice.³⁴

While a physician contemplates reasonable payment for his services, the definition of the word "reasonable" is determined by the MCO, not by the physician. This may be demonstrated by contract wording specifying that the physician's compensation for services be made in accordance with the current MCO "reasonable" fee schedule. Although, legally, "reasonable" is synonymous with "fair, proper, just, moderate, suitable under the circumstances,"³⁵ the definition of "reasonable" usually is not provided in the contract. Compensation is made in accordance with a current MCO "reasonable" fee schedule, which the MCO adjusts as it sees fit. Fee schedules usually are listed in an exhibit according to CPT codes and do not appear in the main text of the contract, but is merely referenced at some point.³⁶ Typical wording appears as phrases such as "incorporated by reference and attached as Exhibit X," or "as set forth in Section Y and incorporated by reference." The product offered by the health care contract is the opportunity for the physician to participate in the health care plan. The MCO directs patients to the preferred provider. If a nonparticipating physician's patients enroll in a particular plan, the physician stands to lose that patient base unless he also enrolls in the same plan. Since at least two of every three privately insured Americans are now enrolled in managed care plans, this may force the physician to find work elsewhere or he or she may feel obligated to accept the MCO's terms without being able to negotiate.³⁷

Despite this risk, some courts have found that a "take it or leave it" contract may not necessarily be unconscionable, assuming no disparity of bargaining power between the parties negotiating the contract. However, the unilateral ability to change contract terms, including fee schedules, the addition of "new products" or benefit plans that the physician must cover, the manner in which a contract may be terminated, etc., represent a distinct advantage for the insurer. Even so, contract law may not always relieve the physician from the effect of a bad bargain since it assumes that if a physician signs a contract, he or she has read and understood it.³⁸

With respect to scope of services or "all products" clauses, unless specifically stated in the agreement, the physician should assume that he or she is obligated to perform all services relevant to their specialty. Nebulous language, such as "services include, but are not limited to...", should be avoided. These "all products" provisions require physicians who wish to participate in one health plan offered by a particular insurer to participate in all health plans that insurer may offer at any time. This means that the physician promises to provide services to different benefits programs administered by the insurer, which allows the insurer to introduce new plans while committing that physician to provide medical services at compensation rates determined by the insurer. If a new product or benefit program uses a fee schedule lower than the one

that the physician originally negotiated for, he or she will be stuck accepting lower reimbursement rates by virtue of their having agreed to participate in "all products."³⁹ The clauses allow the insurer to sell or rent the discounted discount to other health care plans (referred to as "silent PPO's") that the physician did not originally contract with.⁴⁰

Other contracts, for example, may contain language stating that a physician who rejects certain amendments will terminate an entire contract as well as their participation in all products offered by that same insurer. Variations on these terms may depend upon the market dominance of the particular insurer and the importance of the particular physician practice to the insurer in developing its network of participating providers.⁴¹ However, dominance in the market has placed the MCO in a stronger bargaining position than the physician in recent years.⁴² It is this inequality that has driven physicians to seek redress in the courts.

Ability to Negotiate Terms

Payment practice claims have arisen when MCOs delay payment, limit reimbursements by paying for only one service although the physician billed for multiple procedures at the same time ("bundling"), pay for a less costly service than that billed by the physician ("downcoding"), or lower physician reimbursement rates in some geographic areas and not in others.⁴³ Allegations have included improper failure and/or refusal to pay submitted claims promptly or as specified by the provider's contract terms, or paying the provider less than what was billed out. In those situations where physician payment disputes arose, litigation has ensued by medical groups, state medical associations, and/or classes of providers. Antitrust suits have ensued following claims arising from allegations of MCO manipulation of prices for provider services, exclusion of coverage for certain medical services (e.g., x-rays performed in an orthopedist's office, chemotherapy administration in an oncologist's office, etc.), or MCOs refusing to contract certain types of providers (e.g., psychologists, optometrists) often for unexplained reasons. Providers have sued to compel entry into networks from which they have been excluded or to recover damages sustained as a result of their wrongful exclusion, alleging antitrust violations. Other suits have been filed alleging competition practices, alleging tortious interference with business relationships, and seeking to hold the MCO liable for lost income.⁴⁴ Cases have been brought regarding the enforceability of arbitration clauses, with plaintiffs alleging that their ability to recover damages was hampered by those clauses. In those cases where MCOs succeeded in having potential class action suits dismissed based on motions to compel arbitration, class action arbitration complaints have been filed with the American Arbitration Association.⁴⁵

In the past, when health care providers tried to enhance their bargaining position with MCOs by forming unions, courts found their actions illegal because they restricted

trade.⁴⁶ However, an increasing number of lawsuits have been filed by physicians in an effort to combat the problems these court decisions created. The most recent development has been the influx of class action lawsuits brought by physicians against the health care organizations they contracted with, marked by the *In re Managed Care* multi-district litigation brought in Florida in 2002, in which violations of the Racketeer Influenced and Corrupt Organizations (RICO) Act were alleged. Many of the providers who filed suit against the MCOs alleged breach of contractual payment obligations, or they challenged allegedly anticompetitive business practices as being fraudulent, representing unfair competition, or breach of good faith and fair dealing practices. Plaintiffs alleged that the plans ignored “medical necessity” in making treatment decisions; refused to provide physicians with adequate fee schedules despite their being referenced in the contracts; manipulated CPT procedure codes so as to downcode and/or bundle charges; denied the use of modifiers on valid claims so as to reduce physician payments; delayed payments to benefit from the funds available through reimbursements lawfully owed to physicians, thereby violating state contract and “prompt payment” laws (which require that MCOs to pay claims within a certain number of days—usually 30–45 days after submission of medical claims—and impose payment of interest should the claims be unpaid or paid in an untimely fashion). While most of the MCOs initially opposed the cases, most agreed to settle soon thereafter. One result of these settlements was the institution of proactive measures to avert further litigation, including the development of web-based systems allowing providers to check on the status of submitted claims.⁴⁷

CONCLUSION

Physicians must understand that the meaning of “freedom to contract” has changed with the degree of monopoly now enjoyed by the MCO. The physician must be cognizant of his or her rights and must be aware of the consequences that may arise once he or she signs onto a particular health care plan. Given the anxiety of both physicians and patients regarding the affordability of health care, it is notable that physicians often are not advised legally before entering into a contract with an MCO. The important issue of whether or not freedom of contract exists in health care contracts depends upon the physician’s knowledge of the various loopholes found in the language with which the contract is crafted. For this reason, physicians should avail themselves of legal counsel before signing a contract with a health care company.

Endnotes

1. Restatement (Second) of Contracts §1, §3, §4. The right to contract in a free enterprise system is based upon common law, and is guaranteed under the Due Process Clause of the Fourteenth Amendment. *Allgeyer v. Louisiana*, 165 U.S. 578 (1897) (holding a state law unconstitutional for depriving a person of the right to make contracts protected by the Due Process Clause).
2. MCOs include health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs share the risk of providing health care with providers through fixed reimbursement fees and withholds or bonuses based on expense of treatment and utilization experience. PPOs consist of groups of physician providers who agree to provide care for discounted fee-for-service rates. Since patients who go “out of plan” to nonparticipating providers (“nonpreferred providers”) have to pay increased fees for their health care, they are steered to preferred (“participating”) providers so as to contain costs. See Barry R. Furrow et al., *Health Law: Cases, Materials and Problems* 799 (1997) [hereinafter “Furrow, Health Law”].
3. Boilerplate contracts are seen in ordinary consumer transactions, such as life insurance policies, loan agreements, and residential leases, where contracting parties occupy unequal bargaining positions and the weaker party is forced to adhere to the terms in the other’s printed form. See *Wheeler v. St. Joseph Hospital*, 63 Cal. App. 3d 345 (1977). See also Marvin Chirelstein, *Concepts and Case Analysis in the Law of Contracts* 68 (2d ed. 1993); Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 Columbia L. Rev. 629, 631–32 (1943); Bryan A. Liang, *An Overview and Analysis of Challenges to Medical Exclusive Contracts*, 18 J. Legal Med. 1–45 (1997).
4. Rand E. Rosenblatt, *Law and the American Healthcare System* 18, 551–52 (1997). See also Barry R. Furrow et al., *The Law of Healthcare Organization and Finance* 325 (1991) [hereinafter “Furrow, Finance”]; The Business Council of New York State, Inc., *Inside the Business Council* [hereinafter “BCNYS”], *Managing with Care*, at §2 (June 1998). The enactment of Medicare and Medicaid also coincided with a dramatic escalation in national health care spending. See Kenneth W. Wing, *American Health Policy in the 1980s*, 36 Case W.L. Rev. 608, 620 (1986). See also BCNYS, *supra*, at §1; Mark A. Hall & Ira Mark Ellman, *Healthcare Law and Ethics in a Nutshell* 8–13 (1990); E.H. Morreim, *Cost Containment and the Standard of Medical Care*, 75 Calif. L. Rev. 1719 (1987).
5. See *Patel v. Healthplus, Inc.*, 684 A. 2d 904, 909 (finding that because the MCO had bulk buying power, it was able to direct enrollees to seek care from its preferred providers).
6. *Corcoran v. United HealthCare, Inc.*, 965 F. 2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033. See also Daniel R. Sullivan & Perry Oxley, *Managed Care Organizations*, in *The Physician’s Perspective on Health Law* 355 (Howard H. Kaufman & Jeff L. Lewin, eds. 1997).
7. “Medical necessity” has been defined as “efficacious and safe” (*Dallis v. Aetna Life Ins. Co.*, 574 F. Supp. 547 (N.D.Ga. 1983), *aff’d*, 768 F. 2d 1303 (11th Cir. 1985)); “appropriate” and “consistent with community medical standards” (*Hughes v. Blue Cross of Northern Cal.*, 263 Cal. Rptr. 850 (Cal. Ct. App. 1989)); or an issue to be decided by a jury because of the ambiguity of the term (*Siegal v. Healthcare Service Corp.*, 401 N.E. 2d 1037 (Ill. App. Ct. 1980)).
8. See *Managed Care Handbook for Neurological Surgeons* 73–74 (John A. Kusske et al., eds., 1994) [hereinafter “Kusske, Handbook”].
9. See Rosenblatt, *supra* note 4, at 547–48.
10. See *Murphy v. American Home Products Corporation*, 58 N.Y. 2d 293, 300, 461 N.Y.S. 2d 232, 448 N.E. 2d 86 (1983) (where employment is for an indefinite term, it is presumed to be a hiring at will which may be freely terminated by either party at any time for any reason or even for no reason at all); see *Sabetay v. Sterling Drug, Inc.*, 69 N.Y. 2d 329, 514 N.Y.S. 2d 209, 506 N.E. 2d 919 (1987) (holding that termination by either party for any reason or for no reason at all does not imply an obligation on the part of an employer to deal in good faith with an employee at will). See also Andrea M. Kahn-Kothmann, *Your Rights After Termination Without Cause*, Physician’s News Digest (Dec. 1998), <http://www.physiciansnews.com/law/1298kahn.html>.

40 Health Care Provider Contracts

11. See Kusske, *Handbook*, *supra* note 8, at 103.
12. *Black's Law Dictionary* 309 (Pocket Ed., 1996). See also Bryan A. Liang, *Deselection under Harper v. Healthsource: A Blow for Maintaining the Physician-Patient Relationship in the Era of Managed Care*, 72 *Notre Dame L. Rev.* 799, 853 (1997).
13. See John P. Little, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 *Rutgers L. Rev.* 1397, 1446, 1456 (1997).
14. Milt Freudenheim, *Doctors' Incomes Fall as Managed Care Grows*, *N.Y. Times*, Nov. 17, 1995, at A1.
15. See Christopher Guadagnino, *Managed Care Contracting Strategies*, *Physician's News Digest* (July 2000), <http://www.physiciansnews.com/cover/700.html>. See also Maria K. Todd, *Contracting Corner: Parties' Obligations*, 2(9) *Orthopedic Technology Review* (Oct. 2000), <http://www.orthopedictechreview.com/issues/oct00/pg16.htm>.
16. See *Wickline v. State of California*, 239 Cal. Rptr. 661, 810 (Cal. App. 1986), *petition for review dismissed*, 741 P. 2d 613 (Cal. 1987) (holding that a physician is still liable for negligence even if he complies with an MCO decision to deny care that he believes is medically necessary). Implicit in this decision is the theory that the physician has a nondelegable fiduciary duty to do what is in his patient's best interest.
17. See Rebecca Anwar & Judy Capko, *Why Physicians Get Deselected*, *Physician's News Digest* (Sept. 1997), <http://www.physiciansnews.com/business/997anwar.html>. See also Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 *Harvard L. Rev.* 731, 1629 [hereinafter *Medicaid Managed Care*]; Sullivan, *supra* note 6, at 355; Rosenblatt, *supra* note 4, at 1002-11; Kusske, *Handbook*, *supra* note 8, at 26.
18. See Guadagnino, *supra* note 15; Maria K. Todd, *Contracting Corner*, 3(3) *Orthopedic Technology Review* (May/June 2001); Matthew B. Roberts, *Managed Care Contract Issues*, <http://library.findlaw.com/2000/Oct/12/127454.html>; *Harper v. Healthsource New Hampshire, Inc.*, 674 A. 2d 962 (N.H. 1996) (holding that a termination without cause provision in the contract was legal). See also Little, *supra* note 13, at 1456.
19. See Jennifer Arlen & W. Bentley MacLeod, *Torts, Expertise and Authority: Liability of Physicians and Managed Care Organizations*, Social Science Research Network Electronic Paper Collection, <http://ssrn.com/abstract=405740>; Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, Social Science Research Network Electronic Paper Collection, <http://ssrn.com/abstract=453543>.
20. See *Wickline*, *supra* note 16 (holding that while third party payers of health care services can be held legally accountable when medically inappropriate decisions result from implementation of cost containment, the treating physician remains legally responsible for the quality of care).
21. See Lawrence A. Cunningham & Arthur J. Jacobson, *Corbin on Contracts* §559F, at 358; §559H, at 362 (1993 & Supp. 1997).
22. See Paul Gray, *Gagging the Doctors: Critics Charge That Some HMO's Require Physicians to Withhold Vital Information from Their Patients*, *Time*, Jan. 8, 1996. See also Stephanie Rifkinson-Mann, *The Physician's Fiduciary Duty: Its Implications for Judicial Decision-Making*, 47(2) *Medical Trial Technique Quarterly* 317 (2000).
23. See Guadagnino, *supra* note 15.
24. See Kusske, *Managed Care—the Growth of Cost Containment and the Impact on Neurosurgical Practice*, in *Neurosurgery in Transition: The Socioeconomic Transformation of Neurological Surgery* 23 (James R. Bean ed., 1998) [hereinafter "*Kusske, Managed Care*"]. See also Linda O. Prager, *Fee-for-Service Plans Tops Among Doctors in Most Markets*, *Amer. Med. News*, Oct. 12, 1998, at 15; Rosenblatt, *supra* note 4, at 563; Douglas Hastings et al., *Fundamentals of Health Law* 269 (1995).
25. See Peter R. Kongstvedt, *The Essentials of Managed Care* 77-78 (1995). See also Hastings, *supra* note 24, at 269; Rosenblatt, *supra* note 4, at 553, 563; Howard Kim, *Medi-Cal Tells Physicians to Shape Up*, *Amer. Med. News*, Aug. 24/31, 1998, at 51. See also L. Greenberg, *Managed Care Monograph Series: Introduction to Managed Care for State Health Agencies*, Association of State and Territorial Health Officials (ASTHO), ASTHO Primary Care Project, Bureau of Primary Healthcare, Washington, D.C. (1995).
26. See Polly Miller, *Doctors' Incomes: Who's Up, Who's Down*, *Med. Economics* (Oct. 1998), at 45.
27. *Health Insurance Definitions*, *Health Symphony*, <http://www.healthsymphony.com/insurancedefinitions.htm>.
28. See Rosenblatt, *supra* note 4, at 563. See also Joseph A. Snoe, *Selected Managed Care Provider Issues*, in *American Healthcare Delivery Systems* 456, 457 (1998); Little, *supra* note 13, at 1397, 1412.
29. HMOs may seek to shift risks to health care providers including insurance risk, utilization risk, unit price risk, inflation risk, and legal risk. These are reviewed elsewhere in detail. See Charles A. Brown & John B. Reiss, *HMO Contracting Strategies: Protecting the Provider's Interests*, *Healthcare Financial Management* 36-42 (Apr. 2000). See also Maria K. Todd, *Contracting Capitated Services*, 2(2) *Orthopedic Technology Review* (Feb. 2000), <http://www.orthopedictechreview.com/issues/feb00/pg26.htm>; Kusske, *Handbook*, *supra* note 8, at 100.
30. See Guadagnino, *supra* note 15.
31. See Gary L. Lewins, *Making Sense of Physician Managed Care Payment Information with RBRVS*, *Health Systems Direct*, <http://www.helathsystemsdirect.com/article7.html>. The American Medical Association provides a Model Managed Care Contract, a sample contract with annotations and explanations for troublesome clauses, which is available online at www.ama-assn.org/ama/upload/mm/38/mmcmsa.pdf.
32. See *Maltz v. Aetna Plan of N.Y.*, 114 F. 3d 9, 10 (2d Cir. 1997).
33. See Rosenblatt, *supra* note 4, at 418.
34. See BCNYS, *supra* note 4, at §2. See also Stephanie Rifkinson-Mann, *The Impact of Managed Care Payer Contracts on the Subspecialty Medical Provider: Policy Implications That Impact on the Care of Disabled Children*, 27(6) *Fordham Urban L.J.* 1943 (2000).
35. *Black's Law Dictionary* 1265 (6th ed. 1990).
36. See American Medical Association, *Physicians' Current Procedural Terminology* (1997) ["CPT"].
37. Elisabeth Rosenthal, *Doctors Slow to Join HMOs Now Often Find Doors Shut*, *N.Y. Times*, June 25, 1994, at A1. See Snoe, *supra* note 28, at 456, 456. See also *Medicaid Managed Care*, *supra* note 17, at 754; Little, *supra* note 13, at 1397; *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F. 2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985) (finding that because of the large number of subscribers, doctors are under "heavy economic pressure" to take them as patients and to agree to Blue Shield's system for charging the cost of their care).
38. See *Ray v. William G. Eurice & Bros., Inc.*, 201 Md. 115, 93 A. 2d. 272 (1952) (holding that one signing a contract is assumed to have the capacity to understand it, assuming no fraud, duress, or mutual mistake). See also Williston, *Contracts* (Rev. Ed.) §1577 (1936). This assumes that the bargaining parties are on an equal footing socially, economically, and possibly educationally. However, unfair surprise and unconscionability may result if the MCO drafting the contract includes a term, knowing that the term does not accord with the physician's expectations, or that it may include unintelligible legal language. This is "procedural unconscionability," since including such a term without calling it to the other party's attention involves unfair bargaining in the negotiating procedure. See U.C.C.: Comment §2-303. See also Gordon D. Schaber & Claude D. Rohwer, *Contracts* 229 (3d ed. 1990). A contract, or a clause in a contract, is "unconscionable" if it is so grossly unfair to one of the parties because of the stronger bargaining powers of the other party. It suggests

- that no person in their senses, not under any delusion, would make such a contract, and which no fair and honest person would accept. *Black's Law Dictionary* 1525 (6th ed. 1990). See U.C.C.: Unconscionable Contract or Clause §2-302; Restatement (Second) of Contracts §208.
39. See Guadagnino, *supra* note 15. See also Todd, *supra* note 15.
 40. Editorial, *Silent PPOs: Physicians Need to Know Who Holds Their Contracts*, Am. Med. News 22. 3 Oct. 2005. See James D. Wall, *Negotiating a Managed Care Contract*, Doctors First (1999–2000), <http://www.doctorsfirst.com/articles/employment/mccontract.html>. See also Guadagnino, *supra* note 15; Roberts, *supra* note 18.
 41. See *Shell Oil Co. v. Marinello*, 307 A. 2d 598, 601 (1973). See also Guadagnino, *supra* note 15.
 42. Robin Toner, *Harry and Louise Were Right, Sort of*, N.Y. Times, Nov. 24, 1996, at D1. See *Ambroze, M.D., P.C. v. Aetna Health Plans of N.Y., Inc.*, No. 95 CIV. 6631 (DLC), 1996 WL 282069, at 3 (S.D.N.Y. May 28, 1996); *Clinic Masters, Inc. v. District Court*, 556 P. 2d 473, 475–76 (1976).
 43. See *Health Insurance Definitions*, *supra* note 27.
 44. See Guadagnino, *supra* note 15.
 45. The South Carolina Supreme Court found that where a contractual arbitration clause was silent as to class adjudication, class arbitration would be permitted. However, a year later, the Court held that if a contract does not specifically state whether class action arbitration is permissible, the arbitrator must decide whether or not class action treatment is proper. Therefore, provider class action arbitration proceedings may be initiated with the AAA. See *Green Tree Financial Corp. v. Bazzle*, 351 S.C. 244, 569 S.E. 2d 349 (2002).
 46. See Robert Kuttner, *Physician-Operated Networks and the New Antitrust Guidelines*, 336 N. Eng. J. Med. 386 (1997); *Judge Should Deny Class-Action Status in Legal Attack on Managed Care Firms*, The Tampa Tribune, May 7, 2001, http://www.aetna.com/legal_issues/saying/05072001.htm.
 47. Among the plans sued were CIGNA Healthcare, United Healthcare, Aetna U.S. Healthcare, Blue Cross Blue Shield, Oxford, Physician Health Services, Anthem, Coventry Healthcare, Health Net, Humana, PacifiCare Health Systems, and WellPoint Health Networks. See “Louisiana State Medical Society Announces It Will File Suit Against Health Plans,” <http://www.lsms.org/News/PresRels/jul302a.htm>; “HMO Litigation: CT High Court Upholds Dismissal of CSMS’ Lawsuit,” http://bankrupt.com/CAR_Public/050107.mbx; *Leonard J. Klay, M.D. et al. v. Humana, Inc. et al.*, 382 F. 3d 1241 (11th Cir. 2004); *Charles B. Shane et al. v. Prudential Insurance Co. of America et al.*, MDL No. 1334. See also “Physicians Received Favorable Ruling on Arbitration Appeal in RICO Lawsuit Against For-Profit HMOs,.” <http://www.texmed.org/PrintThisPage.spx?id=2650>; “Cigna Healthcare Announces Settlement of Physician Class-Action Lawsuits,” <http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/12-13-2004/0002628217&EDATE=>. See also Guadagnino, *supra* note 15. See also Archie C. Lamb, Jr., *How Doctors Used RICO to Fight Managed Care*, 1(1) ABA Health Source (June 2004), <http://www.abanet.org/health/esource/vol1no1/focus-3.html>.

