A LEGISLATIVE SOLUTION TO THE PROBLEM OF CONCIERGE CARE

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I. Introduction

Dissatisfaction with managed care has led to a well-publicized backlash.[1] Many patients and physicians believe that the efforts of managed care organizations ("MCOs") to lower the cost of healthcare have resulted in a healthcare delivery system that values profits for MCOs more than the health of their members.[2] This lack of confidence in managed care has led both physicians and patients to seek an alternative system that allows for a more intimate physician-patient relationship, and many believe that they have found just that in "concierge care" or "retainer medicine."[3] Patients must pay extra for this level of care, with concierge care organizations charging patients an additional $1500 to $13,500 per year over in-

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[1] David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient's Bill of Rights*, 73 S. CAL. L. REV. 221, 222 (2000).

[2] *See* discussion *infra* Part II.

[3] *See* discussion *infra* Part IV.

surance premiums.[4] For this retainer fee, patients get a physician with a drastically reduced patient load, as well as a wider variety of medical services, ranging from extensive annual physicals to twenty-four-hour access to physicians.[5]

While concierge care may help individual physicians and patients, it hurts the majority of Americans who cannot afford to pay these retainer fees.[6] Each physician who reduces her patient load to start a concierge practice depends on other already overworked physicians to pick up those patients who cannot pay the additional fee.[7] This results in a lower level of care for those who are not part of a concierge practice.[8] Currently, the number of concierge practices is small, but there is substantial evidence that it is growing.[9] Now is the time to examine the needs of patients and physicians who are driving this trend and develop methods to halt it.

This paper approaches concierge care as an indicator of a failing healthcare system and proposes a legislative solution to reduce the number of patients and physicians who feel compelled to join concierge practices. If patients and physicians believe that economic pressures have prevented them from developing the type of doctor–patient relationships necessary for quality healthcare, then the system needs to be changed for everyone, not just for the few who can afford premium service.

II. Problems with Managed Care

Physicians argue that managed care does not allow them sufficient time to properly diagnose patients, and patients argue that managed care does not allow them time to fully discuss their concerns with their doctors.[10] Although the length of the average physician visit has not decreased since the late 1980s, the amount of information that the parties need to exchange in that window of

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[4] *See* discussion *infra* Part IV.

[5] *See* discussion *infra* Part IV.

[6] *See* discussion *infra* Part V.

[7] *See* discussion *infra* Part V.

[8] *See* discussion *infra* Part V.

[9] *See* discussion *infra* Part IV.

[10] Josh Fischman, *Who Will Take Care of You?*, U.S. NEWS & WORLD REP., Jan. 31, 2005, at 44.

time has increased.[11] Patients come into doctors' offices armed with piles of Internet research and a copious amount of questions.[12] Health insurance companies impose numerous diagnostic requirements on physicians, which places additional time constraints on office visits.[13] Furthermore, an average fifteen-minute appointment can actually involve as little as two minutes of face time with the physician, leaving little time for thorough examination and diagnosis.[14] These added demands leave insufficient time for patients and doctors to form a relationship, which is important for patient health and compliance with treatment regimens.[15]

Additionally, there is a shortage of primary care physicians ("PCPs") due to poor compensation and heavy workloads resulting from heavy administrative responsibilities and the necessity of seeing a large number of patients.[16] Doctors claim that low reimbursement rates from insurance companies make it economically impossible for PCPs to practice with fewer than several thousand patients.[17] One California internist reported that low reimbursements of $15 to $40 per patient generally require physicians to see at least thirty patients per day to cover costs.[18] An increasing number of medical students are opting for residencies in specialties

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[11] *Id.* From the late 1980s through the late 1990s, the length of the average physician visit remained steady, lasting between sixteen and twenty-two minutes. *Id.*

[12] *Id.*

[13] *Id.* For example, doctors must ask a lot of pure biomedical questions or risk penalization by insurance companies. *Id.*

[14] Bill Sonn, *Concierge Medicine: Physicians Weigh Financial, Ethical Issues*, PHYSICIANS PRAC., Feb. 2004, *available at* http://www.physicianspractice.com/index.cfm?fuseaction=articles.details&articleID=483.

[15] Fischman, *supra* note 10. "Research has shown that a good conversation that thoroughly explores problems and possible treatments means better health." *Id.* "[The] relationship [between physician and patient] has clearly been shown to affect diagnostic accuracy, adherence to treatment plans, and patient satisfaction." *Id.* (quoting internist Wendy Levinson, chair of medicine at the University of Toronto).

[16] *Consumer-Directed Doctoring: The Doctor Is In Even if Insurance Is Out, Hearing Before the House J. Econ. Comm.*, 108th Cong. 91-99 (2004) (statement of Robert A. Berenson, M.D., Senior Fellow, Health Policy Center, The Urban Institute) [hereinafter *Consumer-Directed Doctoring*].

[17] Katherine Hobson, *Doctors Vanish from View*, U.S. NEWS & WORLD REP., Jan. 31, 2005, at 48. The average PCP sees twenty-five people per day. *Id.* Economic pressure on physicians results from a number of factors, including "reduced reimbursement rates, increased overhead costs, and higher premiums for liability insurance." *Consumer-Directed Doctoring*, *supra* note 16, at 92.

[18] Nancy Luna, *Main News*, VENTURA COUNTY STAR (Cal.), Jan. 12, 2004, at 3.

rather than family medicine, and analysts predict a shortage of up to 200,000 such physicians nationwide by 2020.[19]

III. Why Healthcare Costs Are Rising

The primary causes of rising healthcare costs are expensive technology and pharmaceuticals[20] and patients with increased questions and concerns due to resources such as the Internet.[21] In addition, the "prevalence of unnecessary, duplicative, and sometimes dangerous patient care" contributes to rising healthcare costs.[22] Consequently, encouraging the efficient delivery of healthcare, including providing "the right care at the right time," is an effective method of reducing healthcare costs.[23]

It is indisputable that insufficient information about patients results in prescription errors and duplicate tests, putting patients at risk and increasing healthcare costs.[24] In our current healthcare system, the individual in the best position to ensure high-quality healthcare is the PCP.[25] Legislation that ensures that PCPs have the opportunity to develop strong relationships with their patients and sufficient time to provide accurate diagnoses and proper treatment will undoubtedly lower costs by improving both the

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[19] Hobson, *supra* note 17.

[20] Robert F. Rich & Christopher T. Erb, *Health Care Reform: Where Are We? Where Are We Going? Introduction*, 2004 U. ILL. L. REV. 39, 41 (2004); Clark C. Havighurst, *Contract Failure in the Market for Health Services*, 29 WAKE FOREST L. REV. 47, 49 (1994). In most private and public health insurance systems, about five percent of covered individuals, such as the elderly and others with chronic health problems, are responsible for fifty percent of expenditures. *Consumer-Directed Doctoring*, *supra* note 16, at 98.

[21] Fischman, *supra* note 10.

[22] Dr. Jack Cochran, *Make Wise Health-care Choices*, DENVER POST, Dec. 28, 2003, at E4.

[23] *Id.*

[24] David J. Brailer, M.D., Ph.D., *Care-Based Management of Cost*, HEALTH MGMT. TECH., Nov. 2001, at 60, *available at* http://healthmgttech.com/archives/1101viewpoint2.htm. A 1999 Institute of Medicine report found that fifty percent of physicians and seventy percent of patients believe "overworked, stressed or fatigued healthcare professionals" are one of the main causes of medical errors in the United States. *Patients, Physicians Underestimate Medical Errors*, FAMILY PRAC. MGMT., Jan. 2003, at 20, *available at* http://www.aafp.org/fpm/20030100/monitor.html.

[25] *See* Amy K. Fehn, Comment, *Are We Protected from HMO Negligence?: An Examination of Ohio Law, ERISA Preemption, and Legislative Initiatives*, 30 AKRON L. REV. 501, 506 (1997).

health of patients and the efficiency of the healthcare system.[26]

IV. What Is Concierge Care?

This dissatisfaction with the quality and quantity of healthcare has led physicians and patients to turn to concierge care.[27] Concierge care is a new system of healthcare delivery where patients pay an additional fee with their comprehensive insurance to enable their doctors to reduce their patient load substantially.[28] This arrangement gives patients the benefits of longer office visits, twenty-four-hour access, and greater preventative care.[29]

Concierge care exists in a variety of forms.[30] In one Florida-based group called MDVIP, for example, a family physician with 2400 patients reduced his patient load to 310, allowing him to offer his patients "highly personalized attention, twenty-four-hour access and extensive annual physicals" as well as personal wellness plans designed to address each patient's unique medical concerns.[31] MDVIP franchises exist in thirteen states,[32] and each franchise requires physicians to limit their practices to 600 patients and charge each patient $125 per month.[33] Similarly, the Dare Center in Seattle, Washington operates in three locations, limits

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[26] *See* discussion *infra* Part VI.

[27] Gregory M. Lamb, *Gold-card Healthcare: Is It Boon or Bane?*, CHRISTIAN SCI. MONITOR, May 17, 2004, at 12. Dr. John Blanchard, president and cofounder of the American Society of Concierge Physicians, stated:

> The current model of healthcare delivery, particularly in the primary-care setting, is dysfunctional, to say the least . . . . You're shuttled through offices like cattle. This is not the way healthcare was designed. The quality of healthcare is based largely on the integrity of the patient-physician relationship–and that relationship breaks down in a high-volume healthcare setting.

Id.

[28] Robyn Shelton, *It's Personal Health Care – for a Price*, ORLANDO SENTINEL, Nov. 14, 2004, at A1. A less common form of concierge care requires patients to remit large payments to physicians in lieu of insurance. *Id.*

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] John Dorschner, *Boca Raton Firm Places Premium on Preventive Care*, MIAMI HERALD, Jan. 6, 2005, at 1C. As of early 2005, MDVIP employed 65 physicians and had 20,000 patients. *Id.*

[33] Russ Allen, *Doctors On Retainer Catch on: A New Model Driven by Doctors Dissatisfied with Traditional Managed Care Catches On with the Few Who Can Afford It*, RISK & INS., Mar. 1, 2005, at 20.

patient load to 300, and charges each patient $250 per month.[34] In addition to the retainer fees, MDVIP and the Dare Center also bill their patients' health insurance providers.[35] In contrast, another Seattle-based practice, MD2, charges an annual fee of $13,500 and does not accept insurance.[36]

Concierge care is increasing in popularity. According to a recent survey of 785 physicians conducted by medical publisher Castle Connolly Medical Ltd., forty-five percent favor the concierge model of care, and many believe that it will significantly improve both patient and physician satisfaction.[37] A major venture capital fund's recent investment of six million dollars in MDVIP further indicates the potential for rapid growth in concierge care.[38]

V. Why Is Concierge Care Harmful?

The law should discourage the growth of concierge care because it is detrimental to the American healthcare system.[39] Concierge care results in a two-tiered healthcare system where wealthy patients who enroll in such plans divert resources from the general pool and, as a result, lower the level of care for the majority of Americans.[40] An Indiana physician remarked that concierge care threatens to "shift primary medical ethical obligations of care into

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[34] *Id.*

[35] Robert M. Portman, *Concierge Care: Back to the Future of Medicine?*, HEALTH LAW., Aug. 2003, at 3-4.

[36] *Id.*

[37] *Castle Connolly Medical Ltd.*; *America's Top Doctors Give Mixed Reviews to VIP Practices, Survey Shows*, NURSING HOME & ELDER BUS. WEEK, Sept. 12, 2004, at 25.

[38] Dorschner, *supra* note 32. Summit Partners invested six million dollars in MDVIP on January 5, 2005. *Id.*

[39] Lamb, *supra* note 27.

[40] *Consumer-Directed Doctoring*, *supra* note 16, at 97-98.

> [I]t is likely that relatively healthy, affluent individuals would be the group most likely to opt out of comprehensive insurance products, leading to high insurance costs for those whose health problems give them no choice but to remain in the basic health insurance pool. As healthier families and individuals opt out of traditional insurance coverage, those remaining in comprehensive health plans would be more expensive to insure. This will lead to destructive market segmentation, driving up premiums for traditional coverage even further and setting off a spiral of adverse selection. The comprehensive health insurance option would become unaffordable precisely for those who need its protection.

Id.

the 'extraordinary' realm, expected to be rendered to a very few for a special fee."[41] It is now necessary for individuals to pay a premium over already steep health insurance costs in order to receive the level of physician care that patients used to expect.[42] The Castle Connolly Medical Ltd. study, which shows that a large number of physicians favor concierge care, also reflects the concern of many physicians that a switch to concierge care will lead to an "abandonment" of patients as a consequence of their limited workloads.[43]

The legal parameters of the concierge model of healthcare are still unclear.[44] Physicians with concierge practices who accept Medicare must be careful to charge patients additional fees for uncovered services only or risk exclusion from federal healthcare programs and civil penalties.[45] On March 31, 2004, the Inspector General of the U.S. Department of Health and Human Services ("HHS") warned doctors not to charge patients for services covered by Medicare.[46] It is often difficult, however, for physicians to distinguish between covered and uncovered services.[47] For example, authorities recently fined a physician for double-billing patients by charging a $600 annual fee for "coordination of care, a comprehensive assessment and plan for optimum health, and extra time spent on patient care."[48]

Concierge medical practices also risk falling under state insurance laws, especially those practices that "charge their members a fixed, prepaid amount for a bundle of guaranteed ser-

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[41] Margaret Gaffney, M.D., *VIP Care Conflicts with Medical Ethics*, INDIANAPOLIS STAR, Oct. 10, 2004, at 4E.

[42] *See* Arthur Caplan, Op-Ed, *U.S. Health-care System Truly Shameful*, DESERET MORNING NEWS (Utah), July 4, 2004, at 7.

[43] *Castle Connolly Medical Ltd.*, *supra* note 37. Thirty-one percent of physicians feel that concierge care will have a negative effect on patients. *Id.*

[44] *See* Portman, *supra* note 35, at 1.

[45] *Docs Told to Watch Extra Fees for Medicare Patients*, PODIATRY MGMT., Nov.-Dec. 2004, at 42. Each "improper request" to a patient for payment can result in a $10,000 fine, plus treble damages. Carol M. Ostrom, *'Retainer Fees' Spark Warning; Doctors Could Face Fines or Medicare Expulsion, Says U.S.*, SEATTLE TIMES, Apr. 14, 2004, at B1.

[46] Lamb, *supra* note 27.

[47] *See* Joan R. Rose, *A Caution Light for Concierge Practices*, MED. ECON., May 21, 2004, at 22.

[48] *Id.*

vices."[49] In other words, physician practices that accept payments for future services may be engaging in the sale of insurance policies.[50] If this is the case, then state laws may require these practices to obtain insurer licenses, which may necessitate sufficient evidence of financial stability.[51] The recognition of concierge practices as insurers raises a host of issues uniquely relevant to the insurance context; for example, some lawmakers are examining whether concierge practices that drop patients who are unable to pay the retainer fee are violating state insurance anti-discrimination laws.[52]

Concierge care is a symptom of the inadequacies of the current system of healthcare delivery in the United States.[53] If managed care were meeting physician and patient needs, there would likely be less of a demand for concierge care.[54] Many extremely wealthy people have always used their resources to buy luxury healthcare, but until recently, the upper-middle class has not felt the need to expend extra resources on enhanced healthcare services.[55] However, rushed and impatient physicians have made patients feel like they are receiving inadequate care.[56] This situation has also resulted in incorrect diagnoses and the prescription of ineffective medications.[57] As baby boomers grow older and continue to need more healthcare, these problems will take on greater significance and may further spur the growth of concierge care.[58]

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[49] Portman, *supra* note 35, at 4.

[50] Allen, *supra* note 33.

[51] Sandi Doughton, *State Looks Askance at Extra Fees for Doctors*, SEATTLE TIMES, Aug. 12, 2003, at B1.

[52] Fran Hawthorne, *Patients with Perks; Advocates Say 'Concierge Medicine' Is Like Having the Neighborhood Doctor Back; Critics Call It Elitist*, NEWSDAY (N.Y.), Jan. 1, 2005, at B6.

[53] PHYLLIS GRIFFIN EPPS, CHAMPAGNE HEALTH CARE AND CAVIAR DREAMS: BOUTIQUE MEDICINE IN THE UNITED STATES (2002), *available at* http://www.law.uh.edu/healthlaw/perspectives/Managed/020220Champagne.html.

[54] *See* Amy Schatz, *Some Doctors Are Going on Retainer; Practitioners Say a Trend to 'Boutique' Medicine Shows Just How Sick Managed Care Has Become*, AUSTIN AM.-STATESMAN, Feb. 23, 2003, at J1.

[55] Mike Norbut, *Appeal of Retainer Practices: Boutique Care Goes Mainstream*, AM. MED. NEWS, Aug. 4, 2003, *available at* http://www.amaassn.org/amednews/2003/08/04/bisa0804.htm.

[56] Nellie Kelly, *On Call*, TULSA WORLD, Oct. 7, 2004, at D1.

[57] *See* Brailer, *supra* note 24.

[58] *See* Hawthorne, *supra* note 52.

Concierge care will ultimately do more to exacerbate healthcare problems than to solve them.[59] With more patients willing to pay a premium for a better doctor-patient relationship, there will be a corresponding increase in the number of physicians who significantly reduce their patient load and enter the concierge care system.[60] Consequently, physicians who are already overburdened will experience a substantial increase in their patient loads, further degrading the quality of healthcare for a majority of Americans.[61] This problem is likely to worsen as poor working conditions and low pay result in fewer new physicians choosing to be PCPs.[62] Evidence of this problem lies in the practice areas that new physicians select: for example, in 2004, new medical school graduates filled only forty-one percent of available primary care residency slots.[63] In contrast, new graduates filled ninety-seven percent of dermatology slots, indicating the desire of many new physicians to practice in a specialty considered to be less time-consuming and more lucrative.[64]

VI. Legislating a Solution

Reducing the number of patients that a PCP must see per day in order to maintain a practice will help solve many of the problems caused by the current state of managed care and could effectively stem the flow of patients and physicians to the concierge model of care.[65] More manageable patient loads will make primary care practices more attractive to new doctors, thereby increasing the number of medical school graduates who become PCPs. If patients and physicians have enough time to form a good relationship, patients will feel more confident in the care they receive. Disease prevention and health promotion, along with a reduction

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[59] *See* Kelly, *supra* note 56.

[60] *See* Andrew Haeg, *Top-shelf Health Care–If You Have the Money* (Minn. Pub. Radio broadcast, June 24, 2002), *available at* http://news.minnesota.publicradio.org/features/200206/24_haega_conciergecare.

[61] *See* Laurence Darmiento, *Do No Harm: Doctor Joins the Move Toward 'Concierge' Medical Practices*, L.A. BUS. J., Jan. 17, 2005, at 1.

[62] Charles Peters, *Tilting at Windmills; Young Doctors Rightfully Want to Have Real Lives*, SUNDAY GAZETTE-MAIL (W. Va.), Mar. 13, 2005, at 3E.

[63] *Id.*

[64] *Id.*

[65] *See* discussion *supra* Parts IV–V.

in inappropriate referrals, are a few additional advantages made possible by longer office visits.[66]

A. *Precedent of Government Regulation*

Government regulation of healthcare is not a new idea, as both federal and state governments have legislated minimal standards for managed care.[67] The federal government regulates healthcare indirectly through the Employee Retirement Income Security Act of 1974 ("ERISA"),[68] and directly through laws that require minimum standards of care, such as minimum hospital stays after childbirth[69] and reconstructive surgery after mastectomies.[70] Additionally, states have passed a variety of comprehensive healthcare legislation that effectively overrides the policies of MCOs by vesting patients with additional rights.[71]

In 1998, a new federal statute, the Newborns' and Mothers' Health Protection Act of 1996, took effect.[72] The statute mandates a minimum hospital stay for new mothers and babies.[73] Lawmakers enacted the statute to address concerns over efforts by MCOs to control costs by discharging mothers and babies from hospitals within twelve to twenty-four hours after a normal vaginal birth.[74] The American Medical Association, the American College of Obstetrics and Gynecology, and the American Academy of Pediatrics

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[66] INST. OF MED., PRIMARY CARE: AMERICA'S HEALTH IN A NEW ERA 58 (Mollas S. Donaldson et al. eds., 1996), *available at* http://darwin.nap.edu/books/030905 3994/html/58.html. "Primary care fosters early detection of various disorders (including those that begin insidiously). The benefits include earlier and less onerous health care interventions, better and less hurried decision making between the primary care clinicians and patients and their families, and likely lower costs of an episode of care." *Id.*

[67] *See, e.g.*, 42 U.S.C. § 300gg-4 (2000), MASS. GEN. LAWS ch. 111, § 217 (2005).

[68] 29 U.S.C. §§ 1001-1461 (2000). ERISA preempts state statutes and common-law actions against health plans. ERISA also provides a federal right to sue for recovery of denied benefits. Fehn, *supra* note 25, at 516-17.

[69] 42 U.S.C. § 300gg-4.

[70] 29 U.S.C. § 1185b (2000); 42 U.S.C. §§ 300gg-6, -52.

[71] *See* MARK A. HALL ET AL., THE LAW OF HEALTH CARE FINANCE AND REGULATION 267 (2005). For an example of state legislation regulating healthcare, see MASS. GEN. LAWS ch. 111, § 217 (2004) (establishing state patient protection agency).

[72] 29 U.S.C. § 1185; Beth Mandel Rosenthal, *Drive-through Deliveries, and the Newborns' and Mothers' Health Protection Act of 1996*, 28 RUTGERS L.J. 753, 755 (1997).

[73] 29 U.S.C. § 1185.

[74] Rosenthal, *supra* note 72, at 753.

objected to this practice, citing numerous health risks.[75] After numerous states amended their insurance laws to require coverage of a minimum number of days of post-partum care, Congress passed this statute to ensure a uniform standard of care across the nation.[76]

In 1998, Congress again took action by passing the Women's Health and Cancer Rights Act.[77] This law arose out of concerns that insurance companies were pressuring physicians to perform mastectomies on an outpatient basis.[78] The law thus requires group health plans to cover reconstructive surgery after mastectomies as well as reconstructive surgery of a patient's other breast

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[75] Tracy Wilson Smirnoff, Note, *"Drive-through Deliveries": Indiscriminate Postpartum Early Discharge Practices Presently Necessitate Legislation Mandating Minimum Inpatient Hospital Stays*, 44 CLEV. ST. L. REV. 231, 240 (1996).

> First, numerous health problems faced by newborns, such as dehydration and jaundice, do not appear until after the first 24 hours of life. Since many of these illnesses can only be detected by health professionals, early hospital discharge can cause these conditions to go undetected, leading to brain damage, strokes, or even death. Second, the mother can also develop many serious health problems, including pelvic infections, breast infections, and hemorrhaging. Third, a 24 hour stay does not provide sufficient opportunity for the mother to be taught basic infant care skills such as breastfeeding. This, combined with the fact that many mothers are simply too exhausted to care for their child 24 hours after delivery, often leads to newborns receiving inadequate care and nourishment during their crucial first few days of life.

Id. at 240-41 (quoting 141 CONG. REC. S9175 (1995) (statement of Sen. Bradley)).

[76] Rosenthal, *supra* note 72, at 754-55 (citing *Newborns' and Mothers' Health Protection Act: Hearings on S. 969 Before the Senate Comm. on Labor and Human Res.*, 104th Cong. (1995) (statement of Sen. Bradley)).

[77] 29 U.S.C. § 1185b; 42 U.S.C. §§ 300gg-6, -52 (2000).

[78] *See* 145 CONG. REC. S8443 (1999) (statement of Sen. Abraham).

> Under current law, insurers may have guidelines recommending that mastectomies be performed on an outpatient basis. But a mastectomy is, in fact, a complicated surgical procedure, one from which significant complications can arise. Under these circumstances, sending a woman home immediately after a mastectomy may not be the right thing to do. The woman may not have the information she needs, or even the care she needs during this critical time. We must see to it that doctors are not pressured by health plans to release mastectomy patients before it is medically appropriate. Women suffer immense emotional trauma from mastectomies. They also suffer from scarring and may suffer from significant and even dangerous complications hours after surgery. It simply is not appropriate, then, to have anyone other than the patient and her physician deciding when it is safe and proper for her to go home.

Id.

in order to create a symmetrical appearance.[79] Thirty-six states have passed legislation requiring similar coverage.[80]

States have also enacted a wide variety of legislation requiring health insurers to provide minimum levels of coverage.[81] Many state statutes regulating managed care require external utilization review of patient grievances, public disclosures, and minimum ratios of providers to enrollees.[82] Some state statutes require insurance companies to define "emergency" using a "prudent layperson" standard and provide minimal coverage to subscribers that includes certain providers and benefits.[83] Overall, state statutes regulating health insurers aim to improve accuracy in decision making and access to care.[84] These statutes also seek to enhance the quality of care through accreditation requirements, quality assurance programs, and quality-related information disclosures.[85]

Some critics of managed care regulation agree that consumers have legitimate reasons to be unhappy with the current system.[86] However, those same critics argue that raising regulatory standards makes healthcare more expensive and requires consumers to pay for coverage they might not want if given the choice.[87] This added expense makes healthcare less affordable, thereby contributing to the problem rather than solving it.[88] These critics further argue that regulations should address only issues of disclosure and accountability and that the law should address MCO misconduct by holding MCOs "vicariously, and exclusively, liable for medical malpractice and other torts committed by the healthcare providers [they] procure[] to treat [their] enrollees."[89]

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[79] 29 U.S.C. § 1185b; 42 U.S.C. §§ 300gg-6, -52.

[80] AM. SOC'Y OF PLASTIC SURGEONS, BREAST RECONSTRUCTION RESOURCES (2005), http://www.plasticsurgery.org/public_education/Breast-Reconstruction-Resources-State-Laws.cfm?RenderForPrint=1.

[81] Rosenthal, *supra* note 72, at 772. Some states require coverage for acupuncture, naturopathy, massage, chiropractic care, and in vitro fertilization. *Id.*

[82] BARRY R. FURROW ET AL., HEALTH LAW 625-33 (5th ed. 2001).

[83] *Id.* at 630.

[84] *Id.* at 625-33.

[85] *Id.*

[86] *See* Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 399-400 (2001).

[87] *Id.* at 404.

[88] *Id.*

[89] *Id.* at 415.

However, given the current political leanings toward increased regulation of MCOs, it is unlikely that legislatures will implement such a system in the near future.[90]

Other critics of government healthcare regulation argue that this type of legislation is primarily a reaction to "wrenching, but extraordinarily unrepresentative horror stories," with little evidence that the benefits achieved by this legislation outweigh its corresponding costs.[91] These critics support their claims by citing the lack of conclusive data showing clear benefits stemming from legislation that establishes minimum standards of care.[92] However, in the same studies cited by critics of the Mothers' and Newborns' Protection Act, researchers found up to three-fold increases in hospital readmissions for infants released twenty-four hours after delivery.[93] While research into the consequences of MCO cost-cutting measures is currently inconclusive, most critics and proponents agree that these measures negatively affect health outcomes.[94]

Ideally, legislators would regulate healthcare based solely on solid facts and not as a result of political maneuvering, and such regulations would allow the competing forces of the market to shape a healthcare system tailored to consumer needs and mindful of consumer resources. However, a successful market system requires rational, informed decision makers, and consumers of healthcare lack the tools necessary to fulfill their role in a market system.[95] In reality, consumers do not make decisions to purchase healthcare based on complete information that they can apply to a known set of needs.[96] For example, consumers cannot choose the healthcare plan that best meets their needs in advance because they do not know what those needs will be. Furthermore, sick pa-

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[90] *See* Clark C. Havighurst, *Is the Health Care Revolution Finished? — A Foreward*, 65 LAW & CONTEMP. PROBS. 1, 6-7 (2002).

[91] David A. Hyman, *Drive-through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N.C. L. REV. 5, 9-10 (1999).

[92] *Id.* at 51.

[93] *See id.*; Rosenthal, *supra* note 72, at 756-57.

[94] Hyman, *supra* note 91, at 51; Rosenthal, *supra* note 72, at 756-57.

[95] Hyman, *supra* note 91, at 42-44.

[96] Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 25-28 (1999).

tients are not in a position to make decisions based on a cost-benefit analysis because they generally do not have the knowledge or resources necessary to understand the consequences of their treatment options. Therefore, government regulation is necessary to fill in the gaps left by an imperfect market system.

As MCOs adopt cost-saving measures in response to market pressure, federal and state governments have responded by enacting regulations that limit these measures.[97] For example, cost-cutting measures aimed at childbirth and breast reconstructive surgery threatened patient care and required legislative control.[98] Advocates of additional regulation fear that cost containment continues to take priority over patient needs.[99] In particular, MCOs are paying PCPs such low compensation per patient that physicians must take on heavy patient loads in order to maintain their practices.[100] Mary Frank, M.D., an officer of the American Academy of Family Physicians, said, "I'm hearing this at every chapter I visit: 'I'm working harder, I'm putting in longer hours, I have trouble recruiting, my overhead keeps going up,' . . . they're cutting back as much as they can, but that affects the customer service aspect."[101] The combination of rising costs and declining compensation for PCPs threatens the quality of healthcare that individuals nationwide receive by forcing PCPs, the very people who are often the gatekeepers to healthcare, to lower their standard of care. Therefore, federal and state governments should continue to limit cost-cutting measures that threaten the quality of healthcare received by all Americans and facilitate appropriate and efficient uses of healthcare resources.

B. *Methods of Legislating a Maximum Workload for PCPs*

Legislatures can establish a maximum workload for PCPs working within a managed care system in two ways. First, legisla-

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[97] *See* Rosenthal, *supra* note 72, at 754-55; Jennifer Roberts, *Development, VII. Insurance Law*, 2000 UTAH L. REV. 964, 965-66 (2000).

[98] *See supra* notes 72-80 and accompanying text.

[99] Roberts, *supra* note 97, at 967.

[100] *See* Mike Norbut, *Primary Care Physicians Are Caught in Productivity Squeeze*, AM. MED. NEWS, Sept. 20, 2004, *available at* http://www.amaassn.org/amednews/2004/09/20/bil10920.htm.

[101] *Id.*

tion may set a ceiling on the number of patients a PCP can see per day. Such a law would allow PCPs to provide efficient, quality care to their patients and would put market pressure on physicians to demand a higher reimbursement per patient from MCOs. Under a second, more intrusive solution, legislatures could statutorily mandate a minimum payment to PCPs per patient. This would require the government to determine a reasonable minimum daily rate of compensation for a PCP and divide that by the number of patients that an average PCP can see per day while still providing a reasonable standard of care. Although MCOs could pay a higher rate or physicians could choose to take on a higher patient load under this option, the compensation floor would be sufficient to alleviate the pressure that physicians currently feel to sacrifice quality of care for financial security. Either strategy will help limit cost-saving measures placed on PCPs by MCOs and preserve a quality of care that will increase patient and physician satisfaction. Both options will also help prevent physician errors resulting from overwork, stress, and fatigue.

Although ERISA preempts state laws that "relate to" the management of employer-sponsored benefit plans, it generally does not preempt state laws that regulate insurance.[102] Since legislation that regulates the amount of compensation that insurance companies can pay physicians per patient is considered the regulation of insurance, such legislation should be exempt from ERISA preemption.[103] Additionally, legislation that sets a maximum number of patients a PCP can see per day does not relate to the types of treatment decisions that ERISA preempts.[104]

Instead, this type of regulation is similar to that enacted by New York ("Bell Regulations") to limit the number of hours that

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[102] 29 U.S.C. § 1144(a) (2000); Aaron S. Kesselheim, M.D., J.D. & Troyen A. Brennan, M.D., J.D., M.P.H., *The Swinging Pendulum: The Supreme Court Reverses Course on ERISA and Managed Care*, 5 YALE J. HEALTH POL'Y L. & ETHICS 451, 454-59 (2005).

[103] *See* Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 SANTA CLARA L. REV. 105, 122, 142-43 (2001). The United States Supreme Court has broadly interpreted the "regulates insurance" clause of 29 U.S.C. § 1144(b)(2)(A) "to promote the presumption in favor of the validity of state laws that regulate areas of traditional state interests, and to preserve consumer protection laws." *Id.* at 123 (citing Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 741 (1985)).

[104] *See id.*

hospital residents can legally work.[105] The purpose of the Bell Regulations is to increase patient safety and improve working conditions for medical residents.[106] Similarly, a state statute that provides a ceiling for the number of patients that a PCP can see in a day would protect physicians from exhausting working conditions and patients from the consequences of doctors too overworked to provide effective care.

VII. Conclusion

Legislating caps on patient loads for PCPs participating in managed care or per patient compensation floors to alleviate the current financial pressure on PCPs will provide more time for office visits, lead to higher satisfaction for patients and physicians, and result in more efficient diagnoses and treatment as well as better physician-patient relationships for a majority of Americans.[107] Furthermore, such legislation can be an important step in moderating the power that MCOs have over the practice of medicine.[108] Aside from those who have elected to provide concierge care, most physicians must contract with MCOs to maintain their practices.[109] Under these contracts, MCOs may terminate physicians without cause or for insufficiently containing costs.[110] These agreements also require physicians to hand over an increasing amount of control over treatment decisions to insurance companies.[111] With little or no collective bargaining power, physicians

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[105] *See* N.Y. COMP. CODES R. & REGS. tit. 10, § 405.4(b)(6) (2005); Jennifer F. Whetsell, *Changing the Law, Changing the Culture: Rethinking the "Sleepy Resident" Problem*, 12 ANNALS HEALTH L. 23, 24 (2003); Andrew W. Gefell, Note and Comment, *Dying to Sleep: Using Federal Legislation and Tort Law to Cure the Effects of Fatigue in Medical Residency Programs*, 11 J.L. & POL'Y 645, 646 (2003).

[106] Whetsell, *supra* note 105, at 34-36, 52-54. The Bell Regulations were enacted after a patient treated by an overworked resident died after taking two contraindicated medications. *Id.* at 34-36.

[107] *See* discussion *supra* Part VI.

[108] *See* Ellen L. Luepke, *White Coat, Blue Collar: Physician Unionization and Managed Care*, 8 ANNALS HEALTH L. 275, 276-77 (1999).

[109] John P. Little, D.M.D., *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1402 (1997). In 1995, eighty-three percent of physicians contracted with a managed care plan, up from forty-three percent in 1986. Dionne Koller Fine, *Exploitation of the Elite: A Case for Physician Unionization*, 45 ST. LOUIS U. L.J. 207, 212 (2001).

[110] Fine, *supra* note 109, at 212-13.

[111] Luepke, *supra* note 108, at 276.

feel helpless to stand up for reasonable compensation, control over healthcare decisions, and stronger physician-patient relationships.[112] The legislative solutions proposed here can effectively increase the quality of care for many patients and consequently reduce the number of patients and physicians who feel a need to join concierge practices.

[112] *See* Fine, *supra* note 109, at 211-13.