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MANAGED CARE

Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain



**Health, Education, and
Human Services Division**

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The Honorable Trent Lott
The Honorable Don Nickles
The Honorable Larry E. Craig
United States Senate

For consumers, managed health care not only lowers out-of-pocket costs but has the potential to coordinate medical services and monitor the quality of care. Yet, as more Americans enroll in managed care plans, concerns have been raised about the ability of patients to make informed choices about their medical care. Patients have traditionally relied on physicians to educate them about the appropriate treatment for their conditions and to advocate with their insurers for coverage of necessary care. During the past 2 years, some physician and consumer advocacy groups have claimed that health maintenance organizations (HMO) impose contractual limitations—referred to as “gag” clauses—that interfere with the physician-patient relationship by impeding discussions of treatment options. Health plans contend that these contractual limitations were never intended to hinder communication between physicians and patients about medical care. The controversy has prompted many states to enact legislation to prohibit gag clauses in managed care contracts. Because some health plans are not affected by state laws, federal legislation is also being considered.

It has not been clear, however, how many health care plans include gag clauses in their contracts with physicians or whether such clauses actually inhibit medical communication with patients. Therefore, you asked us to examine (1) the types of contract clauses that could limit a physician’s ability to advise patients of all medically appropriate treatment options, (2) the extent to which these different types of clauses exist in current HMO contracts with physicians, and (3) the likely implications of HMO contract language on physician practice.

To answer these questions we undertook three separate efforts. We wrote to 622 HMOs asking them to submit copies of current contracts that are representative of their agreements with primary care and specialty care physicians. We collected 1,150 physician contracts from 529 HMOs, for a response rate of 85 percent. We reviewed each contract to identify clauses that could be described as specifically or potentially limiting medical communication, as well as clauses that support open discussion of all treatment options with patients. We also surveyed 400 attorneys who

specialize in managed care, asking them about their experience drafting and reviewing contracts between HMOs and physicians. Usable responses were received from 42 percent of our sample.

In addition, we held discussions with officials, staff, and members of eight professional medical societies to discuss their views and experiences with HMO contracting.¹ We also met with representatives from the American Association of Health Plans (AAHP) and the American Medical Association (AMA). To help develop our descriptions of contract clauses and our survey materials for HMOs and health care attorneys, we consulted with managed care contracting experts.

While our approach enabled us to capture a variety of perspectives about the nature of gag clauses, our analysis of their prevalence and implications was limited in two respects. First, we were not able to test the reliability of the HMO responses. Contracts sent to us may not be representative, or missing contracts may contain gag clauses. Second, because we did not investigate any other forms of written or oral communication between physicians and HMOs that could limit discussions of patient treatment options, our findings pertain only to constraints imposed in contracts. HMOs need not rely on written rules in their contracts to modify physician behavior, but may use guidelines, protocols, physician profiling, counseling, and approval procedures as well. (See app. I for a more detailed description of our data collection and analysis methodology.)

Results in Brief

The managed care industry, physicians, and health care attorneys have different views regarding contract language that could limit a physician's ability to advise patients of all medically appropriate treatment options. There is general agreement that a clause that prohibits discussion of procedures or providers not covered by the plan, and, to a lesser extent, one that requires physicians to consult with the plan before discussing treatment options with enrollees, is a gag clause. However, some physicians and health care lawyers believe that other clauses—such as those that bar physicians from disparaging the plan, soliciting patients to join another health plan, or revealing confidential plan information—could restrict the information and advice that physicians provide about a patient's medical options. Other physician groups and lawyers, and the HMO industry disagree that such clauses limit medical communication and

¹We met with the American Society of Internal Medicine, the American Psychiatric Association, the American College of Cardiology, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American College of Physicians, the American Society of Clinical Oncology, and the American Academy of Ophthalmology.

contend that these are standard contract clauses designed and used only to protect HMOs' business interests.

Of the 529 HMOs in our study, none used contract clauses that specifically restricted physicians from discussing all appropriate medical options with their patients. Two-thirds of responding plans and 60 percent of the contracts submitted had a nondisparagement, nonsolicitation, or confidentiality clause that some physicians might interpret as limiting communication about all treatment options. However, contracts with such business clauses often contained anti-gag language stating that the physician should not misconstrue the contract or a specific provision as restricting medical advice to patients or that the physician should foster open communication. Of those contracts with one or more of these business clauses, anti-gag language was found in 67 percent of them. This combination could mitigate the potential for business clauses to be read by physicians as limiting discussion of a patient's treatment options.

It appears that HMO contract provisions that may be interpreted as limiting the medical information that physicians may provide patients are not likely to have a significant impact on physician practice. Physicians we interviewed told us that, in general, they and their colleagues do not carefully read all of their contracts with HMOs. They maintained that they freely communicate with their patients regarding all medically appropriate care because habitual practice, professional ethics, and fear of medical liability are stronger influences on their behavior than contract requirements. Yet, physicians also pointed out that the increasing power of HMOs in the health care marketplace and their ability to terminate physician contracts can bring significant pressure to bear on physicians to modify their practice patterns or discussions with patients, without relying on the clauses discussed above.

Background

In January 1996, the AMA's Council on Ethical and Judicial Affairs issued a statement that gag clauses were an unethical interference in the physician-patient relationship. The AMA accused several large HMOs of having gag clauses and called on all HMOs to cancel contract provisions that physicians believed prevented them from communicating openly with patients. Throughout that year, several HMOs, including U.S. Healthcare and Humana, announced publicly that they were adding language to their contracts that supports open communication between physicians and

patients.² In a December 1996 policy statement, the AAHP's Board of Directors announced that "health plans, by contract or policy, will not prohibit physicians from communicating with patients concerning medical care, medically appropriate treatment options (whether covered or not), or from making factual and nonproprietary statements regarding the plan."

In recent years, several states have taken action on this issue as part of their efforts to strengthen consumer protections in managed care. As of July 1997, 32 states had passed laws that protect the right of physicians and patients to discuss all treatment options.³ In general, provisions in state legislation prohibit contracts from limiting providers from, or penalizing providers for, disclosing information to patients about their medical conditions or treatment options; advocating on behalf of patients; or providing information about HMO policies, including financial incentives or arrangements.

The federal government also has taken action against gag clauses by notifying HMOs and other health plans that they may not restrict what physicians tell Medicare or Medicaid patients about treatment options. In November 1996, the Health Care Financing Administration (HCFA) sent letters to 343 health plans informing them that an existing provision in the government's Medicare contract with the plans would be interpreted as banning gag clauses and calling for a free exchange of information between HMO physicians and patients.⁴ Two months later, the agency sent letters to state Medicaid directors warning that Medicaid HMOs that prevent physicians from discussing treatment options with patients violate federal law.

²In February 1996, U.S. Healthcare announced that it was revising its contracts to allow physicians to talk to patients about the way they are paid and to discuss proprietary company information if it is necessary or appropriate for the diagnosis and care of a patient. However, physicians are not allowed to discuss specific payment rates. In October 1996, Humana informed its providers that it would not enforce nondisparagement clauses in existing contracts, and as contracts are renegotiated or revised, such clauses would be removed.

³According to information obtained from the AMA and Families USA Foundation, the following states have passed patient protection legislation that addresses the gag clause issue: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wyoming.

⁴The notice said that "Medicare HMO patients were entitled to all benefits available in the standard Medicare program, which pays doctors a separate fee for each service." Among those benefits it cites "advice from doctors on medically necessary treatment options." HCFA therefore concluded that "any contract that limits a doctor's ability to advise and counsel a Medicare beneficiary was a violation of the federal Medicare law."

In February and March 1997, bills were introduced in the Congress to prohibit interference with certain types of medical communication between physicians and patients through contracts or agreements.⁵ Medical communication is defined as pertaining to the patient's health status, medical care, or treatment options; any utilization review requirements that may affect treatment options; or any financial incentives that may affect the patient's care. The provisions of the bills would apply to self-funded plans under the Employee Retirement Income Security Act of 1974 (ERISA), and states would be allowed to enforce these or higher standards on those plans subject to state regulation.⁶

What Constitutes a Gag Clause Is Subject to Interpretation

A commonly understood definition of a gag clause is a contract provision that limits physicians' ability to advise patients of all medically appropriate treatment options. There is little consensus, however, about whether certain clauses that may appear in HMO contracts meet this definition.⁷ Most agree that language that prevents physicians from giving patients complete information about their medical care choices or restricts the timing of such discussions is a gag clause. However, there is disagreement about other contract clauses that on their face serve a business purpose—such as those related to nondisparagement, nonsolicitation, and business confidentiality—but are open to physician interpretation. To minimize inappropriate interpretation of such clauses, some HMOs have developed anti-gag language supporting physician freedom to discuss a full range of treatment options.

Clauses That Specifically Restrict Communication Regarding Patient Care

Physicians, the managed care industry, and health care attorneys generally agree that any contract language that places an outright restriction on discussion of treatment options that could be beneficial but that the plan may not cover or may want to discourage for financial or other reasons is a gag clause. This would include contract provisions that bar physicians from discussing procedures that are considered experimental or other treatment alternatives the plan does not offer. It would also include clauses that prevent physicians in HMOs from telling patients about specialists or other providers not covered by their plan.

⁵See H.R. 586 and S. 449, each entitled The Patient Right to Know Act.

⁶Legislation to ban gag clauses in HMO contracts was introduced in the 104th Congress. It would have barred insurance plans covering private sector workers from restricting physician-patient communication regarding treatment options. The legislation failed to pass.

⁷In addition, we found no reported court cases that provide guidance on what constitutes a gag clause.

There is somewhat less agreement whether language that restricts the timing of discussions until after a recommended procedure has been approved by the plan is a gag clause. For example, contract clauses could require physicians to obtain permission from the health plan before discussing the possibility of hospital care with their patients. AMA and other physician associations contend that allowing the plan's utilization manager, medical director, or other plan representative to discourage discussion of certain treatments impedes a physician's ability to advise patients. Most health care attorneys who responded to our survey (91 percent of those representing physicians, 58 percent of those representing HMOs, and 75 percent of those representing both groups) agreed that this type of clause could, to a moderate or great extent, limit a physician's ability to inform patients about all treatment options. However, AAHP argues that this practice ensures quality care by facilitating the most accurate discussion of covered benefits.

Business Clauses That Could Interfere With Medical Communication

There is far less agreement about whether several other types of clauses found in contracts between physicians and HMOs, which on the surface serve a business purpose, could limit physician-patient communication concerning all treatment options. Most of the medical groups we met with told us that these clauses have a "chilling effect," denying physicians the flexibility needed to best advise patients about medical care. However, the HMO industry considers them standard contract provisions necessary to protect the plan's business interests and membership. The health care attorneys we surveyed were divided on whether such clauses could interfere with medical communication.

Nondisparagement Clause

Nondisparagement language requires a physician to refrain from making statements that could undermine patient, employer, union, or public confidence in the health plan. Such clauses may have a penalty, such as termination, attached. For example, one contract contained the following language: "[The plan] may terminate this agreement immediately, . . . if the Specialty Provider acts in such a way that undermines or may undermine the confidence of Members, potential Members or the public in [the plan] or in the quality of care which Members receive."

According to HMO industry representatives, nondisparagement clauses are meant to protect a plan's business interests by requiring that physicians dissatisfied with an HMO complain to the HMO and not to the patient. In May 1996 testimony before the Subcommittee on Health and Environment,

House Committee on Commerce, the President and CEO of AAHP testified that “the primary purpose of an anti-disparagement clause is simply to prevent a provider from involving patients in disputes and disagreements between physicians and health plans.” However, AMA and several other medical associations we met with believe that the nondisparagement language could preclude physicians from expressing disagreement with the plan’s coverage or utilization decisions regarding a course of treatment. Physicians told us that, if broadly interpreted, this clause could prevent physicians from criticizing or questioning a plan’s rulings on behalf of the patient.

The health care attorneys we surveyed had varied opinions on nondisparagement clauses. Sixty-four percent of attorneys representing physicians reported that such clauses could have a moderate to great effect on a physician’s discussion of patient treatment options, while 25 percent of those representing HMOs took this position, and 46 percent of those working with both groups agreed with this statement.

Nonsolicitation Clause

A nonsolicitation clause bars physicians from providing patients with information that might encourage them to enroll in another health plan. For example, a contract may state that the “. . . PHYSICIAN shall not directly or indirectly engage in . . . any action . . . which HEALTH PLAN may reasonably interpret to be designed to persuade a Member to discontinue his/her relationship with HEALTH PLAN, to disenroll from a plan or provider covered by a contract with HEALTH PLAN, or to encourage a Member to receive health care services from PHYSICIAN on a fee-for-service basis.” Such a clause would preclude a participating physician from informing patients about the benefit coverage offered by a competing health plan or that the physician’s health plan affiliation has changed.

The managed care industry believes that health plans should be able to prohibit physicians in their networks from soliciting patients to join a different plan that the physician also works for or will be leaving to work for. However, some physician associations expressed concern that such a clause could constitute “patient abandonment.” In their view, it is essential to notify patients in the course of treatment that their physician will not be able to continue their care under that plan.

Most health care attorneys responding to our survey indicated that nonsolicitation clauses would have little or no effect on physician

discussions of treatment options. Among the attorneys representing HMOs, 89 percent believed nonsolicitation clauses were not a problem for physician-patient medical communication; among those working with physicians, 68 percent shared this opinion, as did 75 percent of those representing both groups.

Although infrequent, some nonsolicitation clauses specify that, if the agreement between the plan and the physician is terminated, the physician is prohibited from communicating with plan members concerning the termination, the options available to members to join other plans or to switch to another doctor in the same plan, or that the physician “will no longer be the member’s health care provider.” Any such communication by a physician with a member or any attempt “directly, indirectly, or by implication, to advise or encourage” a plan member to disenroll from the plan, to switch to another plan, or to change providers is a breach of contract.⁸ According to the AMA, this type of contract provision has strong potential for inhibiting discussion of treatment options between a physician whose relationship with the plan has been terminated and his patients.

Business Confidentiality Clause

Business confidentiality clauses require physicians to maintain the confidentiality of such proprietary information as the plan’s payment and incentive structure, medical management criteria, and clinical practice protocols. One such clause reads “You agree to treat as confidential this Agreement (including the compensation provisions hereof), all provider and Covered Person listings, utilization data, reports and procedures, quality assurance procedures, credentialing procedures, and all other procedures, programs and protocols of [the plan] or Program Sponsors and You agree not to disclose any such information to anyone unless such disclosure is authorized in writing by [the plan] or required by applicable law.”

The HMO industry believes this type of contract clause protects their business interests. Testifying before the Subcommittee on Health and Environment, House Committee on Commerce, in May 1996, the President and CEO of AAHP stated that it is appropriate for health plans to restrict the disclosure of specific coverage decision procedures and compensation amounts because “the competition among health plans is intense, and the

⁸Although the plan agrees to notify members at least 30 days in advance of the physician’s termination, it is not clear that this will always be possible because the contracts in which this clause appears also provide that the plan may terminate the physician immediately in the event that any one of a dozen events occur.

release of such information about one plan can give its competitors an unfair advantage . . . and eliminate the incentive to find more effective methods for delivering care.”

Some physician associations argue that such contract provisions prevent physicians from telling a patient that the HMO financial arrangements may penalize them for making referrals to specialists.⁹ Nevertheless, most of the attorneys responding to our survey believe that confidentiality clauses are unlikely to restrict discussions of treatment options. Among attorneys representing physicians, 68 percent of those took this position, compared to 83 percent of those representing HMOs and 77 percent of those representing both groups.

Anti-Gag Clause Used to Minimize Inappropriate Interpretations

In an effort to mitigate any impact of clauses that physicians say hinder treatment discussions with patients, HMOs may include anti-gag statements in their contracts. In contrast to language that might limit medical communication, an anti-gag clause generally states that provisions in the contract are not to be construed as prohibiting discussions of care-related matters with patients. As expressed in one contract, “The parties agree further that nothing contained in this agreement shall be construed to alter the physician-patient, hospital-patient or health care provider-patient relationship or to interfere with the Group’s or Group Providers’ ability to provide necessary services in accordance with current medical standards.”

Some anti-gag clauses encourage physicians to discuss with their patients recommended treatments and medically appropriate alternatives. For example, one contract affirmed that “A primary care physician shall have the right and is encouraged to discuss with his or her patients pertinent details regarding the diagnosis of the patient’s condition, the nature and purpose of any recommended procedure, the risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment.”

In addition to anti-gag clauses that apply to the contract as a whole, some plans use exculpatory language applicable to a specific business clause. For example, in a nondisparagement clause, one contract stated that “This provision does not prohibit the Group or Group Providers from communicating any information relevant to treatment and Covered

⁹In March 1996, HCFA announced rules requiring managed care plans under Medicare and Medicaid to disclose financial arrangements for physicians to the agency and patients. In *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997), the court held that the failure of an HMO providing services for an employee benefit plan to disclose financial incentives that discourage referrals is a breach of its fiduciary duty.

Services, from responding to Members' queries regarding the Group and Group Providers' Agreement with [the plan], or from discussing the comparative merits of different health care payers even if such discussion is critical of [the plan]."

Current Contracts Contain No Specific Restrictions on Medical Communication, but Other Types of Clauses Appear Often

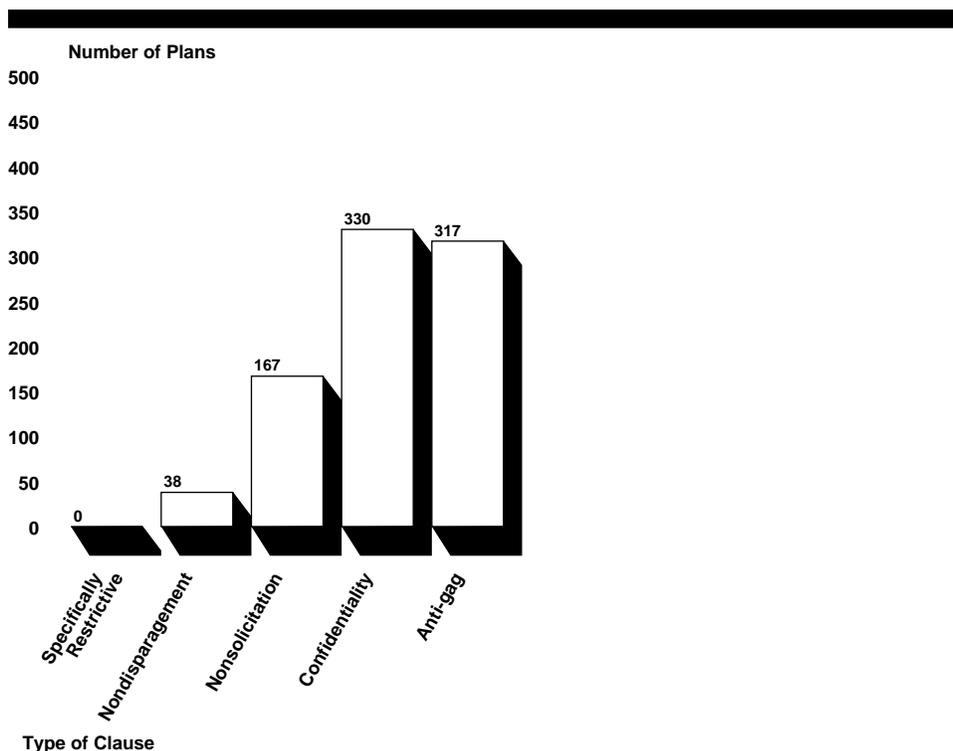
Of the contracts submitted for our review, none specifically restricted discussion of treatment options.¹⁰ Many contracts contained business clauses that—while they do not explicitly limit medical communication—may be viewed by physicians as having that effect. However, most plans did include anti-gag language in their contracts that could mitigate the potential for physicians to construe a contract or a particular provision as preventing them from giving patients complete information about treatment options or financial incentives to limit treatment.

Of the 529 HMOs in our study, two-thirds used one or more business clauses that could be interpreted as imposing restrictions on the exchange of care-related information between physicians and patients. Specifically, 7 percent used nondisparagement clauses, 32 percent used nonsolicitation clauses, and 62 percent used confidentiality clauses. In addition, 60 percent of all responding HMOs used anti-gag language asserting that the contract or a specific business clause does not seek to limit communications between physicians and patients concerning all treatment options.¹¹ (See fig. 1.)

¹⁰This finding is consistent with recent research on Medicaid managed care contracts showing few instances of explicit gag rule provisions. See Sara Rosenbaum, Peter Shin, Barbara Smith, and others, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (Washington, D.C.: The George Washington University Center for Health Policy Research, Feb. 1997).

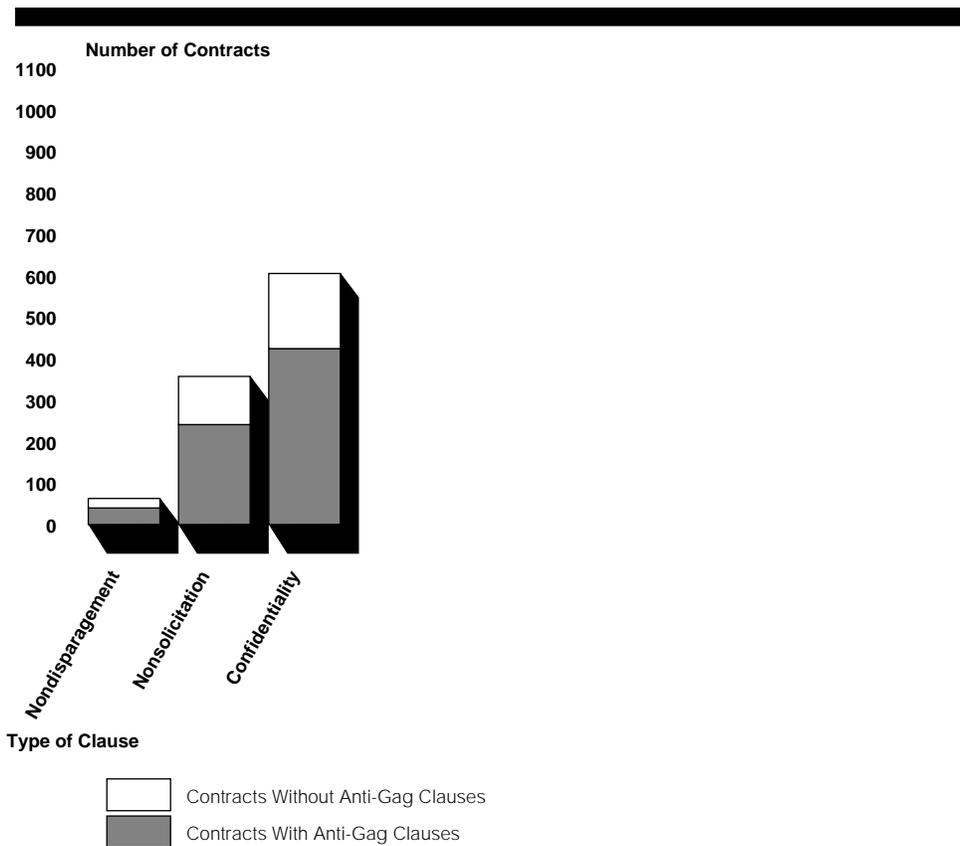
¹¹Because 54 percent of the plans included statements in their contracts that require physicians to comply with limitations set out in other documents, this accounting of contract clauses may not capture all of the potential limitations on physician discussion of treatment options.

Figure 1: Number of HMOs Using Restrictive, Nondisparagement, Nonsolicitation, Confidentiality, and Anti-Gag Clauses



At the contract level, anti-gag language was fairly prevalent in combination with clauses that physicians might interpret as barring them from informing a patient of all medically appropriate treatment alternatives. In 1,150 contracts currently used to engage physicians, 60 percent contained at least one of the three business clauses and 67 percent of those contracts included anti-gag language that could counteract the view of some physicians that the clauses restrict medical communication. Anti-gag language applicable to the contract or a particular provision (and commonly both) were found in 64 percent of contracts that had a nondisparagement clause, 68 percent of the contracts with some form of nonsolicitation clause, and 70 percent of the contracts that contained a business confidentiality clause. (See fig. 2.) Even in contracts with none of the three business clauses that could be viewed as potentially restrictive, 27 percent contained anti-gag provisions.

Figure 2: Number of Contracts Containing Nondisparagement, Nonsolicitation, or Confidentiality Clauses, With and Without Anti-Gag Clauses



Recently, physician networks have started their own health plans to compete with traditional insurance companies and managed care organizations. One presumed advantage of this type of arrangement is that decisions about patient care are not encumbered by constraints from managed care entities. However, the same issues of restrictive contract language arise in provider-based delivery systems. Of the HMOs in our review that identified themselves as being owned and operated by physicians, none used specifically restrictive language and 54 percent used at least one of the business clauses that could be interpreted as limiting participating physician ability to inform patients about the range of treatments available for their conditions. In addition, 43 percent used anti-gag language to clarify that medical communication between physicians and patients is not being constrained.

Business Clauses, Per Se, Unlikely to Affect Physician Practice

Based on our interviews with physician groups, it appears that HMO contract provisions that may be interpreted as limiting the medical information provided to patients are not likely to have a significant impact on physician practice. Such clauses may not actually interfere with patient communication about treatment options because physicians are not fully aware of them, do not interpret them as hindering communication, or choose to disregard them. Still, physicians are concerned about discipline or the threat of termination by health plans for lack of adherence to plan utilization management policies. They say that “terminate at will” clauses in their contracts and their economic dependence on managed care reinforce HMO policies on physician management of patient care and costs.

Physician-Patient Communication Influenced by Many Factors

There are a number of reasons why physicians may not comply with clauses in their HMO contracts. The physician groups consulted in this review reported a lack of awareness of contract language, noting that physicians—especially those under contract with multiple health plans—seldom read the provisions in their HMO agreements carefully. They told us that their behavior is more likely to be influenced by training and experience, professional ethics, and malpractice concerns than by any restrictions imposed by an HMO. As one health care attorney put it, gag clauses “are essentially unenforceable as a practical matter, and doctors are going to talk with their patients regardless of the contract clause.”

According to practicing physicians, their communication with patients is largely governed by their professional code of conduct.¹² Under the principle of informed consent, physicians have an ethical and legal duty to provide patients with information about the benefits, risks, and costs of various treatments. For the most part, medical professionals consider their primary obligation to be to the patient, and patients look to them to be their advisers and advocates, regardless of any contract provisions to the contrary. In 1996, AMA’s Council on Ethical and Judicial Affairs addressed concerns that contractual restrictions on physicians acting in their role as patient adviser could jeopardize informed consent.¹³ It stated that “the physician’s obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient’s managed care plan. Patients cannot be subject to making decisions with

¹²AMA’s Code of Medical Ethics is the governing code of ethics for physicians and is recognized as the profession’s standard by state medical boards, state and federal courts, and the Congress.

¹³For a discussion of the potential conflict of interest of physicians, see Institute of Medicine, Committee on Choice and Managed Care, Improving the Medicare Market: Adding Choice and Protections (Washington, D.C.: National Academy Press, 1996).

inadequate information. This would be an absolute violation of the informed consent requirements.”¹⁴

Some physicians expressed concern that withholding information from patients, even under instructions from an HMO, could increase their risk of being sued. In fact, a study of malpractice depositions identified communication problems between physicians and patients in 70 percent of cases.¹⁵ Others believe that adherence to contract restrictions could result in poorer outcomes and, thus, increase their exposure to medical malpractice claims.

Communication Restrictions Could Be Enforced Through Termination Clauses

Many physicians and attorneys believe that the most powerful incentive for a physician to cooperate with HMO policies on physician-patient communication is the possibility that his or her contract could be canceled. Of the contracts reviewed for this study, nearly all were initially written for a period of 1 year or less, and were renewable for 1-year periods. To the extent that the plan threatens the economic well-being of those ignoring its contract provisions, physicians may feel forced to be more compliant. This is more likely to be the case in regions where managed care dominates the local health care market than where managed care is less prevalent.

One means HMOs have for enforcing physician adherence to plan policies, procedures, and utilization management guidelines is the “without cause” or “at will” termination clause, which we found in 72 percent of the HMO contracts we reviewed. This clause allows an HMO to terminate its contract with a physician without having to specify a reason, generally with a notice period of 30, 60, or 90 days.¹⁶ The HMO industry considers this a standard business clause, giving plans the ability to direct and control its physician network to ensure high-quality medical care. One physician group we met with agreed, saying that HMOs must be able to remove poor-performing physicians from their network.

However, other physicians we spoke with said that terminate-at-will clauses provide an incentive for physicians to comply with restrictions on

¹⁴Report of the Council on Ethical and Judicial Affairs, CEJA Report 1-A-96 (Chicago, Ill.: AMA, 1996) .

¹⁵See H.B. Beckman, K.M. Markakis, A.L. Suchman, and others, “The Doctor-Plaintiff Relationship: Lessons From Plaintiff Depositions,” *Archives of Internal Medicine*, Vol. 154 (1994), pp. 1365-70.

¹⁶This provision limits the physician’s legal ability to contest the discharge because no cause of the discharge is given. See Julia A. Martin and Lisa K. Bjerknes, “The Legal and Ethical Implications of Gag Clauses in Physician Contracts,” *American Journal of Law & Medicine*, Vol. 22, No. 4 (winter 1996), pp. 433-76.

patient communication. An attorney who represents physician groups in contract negotiations told us that compliance with restrictive language “may be somewhat difficult to enforce but the physician is very much aware that a contract breach may likely result in termination from the HMO.” A similar point was made by one of the health care attorneys responding to our survey who commented, “I have recently seen communications from plans advising that termination without cause could result from physicians’ expression of opinion to patients and others on issues relative to level of care and length of stay, if those opinions were at variance from the opinions of the plan medical directors or utilization management personnel.”

Physicians also told us that the termination clause becomes especially relevant in regions where the health care marketplace is dominated by a few large managed care plans. In this situation, physicians may be less willing to challenge HMO policies because they view their participation in managed care plans as essential to sustain their practice. Many physicians, especially those in oversupplied specialties, believe that they have a weak bargaining position and are vulnerable in these relationships.¹⁷ Aware of the possibility of termination, physicians and other practitioners may feel that they must become “managed care friendly.”

Conclusion

The dispute over gag clauses appears to be part of the broader criticism of managed care. The HMO industry is facing growing criticism from consumer groups and physicians over a variety of practices that they consider to be too restrictive. However, restrictive gag clauses in contracts, by themselves, do not appear to be limiting physicians’ ability to advise their patients about all medically appropriate treatment options. Even taking into account the prevalence of business clauses that could be interpreted by physicians as interfering with medical communications, it is unlikely that these contract clauses actually limit physicians’ discussions of all treatment options with their patients. Rather, it is the contractual relationship itself—its short duration and provision for termination without cause—that may make physicians feel constrained from speaking openly with their patients.

Because information in this report does not pertain to federal agencies, we did not seek agency comments. We did, however, obtain comments on our

¹⁷Lynn Etheredge and Stanley B. Jones. “Consumers, Gag Rules, and Health Plans: Strategies for a Patient-Focused Market,” *Research Agenda Brief*, Health Insurance Reform Project (Washington, D.C.: George Washington University, May 1997).

draft report from experts in managed care and health care law. They generally agreed with the information presented.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to interested parties and make copies available to others on request. If you or your staff have any questions regarding this report, please call Rosamond Katz on (202) 512-7148 or me on (202) 512-7119. Major contributors to this report are listed in appendix II.



Bernice Steinhardt
Director, Health Services Quality
and Public Health Issues

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Abbreviations

AAHP	American Association of Health Plans
AMA	American Medical Association
HCFA	Health Care Financing Administration
HMO	health maintenance organization

Data Collection and Analysis Methodology

This appendix describes the approaches we used to examine the nature, extent, and implications of gag clauses in contracts between participating physicians and HMOs. First, we requested contracts from HMOs and reviewed them for evidence of gag clauses. Second, we surveyed lawyers knowledgeable about managed care contracting to learn about their views of various types of contract clauses. Finally, we met with physicians from national medical associations to discuss their experiences in contracting with HMOs. The following discusses the scope, data sources, and the methodology used for each of these efforts.

Collecting and Analyzing HMO Contracts

To determine the prevalence of gag clauses, we sent letters to 622 HMOs asking them to forward contracts for our review.¹⁸ These HMOs represented the universe of plans in operation as of January 1, 1996, as compiled by Interstudy, Inc.¹⁹ In our letter, we requested a representative sample of contracts through which the HMO currently engages physicians, including both direct contracting and subcontracting arrangements. We asked each plan to submit a copy of a representative contract (including amendments) used with primary care physicians and specialists.²⁰

In our letter, we assured the HMOs that the information they submitted to us would be aggregated with information obtained from other sources and that individual respondents would not be separately identified. After a follow-up mailing, we received 1,150 physician contracts from 529 plans, for a response rate of 85 percent of plans.²¹

¹⁸The letter to the HMOs cited our authority (under 29 U.S.C. 1143a) to study “employee benefit plans.” For the purpose of conducting such studies, we have access to the records of parties, including managed care organizations, that are providing services to those employee benefit plans.

¹⁹See *The Interstudy Competitive Edge: HMO Directory 6.2* (St. Paul, Minn.: Interstudy, Aug. 1996). In some cases, the HMO responding to our request submitted contracts that were used by a number of affiliated plans that had been listed individually in the directory. We recorded this response as if it was from each of the individual plans, rather than a single parent entity. In cases where HMOs had merged since the directory was compiled, we recorded the responses from the new entity as representative of each of the former plans. This was done to maintain consistency with the original listing in the directory.

²⁰In asking for copies of representative contracts, we stipulated that such contracts should be reasonably typical of the plan’s universe of contracts with physicians. A contract would be representative, for example, if it (or substantially similar versions of it) covered a majority of physicians under contract or if it contained relevant clauses that are common to the plan’s contracts with a majority of physicians.

²¹The size and geographic distribution of nonrespondents were similar to those plans that did submit contracts. Some of the plans that did not submit contracts notified us that they were no longer offering an HMO product or were not operating as an employee benefit plan.

In addition to requesting contracts, we asked each HMO to provide information on a variety of descriptive characteristics. A compilation of their responses shows the following profile of those HMOs responding to our request letter:²²

- 70 percent were independent practice association or network model HMOs;
- 46 percent had fewer than 25,000 enrollees, 18 percent had 25,001 to 50,000 enrollees, 10 percent had 50,001 to 100,000 enrollees, and 26 percent had more than 100,000 enrollees;
- the median number of primary care physicians under contract with each plan was 727 and the median number of specialists was 1,547;
- 74 percent contracted to serve Medicare beneficiaries, Medicaid recipients, or both;
- 39 percent of respondents were nationwide HMO companies; and
- 67 percent identified their tax status as for-profit, 14 percent as nonprofit (taxable), and 18 percent as nonprofit (nontaxable).

To facilitate the review of contracts, we identified various types of contract clauses that could impede a physician's ability to advise patients of all medically appropriate treatment options. We developed descriptions of restrictive, nondisparagement, nonsolicitation, confidentiality, anti-gag, and terminate-at-will clauses in consultation with health care attorneys and managed care consultants with expertise in HMO contracting. We reviewed the contracts submitted by the HMOs and recorded the presence of each clause that we judged to meet one of the descriptions we developed. A plan was recorded as using a particular clause if any one of its contracts contained such language.²³

In two respects, this approach limits our ability to generalize about the extent of HMO restrictions on medical communication. First, we were not able to test the reliability of the HMO responses; contracts sent to us may not be representative or missing contracts may contain gag clauses. Second, some physicians and health care attorneys have indicated that efforts to control physician communication with patients may also take noncontractual forms, such as policy statements in a provider manual or

²²For the most part, these data were supplied by the HMOs submitting contracts. Where a respondent failed to provide complete information on plan characteristics, we obtained data on missing elements from the Interstudy Directory, if available. Therefore, this analysis accounts for 75 to 93 percent of responding HMOs.

²³As one would expect, we found among plans a great deal of variation in the language of clauses within the same category. For example, some nonsolicitation clauses are worded broadly to prohibit any communications that might influence a patient to change plans, while others are limited to specific efforts by physicians to convince patients to change. The classifications of clauses are therefore to some extent judgmental.

discussions with a medial director. An examination of these forms was beyond the scope of this review.

Survey of Health Care Attorneys

We obtained a list of about 8,500 attorneys from the National Health Lawyers Association directory. From this list, 1,505 attorneys were identified as knowledgeable about managed care. Of those attorneys, 1,023 primarily represented payers, including HMOs; 344 represented physicians or other providers; and 138 were associated with other groups. From each of the first two subgroups we selected a random sample of 200 attorneys, 400 in total, for our mail survey.

The survey consisted of multiple-choice questions that asked about the attorney's perceptions and experiences reviewing or drafting contracts between HMOs and physicians. After we mailed a follow-up letter, our overall response rate was 63 percent. However, we excluded from our analysis 87 respondents who were not sufficiently experienced in HMO-physician contracting to complete the survey. Of the final 166 respondents, 36 told us that they primarily represented HMOs, 86 mostly represented physicians, and 44 said that they represented both physicians and HMOs.

Discussion Groups With Practicing Physicians

To obtain the perspective of physicians, we held discussions with members from eight professional medical societies: the American Society of Internal Medicine, the American Psychiatric Association, the American College of Cardiology, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American College of Physicians, the American Society of Clinical Oncology, and the American Academy of Ophthalmology. At each discussion group, we interviewed 3 to 11 practicing physicians, as well as officials and staff of the association. In total, we spoke with 42 physicians.

At these meetings, we sought the physicians' opinions about what constitutes a gag clause, their familiarity with clauses in their contracts, and the implications of such clauses on how they interact with their patients. We also asked about the potential influence of other written and verbal communications with the HMO on their ability to inform patients of all medically appropriate treatment options.

We conducted our review between February and July 1997 in accordance with generally accepted government auditing standards.

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