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The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?

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by Barbara A. Noah*

I. INTRODUCTION

During the past decade, the United States health care system has undergone a transformation from a market comprised mainly of self-employed physicians in solo or small group practices to one in which far fewer physicians engage in this type of independent practice.[1] More than three quarters of the physicians in this country now practice medicine within some form of managed care organization ("MCO") or see some managed care patients.[2] "Managed care" is a term used to describe a variety of organizations that control costs and utilization of health care services through techniques such as using physicians as "gatekeepers" for hospitalization and specialists and requiring prepayment by subscribers for services.[3] The rate of patient enrollment in MCOs continues to increase rapidly, with approximately sixty million Americans currently enrolled in health maintenance organizations ("HMOs") and another ninety million in other types of managed care

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1. *See* BARRY R. FURROW ET AL., HEALTH LAW 97 (Supp. 1995) (noting that, as late as 1987, more than half of U.S. physicians were in such practices but that the figure had fallen to just 37% by 1993).

2. *See* GENIE JAMES, MAKING MANAGED CARE WORK 93 (1997).

3. *See* PHYSICIANS IN MANAGED CARE: A CAREER GUIDE 22 (Mark A. Bloomberg & Steven R. Mohlie eds., 1994) (defining "managed care" as a system "with the objective of influencing and changing the behavior of providers and of patients . . . in order to affect health care delivery so that covered services of good quality are provided at the least cost possible").

plans.[4] Estimates suggest that if enrollment continues at the current rate, eight out of ten Americans will receive care from some sort of MCO by the year 2000.[5]

Not surprisingly, as growing numbers of patients receive health care services from MCOs, criticisms have proliferated about the quality of care provided by these organizations. In the past few years, HMOs in particular have faced escalating consumer and physician complaints about the effects of cost-cutting on patient care. The public increasingly perceives the care provided through MCOs as inferior to traditional fee-for-service care.[6] Responding to constituent pressures, legislatures in more than twenty states recently have considered bills regulating managed care practices,[7] and Congress has now taken up the issue.[8] Even some employers who offer access to managed care plans as part of their benefits packages have begun to scrutinize HMOs more closely.[9]

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4. *See* Robert Pear, *Laws Won't Let H.M.O.'s Tell Doctors What to Say*, N.Y. TIMES, Sept. 17, 1996, at A12. Other reports estimate that enrollment in HMOs is growing at the rate of nearly 500,000 persons per month. Robert Pear, *Elderly and Poor Do Worse Under H.M.O. Plans' Care*, N.Y. TIMES, Oct. 2, 1996, at A10.

5. *See* PRIVATE SECTOR ADVOCACY AND SUPPORT TEAM, AM. MED. ASS'N, MANAGED CARE AND THE MARKET: A SUMMARY OF NATIONAL TRENDS AFFECTING PHYSICIANS 2 (1995) (noting that approximately 40% of Americans are enrolled in either HMOs or PPOs and estimating that the rate of enrollment would increase 10-15% annually during the next several years); *see also* Ellyn Spragins, *Does Your HMO Stack Up?*, NEWSWEEK, June 24, 1996, at 56 (reporting that enrollment in HMOs has climbed from 6 million in 1976 to 53.3 million in 1995 and is projected to reach 103.2 million by 2000).

6. Recent widespread publicity about HMO cost-control methods has led to a public perception that the quality of care delivered by these organizations, or by their physicians, is substandard compared with fee-for-service care. *See* Stuart Auerbach, *Managed Care Backlash: As Marketplace Changes, Consumers are Caught in the Middle*, WASH. POST., June 25, 1996, at Z12 (discussing study reporting that 53% of respondents felt that the healthcare system was getting worse while only 38% believed it was improving).

7. *See* George Anders & Laura Johannes, *Doctors Are Losing a Lobbying Battle to HMOs*, WALL ST. J., May 15, 1995, at B1; *see also* Bruce D. Platt & Lisa D. Stream, *Dispelling the Negative Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of Care Provided by Health Maintenance Organizations*, 23 FLA. ST. U. L. REV. 489, 493-98 (1995) (discussing anti-managed care legislation).

8. *See* Robert Pear, *Congress Weighs More Regulation on Managed Care*, N.Y. TIMES, Mar. 10, 1997, at A1, A11 (discussing congressional consideration of legislation to protect consumers of managed care services).

9. *See* Steve Sakson, *HMOs Face Restrictive Legislation*, GAINESVILLE SUN, Mar. 15, 1996, at 1A, 6A. Although large corporations strongly support managed care because of its cost efficiency, several corporations have implemented measures to make MCOs more accountable for quality of care. These measures include ranking the HMOs available to employees, discounting monthly premiums for those employees who select the highly ranked providers, and demanding statistical information about effectiveness of care for a variety of diseases. *See id.*

Disputes persist about the quality of care delivered by HMOs and other managed care providers.[10] Critics argue that MCOs will overuse cost-cutting methods and thus provide inferior care to pocket greater profits.[11] In an effort to contain costs, MCOs undeniably make decisions that affect the quality of care, but health care costs cannot continue rising without limitation. Government or private insurance can no longer pay for all medically beneficial treatments for covered individuals without risking bankruptcy.[12] Health care costs now account for nearly fourteen percent of the country's Gross Domestic Product, and this percentage will likely continue to increase.[13] Medical spending increased at an average annual rate of 4.8% from 1960 to 1993.[14] The shift to managed care has magnified dramatically the competing exigencies of quality care and cost control.

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10. New industry-wide data became available under voluntary standards developed by the National Committee for Quality Assurance ("NCQA"), which recently called for HMOs to collect and disclose quality of care data. The NCQA is asking HMOs to disclose information such as whether patients with severe heart disease receive a class of effective medications known as beta-blockers, whether health plans actively advise members to quit smoking, how well HMOs follow-up patients with abnormal pap smears and mammograms, and how well HMOs work to prevent pneumonia in HIV-positive patients. *See* George Anders, *New Rules Press HMOs to Disclose Data: Quality Panel's Standards Cover the Treatment of Cancer Coronaries*, WALL ST. J., July 16, 1996, at A3, A4. After a comment period, the standards went into effect in the fall of 1996 and allow consumers and employers to compare plans more effectively. *See id.*; George Anders, *Polling Quirks Give HMOs Healthy Ratings*, WALL ST. J., Aug. 27, 1996, at B1 (noting that "artful" polling techniques can improve an HMO's member satisfaction scores).

11. *See, e.g.*, Kenneth R. Pedroza, *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 411 (1996) ("[T]he incentive structure created is for the MCO to use fewer resources per patient as a means of realizing a greater profit . . . . When physicians are pressured into underutilization, there is a danger that the quality of care provided will fall below the legally required standard.").

12. *See* JAMES, *supra* note 2, at 25 ("The daunting challenge facing the healthcare industry today is to identify the means to manage the transition and stay financially viable . . . .").

13. *See* BUREAU OF CENSUS, U.S. DEPT. OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1996 (116th ed. 1996), at 111; *see also Health-Care Prognosis*, BUS. WK., Apr. 7, 1997, at 8 (estimating that health care expenditures will constitute 18% of the Gross Domestic Production by the year 2005).

14. *See* Edgar A. Peden & Mark S. Freeland, *A Historical Analysis of Medical Spending Growth, 1960-1993*, HEALTH AFF., Sum. 1995, at 235 (noting also that the overall growth during this period was 373% in real per capita medical spending). Factors such as insurance coverage elasticities and demographic factors such as age, gender, and income growth explain only part of this rate of increase, and the increased capability and availability of medical technology accounts for a sizeable portion of the remainder. *See id.* at 235-36.

Notwithstanding the rapid and substantial transformation of the American health care market, the American legal system has acknowledged only gradually the advent of these fundamental changes, especially the tensions that exist between managed care and the traditional view of medicine in the context of medical malpractice litigation. Those who perceive a conflict between the existing malpractice standard and the need for cost containment tend to assume that cost control necessarily results in a deviation from the traditional medical standard of care. In the past several years, courts have held MCOs liable for medical malpractice akin to the corporate and vicarious liability of hospitals. As courts continue to develop and expand different theories for the imposition of such liability, MCOs will have to grapple with the financial consequences of ever-escalating tort claims while attempting to contain the costs of providing health care to their members.

Although valid criticisms have been leveled against the quality of care delivered by MCOs, recourse to the courts may not provide the optimum solution to the problem. In fact, the imposition of tort liability on MCOs fundamentally challenges the health care philosophy underlying managed care. These organizations evolved in part as a response to the growing scarcity and spiraling costs of medical resources. Individuals seeking both preventive and acute health care understandably desire the best available technology and the most thorough treatment protocols, but it is difficult to reconcile those preferences with managed care's goal of containing costs while providing access to a reasonable standard of care for a diverse patient population. If courts increasingly hold MCOs liable for the effects of their cost-containment measures, it will become more difficult for these organizations to provide wide and relatively inexpensive access to health care services.

Part II of this Article provides a brief description of the different types of managed care organizations and explores the philosophy of managed care, particularly regarding cost containment. Part III canvasses the different theories for imposing liability on MCOs for the effects of cost-containment measures as well as for the malpractice of their physicians. Part IV considers problems associated with the imposition of tort liability, and Part V suggests alternatives to tort liability and explores the ethical implications of reforms that exclude corporate liability altogether. Ultimately, this Article concludes that managed care organizations should receive statutory immunity from malpractice suits so long as government officials meaningfully regulate the delivery of health care services by these entities.

II. EMERGENCE OF THE MANAGED CARE INDUSTRY

To assess the consequences of imposing tort liability on MCOs, one must first understand their basic structure. Managed care organizations include HMOs and other "alternative" health care delivery systems that differ in structure from traditional fee-for-service care.[15] Although this discussion will focus on HMOs, the descriptions below include some of the less common forms of MCOs as well.

A. *Varieties of Managed Care Organizations*

A number of alternative delivery systems have developed to allow for more effective management of health care. Each of these organizations differs in some way from the traditional fee-for-service mode of delivery in which patients or their insurers pay independently practicing physicians a separate fee for each visit or service. Managed care organizations vary in their degree of integration, ranging from simple associations of physicians to joint ventures between physicians and hospitals and, at the extreme end of the scale, to HMOs that fully integrate the insurance and provider aspects of health care delivery.

Generally, HMOs enroll subscribers who prepay a set fee in exchange for both primary care and hospital-based acute care over a certain period of coverage.[16] The enrollment fee remains set regardless of the actual costs of the services utilized by any individual subscriber. HMOs contract with participating physicians to provide office-based primary care and with hospitals to provide acute care. Thus, HMOs function as both insurers and health care providers.[17]

HMO structures vary, but most health maintenance organizations fit into one of three basic models. In the "staff" model, the HMO directly employs its physicians, who work in a centralized care facility and receive salaries from the HMO.[18] In the "group" model, physicians form a partnership or corporation that in turn contracts with the HMO to deliver health care to the organization's subscribers. Physicians in the

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15. *See* Diana J. Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 288-89 (1995) (noting that "[t]hese systems have become so much a part of the mainstream of health care delivery that it is now out-of-date to refer to them as 'alternative'").

16. *See* DONALD K. FREEBORN & CLYDE R. POPE, PROMISE AND PERFORMANCE IN MANAGED CARE: THE PREPAID GROUP PRACTICE MODEL 20-21 (1994).

17. *See id.* at 20 ("The HMO assumes at least part of the financial risk in the provision of services.").

18. *See id.* at 20-23; *see also* Kate T. Christensen, *Ethically Important Distinctions Among Managed Care Organizations*, 23 J.L. MED. & ETHICS 223, 224 (1995).

group, acting as independent contractors for the HMO, care for HMO members at the group's health care facility in exchange for a fixed monthly fee for each enrollee.[19] The group collects these "capitated" fees from the HMO and pays its physicians a base salary and bonuses, usually structured as financial incentives of some sort.[20] Finally, in the "independent practice association" ("IPA") model, an independent physician group, usually a partnership or corporation comprised of independent practicing physicians, contracts on behalf of its members to provide services for the HMO. In the IPA model, physicians practice in their own separate facilities and often continue to practice outside of the HMO. The HMO pays the IPA a capitation fee, and the IPA then compensates the participating physicians based on separate contracts between the IPA and the individual physicians.[21] As explained more fully below, health maintenance organizations also vary dramatically in their methods of risk sharing, utilization review, and internal management.

The various HMO models represent the most common types of organizations that deliver managed care, but other managed care entities are becoming more common as well. For example, IPAs also negotiate payment contracts with other types of insurers to provide care and then pay their member physicians on a fee-for-service basis. Member physicians frequently practice independently outside of their IPAs or join multiple IPAs. Although some IPAs simply negotiate with insurers, others may also engage in utilization review, set practice standards, or engage in other administrative functions such as billing and purchasing for the group in order to reduce costs.[22]

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19. *See* FREEBORN & POPE, *supra* note 16, at 21; *see also* Christensen, *supra* note 18, at 225.

20. *See* Christensen, *supra* note 18, at 224.

21. *See* Bearden & Maedgen, *supra* note 15, at 293.

22. *See* FURROW, *supra* note 1, at 98. A physician-hospital organization ("PHO") is comprised of a hospital and its affiliated physicians and, like the IPA, contracts with payors on behalf of its hospital and physician members. A PHO negotiates health plan contracts and in some instances undertakes utilization review, quality assurance, or credentialing of physicians. As with IPAs, some PHOs also attempt to centralize some of the management functions of the organization, and participating physicians typically continue to practice independently and maintain contracts with payors other than those affiliated with the PHO. Although the typical PHO is comprised of one hospital and its medical staff, some PHOs may be structured as joint ventures between hospitals and physician organizations such as IPAs or other large medical groups. Some PHOs are "open," that is, open to all of the hospital's affiliated physicians, while others are "closed," enabling the PHO to accept some physicians and exclude others from participation. *See id.* at 98-99.

Preferred provider organizations ("PPOs") negotiate fees with groups of providers, physicians or hospitals, often at discounted rates.[23] In contrast to HMOs, PPOs generally contract to pay participating providers on a discounted fee-for-service rather than capitation basis.[24] Many PPO physicians maintain separate practices outside the organization or participate in more than one PPO.[25] Individual subscribers pay premiums to the PPO, and the organization reimburses participating hospitals and physicians for their services.[26] Moreover, patients who subscribe to PPOs may visit nonaffiliated doctors, but the plans impose financial disincentives such as larger co-payments and deductibles when patients choose nonpreferred providers.[27]

B. The Cost-Containment Philosophy of Managed Care

No matter what their form, managed care organizations seek to control costs by restricting how and where patients can seek medical treatment. MCOs employ a variety of cost-containment strategies, including reliance on primary care physicians to serve as gatekeepers for specialist care, reduced hospitalization through outpatient procedures, the use of drug formularies, rigorous prospective utilization review, and refusals to cover virtually any experimental therapies.[28] In particular, HMOs seek to control the use of outside facilities and specialists because the overuse of such services would pose a threat to the fiscal stability of the HMO.[29] For this reason, the gatekeeper function of primary care physicians, who must evaluate enrolled patients before determining the necessity of referrals to specialists, plays an essential role in keeping costs low.

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23. *See* FREEBORN & POPE, *supra* note 16, at 25-26.

24. *See* Christensen, *supra* note 18, at 224.

25. *See id.* (noting that "[b]ecause these physicians are still paid per service rendered, an inherent incentive arises to generate more health care costs by seeing patients more often and/or by ordering more tests and interventions").

26. *See* Bearden & Maedgen, *supra* note 15, at 297-98.

27. *See* BARRY R. FURROW ET AL., HEALTH LAW 723-24 (2d ed. 1991).

28. *See* David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 RICH. L. REV. 155, 158-60 (1996). For an example of the last type of coverage limitation, see Certificate of Coverage for the State of Florida Employee's Group Insurance Program of the AvMed Health Plan (1996), at 52-53 (denying coverage for "experimental or investigational treatment," defined as including all drugs and medical devices that have not received approval for marketing by the Food and Drug Administration ("FDA"), treatments in any phase of FDA-monitored clinical investigations, and other treatments, therapies and devices if "[t]here is no consensus among practicing physicians that the treatment, therapy or device is safe or effective for the treatment in question"); *see also* Lars Noah, *Constraints on the Off-Label Uses of Prescription Drug Products*, 16 J. PROD. & TOXICS LIAB. 139, 142-44 nn.10 & 18 (1994).

29. *See* Bearden & Maedgen, *supra* note 15, at 294.

Other common methods for reducing referrals include using maximum utilization quotas for referrals to outside services and withholding a percentage of the physicians' salaries in a risk pool to cover overuse of specialist services.[30] Some MCOs also discourage or prohibit provider physicians from discussing noncovered treatment options with their patients, a practice that recently has attracted widespread criticism from physicians and government officials.[31]

Financial incentives for physicians to limit patient care represent perhaps the most significant of these cost-containment measures. Alternative compensation methods to the traditional fee-for-service approach contain imbedded financial incentives to limit care.[32] Because physicians will earn the same amount of money regardless of how much care they provide, both the salary and the capitation approach to compensation encourage physicians to limit the amount of care they deliver.[33] Although salary and capitation may discourage excessive care, physicians may respond by altering the mix of services given to patients, increasing the number of diagnostic procedures recommended,

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30. *See id.* at 294-95.

31. President Clinton recently announced a federal policy restricting this practice among HMOs that treat Medicaid patients, and he urged Congress to adopt legislation extending this protection to all patients enrolled in managed care plans. *See* Laurie McGinley, *Clinton to Prohibit Use of 'Gag Clauses' Under Medicaid*, WALL ST. J., Feb. 20, 1997, at A22; Robert Pear, *Clinton Prohibits H.M.O. Limit on Advice to Medicaid Patients*, N.Y. TIMES, Feb. 21, 1997, at 22 (noting that physicians who flouted rules discouraging them from discussing expensive treatments with patients have faced criticism and retaliation from the HMOs with which they are affiliated). The Department of Health and Human Services recently made a similar announcement concerning HMOs that receive Medicare funds, concluding that because Medicare HMO patients are entitled to all benefits available under Medicare, contracts limiting physicians' ability to discuss treatments with Medicare patients would violate federal law. *See* Robert Pear, *U.S. Bans Limits on H.M.O. Advice Within Medicare*, N.Y. TIMES, Dec. 7, 1996, at A1. In 1996, sixteen states adopted laws barring HMOs from limiting what physicians can tell patients about potential treatments. *See* Pear, *supra* note 4, at A12.

32. *See* Carolyn M. Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?*, 273 JAMA 338 (1995). Under traditional fee-for-service care, the financial incentive to overtreat also gives rise to patient complaints, though of a different nature. Although many patients in fee-for-service insurance plans are satisfied because they perceive more care as better care, some patients complain that the provider has delivered unnecessary care. *See id.* at 338-39; *see also* Natalie Angier, *In a Culture of Hysterectomies, Many Question Their Necessity*, N.Y. TIMES, Feb. 17, 1997, at 1.

33. *See* Orentlicher, *supra* note 28, at 159. "With capitation, physicians have an incentive to increase the number of patients for whom they have responsibility while, with salary, physicians have an incentive to reduce the number of patients for whom they have responsibility." *Id.* "Accordingly, salaried physicians are often assigned a certain number of patients for whom they are expected to provide care." *Id.*

or referring their patients to specialists or other providers of ancillary services.[34]

Managed care organizations also have developed a separate system of financial incentives to discourage physicians from overutilizing diagnostic testing, specialists, and other services. In a typical bonus system, the MCO will create a pool of funds to pay for specialist care and other ancillary services; funds remaining in the pool at the end of the year supply bonuses to participating physicians.[35] In a "fee withhold" system, the MCO withholds a percentage of each physician's pay and uses the proceeds to create a pool to pay for ancillary services; at the end of the year, physicians receive a share of any unspent funds. Under both arrangements, physicians understand that by using fewer ancillary services they can increase their earnings.[36] Finally, in an expanded capitation system, the payor calculates the amount of the physician's capitation payment to cover some ancillary services and deducts the cost of referrals and other services from the physician's capitation income.[37]

Managed care organizations undoubtedly have achieved their goal of reducing the costs of health care. Although some cost-containment strategies may backfire,[38] others have proven to be quite effective,[39] and overall health care costs have declined. For example, some studies have shown that health maintenance organizations deliver care at a substantially lower annual cost per person than traditional fee-for-

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34. *See id.* at 159-60.

35. *See id.* at 159.

36. *See id.*

37. *See id.* (noting that "financial incentives to limit care discourage physicians from providing high levels of care by transferring from the health plan to the physician some of the financial risk of costly medical care").

38. A recent study suggested that the use of a formulary, an approved list of medications, by MCOs as a cost-containment measure results in an overall increase in patient costs over the long term. The study, funded by six major HMOs and a drug industry group, assessed the impact of formulary restrictions on the treatment of more than 13,000 patients who were receiving care for asthma, ulcers, high blood pressure, arthritis, and ear infections. The study concluded that patients in HMOs with the fewest restrictions on access to prescription drugs incurred the lowest total health care costs, while patients in HMOs with strict formularies incurred substantially higher costs. *See* Ron Winslow, *Limiting Drugs A Doctor Orders May Cost More*, WALL ST. J., Mar. 20, 1996, at B1, B4. Some MCOs have shifted to drug budgets for each physician. *See* Laura Johannes, *Some HMOs Now Put Doctors on a Budget for Prescription Drugs*, WALL ST. J., May 23, 1997, at A1.

39. For an early study of the effect of utilization review on length of hospital stays, see Paul J. Feldstein et al., *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310 (1988) (concluding that utilization review reduced admission of health plan groups by 12.3%, reduced inpatient days by 8%, and reduced hospital expenditures by 11.9%).

service arrangements, and as a result, HMO plans cost subscribers substantially less than fee-for-service plans.[40] There is also, however, some evidence that at least part of the comparative advantage of HMO plans results from favorable selection patterns.[41]

Managed care's emphasis on cost containment raises troubling issues about the effect on the quality of care rendered to plan subscribers.[42] Low cost and a consequently broader access to health care provide little benefit to consumers unless the system can simultaneously maintain a reasonable standard of quality. Any effort to improve access and lower costs of care must address quality assurance issues.[43] The complex task of evaluating the quality of health care involves consideration of a variety of factors including the nature of the services delivered, the selection and efficacy of those services, and the outcomes of these choices. Although overall quality of care seems most easily gauged by measuring therapeutic outcomes, outcome measures must be adjusted to compensate for variables such as factors extraneous to treatment that affect the patient's condition, difficulties in measuring some types of outcomes, and variations in outcomes that reflect the timing of the patient assessments.[44] Both the traditional fee-for-service structure

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40. *See* Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1515 (1994) (concluding that, in 18 comparisons between managed care and indemnity plans in 9 different studies, HMOs utilized 22% fewer expensive procedures or treatments); *see also* Willard G. Manning et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1505 (1984).

41. For example, because joining an HMO usually entails changing physicians, patients who are chronically ill or have some preexisting condition that has been treated by one physician for some time are less likely to switch. Conversely, young, healthy persons who have not established a regular relationship with one physician are more likely to be attracted to the HMO's lower cost and will tend to utilize fewer of the HMO's resources. *See* Harold S. Luft & Robert H. Miller, *Patient Selection in a Competitive Health Care System*, HEALTH AFF., Sum. 1988, at 97; Ira Strumwasser et al., *The Triple Option Choice: Self-Selection Bias in Traditional Coverage, HMOs, and PPOs*, 26 INQUIRY 432 (1989).

42. *See* David M. Frankford, *Managing Medical Clinicians' Work Through the Use of Financial Incentives*, 29 WAKE FOREST L. REV. 71 (1994) (attacking the use of financial incentives); Orentlicher, *supra* note 28, at 161 (noting that cost controls that give the physician a personal financial interest in limiting the care they provide to patients may result in, among other things, delays in tests and treatments, scheduling appointments at greater than ideal intervals, delays in referrals to specialists, and accelerated hospital discharges).

43. *See* Emily Friedman, *The Eternal Triangle: Cost, Access, and Quality*, PHYSICIAN EXEC., July-Aug., 1991, at 3.

44. *See* Vernellia Randall et al., *Section 1115 Medicaid Waivers: Critiquing the State Applications*, 26 SETON HALL L. REV. 1069, 1110-12 (1996) (discussing the difficulties inherent in evaluating quality of care and suggesting that useful assessments of care must include consideration of the structures and processes by which care is delivered as well as

and the prepaid managed care structure create incentives that influence the choices physicians make in treating their patients.[45]

Unless MCOs impose moderate financial incentives to encourage cost consciousness, physicians will continue to overutilize care, both as defensive medicine and because the fee-for-service compensation system encourages them to do so. If carefully controlled and used in conjunction with safeguards for patient welfare, financial incentives have the virtue of limiting the rise in health care costs while allowing physicians to continue to individualize patient care in a way that overall resource caps do not.[46] Some studies have suggested that the quality of HMO care compares favorably to fee-for-service care.[47] Many health care professionals believe that the HMO payment structure actually results in a better coordination of patient care because a single primary care

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outcomes).

45. One court explained:

> A health maintenance organization . . . offers, for a fixed fee, as much medical care as the patient needs. Providers using traditional fee-for-service methods, by contrast, charge for each procedure. Each method creates an unfortunate incentive: a physician receiving a fee for each service has an incentive to run up the bill by furnishing unnecessary care, and an HMO has an incentive to skimp on care (once patients have signed up and paid) in order to save costs. Each incentive encounters countervailing forces: patients, or insurers on their behalf, resist paying the bills for unnecessary services, and HMOs must afford adequate care if they are to attract patients. HMOs also have a reason to deliver excellent preventive medicine. Prevention may reduce the need for costly services later. Competition among the many providers of health care, and between the principal methods of charging for that care, affords additional protection to consumers.

Anderson v. Humana, Inc., 24 F.3d 889, 890 (7th Cir. 1994).

46. *See id.* at 891-92; *see also* Martin J. Hatlie, *Professional Liability: The Case for Federal Reform*, 263 JAMA 584 (1990) (estimating that the practice of defensive medicine costs nearly $12 billion annually in addition to the costs of necessary care); Mark A. Hall, *The Malpractice Standard Under Cost-Containment*, 17 LAW MED. & HEALTH CARE 347, 351 (1989) (noting that "defensive behavior . . . occurs in a form that is completely in line with incentives created by traditional, fee-for-service insurance").

47. *See* Platt & Stream, *supra* note 7, at 501-09 (discussing multiple studies that demonstrate that HMOs provide care which is equal or better in quality to care provided via traditional fee-for-service models). For example, one 1995 study conducted a case-by-case comparison between the treatment delivered by and the cost of the two types of systems and concluded that those patients treated by HMOs had similar results to those receiving care from traditional medical practices, despite the fact that the HMO care cost substantially less. *See* Sheldon Greenfield et al., *Outcomes of Patients with Hypertension and Non-Insulin-Dependent Diabetes Mellitus Treated by Different Systems and Specialties: Results from the Medical Outcomes Study*, 274 JAMA 1436 (1995) (focusing on diabetes and high blood pressure patients in Boston, Chicago, and Los Angeles). Critics of the study noted that much more data was needed than the results of one study of two diseases in three cities. *See Study: HMO Care Equals That of Regular Practices*, GAINESVILLE SUN, Nov. 8, 1995, at 3A.

physician must consider and approve all medical treatment; in contrast, the traditional fee-for-service system arguably gave physicians a strong financial incentive to overtreat.[48] Because they recognize that preventing illness costs less than treating it, HMOs strongly encourage preventive medicine.[49]

III. EXPANSION OF MANAGED CARE TORT LIABILITY

Patients have sued MCOs to recover damages for injuries allegedly caused by the denial of benefits or services. Although many HMO contracts require patients to settle disputes through internal appeals or arbitration, more patients now seek redress in court with claims that HMO refusals to reimburse for certain types of care constitute malpractice.[50] Patients who experience bad outcomes under plans that employ cost-control strategies (like capitation) often attribute these bad outcomes to the MCO's emphasis on cost containment, and they argue that the plan's structure provides disincentives for quality care. Because managed care organizations frequently influence their physicians' delivery of care, some courts have held MCOs liable for injuries attributable to these cost-containment efforts.[51]

In these cases, courts must grapple with the question of whether the more conservative form of medical practice encouraged by most MCOs constitutes malpractice. The standard of care generally is defined in terms of what the average, reasonable, and prudent person would have done in the same or similar circumstances.[52] In many situations, there

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48. *See* Christensen, *supra* note 18, at 226. The author elaborated as follows:

> The beneficial impact of managed care incentives include[s] the reduction of wasteful treatments, less iatrogenic harm to patients by the avoidance of unnecessary tests and procedures, more emphasis on preventive care, the potential for better case management of very ill patients in an integrated setting, and cost savings. All of these benefits result in improvements in the quality of care under managed care.

Id. (citations omitted).

49. *See* Miller & Luft, *supra* note 40, at 1516 (noting that HMO enrollees receive more preventive care than patients in fee-for-service plans). In fact, some studies have indicated a high degree of patient satisfaction with the care that they have received from MCOs. *See, e.g.*, Sakson, *supra* note 9, at 1A, 6A.

50. *See* Edward Felsenthal, *When HMOs Say No to Health Coverage, More Patients Are Taking Them to Court*, WALL ST. J., May 17, 1996, at B1 (noting a recent legislative proposal in New York to standardize the HMO decisionmaking process regarding medically necessary treatments and create a uniform patient appeals process).

51. *See* CHARLES G. BENDA & FAY A. ROZOVSKY, MANAGED CARE AND THE LAW § 13.54 (1996).

52. *See, e.g.*, Hall v. Hilbun, 466 So. 2d 856, 872-73 (Miss. 1985) (describing both the national standard and the locality rule).

is no uniform national standard of care, only a continuum of care that varies according to geographic location and patient population.[53] Courts also recognize resource limitations in evaluating adherence to the standard of care, as when physicians practice in rural communities,[54] but these do not encompass limitations aimed at containing costs. To date, courts have not recognized a lower medical malpractice standard of care for MCOs.[55] Ironically, advertising and promotional materials aimed at potential enrollees may provide evidence creating a heightened duty to provide services compared with that demanded by the general standard of care in medical malpractice.[56]

Within limits, MCOs can encourage the practice of cost-effective medicine by their physicians without breaching the broad standard of care and thus without raising malpractice issues. The malpractice standard of care and cost containment do not fundamentally conflict with one another; the more conservative style of medicine that MCOs encourage can remain within the rather elastic concept of the malprac-

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53. *See* Hall, *supra* note 46, at 348. Professor Hall discusses a volume of work by medical epidemiologists that demonstrated a substantial variation in practice patterns (using examples of rates of tonsillectomies and hysterectomies) among different New England communities, noting that "in virtually every instance where researchers have studied medical procedures that involve any significant degree of judgment, they have found large variations in the frequency with which the procedure is employed for similar population groups, often several-fold variations." *Id.* As he notes, adhering to the approach of a "respectable minority" of practitioners does not constitute malpractice, and, "[i]f the existing legal standard is as broad as [the] evidence suggests, it can amply accommodate massive cutbacks in care within the tremendous variations in practice patterns that the established custom encompasses." *Id.*

54. *See, e.g.*, Hall v. Hilbun, 466 So. 2d at 873 ("[W]e have added to [the national standard of care] a pragmatic addendum by today's recognition that the physician's duty of care must take into consideration the quality and kind of facilities, services, equipment and other resources available."); Chapel v. Allison, 785 P.2d 204, 210 (Mont. 1990) (using similar reasoning).

55. *See* Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 363-65 (1994) (discussing opposition to permitting physicians or hospitals to assert a cost defense to avoid liability for substandard medical treatment given to patients who cannot pay for better care). Courts can consult a variety of sources to determine the appropriate standard of care in a negligence lawsuit against a managed care organization. *See* BENDA & ROSOVSKY, *supra* note 51, at § 6.4 (suggesting, as sources, accreditation requirements, advertising or promotional materials, learned treatises, bylaws, clinical practice guidelines, contracts, expert witness testimony, journal articles, membership handbooks, and federal and state statutes and regulations).

56. *See* BENDA & ROSOVSKY, *supra* note 51, at § 6.4.3 ("Ironically, had the managed care entity positioned itself to perform at a level of care recognized as commonplace and appropriate to the industry, the plaintiff would be less likely to prevail in a negligence suit.").

tice standard of care.[57] Because of the significant medical judgment involved in many decisions regarding treatment, studies have found large variations in the utilization rates of medical procedures among similar population groups. Yet the standard of care accommodates even several-fold variations in these utilization rates.[58] The standard of care partially recognizes resource limitations to accommodate variations in available physical facilities and equipment.[59] If courts recognize the full flexibility of the malpractice standard of care, MCOs could deliver a conservative style of health care without undue liability exposure. Courts have not, however, adopted this approach.

In the last decade, patients have begun to succeed in pursuing tort claims against managed care organizations. In addition to direct liability, HMOs and other managed care organizations now face liability for the malpractice of their participating physicians under principles of vicarious liability. Courts have offered various rationales to justify imposing such organizational liability on MCOs: (1) the risk of liability will force them to protect profits by combining cost effectiveness with more emphasis on quality care; (2) plaintiffs will be able to identify the source or cause of their injuries more easily (promoting recovery and reducing judicial burdens); and (3) institutions provide a more dependable source of funds for compensating injured patients.[60] A brief overview of the different theories of direct and vicarious corporate liability suggests that the law in this area, as it has evolved to this

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57. *See* Hall, *supra* note 46, at 347 (arguing generally that the law as it currently exists "is perfectly *capable* of incorporating cost-sensitive medical decisions within its existing doctrinal framework").

58. *See id.* at 348-49 (discussing variations in local practice patterns and noting that even the so-called "national" standard of care requires only those medical practices that prevail in "the same or similar circumstances" as those of the defendant).

59. Professor Mark Hall has argued that the rationale underlying this so-called "locality rule" amply supports its extension to the modern problem of financing care:

> The locality component of the malpractice standard arose because funding restrictions in rural areas had a detrimental effect on the numbers and quality of medical personnel locating in small towns and their ability to purchase and construct state-of-the-art equipment and facilities. Likewise, it is funding restrictions that are pressuring health care providers in metropolitan areas to refrain from using their facilities to the fullest extent possible. Thus, while the precise form and content of modern responses to funding differentials may be different, the origins are precisely the same: insurance limitations.

Id. at 350.

60. *See* Barry R. Furrow, *Enterprise Liability and Health Care Reform: Managing Care and Managing Risk*, 39 ST. LOUIS U. L.J. 79, 110 (1994) ("Rather than focusing on the individual agent's fault, as the courts must under the fault system, the enterprise could penalize the whole work group of which the agent is a part, restructure a work environment, or take other steps that transcend the responsibility of an individual agent.").

point, has created an unpredictable and somewhat inefficient approach to addressing concerns about cost containment and other influences exerted by MCOs on the behavior of physicians.

A. *Direct Corporate Liability*

Initially, courts only reluctantly held MCOs directly liable for malpractice because they viewed managed care purely as a business arrangement with the organizations themselves facilitating but not actually delivering health care. The protection derived from this "corporate practice of medicine" doctrine is, however, fading. As courts began to recognize that MCO cost-containment strategies could have a direct influence on the quality of health care provided, their reluctance to hold MCOs liable in tort began to disappear. This turnabout parallels the shift that the courts previously had made in recognizing the potential liability of hospitals in delivering health care services.[61]

Over the past decade, courts have applied theories of direct corporate liability to the alleged negligence of MCOs. In *Wickline v. California*,[62] one of the first cases to suggest the possibility of direct third-party payor negligence, plaintiff claimed that the decision of the state's Medi-Cal program to discharge her prematurely from the hospital after vascular surgery resulted in the amputation of her leg.[63] Although the court found that the State had not departed from the standard of care in this case,[64] it suggested that the payor implementing the cost-containment strategy should be held liable when cost-containment procedures result

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61. For example, in *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253 (Ill. 1965), the court reasoned that

> [t]he conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment.

Id. at 257 (internal quotation marks omitted). The court noted that a jury could conclude that the hospital itself was negligent in failing to review the work of the treating physician, which resulted in injury to the patient. *Id.* at 258; *see also* Fridena v. Evans, 622 P.2d 463 (Ariz. 1980); Purcell v. Zimbelman, 500 P.2d 335 (Ariz. Ct. App. 1972); Felice v. St. Agnes Hosp., 411 N.Y.S.2d 901 (App. Div. 1978); Bost v. Riley, 262 S.E.2d 391 (N.C. Ct. App.), *cert. denied*, 269 S.E.2d 621 (N.C. 1980).

62. 239 Cal. Rptr. 810 (Ct. App. 1986).

63. *See id.* at 811.

64. *See id.* at 818 (finding that the decision to discharge plaintiff from the hospital, rather than extending plaintiff's stay for an additional eight days, met the prevailing standard of care).

in a breach of the standard of care.[65] In refusing to foreclose causes of action against third-party payors for medical malpractice, the *Wickline* decision sent a strong message to the managed care industry and opened the door to subsequent lawsuits against MCOs based on cost-containment theories of liability. Moreover, by suggesting that the physician had a duty to appeal his patient's case to the payor, the court made no attempt to adjust the treating physician's duty of care to reflect the fact that he was working within a cost-conscious system.[66]

In *Wilson v. Blue Cross*,[67] another California court suggested that a utilization review company could be liable to a patient if its conduct was a "substantial factor" in bringing about the injury.[68] Howard Wilson, Jr., a subscriber to a Blue Cross managed care plan, admitted himself to a hospital for treatment of psychiatric problems. His physician recommended that Wilson remain as an inpatient for three to four weeks, but a utilization review firm employed by Blue Cross recommended that it refuse payment for more than eleven days of treatment. Shortly after being discharged from the hospital following a ten day stay, Mr. Wilson committed suicide, prompting his family to bring a wrongful death action against Blue Cross and the utilization review firm.[69] The defendant utilization review organization unsuccessfully argued that public policy considerations favoring concurrent utilization review should alter the normal rules of tort liability.[70] Although the court rejected the *Wickline* dicta as overbroad,[71] it added that any "important public

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65. The court discussed at some length the potential liability of third-party payors for their cost-containment strategies:

> The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms .... However, the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care.

Id. at 819.

66. *See* Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1306-07 (1994).

67. 271 Cal. Rptr. 876 (Ct. App. 1990).

68. *See id.* at 885 ("[T]here is a triable issue as to whether the refusal to allow the decedent to stay in the hospital was a 'substantial factor' in bringing about his death.").

69. *See id.* at 878, 881-82.

70. *See id.* at 884.

71. *See id.* at 885. The court also distinguished the holding in *Wickline* as limited to public insurers based on directives from the state legislature to fund the public health care

policy considerations" favoring utilization review did not justify a departure from the normal standard of tort liability.[72] The court concluded that a jury could find that the termination of insurance coverage caused Wilson's death,[73] but it failed to resolve the issue of what would constitute utilization review negligence by MCOs.

Surprisingly few courts have examined the liability of MCOs for negligence based on the effects that cost-containment financial incentives have on medical decisions made by participating physicians. In one case, plaintiff sued her HMO to recover damages suffered from an alleged negligent failure to diagnose and treat her uterine cancer in a timely manner.[74] The terms of the HMO contract required that plaintiff consult her primary care physician prior to being referred to a specialist.[75] The court suggested that MCOs may face liability if their cost-containment methods contributed to the physician's malpractice.[76] In another case, plaintiff claimed that her HMO's cost-containment

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program. *See id.* at 878-80.

72. *See id.* at 884; *see also* Allen D. Allred & Terry O. Tottenham, *Liability and Indemnity Issues for Integrated Delivery Systems*, 40 ST. LOUIS U. L.J. 457, 461-62 (1996) (noting "the trend among courts to hold insurers accountable for the withholding of medically necessary care when defects in the design or implementation of a utilization review program caused the injury").

73. The court stated:

> The sole reason for the discharge, based on the evidence adduced in connection with the summary judgment motion, was that the decedent had no insurance or money to pay for any further in-patient benefits . . . . [T]he decedent's treating physician believed that had the decedent completed his planned hospitalization that there was a reasonable medical probability that he would not have committed suicide.

271 Cal. Rptr. at 883; *see also* Hughes v. Blue Cross, 263 Cal. Rptr. 850, 857-58 (Ct. App. 1989) (finding that a plan's utilization denial rates greatly exceeded the industry average and that this deviation from the norm suggested noncompliance with the standard of care).

74. *See* Bush v. Dake, No. 86-25767 NM-2 slip op. (Mich. Cir. Ct., Saginaw County, 1989).

75. *See id.* The plan paid participating providers on a capitation basis, and it also funded a "referral pool" that paid for specialist care as needed. Each referral of a plan subscriber to a specialist further depleted the pool, and, at the end of the year, the HMO and the physicians divided any remaining funds. *See id.* at 3-4. The court in *Bush* declined to second-guess the legislature, which had approved HMOs' use of financial incentives, risk sharing, and other techniques in order to contain health care costs, despite plaintiff's argument that the system violated public policy. *See id.*

76. With regard to the claim that the HMO's use of financial incentives contributed to the malpractice, the court in *Bush* found that the HMO's system itself may have proximately contributed to the malpractice in the case and left the causation question for the jury. *See id.* While the case awaited appeal, the parties settled for an undisclosed sum. *See* Sharon M. Glenn, Comment, *Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability*, 29 WAKE FOREST L. REV. 305, 337 (1994).

practices resulted in a delay in the diagnosis of her cancer.[77] Because the HMO structure did not tie the refund of the withheld fees to the number of referrals made by any individual physician, the court found no basis for imposing punitive damages on the physician for the injuries that resulted from the delayed diagnosis.[78] Very few plaintiffs have proceeded on this theory to date, but as enrollment in HMOs continues to grow, more of these suits may be filed.

Although the managed care organization's ability to manage risk efficiently appears to favor shifting the locus of liability from the physicians to the organization, the benefits of centralized risk management may not be as great in the MCO context as they appear at first glance. Certainly, hospitals are better able than their physicians to detect patterns of poor care and to improve overall quality. But, as one commentator has observed, "the new enterprises are both more complex and more diffuse than the traditional hospital."[79] The decentralization of the new integrated systems seriously weakens the supposed risk management benefits of imposing direct corporate liability while excluding individual providers from all liability.[80]

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77. *See* Sweede v. CIGNA Healthplan, 1989 WL 12608 (Del. Super. Ct. Feb. 2, 1989). The HMO contracted with an IPA on a capitation basis for the delivery of medical services, and it withheld 20% of each monthly payment in a performance risk pool. At the end of each twelve-month period, the HMO calculated the actual costs of the services provided, compared these costs with budgeted amounts, and returned the fees to the physicians only if the amount in the pool exceeded the budget. The total number of referrals to specialists made by the participating primary care physicians determined the profitability of the plan. The actual number of referrals made by any individual physician was not considered in the refund decision. *See id.* at *1.

78. *See id.* at *5. For an earlier example, see Pulvers v. Kaiser Found. Health Plan, 160 Cal. Rptr. 392 (Ct. App. 1979). In this case, the defendant HMO used financial incentives to discourage physicians from utilizing unnecessary treatments and diagnostic tests. *See id.* at 393-94. Plaintiffs sued on a fraud theory, alleging that defendant's representations about the high quality of care delivered by the plan were misleading. *Id.* at 393. The California Court of Appeal found nothing in the plan's procedures that encouraged physicians to act negligently or withhold tests or treatments in violation of the professional standard of care, and it noted further that the cost-containment incentives used by the plan were required by statute and supported by professional medical organizations. *See id.* at 394. Although the court considered the nature of the incentives themselves, the fact that the incentives were specifically authorized by statute seems to have been determinative.

79. Furrow, *supra* note 60, at 124.

80. *See id.* at 125 ("Peer review, peer pressure, and collegial forces are important sources of quality improvement by physicians, and such forces are more diffuse in loosely aligned medical groups within integrated networks.").

B. *Vicarious Liability*

Under settled principles of vicarious liability, MCOs can be held liable for the torts of their member physicians. The degree of control exercised by MCOs over health care personnel varies greatly,[81] and the nature of the relationship between the managed care plan and its physicians will determine the extent of liability. When MCOs exert substantial control, some courts have held them vicariously liable for the negligence of their physicians.[82]

The doctrine of *respondeat superior* holds an employer liable for the wrongful or negligent acts of its employee provided that the acts occurred within the scope of the employment.[83] This vicarious liability depends on the existence of an employer-employee or closely analogous relationship; it generally does not apply to the acts of an independent contractor. In instances when hospitals exercised substantial control over the acts of their nonemployee physicians,[84] however, courts have

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81. *See supra* Part II. A.

82. *See* BARRY R. FURROW ET AL., HEALTH LAW 312 (1995):

> The liability analysis begins with the control exercised by the plan over its physicians . . . . Courts look at the operation of the managed care organization, asking whether it "conducts itself in a fashion akin to a health care provider." If so, it will be subject to the same liabilities, regardless of its organizational structure.

Id.

83. *See, e.g.*, Burger Chef Sys., Inc. v. Govro, 407 F.2d 921, 925 (8th Cir. 1969); Thompson v. Travelers Indem. Co., 789 S.W.2d 277, 278 (Tex. 1990); Shell Petroleum Corp. v. Magnolia Pipe Line Co., 85 S.W.2d 829, 832 (Tex. Ct. App. 1935). During the first half of the twentieth century, courts gave hospitals immunity from the application of this doctrine, based in part on the charitable purposes of the institutions and in part on the notion that hospitals merely provided sites in which physicians could treat their patients. By 1957, however, a New York court noted that the hospital's growing role in providing health care and in supervising its staff, as opposed to simply providing a venue for independent physicians to practice medicine, required reconsideration of the charitable immunity doctrine for hospitals. *See* Bing v. Thunig, 143 N.E.2d 3 (N.Y. Sup. Ct. 1957). Although the court noted that the doctrine originally evolved out of the fear that the imposition of liability would do irreparable financial harm to the charitable hospital, it concluded that there was

> no reason to continue their exemption from the universal rule of respondeat superior. The test should be, for these institutions, whether charitable or profit-making, as it is for every other employer, was the person who committed the negligent injury-producing act one of its employees and, if he was, was he acting within the scope of his employment.

Id. at 8.

84. *See* Furrow, *supra* note 60, at 87:

> If the contract gave the hospital substantial control over the doctor's choice of patients or if the hospital furnished equipment, many courts have found a master-

imposed vicarious liability on hospitals.[85] An employer need not exercise actual control over its employees; rather, whenever an employer possesses "the right, power, or authority" to exercise control over the acts of its employees, courts have held that imposing liability on the employer is proper.[86]

In both hospital and MCO settings, physicians experience some constraints affecting utilization and quality assurance.[87] Because HMOs arguably exercise less control over their physicians than a hospital might exercise, however, liability under a theory of *respondeat superior* remains more difficult to establish. In light of this control test, the vicarious liability of MCOs for the torts of their physicians will depend a great deal on the structure of the organization. Staff model HMOs are most susceptible to vicarious liability because they directly employ their physicians.[88] In addition to the general degree of control

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servant relationship. As hospitals expand their quality assurance activities over all physicians, the control test may be sufficiently elastic to cover independent contractors, further limiting agency law protection for hospitals.

Id. Courts have considered several factors in determining hospital liability, including: (1) "[t]he degree of control exercised by the hospital over the physician"; (2) "the method of payment by the hospital to the physician"; and (3) "ownership of the instrumentalities used to deliver care—such as the facility itself and the medical equipment." Bearden & Maedgen, *supra* note 15, at 300; *see also* David J. Oakley & Eileen M. Kelley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT & INS. L.J. 624, 627-29 (1988); Michael Kanute, Comment, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841, 848-49 (1989).

85. *See* Kober v. Stewart, 417 P.2d 476 (Mont. 1966) (holding hospital liable for doctor's malpractice when contract demonstrated that hospital hired doctor as supervisor); Mduba v. Benedictine Hosp., 384 N.Y.S.2d 527 (App. Div. 1976) (holding hospital liable for doctor's failure to give blood to patient when hospital guaranteed doctor's salary and controlled his practice); Berel v. HCA Health Servs., 881 S.W.2d 21, 23-24 (Tex. Ct. App. 1994) (noting that quality assurance activities might be enough to conclude that a hospital exercised control over an independent contractor physician, thereby allowing vicarious liability to apply to the hospital); *cf.* Martell v. St. Charles Hosp., 523 N.Y.S.2d 342, 352 (Sup. Ct. 1987) (holding that contractual relationship between hospital and physician should not determine hospital's liability).

86. *See* GEORGE D. POZGAR, LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION 206 (6th ed. 1996).

87. *See* Bearden & Maedgen, *supra* note 15, at 300-01; Oakley & Kelley, *supra* note 84, at 626-28.

88. *See* Sloan v. Metropolitan Health Council, 516 N.E.2d 1104 (Ind. Ct. App. 1987). In this case, a staff model HMO attempted to avoid liability by claiming that its physicians practiced medicine independently and that it exercised no control over their judgments. Plaintiffs sued the HMO, alleging that one of its physicians was negligent in failing to diagnose plaintiff's condition. *See id.* at 1105-06. The court rejected the corporate practice of medicine defense, holding that "[t]he circumstances establish an employment relationship where the employee performed acts within the scope of his employment." *Id.* at 1109. The court carefully considered the structure of the HMO, emphasizing that the

exercised by an HMO or other MCO over its physicians, factors such as the method of compensation of the physician,[89] the ownership of instrumentalities used to deliver health care to patients,[90] and the language used in contracts and other guidelines can be used to evaluate the existence of an employer-employee relationship.[91]

A few courts have recognized "an expanded notion of accountability"[92] in rejecting independent contractor defenses asserted by managed care organizations.[93] In *Dunn v. Praiss*,[94] for instance, a New Jersey appellate court held a group model HMO vicariously liable for the malpractice of one of its physicians.[95] The court pointed to several factors that supported finding an agency relationship, including the capitation payments to the group, the physicians' use of the HMO's facilities in delivering care to enrolled patients, and the HMO's control over referrals to the physicians.[96] In *Raglin v. HMO Illinois, Inc.*,[97]

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participating physicians had signed a contract that was designated as an "employment contract" and that the physicians were compensated on a salary basis and had agreed not to practice outside the HMO. *See id.* at 1105. Most significantly, the HMO's medical director was given the final authority in matters of dispute between the participating physicians and the HMO under the terms of the contract. *See id.* About 11% of HMOs now employ their own physicians. *See* Furrow, *supra* note 60, at 80.

89. *See* Bearden & Maedgen, *supra* note 15, at 301 (noting that capitation payments resemble salaries more than do fee-for-service payments).

90. *See id.* at 301-02. In nonstaff model HMOs, the participating physicians maintain separate offices and the HMO therefore has less control over the facilities and equipment used to deliver care. By comparison, physicians in hospitals use hospital-owned and maintained equipment; therefore, in the nonstaff model HMO context, a physician is less likely to appear to a patient to be an HMO employee. *See id.*

91. *See id.* at 302 (suggesting that contractual language between the HMO and the enrollee that places the HMO in the position of preapproving physician recommendations for hospitalization or testing, for example, might support a finding that the HMO has sufficient control to justify imposing liability).

92. *See* Furrow, *supra* note 60, at 87.

93. *See* Decker v. Saini, No. 88-361768 NH, 1991 WL 277590, at *4 (Mich. Cir. Ct., Sept. 17, 1991) ("[I]mposing vicarious liability on HMOs for the malpractice of their member physicians would strongly encourage them to select physicians with the best credentials. Otherwise, HMO's [sic] would have no such incentive and might be driven by economics to retain physicians with the least desirable credentials, for the lowest prices.").

94. 606 A.2d 862 (N.J. App. Div. 1992).

95. *See id.* at 872. Plaintiff sued the HMO and the treating physician, among others, alleging that the physician committed malpractice in failing to diagnose cancer in plaintiff's deceased husband. The group model HMO in which the physician practiced maintained offices where the physician treated HMO patients although the physician apparently practiced independently as well. In addition, the physician's urology practice group contracted to provide services to the HMO. *See id.* at 865.

96. *See id.* at 868.

97. 595 N.E.2d 153 (Ill. App. Ct. 1992).

however, an Illinois court found that no actual or apparent agency relationship existed between the IPA model HMO and its physicians.[98] Instead, the court held that the physicians were independent contractors of the HMO based on the structure of the organization.[99] Thus, the applicability of vicarious liability will depend on the court's assessment of the particular arrangement between a managed care organization and its physicians.

C. Ostensible Agency

The doctrines of ostensible agency and agency by estoppel provide other vehicles through which courts can impose liability on MCOs for the torts of their participating physicians. In contrast to the vicarious liability cases, courts may find the organization liable in these situations even if the treating physician is clearly an independent contractor. The *Restatement (Second) of Torts* describes "ostensible agency" as follows:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.[100]

Thus, this doctrine focuses on the patient's expectations as to the source of treatment. Courts have used two factors to evaluate the patient's expectations: (1) whether the patient looks to the institution, in this case the MCO, rather than the individual physician for treatment, and (2) whether the institution "holds out" the physician as its employee.[101] A related, but stricter, theory of liability, "apparent agency" or "agency

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98. *See id.* at 155-56.

99. *See id.* at 158. The court stated:

> Nor do we see any basis for finding that [the HMO] advertised or held itself out as exerting control over its physicians so that one might reasonably conclude that the physicians were the employees of [the HMO]. In fact, the subscriber certificate . . . specifically informed [the plaintiff] that [the HMO] did not directly furnish medical care and could not make medical judgments.

Id.

100. RESTATEMENT (SECOND) OF TORTS § 429 (1965).

101. *See* FURROW, *supra* note 82, at 294; *see also* Allred & Tottenham, *supra* note 72, at 474-75 (suggesting a variety of factors relevant to imposing vicarious liability through ostensible agency, including whether a patient received treatment at a hospital by a physician not selected by the patient and whether the hospital directly billed the patient for the services of its treating physicians).

by estoppel," requires that a plaintiff prove actual and justifiable reliance on the representations of the institution.[102]

Courts commonly apply these doctrines in the cases alleging negligence in the delivery of emergency room services or by independent contractors working at a hospital.[103] Whether an HMO or other managed care organization will be found liable under an ostensible agency theory will depend on the nature and extent of that organization's representations about the quality of the services delivered. MCOs that promote themselves in a manner suggesting that they have significant control over the behavior of their participating physicians may find it difficult to defend successfully against malpractice claims under the ostensible agency theory.

Commentators have suggested that HMOs include clear statements in their promotional materials identifying their physicians as independent contractors,[104] but even this approach may not preclude liability if the plaintiff can show detrimental reliance on the organization itself to maintain the quality of care delivered by its physicians. For example, in *Boyd v. Albert Einstein Medical Center*,[105] a Pennsylvania court considered the application of ostensible agency doctrine to an IPA model HMO. The court cited a number of factors suggesting that the HMO held itself out as a provider of health care, including the fact that the HMO employed detailed screening mechanisms for its participating physicians and required physicians to comply with extensive HMO regulations, and that the subscriber paid fees directly to the HMO, selected physicians from a limited list, and could not visit a specialist

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102. The *Restatement (Second) of Agency* describes the doctrine of agency by estoppel as follows:

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care of skill of the one appearing to be a servant or other agent as if he were such.

RESTATEMENT (SECOND) OF AGENCY § 267 (1958). In a few cases, courts have required that the plaintiff aver that he would have refused treatment if he had known that the treating physician was independent of the hospital. *See, e.g.*, Gasbarra v. St. James Hosp., 406 N.E.2d 544 (Ill. App. Ct. 1979).

103. Hospitals commonly utilize independent contractors such as radiologists and anesthesiologists. *See, e.g.*, Strach v. St. John Hosp. Corp., 408 N.W.2d 441 (Mich. Ct. App. 1987); Kober v. Stewart, 417 P.2d 476 (Mont. 1966); White v. Methodist Hosp. S., 844 S.W.2d 642 (Tenn. Ct. App. 1992).

104. *See* Bearden & Maedgen, *supra* note 15, at 317; *see also Raglin*, 595 N.E.2d at 158 (holding that HMO avoided apparent agency liability by specifically stating to patients that it did not provide medical services).

105. 547 A.2d 1229 (Pa. Super. Ct. 1988).

without permission from the HMO.[106] The court concluded that the subscriber could reasonably believe that the HMO provided the care and that, therefore, a jury could find that the HMO, as well as the treating physician, committed malpractice.[107]

D. The Constraints of ERISA Preemption

The Employee Retirement Income Security Act ("ERISA")[108] contains a broad preemption clause that provides that ERISA's provisions supersede all state laws to the extent that they "relate to" any employee benefit plan.[109] ERISA covers employee health plans, including those administered by HMOs and other managed care organizations.[110] For example, ERISA preempts state law claims based on an MCO's refusal to provide reimbursement for services,[111] and it probably also will preempt claims of misrepresentation, fraud and deceit, and unfair and deceptive trade practices. The disclosure provisions of the federal

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106. *See id.* at 1232-35.

107. *See id.* at 1235 ("In our opinion, because [the patient] was required to follow the mandates of HMO and did not directly seek the attention of the specialist, there is an inference that [the patient] looked to the institution for care and not solely to the physicians . . . . "); *see also Decker*, 1991 WL 277590 at *3 (holding an IPA model HMO liable under ostensible agency principles because, although the HMO argued that it was merely acting as an insurer rather than a health care provider, its advertising promised the "best care" available); *cf.* Williams v. Good Health Plus, Inc., 743 S.W.2d 373, 378 (Tex. Ct. App. 1987) (concluding that nothing in the record supported plaintiff's claim that the HMO held itself out as a provider of medical care).

108. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1994)).

109. *See id.* § 514(a) (codified at 29 U.S.C. § 1144(a) (1994)). A state law is considered to "relate to" an employee benefit plan if it falls into one of four categories:

> First, laws that regulate the type of benefits or terms of ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan.

National Elevator Indus. v. Calhoon, 957 F.2d 1555, 1558-59 (10th Cir. 1992); *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48 (1987).

110. *See* 29 U.S.C. § 1002(1) (1994) (defining an employee benefit plan as any plan or fund "established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits"). The only significant exception to ERISA preemption is the "savings clause," which states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A). However, the statute's "deemer clause" limits the savings clause by prohibiting states from deeming an employee benefit plan to be an insurer, bank, trust, or investment company in order to implement the savings clause. *See id.* § 1144(b)(2)(B).

111. *See, e.g.*, Makar v. Health Care Corp., 872 F.2d 80 (4th Cir. 1989).

statute preempt state laws that conflict with these requirements.[112] Persons injured under plans covered by ERISA may receive only restitution and equitable relief for benefits improperly denied under the plan; punitive damages generally are not available.[113] ERISA also includes certain barriers to tort litigation, particularly a requirement that aggrieved members exhaust all administrative remedies in the plan for disputes about the denial of benefits.[114]

The vast majority of MCOs qualify as employee benefit plans under ERISA. A broad reading of the phrase "relate to" in the preemption provision would grant managed care entities protection from most state law tort claims. Widespread immunity for MCOs and utilization review organizations ("UROs") via complete ERISA preemption would leave physicians solely liable for medical malpractice in many cases.[115] Recent decisions suggest a narrower reading of the preemption clause, at least with regard to claims based on vicarious liability theories, thus leaving MCOs open to tort claims that do not "relate to" an employee benefit plan.

HMOs have successfully used ERISA preemption as a defense in medical malpractice claims based on direct corporate liability. Courts generally agree that direct liability claims based on, for example, rationing decisions made by plan administrators "relate to" the plan and thus are preempted.[116] In addition, courts have held that, when a

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112. *See, e.g.*, Degan v. Ford Motor Co., 869 F.2d 889 (5th Cir. 1989); FURROW ET AL., *supra* note 82, at 329 (describing ERISA preemption).

113. *See* 29 U.S.C. § 1132(a).

114. *See* BENDA & ROZOVSKY, *supra* note 51, at § 6.1 n.2.

115. *See* Robert Pear, *H.M.O.'s Using Federal Law to Deflect Malpractice Suits*, N.Y. TIMES, Nov. 17, 1996, at A24 (describing the federal government's concern that complete ERISA preemption could produce the "absurd" result of depriving consumers of the right to sue for injuries caused by HMO negligence).

116. *See, e.g.*, Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 303 (8th Cir. 1993) (holding wrongful death action against HMO for utilization review decision that allegedly led to patient's death preempted under ERISA); Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1339 (5th Cir. 1992) (holding state tort action for wrongful death of unborn child against HMO, for failing to allow hospital stay for mother during end of high-risk pregnancy, preempted by ERISA); Thomas-Wilson v. Keystone Health Plan East HMO, 1997 U.S. Dist. LEXIS 454, *9 (E.D. Pa. Jan. 23, 1997) (holding state law claims for punitive damages, loss of society, income and earning power, and breach of contract preempted by ERISA); DeArmas v. Av-Med, Inc., 865 F. Supp. 816, 817-18 (S.D. Fla. 1994) (holding that ERISA preempted claim relating to negligence in administration of health plan but did not preempt vicarious liability action against plan for the negligence of its physicians); *cf.* Lars Noah, *Reconceptualizing Federal Preemption of Tort Claims as the Government Standards Defense*, 37 WM. & MARY L. REV. 903, 913-38 (1996) (discussing the emerging judicial recognition of preemption defenses under a number of federal safety statutes).

managed care plan wrongly informs a physician about covered plan benefits, this activity "relates to" the plan.[117] ERISA preemption is less certain, however, in cases of indirect negligence such as in vicarious liability claims against HMOs.[118] Under an ostensible agency theory, for example, the plaintiff claims that the MCO is liable for its physician's negligence because of the relationship that exists between the physician and the organization. Courts have split on the issue of ERISA preemption of vicarious liability claims; a number of courts recently have held that ERISA does not preempt such tort claims because they do not "relate to" benefits provided under the employee benefit plan, concluding instead that the physician negligently provided the benefits received by the employee under the plan.[119] Other courts, however, have ruled that ERISA preempts claims based on vicarious liability theories.[120]

Careful consideration of the preemption issue in several recent cases suggests that MCOs will be more vulnerable in the future to certain types of claims that fall outside of ERISA's preemptive scope. Courts have begun to read the preemption provision in conjunction with the purpose of the statute as a whole to decide where to draw the line. As the United States Supreme Court recently explained, the "basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in

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117. *See, e.g., Corcoran*, 965 F.2d at 1332-34 (holding that ERISA preempted plaintiff's claim that the utilization review organization wrongly denied payment for prenatal care and resulted in death of infant); *see also* Laura H. Harshbarger, *ERISA Preemption Meets the Age of Managed Care: Toward a Comprehensive Social Policy*, 47 SYRACUSE L. REV. 191, 198 (1996) (criticizing the results of ERISA preemption of direct liability claims).

118. The Third Circuit, reviewing two cases consolidated on appeal, held that ERISA did not preempt vicarious liability claims against the HMOs for the alleged malpractice of participating physicians. *See* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 353-54 (3rd Cir. 1995).

119. *See, e.g.*, PacifiCare of Oklahoma, Inc. v. Burrage, 59 F.3d 151, 155 (10th Cir. 1995); Prihoda v. Shpritz, 914 F. Supp. 113, 117-18 (D. Md. 1996) (holding that when the issue is the quality of services provided, not whether benefits were provided under the plan, ERISA did not preempt a vicarious liability suit against the HMO); Jackson v. Roseman, 878 F. Supp. 820, 825 (D. Md. 1995); Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 548 (S.D. Ill. 1994); Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 185-86 (E.D. Pa. 1994); *see also* Seema R. Shah, Comment, *Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to* PacifiCare of Oklahoma v. Burrage, 80 MINN. L. REV. 1545, 1560-63 (1996) (discussing approaches to ERISA preemption in malpractice claims).

120. *See, e.g*, Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482, 1493 (7th Cir. 1996) (reasoning that, because plaintiff's vicarious liability claim required the court to determine the relationship between the HMO and the physician provider, the court would be required to examine the terms of the plan itself and that the claim was thus preempted); Butler v. Wu, 853 F. Supp. 125 (D.N.J. 1994); Ricci v. Gooberman, 840 F. Supp. 316, 317 (D.N.J. 1993); Altieri v. CIGNA Dental Health, Inc., 753 F. Supp. 61 (D. Conn. 1990).

order to permit the nationally uniform administration of employee benefit plans."[121] The Court concluded that "a law operating as an indirect source of merely economic influence on administrative decisions . . . should not suffice to trigger pre-emption."[122] When a plaintiff seeks to recover damages based on allegedly negligent delay in rendering care due to cost-containment restrictions, another court has explained that preempting such a claim would be "diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries."[123] Several other decisions have indicated that many tort claims based on vicarious liability do not "relate to" the administration of pension plans or other employee benefits plans and that suits based on such theories are therefore not preempted by ERISA.[124] To the extent that ERISA preemption of state law claims against MCOs appears to be narrowing, the accompanying increase in successful lawsuits against MCOs may leave these organizations scrambling to absorb costs without sacrificing quality care.

IV. CONSEQUENCES OF EXPANDING TORT LIABILITY

The common law of managed care organization liability has developed as a patchwork of unpredictable standards that vary from one jurisdiction to the next and that are quite difficult to apply. Some proposed tort reforms would improve the uniformity and predictability of the law,[125]

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121. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1677-78 (1995).

122. *Id.* at 1680; *see also* California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., 117 S. Ct. 832 (1997) (holding that California's wage law does not "relate to" employee benefit plans and is thus not preempted by ERISA).

123. Pappas v. Asbel, 675 A.2d 711, 716 (Pa. Super. Ct. 1996); *see also* McClellan v. Health Maintenance Org., 604 A.2d 1053 (Pa. Super. Ct. 1992) (holding suit based on liability of HMO for negligence of agent-physician and on intentional representation or fraud by HMO itself not preempted by ERISA); DeGenova v. Ansel, 555 A.2d 147 (Pa. Super. Ct. 1988) (holding suit based on vicarious liability of HMO for the negligence of its agent-physician not preempted by ERISA).

124. *See, e.g.*, Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182 (E.D. Pa. 1994) (holding that ERISA preempts plaintiff's direct negligence claim but not plaintiff's vicarious liability claim); Elsesser v. Hospital of the Phil. College of Osteopathic Medicine, 802 F. Supp. 1286 (E.D. Pa. 1992) (holding that ERISA does not preempt claim against an HMO for negligence in selecting and retaining plaintiff's primary care physician); Independence HMO, Inc. v. Smith, 733 F. Supp. 983 (E.D. Pa. 1990) (holding that ERISA does not preempt medical malpractice claims brought against HMOs under theory of vicarious liability).

125. Florida Governor Lawton Chiles recently vetoed a bill that would have permitted subscribers to sue HMOs directly for refusing to provide covered services that an HMO doctor says are medically necessary. *See* Florida H.B. No. 1853 (Reg. Session 1996). Governor Chiles noted that, although the potential for HMOs to deny care is troubling,

but it appears that the costs of these reforms to health care organizations would remain prohibitive. Although patients may benefit from an organizational liability approach,[126] the imposition of tort liability on managed care organizations has some negative consequences, including reduced cost containment, increased adverse selection, and interference with physician autonomy.

A. Reduced Cost Containment

The erratic development of malpractice law has created an unpredictable compensation system for patients and has placed an enormous financial burden on managed care organizations.[127] In addition to resources consumed in litigating such cases, evidence suggests that enterprise liability may increase the volume of claims filed, creating an overall increase in health care costs.[128] The insistence on the best available care for every patient continually drives up costs; eventually MCOs will either charge impossible premiums or cease operations altogether. Holding MCOs directly liable for the effects of reasonable cost-containment strategies or indirectly liable for physician malpractice will further increase costs. To counteract these pressures, policymakers might consider granting statutory immunity to all or at least certain classes of MCOs.

Managed care organizations, HMOs in particular, have experienced solvency problems of different sorts in recent years. Some states have adopted statutes that attempt to stabilize the financial status of HMOs or have established guaranty funds to which all HMOs must contribute to protect the subscribers of those plans that go bankrupt.[129] None of

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permitting these disputes to be resolved in the already overcrowded court system would "threaten to gut concepts at the heart of managed care: keeping costs down by cutting down on unneeded services." *Gov. Chiles Vetoes Bill Letting People Sue HMOs*, GAINESVILLE SUN, May 29, 1996, at 4B.

126. *See supra* note 60 and accompanying text. For a succinct discussion of the merits and different permutations of pure enterprise liability, including organizational enterprise models, see Furrow, *supra* note 60, at 109-24.

127. *See* Furrow, *supra* note 60, at 133 (Appendix).

128. *See* Edelen v. Osterman, 943 F. Supp. 75, 77 (D.D.C. 1996) (commenting on "the burgeoning HMO industry and the legions of potential HMO-related medical malpractice claims that can be brought by innumerable HMO participants"); *see also* Allred & Tottenham, *supra* note 72, at 541 (noting that patients are more likely to sue MCOs than their individual physicians); Furrow, *supra* note 60, at 131.

129. *See* Allred & Tottenham, *supra* note 72, at 513-14 (discussing statutes governing financial solvency of integrated delivery systems); Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. 1007, 1024-25 (1996) (noting that 1995 legislation proposed in Congress would exempt provider-sponsored networks from state insurance regulations designed to protect the financial stability of

these approaches, however, directly addresses the problems created by the imposition of organizational liability for medical malpractice. If one accepts the reality that rising costs now prevent unfettered patient access to all medically-beneficial care, it seems equally apparent that the legal system must tolerate rather than hamper cost-containment efforts by managed care organizations. To promote the efficient utilization of resources, MCOs should not fear civil liability for the effects of reasonable cost-containment measures or the malpractice of their physicians. To the extent that cost-containment measures require policing, legislatures and regulators can more effectively establish and maintain reasonable limits than can the courts. Administrative agencies can supervise MCOs, allowing these organizations to build regulatory constraints into their risk management and cost-containment activities.

Tort law, in contrast, is unsuited to the task of policing cost-containment measures because it focuses on identifiable cases of managed care negligence while sacrificing the overall efficiency of the managed care system.[130] As highlighted in Part III of this Article, different attempts to modify tort law to address the conflict between rationing health care resources and maintaining quality care have created a partial and largely unsatisfactory solution. None of the approaches discussed effectively limits MCO liability to those extreme cases most deserving of compensation. Instead, each new theory of organizational liability risks opening the floodgates to suits of varying merit, which drain the resources of the organizations.[131] To encourage further market-based

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MCOs); FURROW ET AL., *supra* note 27, at 718-19. Other states have passed legislation requiring all provider contracts to contain "hold harmless" clauses that protect employers and subscribers against claims from unpaid providers in the case of financial difficulties with the MCO. *See, e.g.*, ILL. REV. STAT. ch. 111 1/2, para. 1407.01, § 2-8(a) (1995).

130. *Cf.* Lars Noah, *The Imperative to Warn: Disentangling the "Right to Know" from the "Need to Know" About Consumer Product Hazards*, 11 YALE J. ON REG. 293, 375 (1994) ("Courts in particular seem oblivious to the overall effect of their many decisions regarding the need to warn of individual and often trivial risks.").

131. One of the most interesting models under consideration is the American Law Institute's ("ALI") proposed "channelling" model, which would channel liability to the institution and treat physicians as part of the enterprise with no separate liability and without otherwise significantly altering the rules of proof. Under such a plan, injured patients could easily identify the source of their injuries, legal costs would be lowered with a single defendant, insurers would be able to predict risk more accurately, physicians would be relieved of their constant fear of malpractice suits, and institutions could use their centralized data collecting abilities to minimize future risks. *See* ALI REPORTERS' STUDY, 2 ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY: APPROACHES TO LEGAL AND INSTITUTIONAL CHANGE 111 (1991). Under some proposed enterprise liability reforms, experts predict that the rate of lawsuits will increase significantly. Patients are more willing to sue their managed care organization than their personal physician at the outset. Proposed no-fault systems raise the largest concerns about increased suits. Twenty years

reforms of the health care system, either the legislature or the courts must remove tort law from the calculus.[132]

B. Increased Adverse Selection

Organizational liability may lead MCOs to seek other effective methods for reducing their expenses. One of the more obvious approaches is to increase adverse selection against higher risk enrollees. Such liability encourages providers to avoid covering high risk patients or patient groups through a variety of adverse selection techniques including patient and geographical profiling.[133] In particular, patients with chronic illnesses may find it more difficult to procure insurance through an HMO than through traditional indemnity plans.

One recent study compared data on privately insured, noninstitutionalized patients under age sixty-five to test this adverse selection theory. The results were equivocal. The study found surprisingly little variation in the overall prevalence of the fifteen studied chronic conditions among insureds in HMOs and indemnity plans, but significantly more patients with two common chronic conditions had insurance through indemnity plans.[134] For another common condition, HMOs covered a larger number of patients than indemnity plans.[135] Although this study suggests that HMOs do not discriminate against chronically ill patients at the present time, adverse selection may well increase as suits against

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ago, a California study estimated that a no-fault insurance system in California could increase malpractice premiums by 300% over the tort system then in place. *See* CALIFORNIA MED. ASS'N & CALIFORNIA HOSP. ASS'N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (Don H. Mills ed., 1977).

132. *See supra* note 125 (discussing rationales offered by Gov. Chiles for recently vetoing a Florida bill that would have permitted subscribers to sue HMOs directly for refusing to provide covered services that an HMO doctor says are medically necessary).

133. *See* Furrow, *supra* note 60, at 130.

134. *See* Teresa Fama et al., *Do HMOs Care For the Chronically Ill?*, HEALTH AFF., Spr. 1995, at 234, 237-39 (concluding that, for arthritis, 81.7% of patients were covered through indemnity insurance compared with 68% in HMOs and, for hypertension, 79.4% of patients had indemnity insurance compared with 71.1% in HMOs); *cf.* George Anders, *Quality of Care for Poor and Elderly at HMOs Is Questioned in New Study*, WALL ST. J., Oct. 2, 1996, at B5. In a four year study comparing HMO and fee-for-service care and focusing on elderly and poor patients with chronic disease, surveyors found that 54% of elderly respondents in HMOs reported a decline in health during the study period, compared with 28% of the elderly in fee-for-service plans; and 33% of poor, chronically ill HMO patients reported a decline in health compared with only 5% in fee-for-service plans. Critics of the study urged caution in drawing negative conclusions from its results, noting that reports were based solely on patient self-assessment and that only a small population of patients was surveyed. *See id.*

135. *See* Fama, *supra* note 134, at 237-39 (concluding that, for patients with asthma, 46.2% were insured through indemnity plans while 57% received care from HMOs).

managed care organizations become more common and impose greater costs. To the extent that statutes attempt to prevent such discrimination,[136] MCOs will have to bear the costs associated with tort liability.

C. *Interference With Physician Autonomy*

The threat of organizational liability may tend to increase organizational interference with the MCO physicians' practice of medicine.[137] Physicians already complain that HMOs and other MCOs micromanage their treatment decisions and that the current system of financial incentives conflicts with their traditional role as patient advocate.[138] Statutory limitations on the amounts and types of these incentives would help to limit MCO manipulation of medical decisionmaking by participating physicians, and statutory immunity from tort liability would remove one of the incentives for this type of manipulation.

Physicians may contend that an MCO's influence over their practice decisions inappropriately interferes with their ability to deliver quality care, but at least one court has sharply refused to accept such interference as an excuse for poor judgment on the part of the physician. In

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136. For example, the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 100 Stat. 1936 (codified at 42 U.S.C.A. §§ 300gg-1 - 300gg-92 (West Supp. 1997)), requires health insurers to make their policies available to anyone who has had health insurance (and who meets other requirements of the Act) and requires insurers offering dependent coverage to enroll dependents of insured persons without waiting periods or preexisting condition exclusions provided that these dependents are enrolled within 30 days of birth, adoption, or marriage. In addition, health insurers must accept those who had group health insurance but can no longer get it, provided that the insured has exhausted COBRA continuation coverage and has at least 18 months of prior health insurance coverage. *See* 42 U.S.C.A. § 300gg-41.

137. *See* Furrow, *supra* note 60, at 128.

138. Direct or vicarious managed care liability also will tend to foster another form of perceived interference with physicians' autonomy, the now pervasive use of information-gathering to evaluate performance. Medical organizations maintain databases that track physician credentials and performance in detail, and health networks can use this data to hire those physicians who have the best track records and are least likely to cause patient injuries. *See id.* at 126. Obviously, this type of "interference" with autonomy is desirable from the patient's perspective and will likely become more common under various enterprise liability reform proposals, as health plans seek to improve quality and reduce the incidence of patient injuries. However, data suggesting that a physician falls "below average" may have a serious negative impact on the physician's career and on the liability of the MCO that employs him or her. *See id.* at 126-28 ("Any enterprise liability proposal is likely to reduce physician autonomy and subject them to constant evaluation of their practice techniques and patient outcomes."). Clearly, from patients' perspective, more available information about physicians is better, and there would be no reason to limit the gathering of (or access to) such information, even if MCOs receive statutory immunity.

Varol v. Blue Cross & Blue Shield,[139] the court expressed impatience with a group of physicians who claimed that the threat of withheld payment for services under utilization review procedures might influence them improperly and unfairly to render what they perceived as less than the ideal treatment.[140] Similarly, the court in *Wickline* noted that treating physicians had a duty to appeal to the state payor if they believed the proposed care was medically insufficient, and it reproved a physician for failing to attempt to protest the payor's decision to discharge his patient from the hospital prematurely.[141] The court emphasized that the physician "cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour."[142] It seems reasonable to hold physicians ultimately responsible for their patients' care so long as the particular MCO's incentives or utilization review procedures do not unduly constrain them in providing reasonable care. Extending tort liability to managed care organizations may have the perverse effect of increasing their interference with physician autonomy.

V. ALTERNATIVES TO MANAGED CARE LIABILITY

The competing concerns of quality health care and cost containment create a significant challenge for managed care. The added fiscal pressures arising out of potential tort liability may further handicap these organizations' attempts to meet the challenge. Health care providers and policymakers seem increasingly willing to consider alternatives to liability as they recognize the associated difficulties faced by managed care organizations in striving to deliver quality care at a reasonable cost. Permitting MCOs to assert cost constraints as a defense to liability or granting total immunity from suit to these organizations

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139. 708 F. Supp. 826 (E.D. Mich. 1989).

140. The court reminded the complaining physicians that, "[w]hether or not the proposed treatment is approved, the physician retains the right and indeed the ethical and legal obligation to provide appropriate treatment to the patient. Thus, there is no direct interference with the physician-patient relationship nor in the treatment rendered." *Id.* at 833 ("Plaintiffs are saying in effect, 'Since I am weak in my resolve to afford proper treatment, [Blue Cross and Blue Shield's] preauthorization program would induce me to breach my ethical and legal duties, and the Court must protect me from my own weakness.'").

141. *See* Wickline v. California, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) ("There is little doubt that [the physician] was intimidated by the Medi-Cal program but he was not paralyzed by [its] response nor rendered powerless to act appropriately if other action was required under the circumstances.").

142. *Id. But see* Jonathan J. Frankel, *supra* note 66, at 1306 (arguing that it was reasonable for the physician in the *Wickline* case to believe that the public payor for his indigent patient's care had some authority to direct the nature and duration of treatment).

under certain circumstances may represent the most sensible solution to the pressing problems of access and quality.

A. *Cost as a Defense to Liability*

Although some commentators have argued that the existing standard of care is flexible enough to accommodate the conservative approach to medical practice of managed care organizations,[143] courts have not demonstrated any willingness to embrace this view. In response, some commentators have suggested permitting physicians and provider organizations working under severe financial constraints to rebut the presumption of a uniform standard of care by asserting a cost defense—by claiming that they were financially unable to provide the care required with the resources available to them.[144] Under this proposal, the physician would have to demonstrate a heavy fiscal burden (based on severely limited resources in the hospital) and would further have to prove that no alternatives to the substandard treatment were readily available.[145]

The cost defense should be distinguished from the locality rule, which allows a court, in defining the standard of care, to consider or account for limited resources available in an isolated rural community.[146] The cost defense differs from the locality rule in that it seeks to address instead the problem of resource variations within the same city or region that become apparent when an indigent or uninsured patient is denied useful, available treatment because of its cost. This situation is beyond the reach of the locality rule.[147]

This proposed cost defense seems ideally suited to application in the managed care context. A managed care entity must justify the criteria

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143. *See supra* notes 53-59 and accompanying text.

144. *See* E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1757 (1987) (suggesting that, although the law presumes that physicians owe all patients a unitary standard of care regardless of the individual patient's financial resources, a physician may rebut this legal presumption under certain circumstances).

145. *See id.* at 1757-58. Professor Morreim emphasizes that she is not proposing to require the physician to demonstrate that he or she pursued every possible opportunity on the patient's behalf: "If the law required the physician to treat each patient as an exception to the otherwise applicable cost guidelines, it would in effect demand that he systematically ignore costs." *Id.* at 1758.

146. *See id.* at 1730 (describing the example of a physician who fails to order a CAT scan for a patient because there is no CT scanner within reasonable travelling distance, and explaining that, under the locality rule, courts will not hold that physician to have deviated from the standard of care even though a CAT scan would ordinarily be required under the national standard).

147. *See id.*

under which it agrees to provide a particular treatment or procedure as adequate medical practice in the face of significant economic restrictions. Then, the defendant organization must prove that the individual patient's condition fits these guidelines and that no reason existed to provide an exception to the rule.[148] Under these circumstances, a cost defense appears to provide a potential solution to the quandary faced by managed care organizations and their participating physicians.

Fundamental tort principles of fairness and reasonableness support recognition of a cost defense. Managed care represents a response to the reality of finite health care resources. Treatments that may seem appropriate under bountiful circumstances become less justifiable when resources are limited, because the effect of allocating resources to a particular patient indirectly affects other patients within the system as well.[149] However, no court has yet explicitly accepted a cost defense to a medical malpractice lawsuit, and commentators have argued that, when faced with a disagreement about the medical necessity of a treatment, courts will inevitably balance the equities in a way that favors compensating plaintiffs over protecting insurers against financial loss.[150]

B. Contractual Waivers and Disclosure

Incorporating waivers of the patient's right to sue the organization in the initial enrollment contract provides another avenue for limiting the potential liability of MCOs for actions in tort or breach of contract. Arbitration clauses represent one type of waiver. Arbitration provisions offer significant advantages for MCOs, including lower payments for damages and resolution of disputes without setting precedent, as well as swifter claims resolution and reduced administrative costs.[151] More

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148. *See id.* at 1758.

149. *See id.* at 1759; *see also* Robert C. Macaulay, Jr., *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 21 SUFF. U. L. REV. 91, 118 (1986) ("To enable cost containment to serve the public interest in maintaining affordable health care, payors should not be subject to tort liability in connection with cost containment in the absence of intentional wrongdoing or gross negligence.").

150. *See* Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1655 (1992) (citing Dozsa v. Crum & Forster Ins. Co., 716 F. Supp. 131, 140 (D.N.J. 1989)). Professors Hall and Anderson describe the tendancy of courts, in evaluating prospective utilization review, to "assume the worst-case, life-or-death scenario prior to treatment: that the patient will certainly die without the requested treatment and that the treatment will definitely save the patient's life." *Id.*

151. *See* Stanley D. Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947, 997-98 (1972) (concluding that, "once widespread use of malpractice arbitration develops, the incidence of enforcement will depend primarily on whether the arbitration clause is viewed as representing actual

sweeping contractual waivers might deny patients any right to compensation through either litigation or arbitration. To withstand judicial scrutiny, the contractual waiver should include full disclosure to the potential enrollee of all financial incentives, both to participating physicians and to the organization itself, to ration care. Without the enrollee's informed consent to these financial incentives, a contractual waiver of the right to sue arguably would be invalid. Even with full disclosure, courts must grapple with the disparity in bargaining power between the patient and the health plan.

Courts have permitted employers to bind the employee group to arbitration without expressing concern that the resulting agreement is a contract of adhesion. For example, in *Madden v. Kaiser Foundation Hospitals*,[152] the court upheld an arbitration clause, rejecting concerns over disparity in bargaining power (which had caused courts to reject waivers of liability in other medical care settings) because the employer-payor negotiated the HMO group contract.[153] The opinion expressed little concern, at least in the case of health care contracts negotiated by an employer for the benefit of and with input from employees, about the contractual requirement of using an alternative forum for dispute resolution.[154] Some courts have demonstrated a willingness to uphold

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agreement or a unilateral decision by the medical industry"); *see also* Barry Meier, *In Fine Print, Customers Lose Ability to Sue*, N.Y. TIMES, Mar. 10, 1997, at A1, C7 (discussing increasing prevalence of arbitration clauses in a variety of consumer contexts, including health care).

152. 552 P.2d 1178 (Cal. 1976).

153. *See id.* at 1185.

> The Kaiser plan . . . represents the product of negotiation between two parties . . . possessing parity of bargaining strength. Although plaintiff did not engage in the personal negotiation of the contract's terms, she . . . benefitted from representation by a board, composed in part of persons elected by the affected employees, which exerted its bargaining strength to secure medical protection for employees on more favorable terms than any employee could individually obtain.

Id.; *see also* Branham v. CIGNA Healthcare, 1996 Ohio App. LEXIS 3395 (Aug. 6, 1996) (holding that state employee was properly bound by the arbitration clause negotiated with a health plan on her behalf), *app. granted*, 674 N.E.2d 374 (Ohio 1997).

154. *See Madden*, 552 P.2d at 1180 ("[P]rinciples pertaining to adhesion contracts . . . do not apply to the arbitration provision in this case, . . . providing merely for a forum for enforcement of the rights of the enrolled employees rather than a substantive limitation of them."); *see also* Dinong v. Superior Court, 162 Cal. Rptr. 606, 610 (1980); *cf.* Tunkl v. Regents of the Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963) (holding hospital-patient contract releasing hospital from future liability as a condition of patient admission invalid on grounds that the contract provision affected the public interest and "manifested the characteristics of the so-called adhesion contract"); Colorado Permanente Medical Group, P.C. v. Evans, 926 P.2d 1218, 1226 (Colo. 1996) (refusing to enforce binding arbitration clause when arbitration provision did not comply with state statute governing such

binding arbitration agreements in MCO contracts even under circumstances that clearly suggest abuse of the process by the organization.[155]

Requiring disclosure of financial incentives, cost-containment measures, and contractual tort immunity to MCO patients at the time of enrollment would enable patients to make informed, well-considered choices about the quality and quantity of care they will receive in exchange for a lower premium.[156] Patients can, in effect, consent to a more conservative style of medical practice, including restricted choice of physicians and noncoverage of certain services, than they would receive in a traditional fee-for-service plan. Courts have not, however, imposed a duty on MCOs to disclose financial incentives and have been reluctant to consider causes of action for negligent physician decision-making attributable to such incentives.[157] Instead, a number of recent

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agreements).

155. *See, e.g.*, Engalla v. Permanente Medical Group, Inc., 43 Cal. Rptr. 2d 621, 646-47 (Ct. App.), *review granted*, 905 P.2d 416 (Cal. 1995). In this case, the appellate court reversed the trial court's refusal to enforce the binding arbitration clause in a group medical contract. The arbitration program was designed and administered by Kaiser, and the fact that Kaiser (and not a neutral entity) administered the program was not disclosed to subscribers in the contract. *See id.* at 626. The court noted that, although the arbitration provisions required the appointment of a neutral arbitrator within 60 days of a request for arbitration, on average this first step in the process took 674 days. *See id.* at 629. Nonetheless, the court concluded that the actions of Kaiser in delaying the arbitration process were not sufficient to set aside the agreement: "While some or all of this conduct may have been improper under statutes that regulate lawyers' actions . . . , and morally reprehensible if undertaken by Kaiser and its attorneys simply to stall the litigation until the claimant died, it is not the stuff of which a claim of fraud is made." *Id.* at 640.

156. Disclosure issues also contain an embedded informed consent question. As one commentator has noted, physicians, in obtaining informed consent to treatment, often bear "the burden of explaining the details of the plan's operation" to the patient. Alice C. Gosfield, *The Legal Subtext of the Managed Care Environment: A Practitioner's Perspective*, 23 J.L. MED. & ETHICS 230, 232 (1995).

> In addition to explaining gatekeeping, prior authorizations for services, and the inability to obtain coverage outside the network of providers, physicians must also confront informed consent. When the plan does not offer a benefit that the physician would recommend in other circumstances, what is his or her obligation to reveal the options that are not covered? There is no clear legal answer to this question.

Id. Once the subscriber has already joined the plan, the physician inherits a task that more properly belongs to the MCO at the time of enrollment. *See* Wendy K. Mariner, *Business v. Medical Ethics: Conflicting Standards for Managed Care*, 23 J.L. MED. & ETHICS 236, 242 (1995) ("If a subscriber is validly to consent to join a health plan (and to be bound by its terms), then the MCO—the entity with the relevant information—should have a duty to disclose all information relevant to the subscriber's decision.").

157. *See* Madsen v. Park Nicollet Medical Ctr., 419 N.W.2d 511, 515 (Minn. Ct. App.) (holding that a profit motive that may have influenced a physician not to hospitalize a

state legislative proposals contain disclosure provisions similar to those found in the American Medical Association's 1994 Model Patient Protection Act ("MPPA"), and these provisions would require detailed disclosure to patients of their health plan's terms and contracts with its providers.[158] Thorough disclosure at the time of enrollment would enable patients to make informed choices and would protect MCOs from claims of fraudulent or misleading conduct.[159]

C. *Statutory Immunities*

The recent upswing in malpractice litigation against MCOs highlights some of the problems with recognizing institutional tort liability in this field. Both employers and individual subscribers have noted the steady increase in the costs of participating in HMOs and other MCO plans, no doubt attributable in part to increased liability exposure. The quantity of litigation and the unpredictability of outcomes suggest that the courts may not be ideally suited to the task of effectively regulating cost-containment mechanisms. A few states have granted immunity to MCOs in an attempt to preserve these organizations as cost-effective vehicles for delivering quality care. Statutory immunity for MCOs, in combination with careful regulatory monitoring of these organizations, might accomplish in a more predictable and orderly fashion what the courts have failed to do.

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patient was "only marginally relevant, and potentially very prejudicial" and was therefore properly excluded), *rev'd on other grounds*, 431 N.W.2d 855 (Minn. 1988); Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1832 (1995). *But see* Teti v. U.S. Healthcare, 1989 WL 143274, at *3 (E.D. Pa.) (discussing plaintiff's complaint alleging that the defendant HMO's concealment of a "compensation referral fund" from purchasers of health care coverage constituted fraudulent nondisclosure in violation of federal law), *aff'd*, 904 F.2d 696 (3d Cir. 1990). The court, however, dismissed the case on jurisdictional grounds.

158. *See* Platt & Stream, *supra* note 7, at 493-94. A 1995 Florida bill, modeled on the MPPA,

> would have required HMOs and other managed care plans to inform prospective enrollees of a plan's coverage provisions and exclusions, treatment policies and any restrictions or limitations on services, prior authorization or review requirements, any financial arrangements or contracts a plan has with hospitals, physicians or other providers that would limit services, referral or treatment, including financial incentives not to provide services.

Id. at 494 n.38 (discussing Fla. H.B. 841, § 100 (1995)).

159. For example, in *Teti*, 1989 WL 143274, the plaintiff argued that, had she been informed of her health plan's gatekeeping system, she would not have enrolled with the insurer. Although the case was dismissed, it generated significant controversy within the managed care industry about the extent of an HMO's duty to disclose to subscribers the HMO's structural incentives and limitations on access to specialists and other non-primary care parts of the system. *See* Gosfield, *supra* note 156, at 232 (discussing *Teti*).

A few states have already begun to experiment with statutory immunity for HMOs and other managed care organizations. The New Jersey legislature concluded that HMOs do not practice medicine and exempted these organizations from liability for "negligence, misfeasance, nonfeasance or malpractice" in connection with the furnishing of health services.[160] The statute explicitly states that courts can only hold the actual provider of health care liable.[161] In Illinois, nonprofit "health services plan corporations" that have no affiliation with any hospital have statutory immunity from liability for injuries resulting from the malpractice of any employee or other person or organization rendering health care on behalf of the corporation.[162] Colorado immunizes HMOs from civil liability under the theory that these organizations "shall not be deemed to be practicing medicine."[163]

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160. *See* N.J. STAT. ANN. § 26:2J-25(c) & (d) (West 1994). The New Jersey Department of Health and Human Services recently promulgated an array of regulations governing HMOs and addressing issues of consumer protection, health decisions and access, and quality and performance. The regulations provide for a two-step appeal process for denials of treatment, the right of patients to see specialists for their chronic conditions, and the right to information about how HMOs pay their physicians, among other things. *See New Jersey Announces New HMO Regulations*, 1 MEALEY'S LITIGATION RPTS: MANAGED CARE No. 4 (Feb. 19, 1997), *available in* LEXIS, LegNews library, MEAMC file.

161. *See New Jersey Announces New HMO Regulations*, 1 MEALEY'S LITIGATION RPTS: MANAGED CARE No. 4 (Feb. 19, 1997), *available in* LEXIS, LegNews library, MEAMC file.

162. ILL. REV. STAT. ch. 215, para. 165/26 (1993), provides as follows:

> A health services plan corporation . . . operated on a not for profit basis, and neither owned nor controlled by a hospital shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any officer or employee of the corporation, or on the part of any person, organization, agency or corporation rendering health services to the health services plan corporation's subscribers and beneficiaries.

Id.; *see also id.* para. 165/2(a) (defining "health services plan corporation"). The state court upheld the limited immunity provided for in this statute in the face of a state constitutional equal protection challenge. *See* Jolly v. Michael Reese Health Plan Found., 587 N.E.2d 1063, 1067 (Ill. 1992) (holding that statutory immunity granted to health care providers under the Voluntary Health Services Plans Act does not violate special legislation and equal protection provisions of the Illinois Constitution).

163. *See* COLO. REV. STAT. ANN. § 10-16-421(3) (West 1994). The statute defines HMOs broadly, including both for-profit and nonprofit organizations. *Id.* § 10-16-102(23). Courts have concluded, under the statute, that breach of contract claims and tort claims may not be brought against HMOs. *See* Evans v. Colorado Permanente Medical Group, P.C., 902 P.2d 867, 877 (Colo. App. 1995), *modified*, 926 P.2d 1218 (Colo. 1996); Freedman v. Kaiser Found. Health Plan, 849 P.2d 811, 816 (Colo. App. 1992).

> Because an HMO is specifically precluded from practicing medicine, no HMO can direct the actions of the independent physicians with whom it contracts. Thus, we conclude that the concept of respondeat superior cannot be invoked to make an HMO responsible for the medical malpractice of those independent contractor physicians that it is statutorily precluded from directing or controlling.

In *Harrell v. Total Health Care, Inc.*,[164] the Missouri Supreme Court considered the constitutionality of a state statute that exempted nonprofit "health services corporations" from liability for the negligence of physicians rendering services to the organization's members.[165] The plaintiff belonged to a health services corporation that required members to consult a participating primary care physician before being referred to a specialist on the organization's approved list of specialists.[166] The plaintiff sought to recover damages for an injury sustained during surgery performed by one of the organization's specialists, arguing that the MCO had breached its duty to use due care in selecting its physicians and specialists and had impliedly warranted the competence of its contracting physicians. The trial court granted summary judgment in favor of the organization based on the immunity provided for in the statute.[167]

Although the Missouri statute grants immunity only to not-for-profit health services corporations,[168] the arguments recognized by the court in support of statutory immunity apply to any MCO that provides health care in exchange for set patient dues with cost-containment as one of its goals. Both for-profit and not-for-profit MCOs face insolvency, or at least rapidly escalating costs, when they must defend against claims of malpractice. According to the court in *Harrell*, the state legislature clearly felt that prepaid health care served the public interest and should not be burdened with the ever-increasing costs of malpractice litigation.[169] The court also pointed out that plaintiff had adequate

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Sciarretta v. Multi-Specialty Medical, P.C., *described in* 1 MEALEY'S LITIGATION RPTS: MANAGED CARE No. 1 (Jan. 8, 1997), *available in* LEXIS, LegNews library, MEAMC file (holding that state's corporate practice of medicine statute specifically exempts HMOs from malpractice liability).

164. 781 S.W.2d 58 (Mo. 1989).

165. *See* MO. ANN. STAT. § 354.125 (Vernon 1991) ("A health services corporation shall not be liable for injuries resulting from neglect, misfeasance, malfeasance or malpractice on the part of any person, organization, agency or corporation rendering health services to the health services corporation's members and beneficiaries.").

166. *See Harrell*, 781 S.W.2d at 59.

167. *See id.* at 59-61.

168. *See id.* at 60; *see also* MO. ANN. STAT. §§ 354.010(4) & 354.025 (requiring not-for-profit status to be eligible for statutory immunity, and granting immunity to eligible health services corporations, whether providing health care directly or reimbursing for services provided by others).

169. *See Harrell*, 781 S.W.2d at 61 ("The legislature might easily perceive that the costs of [malpractice claims] . . . would necessarily be shared by other plan members, and that malpractice liability might threaten the solvency of the plan."). "Just as the ancient Chinese are reputed to have paid their doctors while they remained well, a person may elect to pay fixed dues in advance so that medical services may be available without additional cost when they are needed." *Id.*

recourse for her injuries against the physicians who actually committed the malpractice and cannot complain that she may not also sue the nonprofit organization that facilitated the delivery of the negligent services.[170]

In lieu of such a limited patchwork of state statutes, Congress should consider legislation protecting managed care organizations. A federal statute immunizing MCOs would have to contain provisions designed to ensure an adequate standard of care at the organizational level. Under a statutory immunity plan, MCO subscribers would retain their right to sue participating physicians for malpractice. Because certain managed care practices can result in indirect injury to patients, however, organizational immunity from liability is only justifiable if granted in conjunction with regulations that protect patient welfare by preventing MCOs from imposing overly stringent cost controls.

Some states have already enacted statutes or promulgated regulations limiting the ability of HMOs and other health care organizations to assume risk through insurance contracts.[171] The federal government also has begun to regulate financial incentives for physicians who participate in plans that provide care for Medicare and Medicaid recipients, prohibiting "specific" payments directly or indirectly to physicians "as an inducement to reduce or limit medically necessary services."[172] If a plan uses financial incentives to put physicians at substantial financial risk,[173] then it must provide "stop-loss protection" for the plan physicians based on standards developed by the Secretary of Health and Human Services ("HHS").[174] Stop-loss protection limits the amount of financial risk borne by an MCO's physicians. HHS finalized implementing regulations in 1996,[175] and these rules do not include capitation payments, bonuses, or fee withholds as "specific" payments within the meaning of the statute. Although the regulations

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170. *See id.* at 61-62 (The statute "does not deny the plaintiff a remedy for the wrong done to her. She has her right of action against the negligent surgeon. The statute simply limits her access to an additional pocket.").

171. *See* BENDA & ROZOVSKY, *supra* note 51, at § 13.6.

172. 42 U.S.C. § 1395mm(i)(8)(A)(i) (1994).

173. *See id.* § 1395mm(i)(8)(A)(ii) (requiring the Secretary of Health and Human Services to define substantial financial risk).

174. *See* Orentlicher, *supra* note 28, at 162 n.28:

> For example, in an expanded capitation plan in which the capitation payments are designed to cover all patient costs, physicians might only be responsible for patient costs up to a maximum of $5,000 or $10,000 for any one patient . . . . There might also be a cap on the total amount of costs for which the physicians are responsible.

175. *See* 61 Fed. Reg. 69,034, 69,049 (1996) (to be codified at 42 C.F.R. pts. 417 & 434).

permit these types of incentives, they restrict the amount of financial risk that the health plan may shift to the participating physicians.[176]

A similar approach could encompass all MCOs regardless of participation in Medicare or Medicaid. Physicians would bear the risks of a plan's cost containment to a limited extent, but if the plan's financial incentives put more than twenty-five percent of the physician's income at risk (for example), then the MCO would lose its immunity from suit for the results of its cost-containment measures. To protect patients further, incentive payments should be calculated on an annual rather than a monthly basis to allow for variations in the cost of treating a group of patients from one month to the next. Similarly, the legislation should base physician incentives on large patient groups to achieve a reasonable average cost of overall treatment.[177] Capitation arrangements, fee-withholds, bonuses, quotas, and similar arrangements should be designed or set at reasonable levels to reflect industry averages. Regulations also might prohibit certain cost-control arrangements outright.

Statutes governing the structure and financial incentives used by MCOs that have been granted tort immunity also might include requirements such as salaries for physicians, which have the effect of guaranteeing the physicians' incomes and separating those incomes from treatment decisions made for individual patients.[178] Diluting the risk of capitation payments by spreading capitation funds and costs across large physician populations might provide another safeguard for patient welfare.[179] Finally, these statutes might require that MCOs give physicians significant input into utilization review and quality assurance guidelines.[180]

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176. The regulations define substantial financial risk as existing when financial incentives involve the risk of more than 25% of the physician's income, but only if the incentives are based on a patient threshold of 25,000 or fewer patients. *See id.* at 69,049. Once a patient group exceeds 25,000, a HCFA study determined that health care costs did not vary significantly and that therefore risks could be spread effectively. Thus, in these larger patient populations, the regulations do not limit the degree of risk that can be shifted to the plans' physicians. *See id.*; *see also* Orentlicher, *supra* note 28, at 163-64 (detailing HCFA's earlier stop-loss regulations).

177. *See* Orentlicher, *supra* note 28, at 195-96 (also suggesting audits to detect patterns of substandard care and financial penalties against physicians for inappropriate care).

178. *See id.* at 226-27.

179. *See id.* at 227; *see also* Joan B. Trauner & Julie S. Chesnutt, *Medical Groups in California: Managing Care Under Capitation*, HEALTH AFF., Spr. 1996, at 159 (noting that many larger physician organizations have turned to in-house processing of claims and tracking of referrals and hospital admissions in order to maintain their incomes in the face of little or no recent increases in capitation payments).

180. *See* Christensen, *supra* note 18, at 227.

Regulations also might specify utilization review procedures designed to protect patient interests, particularly with regard to denials of coverage. For example, some commentators have suggested that only physicians specializing in the relevant medical specialty should make the final decision to deny coverage for a treatment and that the reviewer should be required to consult with the patient's physician. In addition, regulations should provide for an expeditious appeal procedure, and patients should receive immediate notification of coverage denials and assistance with appeals.[181] The federal government is considering regulations to protect Medicare beneficiaries who receive care from HMOs. Although HCFA has not yet issued proposed rules, the regulations evidently will include a seventy-two hour limit for resolving most appeals in cases when members' lives are at stake and the right to appeal decisions to reduce, terminate, or completely deny coverage.[182]

As an alternative to a general grant of tort immunity to all MCOs, a legislature might consider drawing distinctions between different categories of MCOs and granting immunity only to particular categories. For example, one commentator has identified several important differences between for-profit and nonprofit MCOs that might provide grounds for determining whether or not to grant statutory immunity to a particular class of managed care organization.[183] For-profit plans have higher administrative costs than nonprofit MCOs because for-profits trade their shares publicly, pay high salaries and bonuses to CEOs, and pay dividends to shareholders.[184] Because nonprofit MCOs devote a higher percentage of income to health services, for-profits presumably feel a greater need to limit health services costs and may rely more heavily on financial incentives to physicians to limit care.[185]

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181. *See* Allred & Tottenham, *supra* note 72, at 463-64. For suggested contractual language regarding appeals, see *id.* at 532 n.542.

182. *See* George Anders & Laurie McGinley, *HMO-Medicare Recipients to Get Broader Rights*, WALL ST. J., Feb. 13, 1997, at B2 (reporting that HMOs currently have as long as 60 days to resolve complaints, even when patient lives or their ultimate return to health is at stake).

183. *See* Christensen, *supra* note 18, at 223.

184. *See id.*; *see also* KAREN DAVIS ET AL., HEALTH CARE COST CONTAINMENT 142 (1990) (noting that the percentage of for-profit MCOs out of total MCOs grew from 18% in 1982 to 67% in 1988).

185. *See* Christensen, *supra* note 18, at 223 ("It stands to reason that physicians in an MCO that has both less to spend on patient care and stockholders to please will be under more pressure to cut corners."). A recent study identified a comparable distinction between not-for-profit and for-profit hospitals. *See* Robert Pear, *In Separate Studies, Costs of Hospitals Are Debated*, N.Y. TIMES, Mar. 13, 1997, at C2 (noting that for-profit hospitals spend significantly more on administration than nonprofit hospitals, and describing a recent study that concluded that for-profit hospitals "'save money by laying off nurses, then

A system that grants immunity from tort liability to MCOs requires regulations to ensure that these organizations maintain reasonable cost-containment strategies to protect patient welfare. In addition, the use of any cost-containment arrangements also requires that someone make the health care rationing decisions that arise in these arrangements. Although a number of commentators have criticized the use of physicians as rationing decisionmakers,[186] in a system where MCOs enjoy tort immunity, physicians would be most effective in making these decisions,[187] and further, they must remain involved in the rationing process to protect themselves from individual liability. In contrast, MCOs will find it virtually impossible to develop guidelines for making individual rationing decisions.[188] By controlling MCOs' use of financial incentives and other cost-containment measures and by placing the actual rationing decisions in the hands of physicians, the proposed system can effectively accomplish its twin goals of keeping costs down and protecting patient welfare. When medical error occurs, the victim of malpractice has recourse against the treating physician in whose hands the ultimate responsibility of maintaining the standard of care rests. Regulations limiting MCO cost-containment measures thus would protect both the patient and the treating physician while allowing MCOs and patients to reap the benefits of lower health care costs.

Realistically, courts and legislatures must acknowledge the effects of financial measures on physicians. The proposed statutory immunity discussed here would insulate physicians from liability for their plans' cost-containment policies to the extent that the regulations permit the policies. Of course, this does not address the problem of physicians'

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hire consultants and bureaucrats to . . . maximize revenues'").

186. *See, e.g.*, Norman G. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573 (1984); Robert M. Veatch, *DRGs and the Ethical Allocation of Resources*, HASTINGS CTR. REP., June 1986, at 32, 37-39. *But see* Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 727-58 (1994) (rejecting the view that physicians should not make rationing decisions when treating patients); Orentlicher, *supra* note 28, at 167-73.

187. *See* Orentlicher, *supra* note 28, at 168-69 (noting that it is virtually impossible for nonphysicians to develop rationing guidelines, that the development and implementation of such guidelines are difficult to separate, and that health care plans cannot develop guidelines with sufficient specificity to be of much use to physicians).

188. *See id.* at 170-71.

> [B]ecause specific guidelines cannot be created, and general rationing principles will always be indeterminate for particular rationing decisions, the development and implementation of rationing guidelines must occur as intertwined endeavors. As a corollary, because each patient's circumstances are unique, every time physicians decide whether or not to provide a medical service, they are essentially both creating and implementing a new rationing policy.

Id.

moral or professional obligations to treat when noncovered treatments are medically necessary. The proposal would relieve physicians of legal liability in these instances but would sometimes leave them in an ethical dilemma.

D. Ethical Implications and Mass Justice

Managed care provides basic health care that meets the needs of the vast majority of enrollees. Nonetheless, a few patients requiring extraordinary measures not covered under the plan will suffer from the unavailability of certain treatments. Is it ethical to encourage patients to enroll in plans that provide less than the full panoply of medically beneficial care to keep premiums, and thus health care, within the reach of a larger population? By their very nature, MCOs pose issues of this sort, but a decision to grant malpractice immunity to these organizations would place these issues in even starker relief. Critics have expressed concerns about the failure of HMOs to meet the needs of the atypical patient, but some have recognized that permitting physicians to retain significant autonomy in making patient care decisions can counter this problem to some extent.[189]

In fact, some commentators have suggested that patients who opt for lower-cost MCO plans rather than expensive fee-for-service policies receive financial rewards for their cost-consciousness.[190] Under that approach, patients also might receive financial incentives to keep the costs of routine care low and utilize preventive care, such as childhood vaccinations and pap smears, that could obviate the need for higher cost care in the future.[191] In this era of growing patient autonomy, properly informed patients may reasonably decide to forego medical care of little or no utility in exchange for lower health plan premiums.[192]

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189. *See id.* at 175-76 ("If physicians are given broad latitude in allocating health care resources, they can individualize the care, taking into account the particular needs and circumstances of each patient.").

190. *See* Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy (pt. 1)*, 320 NEW ENG. J. MED. 29, 33 (1989); E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 99-100 (1994); E. Haavi Morreim, *The Ethics of Incentives in Managed Care*, 10 TRENDS HEALTH CARE L. & ETHICS 56, 59-60 (1995).

191. *See* Orentlicher, *supra* note 28, at 186-87 (discussing financial incentives for patients).

192. *See id.* at 187 ("If patients are able to reject health care because they do not like physical side effects or simply because they no longer want to live, they should also be able to reject health care because it is not worth its cost.").

Immunizing MCOs for the torts of their physicians and for the effects of their cost-containment measures contemplates a kind of mass justice that may trouble some observers, but that approach is far from unique in the American legal system.[193] The workers' compensation system, for example, arose in the first half of this century in response to the difficulties that employees encountered in suing their employers for employment-related injuries.[194] Although the injured employees generally do not receive full compensation, the system provides a reliable, predictable, and relatively speedy response to workplace injuries. Similarly, the National Childhood Vaccine Injury Act[195] represents a carefully considered response to the ballooning liability once faced by manufacturers of vaccines, which threatened to bankrupt them and make these important products unavailable.[196]

VI. CONCLUSION

Managed care organizations provide patients with comprehensive, coordinated health care in a cost-efficient setting with an emphasis on preventive care and controlling costs. MCOs seek to maximize the availability of scarce health care resources while avoiding cost increases that would make these services financially inaccessible. Achieving a balance between cost containment and quality care becomes more difficult as lawsuits against MCOs proliferate. Holding MCOs liable for

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193. *See, e.g.*, JERRY L. MASHAW, BUREAUCRATIC JUSTICE 222 (1983) ("[B]ureaucratic rationality . . . is a promising form of administrative justice. It permits the effective pursuit of collective ends without inordinately sacrificing individualistic or democratic ideals.").

194. *See generally* ORIN KRAMER & RICHARD BRIFFAULT, WORKERS COMPENSATION: STRENGTHENING THE SOCIAL COMPACT 13-27 (1991) (noting that employers routinely and successfully raised defenses such as contributory negligence, assumption of risk, and the fellow-servant doctrine and that the alternative to a no-fault worker's compensation statute was the judicial erosion of these tort defenses in the employment context, out of recognition of the unfairness of these doctrines when applied in such circumstances). The judicial approach, however, would have negatively impacted both injured employees and employers; employees would have had to grapple with unpredictable trial outcomes and long delays in recovery of compensation, and employers would have likewise shouldered the burden of frequent litigation, unpredictable risks, and, at times, disproportionately high levels of compensation for workplace injuries from sympathetic juries. *See id.*

195. 42 U.S.C. §§ 300aa-1 - 300aa-34 (1994).

196. The Act created a compensation fund by imposing a manufacturer's excise tax on vaccines. *See* 26 U.S.C. §§ 4131, 9510 (1994). The Act allows manufacturers to predict the degree of their liability, thereby encouraging research, development, and continued manufacturing of needed products. *See* Shalala v. Whitecotton, 115 S. Ct. 1477, 1478-80 (1995) (describing operation of statute); Lisa J. Steel, Note, *National Childhood Vaccine Injury Compensation Program: Is This the Best We Can Do for Our Children?*, 63 GEO. WASH. L. REV. 144 (1994).

the effects of cost-containment measures defeats the purpose of these organizations. Perhaps it is more realistic to view the operation of MCOs from a mass justice perspective: the philosophy of cost containment seeks to provide adequate health care to the vast majority of the patient population even though a few patients will suffer injury from lack of access to state-of-the-art medicine.

Recipients of health care provided directly or facilitated by MCOs may genuinely have reason to complain about the quality of care received. MCOs undoubtedly restrict patient choice of health services, and in some instances, relieving MCOs of liability based on these restrictions will lead to an unwise or unfair result. But regulatory officials rather than the courts may address these concerns more effectively. Providing statutory immunity for MCOs relieves these organizations of the uncertainty and financial burden of contending with malpractice claims, leaving the organizations free to focus on providing quality care at a reasonable cost. State and federal legislators and regulators can effectively balance the competing interests of MCOs and health care recipients by establishing minimum standards of coverage for health insurance policies while immunizing MCOs from liability for the torts of their physicians and for the effects of legal cost-containment measures. Physicians must retain the ultimate responsibility for their patients' welfare, and a system that acknowledges this responsibility while limiting organizational influences over treatment choices may provide the most effective balance of quality care and cost containment.