Saint Louis University Law Journal

Volume 47
Number 2 *(Spring 2003)*

Article 5

4-10-2003

What If You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield

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WHAT IF YOU *COULD* SUE YOUR HMO? MANAGED CARE LIABILITY BEYOND THE ERISA SHIELD

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I. INTRODUCTION

From the bright red cover of *Time* Magazine to the smudged ink pages of student newspapers, headlines have trumpeted the news that "you can't sue your HMO."[1] While never literally true, the more accurate statement—a managed-care enrollee's ability to prevail in a lawsuit against a managed care organization can depend upon complex factors unrelated to the merits of the case—is somewhat harder to capture in a headline and considerably less likely to grab the attention of the average reader. While the public has lamented the alleged inability to hold managed care organizations legally accountable for their actions, courts and health law scholars have devoted countless pages to deciphering the complexities of when and where disgruntled enrollees could seek legal redress for harm.

Some rules are straightforward. Individuals who obtain their health care coverage from a private employer-sponsored health benefit plan can enforce their contract rights to plan benefits in federal court under the Employee Retirement Income Security Act (ERISA).[2] ERISA plan beneficiaries, however, cannot recover consequential personal injury or punitive damages in such suits.[3] The ability to seek damages or injunctive relief under state law has

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1. Robert F. Howe, *The People vs. HMOs*, TIME, Feb. 1, 1999, at 46.

2. *See* 29 U.S.C. §§ 1001-1426 (2000). A full discussion of ERISA is beyond the scope of this Article. For an excellent discussion of these issues, see Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985 (1998).

3. *See* 29 U.S.C. § 1132 (2000). *See also* Mertens v. Hewitt Assocs., 508 U.S. 248, 262 (1993) (extra contractual damages not recoverable in ERISA action).

been curtailed by ERISA's preemption of state laws that relate to such plans.[4] The degree of curtailment depends upon the theory of liability. At least since the decision of the United States Court of Appeals for the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*,[5] theories of vicarious liability for the negligence of treating physicians have not been preempted in most jurisdictions.[6] Yet, it is undeniable that ERISA has significantly restricted the abilities of plan beneficiaries to seek damages for the conduct of managed care organizations, including medical necessity decisions, medical management policies, or other coverage determinations that affect the care received by a beneficiary.[7]

Courts and commentators alike have addressed the wisdom, or lack thereof, of shielding managed care organizations from state law remedies.[8] Comparatively less substantive attention has been afforded, however, to analyzing or adjudicating the merits of such suits.[9] In large part, this is because so few survived preemption, and of those that did, many were settled by managed care organizations to avoid establishing unfavorable precedents.

Recently, the legal environment that has afforded managed care organizations protection from liability for cost containment activities has begun to change, and their risk of liability under state law has begun to increase. Various legal doctrines have created cracks in the ERISA shield. Some states are attempting to circumvent ERISA preemption through statutory declarations of managed care liability, and preemption may fall altogether if legislation pending in Congress for several years is ever enacted. This Article

4. *See* 29 U.S.C. § 1144 (2000) ("the provisions of this title . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). Similar forms of preemption may apply to private insurers who contract with Medicare or the Federal Employee Health Benefits Program, although this issue has not yet been resolved. *See* Ardary v. Aetna Health Plans of Cal., Inc., 98 F.3d 496, 501 (9th Cir. 1996) (finding no preemption under Medicare). ERISA preemption does not apply, however, to health insurance purchased outside the workplace, or for insurance provided by religious institutions, and by state and local governments for their employees.

5. 57 F.3d 350 (3d Cir. 1995). *See* discussion *infra* notes 50-53.

6. *See, e.g.*, Rice v. Panchal, 65 F.3d 637, 646 (7th Cir. 1995) (vicarious liability claims not preempted); Ray v. Value Behavioral Health, Inc., 967 F. Supp. 417, 423-24 (D. Nev. 1997) (same); Yanez v. Humana Med. Plan, Inc., 969 F. Supp. 1314, 1316 (S.D. Fla. 1997) (same).

7. *See, e.g.*, Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992) (ERISA preempts state law wrongful death claim in which parents allege medical necessity coverage determination proximately caused the death of their unborn child).

8. *See, e.g.*, Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J.L. MED. & ETHICS 253 (2001) (favoring enhanced liability); David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For*?, 32 MICH. J. L. REFORM 785 (1999) (opposing enhanced state law liability). *See also* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997) (state law claim preempted by ERISA).

9. *But see* E. HAVVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE (2001).

looks ahead to a time when it will be possible to sue managed care organizations for a broader range of managed care activities, and it considers how legislatures and courts should develop the law that will govern these new causes of action.[10] It does so by combining conventional legal analysis with empirical findings from a large number of confidential interviews with experienced health care lawyers, health plan managers, and industry observers.[11]

Part II of the Article explains why managed care liability exposure has been low and why it is increasing. Part III briefly outlines the costs and benefits of enhanced liability of managed care organizations to provide a guide for those who would create the law that governs the merits of these suits. Part IV describes the new liability statutes enacted by states and proposed in Congress, and explains their differing scopes and standards of liability. In Part V, a framework is developed for the adjudication of lawsuits challenging the clinically based actions taken by managed care organizations.

II. THE CONFUSING AND CHANGING FACE OF MANAGED CARE LIABILITY

A. Liability Risk Viewed from the Trenches

A confluence of events has increased the potential risk of liability for managed care organizations: (1) State courts have indicated their willingness to extend common-law theories of institutional negligence and vicarious liability, originally developed to expand hospital liability, to managed care

10. In this Article, we use the terms "health plan" or "health insurer" interchangeably with "managed care organization" or "health maintenance organization" (HMO). For many of the issues, it is not necessary to distinguish among different types of health insurance, and in our interviews it was common to refer to managed care insurers as health plans. Also, we do differentiate between the primary health insurer and those entities to which the insurer may have delegated some or all of its managed care functions, but we do not consider situations where an employer may retain some of these functions. These are important complexities, but they fall outside the scope of this Article.

11. Because of the confidentiality protections given to these research subjects, their identities cannot be revealed through citations to particular interviews that support various statements in this Article. Instead, this Article itself is the original report of these research findings. This research was conducted in 2002, and consisted of two focus groups and a variety of interviews with eighty-four subjects, including twenty-one in-house lawyers with health plans (seven national and fourteen more locally or regionally focused), forty-seven managed care executives or advisors, ten independent defense-oriented lawyers (mainly representing health plans), twenty-three plaintiffs' lawyers or patient advocates, and thirteen other market participants or observers (for example, regulators or industry analysts). About half of these interviews focused on liability issues in one of the six states we selected for in-depth study: Iowa, Louisiana, Michigan, New Jersey, Virginia and Texas. Half of these states (Louisiana, New York and Texas) have managed care liability statutes. The rest of the interviews addressed liability issues nationally or in a scattering of ten other specific states, including four other states with managed care liability statutes (California, Georgia, North Carolina and Oklahoma).

organizations; (2) the United States Supreme Court has narrowed the scope of ERISA preemption of state law, and in doing so has left a trail of puzzling dicta that appears to lead inexorably to greater liability exposure under state law; (3) State legislatures have accepted the Court's invitation to create new theories of liability and causes of action for individuals harmed by managed care cost containment initiatives, while Congress repeatedly flirts with its own version of expanded liability; (4) the "managed care backlash" has created a social environment conducive to such lawsuits;[12] and (5) a group of prominent plaintiffs' lawyers, flush from victories over tobacco companies, has brought large class action suits against the major national managed care organizations under both ERISA and the Racketeer Influenced and Corrupt Organizations Act (RICO), the federal white-collar crime statute.[13]

This series of events has produced a complicated, evolving, and somewhat dichotomized liability landscape.[14] This is reflected in the contrasting views

12. *See* Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395 (2001) (analyzing the backlash against managed care organizations). Not even the judiciary is immune from negative views of managed care organizations. *See, e.g.*, Wagner v. Magellan Health Servs., Inc., 125 F. Supp. 2d 302, 304 (N.D. Ill. 2000) ("Magellan behaved like the stereotypical HMO, with a beady eye on the bottom line and stony indifference to patient welfare. . . .").

13. 18 U.S.C. §§ 1961-1968 (2000). These class actions allege that HMOs systematically misrepresent how generous they are in making coverage decisions and that they fail to disclose utilization review restrictions and methods of physician payment. These non-disclosures are also alleged to violate fiduciary principles under the ERISA statute itself. Physicians have brought another set of class action suits in which they use a variety of state common law theories, as well as the federal statutes, to claim various economic injuries under their contracts with HMOs. So far, the only federal appellate decision has dismissed the RICO claims based on the plaintiffs' failure to allege any injury cognizable under the statute. The plaintiffs in that case claimed only that, due to managed care practices, their insurance policies had a lower market value than their employers paid for them, and not that they had suffered any *actual* denial of services. *See* Maio v. Aetna, Inc. 221 F.3d 472 (3d Cir. 2000). However, a lower court ruling has indicated that various legal theories under both RICO and ERISA, especially those in the physician class action suits, may be viable. *In re* Managed Care Litigation, 135 F. Supp. 2d 1253, 1259 (S.D. Fla. 2001). For analysis, see David M. Studdert & Troyen A. Brennan, *The Problems with Punitive Damages in Lawsuits against Managed-Care Organizations*, 342 NEW ENG. J. MED. 280 (2000); Clark C. Havighurst, *Consumers Versus Managed Care: The New Class Actions*, HEALTH AFF., July-Aug. 2001, at 8; Kathy L. Cerminara, *Taking a Closer Look at the Managed Care Class Actions: Impact Litigation as an Assist to the Market*, 11 ANNALS HEALTH L. 1 (2002).

14. We are reminded of the following words from Peter Hammer:

> Within this patchwork system, it is nearly impossible to answer legal questions concerning managed care liability with any level of generality, other than "it depends." Liability depends upon the structure of the managed care organization, an economic entity that is constantly evolving and taking different shapes. Liability depends upon which state the plan is in, and the extent to which that state's tort law has evolved to address changing institutional forms in health care. Liability depends upon whether the plan is in an ERISA-qualified plan, and potentially on whether that plan is self-funded. Liability also depends upon the prevailing judicial attitudes toward ERISA preemption.

on the overall level of liability exposure that have been expressed in our interviews with lawyers and health plan managers. Views differed most sharply according to whether the subjects presented a national or more local perspective. Most subjects who were focused on one of our particular study states (Iowa, Louisiana, Michigan, New Jersey, Texas and Virginia), such as lawyers with local HMOs or Blue Cross plans, felt that the liability threat was low or only moderate. The local health plans noted that a variety of theories of liability might exist in their states and that HMOs or other MCOs had been sued. Nonetheless, these plans had not experienced any large verdicts or prominent appellate court decisions, nor were a rash of lawsuits being filed locally. In the words of one health plan executive, liability is more of a "theoretical concern" or general "cloud," created by the sense that "anyone can sue over anything," rather than a specific threat that was driving health plan decision-making. Many local health plan lawyers could think of only one or two suits, and sometimes none, having been filed against their company, and these were typically dismissed or settled for small amounts. Therefore, liability concerns remained largely speculative or "theoretical" in the minds of most subjects with a focus on a particular state. For reasons noted below, this result was true both in states with and without a statute specifically creating liability. Even in New Jersey, the one state in this study with the strongest liability precedents, interview subjects commented that the liability threat was not strong and was largely theoretical, since only a modest number of suits had been filed, and only a handful had been successful.

Quite a different perspective came from subjects who have a more national perspective.[15] Although some agreed with the assessment of a low liability exposure, most thought liability exposure was strong or substantial. In the words of one defense lawyer, the "sharks are in the water" and are "sniffing blood." Another observer felt that the "real impact" of liability would be felt in a few more years, since very large verdicts are just starting to appear. Others said that "lawsuits are coming at us from places they haven't come before," that the liability threat is "real, not imagined," that there is enough potential for liability "to get into trouble," and that, although there was little real concern five years ago, there is "more panic" now due to the erosion of ERISA preemption and the other factors noted below. Other subjects said that litigation is "fueled by" the "constant drumbeat" of negative press generated by media and patient advocacy groups, which create the perception that managed care companies are "cruel and heartless."

Peter J. Hammer, Pegram v. Herdrich: *On Peritonitis, Preemption, and the Elusive Goal of Managed Care Accountability*, 26 J. HEALTH POL. POL'Y & L. 767, 768 n.2 (2001).

15. Due to the study design, the national perspective reported here reflects primarily the viewpoints of health plans. However, these viewpoints appear genuine and well grounded for the reasons noted in the text.

When asked to identify the primary drivers of liability, subjects pointed to a variety of sources. Prominent in the minds of many were the large class action suits noted above. Also mentioned frequently were the very large punitive damage verdicts, approaching $100 million, which have been issued by juries in a few cases.[16] Health plan lawyers described these verdicts as "bolts of lightening" "out of the blue" that create a "lottery mentality" among plaintiffs' lawyers. Therefore, health plans have much greater difficulty treating these cases as simply a cost of doing business against which they can insure. Instead, they believe that liability of this magnitude threatens the economic viability of managed care as an enterprise. As one health plan representative explained, even if "the sky has not fallen yet," it "only takes one big case to put you out of business."

Other interview subjects attributed the liability threat to more traditional types of suits. One health plan lawyer commented that the class action lawsuits and big punitive damage cases produce most of the worry, but most of the work is focused on the everyday claims. One defense lawyer said that no one thing accounts for the liability threat, rather "it's everything," as managed care organizations confront multiple different theories of liability. Several health plan lawyers said that although the number of lawsuits is not increasing, their "severity" (the average cost of resolving them) is increasing substantially (up 33% in one year at one large insurer) due to the complexities of litigating ERISA preemption and the need to avoid risking huge punitive damage verdicts.

16. For example, in *Fox v. Health Net*, a California jury awarded $77 million in punitive damages (in addition to the more than $12 million in compensatory damages) against an HMO that had refused to pay for an innovative cancer treatment, which Ms. Fox's surviving family members claimed resulted in her death. Fox v. Health Net, No. 219692, 1993 WL 794305, at *1-2 (Ca. Super. Ct. Dec. 23, 1993). This award was eclipsed by the $120 million dollar verdict in *Goodrich v. Aetna U.S. Healthcare of Cal., Inc.*, No. rcv 20499 1999 WL 181418, at *4 (Cal. App. Dep't Super. Ct. Mar. 29, 1999). Like *Fox*, the *Goodrich* verdict was based on an HMO's refusal to authorize payment for an expensive, state-of-the-art treatment for terminal cancer that it considered to be experimental. *See id.*; *see also* Michael J. Bidart & Ricardo Echeverria, *Litigating an HMO Bad Faith Case From the Plaintiff's Perspective and the Lessons of* Goodrich v. Aetna, 22 WHITTIER L. REV. 427, 445 (2000) (total damages in *Goodrich* amounting to $120,564,363.40, $116,026,104,104.00 of which were punitive). Similarly, an Ohio jury awarded $51 million against a Blue Cross plan for failing to pay for cancer treatment. Dardinger v. Anthem Blue Cross & Blue Shield, No. 99-CA-127 2001 WL 575129, at *3 (Ohio Ct. App. May 22, 2001), *aff'd*, 2002 Ohio 7113, 2002 Ohio LEXIS 3081, at *54-55 (Ohio December 20, 2002) (noting that "Anthem had worn [plaintiffs] down as surely as the cancer had" and that "the level of reprehensibility [of defendants' conduct] sufficient to warrant the substantial punitive damages award the jury imposed"). A Florida jury awarded nearly $80 million against Humana for terminating coverage for a special therapy program for a child with cerebral palsy, although the verdict was subsequently set aside for improper jury instructions and evidentiary errors. Humana Health Ins. Co. of Fla. v. Chipps, 802 So. 2d 492, 495 (Fla. Ct. App. 2001).

These conflicting views can be explained, at least in part, by a survey of the several different bodies of law that affect the liability exposure of managed care organizations. The next section compares the law "on the books" with the "law in action."

B. State law claims of direct corporate and vicarious liability

1. The Law "On the Books"

States have systematically expanded the theories upon which managed care organizations can be held liable to injured enrollees when they have not been prohibited from doing so by federal preemption of state laws. State courts have looked to hospital liability cases decided in medicine's pre-managed-care era to develop the doctrinal bases for managed care liability.[17] Health maintenance organizations that directly provide care to enrollees present the closest analogy to hospitals, and, therefore, the clearest case for imposing liability under direct negligence theories developed in the hospital context. In *Shannon v. McNulty*,[18] a Pennsylvania court reasoned, "[w]e see no reason why the duties applicable to hospitals should not be equally applied to an HMO when that HMO is performing the same or similar functions as a hospital."[19] Those duties included a duty to select and retain competent caregivers, to oversee the care they provide, and to establish and adhere to policies to ensure quality care.[20]

Few managed care organizations employ licensed individuals to provide health care services to their enrollees, and fewer still operate inpatient facilities. Most simply arrange for the provision of services by contracting with independent caregivers and institutions. Moreover, managed care organizations do not have physical custody of their enrollees as hospitals do of

17. The legal doctrine of institutional, or direct corporate, negligence in health care can be traced to the 1965 opinion in *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965). The court there held that a hospital could be held directly liable for "[f]ail[ing] to have "a sufficient number of trained nurses for bedside care of all patients at all times," to bring patients' complications to the attention of hospital administration or the medical staff, to require specialty consultation, and to oversee the treatment provided to patients in the hospital. *Id*. at 258. The court based its holding on its finding that hospitals did "more than furnish facilities for treatment." *Id*. at 257. Patients looked to hospitals for treatment, and hospitals obliged, charging and collecting for treatment provided by nurses, physicians, administrative, and other staff employed on a salaried basis by the hospital. *Id*. at 257 (citing Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957)).

18. 718 A.2d 828 (Pa. Super. Ct. 1998). The court held that an HMO that employed nurses to provide a telephone service for emergencies could be directly liable for failing to oversee them and for failing to adopt and enforce policies to ensure the quality of information provided to enrollees. *Id*. at 835-36.

19. *Id*. at 836.

20. *Id*. at 831 (citing Thompson v. Nason Hosp., 591 A.2d 703, 707 (Pa. 1991)).

their patients. Nonetheless, state courts barely paused in extending notions of institutional liability to those managed care organizations as well.[21] As the *Darling* court relied on the expanding role of the hospital in the health care delivery system of the 1960s to formulate the theory of direct institutional liability, courts have relied on the central role of managed care organizations in the modern-day medical landscape to expand theories of direct corporate responsibility and liability to managed care organizations that merely arrange, but do not provide, medical services. Courts have reasoned, "HMOs undertake an expansive role in arranging for and providing health care services,"[22] and "healthcare is channeled through HMOs with the subscribers being given little or no say in the stewardship of their care."[23] In distinguishing more limited types of health care organizations not subject to institutional liability from managed care organizations, courts have pointed to the "central role in the total health care" of enrollees that is played by managed care organizations.[24] They have analogized the legal constraint on patient choice that is embedded in managed care benefit designs, to the practical constraint on patient choice that arises from inpatient confinement.[25] The corporate negligence doctrine as applied to a managed care organization, then, is not based primarily on its role in direct provision of health care services—the central factor in applying the doctrine to hospitals—but rather on its contractual commitment to arrange or provide comprehensive health care services and the constraints imposed on enrollee choice.[26] The laudable purpose of controlling health care spending, it seems has not protected managed care organizations from state law liability anymore than the critical nature of hospitals to medical care delivery shielded the hospital.

21. *Cf.* Harrell v. Total Health Care, Inc., 781 S.W.2d 58 (Mo. 1989) (en banc) (non-profit HMO not liable for negligent selection of surgeon based on state statute that exempted non-profit health services corporations from certain forms of liability); McClellan v. Health Maint. Org. of Pa., 604 A.2d 1053 (Pa. Super. Ct. 1992) (HMO can be held liable for negligent selection and retention of physicians under RESTATEMENT (SECOND) OF TORTS § 323, rather than by extension of doctrine of institutional negligence). *McClennan* was later clarified in *Shannon*, 718 A.2d at 836.

22. Jones v. Chicago HMO Ltd. of Ill., 730 N.E.2d 1119, 1128 (Ill. 2000) (HMO can be held liable if it negligently assigned more patients to a contract physician than he was capable of serving).

23. *Shannon*, 718 A.2d at 835.

24. Dowhouer v. Judson, 45 Pa. D. & C.4th 172, 181 (Pa. Ct. Com. Pl. 2000) (distinguishing physicians' practice group from hospitals and HMOs in declining to extend corporate negligence doctrine); s*ee* Milan v. Am. Vision Ctr., 34 F. Supp. 2d 279 (E.D. Pa. 1998) (distinguishing an optometrist's office from a hospital and an HMO to decline to extend corporate liability doctrine).

25. *See Milan*, 34 F. Supp. 2d at 282.

26. *See* Mennecke v. Saint Vincent Health Ctr., No. Civ. Ap. 98-50, 1998 WL 1753663, at *7 (W.D. Pa. Apr. 14, 2000). The doctrine of corporate negligence extends to "organizations that provide 'total health care' if the individual is given no meaningful choice in their health care."*Id.*

State courts have readily extended vicarious liability theories developed to hold hospitals legally accountable for the negligence of independent medical staff physicians to network-based managed care organizations and their contracted physicians. Many courts have adopted the theory of apparent or ostensible agency to find an agency relationship between a managed care organization and an independent physician, exposing the managed care organization to vicarious liability for the physician's negligence.[27] Although the precise parameters of the apparent agency doctrine vary by state, a plaintiff typically must establish that the managed care organization held itself out as a provider of health care, and that she relied upon that conduct, looking to the managed care organization rather than to the individual physician to obtain health care services.[28] Because most of the reported cases have arisen in appeals of summary judgment motions granted to the HMO, the factors that a trier of fact will consider persuasive evidence of agency cannot be determined with certainty. In discussing whether an HMO has held itself out as a provider of care, courts have looked to marketing materials promising the "best care,"[29] member handbooks stating that the HMO will "provide 'all your health care needs,'"[30] and advertisements characterizing the HMO as a "total [health] care program which not only insures . . . but provides medical care, guarantees the quality of the care and controls the costs . . . ."[31]In contrast, a managed care organization characterizing itself as "a corporation formed to *arrange for* professional health services," without more, was not found to hold itself out as a provider of health care services.[32] After concluding that a managed care organization meets the apparent agency doctrinal requirement that it hold itself out as a provider of care, courts typically find that the restrictions imposed on enrollees in their choice of physicians and in their ability to access care satisfy the justifiable-reliance prong of the analysis.[33] As one court stated, an

27. *See, e.g.*, Decker v. Saini, No. 88-361768 NH, 1991 WL 277590, at *3-4 (Mich. Cir. Ct. Sept. 17, 1991); Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988).

28. *Compare Decker*, 1991 WL 277590, at *2 (doctrine based on estoppel), *with Boyd*, 547 A.2d at 1234 (doctrine based on RESTATEMENT (SECOND) OF TORTS § 429).

29. *Decker*, 1991 WL 277590, at *4.

30. Petrovich v. Share Health Plan of Ill., Inc., 719 N.E.2d 756, 762 (Ill. 1999).

31. *Boyd*, 547 A.2d at 1232 n.6.

32. Chase v. Indep. Practice Ass'n, Inc., 583 N.E.2d 251, 255 (Mass. App. Ct. 1991).

33. Reliance has been proved by evidence that the enrollee paid a membership fee to the managed care organization, rather than fees for services to caregivers. Justifiable reliance has also been based on a finding that an enrollee selected a primary care physician from a list provided by the managed care organization. Other factors include that the enrollee must receive a referral to see a specialist to obtain reimbursement and that the primary care physician, not the enrollee, selects the specialist from a list provided by the managed care organization. *See Boyd*, 547 A.2d at 1234-35; *Decker*, 1991 WL 277590, at *4. A finding of reliance might be defeated, however, if the enrollee had a relationship with the negligent physician that predated her enrollment in the defendant-managed care organization. *See* Lewis v. Cent. Okla. Med. Group,

enrollee's "reliance [upon the HMO] is shown not only to be compelling, but literally compelled" by the HMO's "method of operation."[34]

States have also expanded the common law bases for holding managed care organizations liable for the acts of the independent physicians with whom they contract. At least one court has held that a managed care organization can be held vicariously liable under the doctrine of respondeat superior for the medical malpractice of an independent physician if the managed care organization had implied authority to exercise sufficient control over the physician to negate an independent contractor status.[35] In *Petrovich v. Share Health Plan*, the Illinois court found implied authority to control independent physicians on the basis of common managed care practices, including reimbursing physicians through capitation payments, conducting quality assurance review of physicians' medical records, requiring patients to select primary care physician gatekeepers and mandating approval of referrals to specialists as a condition of payment for services.[36]

Managed care organizations have seen their affirmative defenses to medical malpractice claims erode. For example, in early cases, managed care organizations argued that they could not be liable for medical malpractice because the so-called corporate practice of medicine doctrine prohibited them from practicing medicine.[37] Later cases undercut this argument. In *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*,[38] for example, an Indiana court of appeals analogized the argument that a managed care organization cannot be liable for the acts of physicians because it cannot be licensed to medicine, to one that a city cannot be liable for the negligence of an agent driving a car because the city cannot obtain a driver's license. In other states, legislatures have enacted statutes that preclude managed care organizations from using the corporate practice of medicine doctrine to defend against claims

998 P.2d 202, 205 (1999) (noting that the plaintiffs had not been treated by the defendant-physicians prior to their enrollment in the defendant-managed care organization).

34. *Petrovich*, 719 N.E.2d at 769.

35. *See id*. at 764. "Implied authority" was defined as actual right to control proved by circumstantial evidence. *Id.* at 770. *But see Chase*, 583 N.E.2d at 254 (cost-containment and utilization-review measures do not establish right to control when the responsibility for actual provision of medical treatment rests with the physician).

36. *Petrovich*, 719 N.E.2d at 774-75.

37. The corporate practice of medicine doctrine holds that only natural persons who hold medical licenses can lawfully practice medicine. Under this doctrine, a corporate entity that employs physicians to provide medical services is engaged in the unlawful practice of medicine. The doctrine is subject to many exceptions, for example, for non-profit hospitals, and has been widely criticized. For a discussion of the corporate practice of medicine doctrine, see Adam M. Freiman, Comment, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency into the Modern Health Care Environment*, 47 EMORY L.J. 697 (1998).

38. 516 N.E.2d 1104 (Ind. Ct. App. 1987).

involving medical malpractice.[39] Perhaps a Michigan circuit court offered the best, or at least the most candid, explanation for the state courts' willingness to expand or create new theories of liability to hold managed care organizations legally accountable, acknowledging that imposing liability on HMOs is a "matter of public policy" intended to "strongly encourage them to select physicians with the best credentials," and to counter any tendency to "be driven by economics to retain physicians with the least desirable credentials, for the lowest prices."[40]

2. The "Law in Action"

Considering the variety of legal theories under which health plans might be held vicariously liable as a matter of course, and that ERISA does not preempt vicarious theories, we expected to hear in our interviews with lawyers and health plan managers that vicarious liability was a major concern. That expectation proved accurate for staff model HMOs, and to a lesser extent for HMOs organized by hospitals or physicians, but not for the other models of managed care organizations that dominate the market.

Staff model HMOs we interviewed considered themselves clearly responsible for their physicians' negligence. For instance, one lawyer with a staff model HMO that focuses on the Medicaid population said that vicarious liability for "bad baby" cases is a major cost and concern for the company. However, there are relatively few staff model HMOs in most insurance markets. More common, but still in the minority, are HMOs organized by and affiliated with hospitals and/or large physician groups. Although these group model HMOs craft their legal relationship with providers as independent contractors rather than employees, some report being named in vicarious liability suits more frequently than HMOs that have no visible institutional affiliation with their contracted providers. Other provider-based plans, however, said that vicarious suits are rare, opining that it is easier for lawyers to simply sue the hospital or the university that owns the health plan, rather than the health plan itself. They noted the hospital or university would be sued in any event, even if no health plan were involved.

The most common form of managed care network structure is a contractual affiliation with many or most providers in the market, the so-called mixed independent practice association, or IPA, model. Regarding these arrangements, some defense lawyers said an "extreme sense" of the ostensible agency doctrine is "spreading" in which agency is determined solely by

39. *E.g.*, ARIZ. REV. STAT. § 20-3153 (2002); GA. CODE ANN. § 54-1-48 (2000).

40. Decker v. Saini, No. 88-361768 NH, 1991 WL 277590, at *4 (Mich. Cir. Ct. Sept. 17, 1991). *See Petrovich*, 719 N.E.2d at 764 ("HMO accountability is essential to counterbalance the HMO goal of cost-containment" and "the inherent drive to achieve a large and ever-increasing profit margin").

"what's in the member's head," if a patient "had some reason to think that the doc was your agent, that's it." Even if there is not a strong legal case for vicarious liability, one health plan lawyer said that naming the insurer in a medical malpractice causes its own liability insurer to increase the pressure to settle, which leads the insurer to pay even when it feels that it did not do anything wrong.

However, this is a minority view. The prevailing view among both defense and plaintiffs' lawyers is that, in most states, the simple existence of a network and of gatekeeping features is not enough to create vicarious liability. Rulings in most states, especially trial court rulings, have been much less receptive to the more sweeping claims of vicarious responsibility for the quality of care discussed above. One observer explained that HMOs may fear courts will always find vicarious liability, but this is "just paranoia." One large health plan initially thought that vicarious liability would become significant enough that going into the medical malpractice insurance business might make sense, but stated that it had since changed its mind, in part, because it was so rarely sued along with its physicians. Even one prominent plaintiffs' lawyer thought that holding health plans responsible for the medical mistakes of "tens of thousands of physicians" would impose "too much burden" on them.

According to the more restricted view, vicarious liability does not exist unless the physician is an actual agent of the health plan, or the health plan intervened in some way to influence the physician's decision. Defense lawyers noted that vicarious liability claims usually involve allegations that the health plan influenced the physicians' treatment decisions (or non-decisions) in some way, for instance, through the use of financial incentives or utilization guidelines, rather than the more general structural claim that MCOs are automatically responsible for physicians' negligence based on the existence of a contracted network. Both plaintiffs' and defense lawyers explained that most potential cases do not involve these kinds of special facts, since most medical mistakes do not involve explicit clinical decisions about whether or not to treat, which might be based on resource considerations; instead, typically they are ordinary acts of carelessness or oversight.

Most health plans we interviewed attempt to minimize their exposure to vicarious liability by disavowing agency in member materials and on membership cards. These disclaimers state that physicians are independent contractors not subject to the control of the managed care organization. They also attempt to clarify that providers are solely responsible for treatment decisions, and that the health plan makes decisions only about coverage and payment. Health plans regard "educating" patients in this fashion as one of their primary risk management strategies. We were told, and we observed, that the treatment/payment or plan/provider distinction is "all over" health plan materials, including on web sites and even on the member identification cards of at least one prominent health plan. The effort to maintain this distinction

has also led HMOs to stop displaying their names in the offices of physicians and hospitals. One lawyer noted, "The marketing imperative led them to do things like that. Now the liability imperative is getting them to stop. The MCOs finally figured that out." Health plan lawyers consider these disclaimers or statements about legal relationships and respective responsibilities reasonably effective in court.[41] One lawyer with a provider-based health plan said that, after the health plan defeated a couple of vicarious liability suits on the strength of this language, the plaintiffs' lawyer who had brought several more of these suits dismissed the remainder of them; no more have been filed.

A final factor mitigating health plans' liability exposure for medical negligence is the added complexity and cost created by naming a large insurer as a defendant in what otherwise is a garden-variety medical malpractice case. Contrary to the common perception that plaintiffs' lawyers are eager to add more deep pocket defendants to their lawsuits, almost all of the plaintiffs' lawyers we interviewed said they are very reluctant to sue health plans unless the right set of facts presents itself. Because plaintiffs' lawyers work on a contingency fee basis, they have to fund the costs of litigation out-of-pocket. These expenses are usually several tens of thousands of dollars, even in ordinary medical malpractice cases. Adding an entirely different theory of liability and a large institutional defendant with "infinite resources" to defend itself greatly magnifies the anticipated cost and length of litigation, as does the introduction of ERISA preemption issues. Plaintiffs' lawyers explained that taking on these additional challenges is unnecessary if the facts point to other well-insured defendants such as the physician or hospital as the potential wrongdoer. In the words of one lawyer, "What do I need with another set of lawyers when I already have the [providers] on the hook?" He explained that, so far, he has always been able to achieve his main goal, which is to "economically rehabilitate his client," without "taking on an 800 pound gorilla." "You have to be ready to go the full distance" if you sue an insurer. Another lawyer said that he likes to "use a rifle rather than a shotgun," meaning that he needs a "very good reason" to add another defendant that will bring in another set of lawyers, experts and depositions, and another said "if you have a great medical malpractice case, why would you want to screw it up

41. *See, e.g.*, Jones v. U.S. Healthcare, 723 N.Y.S.2d 478, 478 (N.Y. App. Div. 2001) (HMO "cannot be held vicariously liable . . ., where the documentary evidence, including, in particular, plaintiff's Group Master Contract, membership card and Member Handbook, clearly states that doctors and hospitals . . . are independent contractors" (citation omitted)). The disclosure might have to be prominent and consistent; a "single disclaimer of an agency relationship . . . within a 'whole stack' of information" might not be determinative if other evidence supports an agency relationship. *Petrovich*, 719 N.E.2d at 767.

by bringing in an HMO."[42] Defense lawyers agreed that suits against health plans are "one of the most complex you'll ever encounter."

Because Texas has generated the most litigation experience against health plans under its managed care liability statute, Texas lawyers were especially articulate about the variety of complexities in these cases. First, because vicarious liability requires showing some degree of influence or control, having two sets of experts is advisable, one concerning the quality of medical care and the extent of injury, and a second concerning how managed care organizations function and how decisions were made in this particular case. Second, a suit against a health plan requires a showing that it did something to alter the course of care, which creates an additional causation issue that must be proved. Doing so is difficult, since, in the words of one defense lawyer, "it is going to be a freak situation where a doctor comes forward and says he altered his treatment based on what the insurance will pay for." Texas lawyers also noted that suing multiple parties under newer theories of liability makes cases harder to settle and more likely to result in an appeal if they succeed at trial. Also, the absence of state appellate decisions under the Texas liability statute creates tremendous uncertainties about how jury instructions should be framed, which creates a much higher risk of reversal on appeal. According to one experienced Texas lawyer, "the simple truth of the matter is that no one is going to invest a small fortune in a case whose outcome is uncertain."

Lawyers in several states explained that the major advantage to naming a managed care organization as a defendant is the possibility of obtaining very large punitive damages or higher compensatory damages by introducing economic issues in order to "poison the well." This advantage is minimized, however, in states with caps on damages that apply to health insurers. In addition, the prospect of punitive damages is more promising when the health plan appears to be the primary wrongdoer than it is in a lawsuit aimed primarily against the physician in which the health plan's liability is based solely on a vicarious theory.

Consistent with this reported litigation experience, we found very little evidence in our interviews that health plans are motivated by the threat of liability to improve the quality of medical care delivered by their providers. Instead, the strong market-driven trend among most managed care plans is to contract with as many providers of acceptable quality as possible, screening out only those few with very bad credentials, and leaving patients to decide which providers offer the best quality of care. Health plans do engage

42. One instance where a plaintiffs' lawyer said it makes good sense to name the HMO is if it is clearly vicariously liable due to an employment relationship where the HMO pays for liability coverage. Then, the ability to deal with an institutional defendant and drop the individual physician facilitates settlement by avoiding the need to report the physician to the National Practitioner Data Bank.

regularly in checking the credentials of physicians in their networks, much as hospitals do for their medical staff members. However, we consistently heard in our interviews that regulatory and private accreditation requirements, rather than attempts to reduce liability, direct credentialing efforts. Some subjects commented that liability makes re-credentialing more rigorous than it would be otherwise, or that liability concerns can cause a health plan to refuse a physician whose credentials are "on the bubble." Several subjects noted that, in their experience, virtually the only time that health plans terminate a physician's contract before it expires is over concerns about malpractice history or failure to carry sufficient malpractice insurance. The vast majority of interviewees, however, said that credentialing is simply done "by the book," and often delegated outright to medical groups, without any searching inquiry motivated by serious concerns over potential health plan liability. As one defense lawyer explained: "[t]he fact of the matter is that you can't credential to a sufficient level of detail to defend yourself when you've got a doc who does something bad." Therefore, managed care organizations do not view credentialing as primarily a risk management function. Plaintiffs' lawyers had consistent views, explaining that credentialing suits are very hard to win, even against hospitals, so they are not inclined to try this largely untested theory against health plans. Defense lawyers agreed that, whereas credentialing liability exists in theory, they could think of only a very few or no such suits actually having been filed.

C. Claims of managed-care organization wrongdoing.

Managed care liability exposure is potentially much greater under theories of direct liability that point to the health plan as the primary wrongdoer.[43] Managed care organizations engage in a variety of practices to control health care spending and to create incentives intended to cause physicians to take cost effective approaches to medical care.[44] A managed care organization might

43. For purposes of this Article, the distinction between vicarious liability and direct liability turns on whether the treating physician or the health plan was the decision-maker who was responsible for making or influencing the medical decision at issue. Therefore, we group negligent credentialing claims with pure vicarious liability claims. Even though a negligent credentialing claim is typically treated as a claim of institutional negligence and therefore viewed as a form of direct liability, negligent credentialing claims still assume that the treating physician made a medical mistake. Such claims seek to hold the health plan secondarily liable, on the theory that the health plan wrongfully included the negligent physician in its network, thereby failing to protect the patient from harm. The version of direct liability we are focused on here is one that claims the managed care organization caused the complained of harm as a result of a cost containment initiative.

44. In *Pegram v. Herdrich*, 530 U.S. 211 (2000), the Court classified "pure eligibility decisions" as those determining whether a certain type of illness or treatment is covered under the terms of the coverage documents. *Id.* at 228. Such decisions can be made within the four corners of the contract, and do not involve consideration of individual medical factors or circumstances.

require pre-certification of proposed treatment as a condition of payment, restrict coverage to services it deems "medically necessary", or use reimbursement strategies intended to shift the financial risk of patient care to their caregivers.[45] Population-based data tend to show that, with the possible exception of certain vulnerable populations, care provided in a managed care system subject to such practices is of comparable quality with care provided in a fee-for-service system.[46] Inevitably, however, managed care practices or incentives will cause or contribute to harm in some individual cases.

In such circumstances, individuals who are not ERISA plan beneficiaries have been free to seek legal redress against the managed care organization. For example, in *Jones v. Chicago HMO Ltd. of Illinois*, the court held that an HMO could be liable to a Medicaid recipient, who received services through a managed Medicaid plan, for institutional negligence if it had assigned more patients to a contract physician than he was capable of serving.[47] ERISA plan beneficiaries, however, have been barred from seeking legal redress under state law.[48] Thus, managed care organizations have enjoyed a shield from liability for challenges to cost containment initiatives, at least as to claims by those 137 million Americans who are ERISA plan beneficiaries.[49] This section reports how effective this liability shield is perceived to be by lawyers and managers in the field, and then explores recent trends in the case law that are influencing legal perceptions and strategies.

Such benefit determinations should be viewed as contract disputes to be resolved under the common law of contract, which is modified somewhat in the ERISA context. *See, e.g.,* Jordan v. Cameron Iron Works, Inc., 900 F.2d 53 (5th Cir. 1990) (court must determine when the plan administration has given the plan documents a uniform construction that is consistent with a fair reading of the plan). Benefit determinations that do not involve clinical decisions are beyond the scope of this Article.

45. For a more complete discussion of these practices, see Gail B. Agrawal, *Resuscitating Professionalism: Self Regulation in the Medical Marketplace,* 66 MO. L. REV. 341, 351-59 (2001).

46. Joseph Gottfried & Frank A. Sloan, *The Quality of Managed Care: Evidence from the Medical Literature*, LAW & CONTEMP. PROBS., Fall 2002, at 103; Robert H. Miller & Harold S. Luft, *HMO Plan Performance Update: An Analysis of The Literature*, HEALTH AFF., July 2002, at 63; James D. Reschovsky & Peter Kemper, *Do HMOs Make a Difference?*, 36 INQUIRY 374 (1999).

47. 730 N.E.2d 1119 (Ill. 2000).

48. *See, e.g.*, Nealy v. U.S. Healthcare HMO, 844 F. Supp. 966 (S.D.N.Y. 1994) (plaintiff's attempt to hold HMO liable under state common law theories preempted).

49. The United States Census Bureau estimates that eighty percent of the 172 million Americans insured through employer health benefit plans are covered by private sector secular employer plans subject to ERISA. *See* Labor Force, Employment and Earnings 2001 at http://www.census.gov/prod/2002pubs/01statab/labor.pdf (last visited August 2, 2002).

1. ERISA Preemption in Practice

Health plan lawyers and managers view ERISA preemption as a major determinant of liability exposure for health plans' coverage decisions. For instance, lawyers and business managers consider the liability threat to be much greater with state and local government employees, who are not covered by ERISA, than with ERISA plan beneficiaries.[50] Thus, experienced lawyers have little or no doubt that state law would, under one theory or another, impose liability for wrongful denial of covered benefits or interference with good medical practice.[51] ERISA, however, introduces major uncertainties.

A number of plaintiffs lawyers said in interviews that the complications and uncertainties created by "the ERISA monster" made them more reluctant to take on suits against HMOs when there were other available defendants, such as the treating physician, who can be sued without involving complex issues of federal law or having the case removed from state to federal court. Most plaintiffs' lawyers we spoke to said that, with the "right set of facts" where there is serious injury and the health plan rather than the provider is clearly implicated, they would be willing to challenge conventional thinking or existing precedents. In the more typical case, however, plaintiffs' lawyers said that, if they could avoid ERISA issues, they would. One plaintiffs lawyer declared that, "if it's an employee benefit, you're out of luck right away." Another explained that he is "a lot more scared to spend the firm's money" when the law is unsettled, since "the legal landscape is littered with firms that have invested in [expensive] cases they shouldn't have," which can bring down the entire firm. Accordingly, most of the plaintiffs' lawyers we interviewed have almost always focused their lawsuits for medical injury on conventional defendants.

Defense lawyers acknowledged that ERISA preemption has deterred plaintiffs from filing as many suits against health plans as they might have. In the words of one defense lawyer, there has been a "learning curve" in which the plaintiffs' bar has "caught on" to the fact that ERISA issues make these cases much more complicated than ordinary tort suits. Defense lawyers also noted that it is much easier to establish preemption for theories of direct liability than for vicarious liability. Two defense lawyers said that, when a case involves an ERISA plan and they think their position is correct on the merits, they are more willing to go to court to attempt having it dismissed on preemption grounds rather than agreeing to settle it out of court for a

50. This increased liability exposure for government workers causes one large health plan we interviewed to avoid selling to state and local government employee plans altogether. However, other plans said they simply add the cost of this liability exposure into their rates or bids for this business.

51. This is not to say, however, that the particular theory of liability is irrelevant, since this might affect the standard of care or the availability of punitive damages.

substantial amount. One experienced plaintiffs' lawyer explained that less experienced lawyers often make the mistake of pleading too many different theories of liability, some of which are clearly preempted.

However, ERISA preemption is far from absolute. There was widespread agreement in our interviews that ERISA preemption is "eroding" or being "diluted" "month by month" by various appellate court decisions that have "chipped away at the veneer" of the idea that "you can't sue your HMO." One defense lawyer said, "nobody can be sure what court is going to rule which way" on preemption or whether a lawyer "can find a creative way to keep it in state court." One health plan lawyer said that he assumed that, for "something egregious," the health plan would have to be able to defend itself on the merits in court. There may be various defenses, the defense lawyers noted, such as ERISA preemption, but none of these are viewed as "airtight."

Several defense lawyers said that "smart plaintiffs' lawyers" are learning how to plead their cases to "get around ERISA," by framing almost any scenario as a quality of care issue rather than a covered benefits issue. Plaintiffs' lawyers in some states agreed that ERISA is not a bar to suing as long as you can avoid "pleading into the teeth of ERISA" by taking the "square peg of a benefits denial case and fitting it into the round hold of a direct liability theory." Two very experienced lawyers said the only kinds of cases they would decline to take based on ERISA preemption are denials of coverage based on explicitly excluded services, such as not covering any organ transplants. However, ERISA does not bar them from taking cases that involve coverage denials that are based in part on medical criteria, such as whether care is medically necessary, experimental, cosmetic, or custodial, and they are taking cases now that they would have turned down five years ago based on ERISA preemption.[52]

One experienced defense lawyer noted that ERISA preemption is especially weak in state courts, where judges have been more reluctant to engage with ERISA's obscure distinctions, instead preferring to send these cases to the jury. This lawyer explained:

> When the case focuses on medical records and [when] two physicians, the attending physician and the medical director, are looking at the same medical records and disagreeing about the necessity or appropriateness of treatment, convincing a state court judge that one is making a treatment decision and the other is making only a coverage determination is a complex sell.

A health plan lawyer agreed, explaining that state courts "pay attention to what they know, and they don't know about ERISA, they don't understand it,

52. Two lawyers were even prepared to take cases based on denial of prescriptions drugs specifically excluded from formularies, since health plans have discretion over what to include in formularies, and physicians can request exceptions to formularies when justified by medical criteria.

and they could care less about" federal preemption. This lawyer also noted that remand orders are not appealable, so even if he feels like he has a good ERISA defense, it doesn't do any good "as a practical matter" if the case is not in federal court. In state court, the defense might work at the appellate level, but the lawyer needs to get to the appellate level to have any argument, which means the lawyer first has to lose at the trial court, which no lawyer wants to risk. Therefore, several lawyers noted that, in most cases, the ERISA defense is fought and resolved at the level of removal and remand, rather than providing a basis for dismissal by trial courts.

2. ERISA Preemption on the Horizon

The first prominent crack in the ERISA preemption shield was created by the Third Circuit's decision in *Dukes v. U.S. Healthcare*.[53] Confronting a particularly tragic set of facts in one of two companion cases,[54] the Third Circuit distinguished claims challenging the *quality* of services provided from claims challenging the *quantity* of services. The former survived preemption; the latter did not.[55] Although this distinction might have been interpreted as simply stating a shorthand rule-of-thumb for vicarious versus direct theories of liability, subsequent decisions have stretched the quantity/quality distinction, some would say beyond recognition, to allow suits to proceed that challenge core managed care practices such as prior authorization or gatekeeping.[56]

53. 57 F.3d 350 (3d Cir. 1994), *cert. denied*, 516 U.S. 1009 (1995). For a complete discussion of this case and the quality-quantity distinction, see James F. Henry, *Liability of Managed Care Organizations After* Dukes v. U.S. Healthcare: *An Elemental Analysis*, 27 CUMB. L. REV. 681 (1996).

54. The companion case, *Visconti v. U.S. Healthcare*, 857 F. Supp. 1097 (E.D. Pa. 1994), involved a deceased infant and an obstetrician who was suffering from severe substance abuse and mental health problems. The physician later surrendered his license to practice medicine. The plaintiffs claimed that U.S. Healthcare was negligent in allowing the physician to remain in the network. For a discussion of the facts underlying the Viscontis' claim against the HMO, see Darryl Van Duch, *New Danger for HMOs*, NAT'L L.J., May 13, 1996, at A-1 (describing the physician as a "physical and psychological wreck" who had a "history of alcohol and drug abuse with memory lapses" and who was "preoccupied at the time of treatment with deciding whether to have a sex change operation").

55. *Dukes*, 57 F.3d at 358.

56. For instance, no preemption was found in a case where the HMO sent a mother and newborn baby patient home after only twenty-four hours (a so-called "drive-through delivery"). The HMO and the doctor failed to order sufficient follow-up care when the mother called in to report that the baby was sick, the baby died, and the parents sued. *In re* U.S. Healthcare, Inc., 193 F.3d 151, 156 (3d Cir. 1999). The court interpreted "quantity" narrowly to mean "a claim that a certain benefit was requested and denied." *Id.* at 163. It interpreted quality-related issues to include anything relating to the provision and management of care, including decisions that care is not medically appropriate or necessary. *Id.* at 162. Here, the plaintiff alleged that the twenty-four hour rule was negligent in its inception and interpretation, and, even with the rule, the HMO and the doctor should have given better follow-up care. *Id.* at 156. The plaintiffs also alleged

The perception that ERISA preemption was being systematically chipped away began in earnest the following year, with the Supreme Court's 1995 decision in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company*,[57] a case challenging a New York state surcharge on hospital rates to fund care for uninsured patients. Writing for a unanimous Court, Justice David Souter observed that Congress did not "[choose] to displace general health care regulation, which historically has been a matter of local concern."[58] This comment, while clearly dicta, fueled speculation that ERISA might not preempt a state law aimed at protecting managed-care enrollees from poor quality care, given that the quality of care and qualifications of caregivers were the preeminent historical justifications for state regulation of the health care industry.[59] Might the state's authority extend to laws targeted to unsatisfactory patient outcomes that resulted from managed care practices? We still have no definitive answer.

The trend continued five years later in *Pegram v. Herdrich*.[60] Justice Souter, again writing for a unanimous Court, stirred the ERISA preemption pot in a case that did not, in fact, present a preemption issue. The Court's holding was that ERISA itself is not violated when an HMO physician simultaneously makes a treatment and a coverage decision, [61] even though this might appear to be a conflict of interest that breaches fiduciary duties. In the course of reaching its conclusion on the scope of ERISA fiduciary obligations, the Court, mused: "What would be the value to the plan participant of having this kind of ERISA fiduciary action? It would simply apply the law already available in state courts and federal diversity actions today."[62] However, a state court remedy is "*available"* only if it is not subject to preemption by ERISA.[63]

that the HMO pressured its doctors to compromise quality in order to save money. *Id. See also* Lazorko v. Pennsylvania Hosp., 237 F.3d 242 (3d Cir. 2000) (allegation that HMO financial incentives caused physicians to withhold necessary care goes to quality rather than quantity of care).

57. 514 U.S. 645 (1995).

58. *Id*. at 680.

59. *See* Dent v. West Virginia, 129 U.S. 114 (1889) (physician licensure with state board of medicine oversight). *See also* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 288-90 (2000) (noting "tort law can be an important tool for advancing the public's health").

60. 530 U.S. 211 (2000).

61. Such decisions were classified as "mixed eligibility and treatment decisions" and contrasted with "pure unmixed eligibility decisions", which determined coverage under plan documents without reference to patient needs, and "treatment decisions," which determine a course of treatment based on a patient's conditions without regard to coverage. *Id.* at 228.

62. *Id*. at 236.

63. *See* Miller v. HealthAmerica Pa., Inc., 50 Pa. D. & C.4th 1, 26 (Pa. Ct. Com. Pl. 2000) ("the U.S. Supreme Court appears to acknowledge, that, in connection with certain claims against an HMO . . ., a state court remedy is 'already available.' Such a remedy is 'available,' in state court, of course, only if it is not subject to preemption by ERISA").

Conventional wisdom had been that all state law challenges to ERISA plan benefit determinations were preempted, regardless of whether they were "mixed" or "pure" in their reliance on contractual coverage criteria or on individual clinical criteria. In *Pegram*, the Court characterized its earlier opinion in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers* as one that "throws some cold water on the preemption theory," and reiterated that the burden was high to establish preemption of subjects of "traditional state regulation."[64] Did the Court mean to suggest, contrary to widely held belief, that state law claims involving coverage decisions that were intertwined with any medical issue (now designated "mixed eligibility and treatment determinations") are not preempted?[65]

Federal and state courts continue to struggle with the answer to that question. The Pennsylvania Supreme Court had the first opportunity to consider the ramifications of *Pegram* when the U.S. Supreme Court vacated and remanded its opinion in *Pappas v. Asbel* for reconsideration in light of *Pegram*.[66] The court accepted this apparent invitation to expand the permissible scope of state law challenges to managed care practices.[67] It reasoned that an HMO's denial of permission to use a hospital outside of its network was a mixed eligibility and treatment decision under the categorization established in *Pegram*.[68] The medical director, a physician employed by the HMO, "reviewed Pappas' case, and rejected another medical doctor's opinion based on his clinical judgment."[69] In doing so, the medical director "determined where and, under the circumstances, when" the patient's medical condition would be treated.[70] If he erred in this determination, the court held that the harm caused by that error could be redressed as medical

64. *Pegram*, 530 U.S. at 237.

65. *See, e.g.*, Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After* Pegram v. Herdrich*: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1 (2001). For general commentary on this case and its implications for ERISA preemption, see Symposium, *Current Racial and Ethnic Disparities in Health*, 1 YALE J. HEALTH POL'Y, L. & ETHICS (2001); Peter J. Hammer, *On Peritonitis, Preemption, and the Elusive Goal of Managed Care Accountability*, 26 J. HEALTH POL. POL'Y & L. 767 (2001); Michael T. Cahill & Peter D. Jacobson, Pegram's *Regress: A Missed Chance For Sensible Judicial Review of Managed Care Decisions*, 27 AM. J.L. & MED. 421(2001); Richard A. Ippolito, *Freedom to Contract In Medical Care: HMOs, ERISA and* Pegram v. Herdrich, 9 SUP. CT. ECON. REV. 1 (2001); Arnold J. Rosoff, *Breach of Fiduciary Duty Lawsuits Against MCOs*, 22 J. LEGAL MED. 55 (2001); William M. Sage, *UR Here: The Supreme Court's Guide for Managed Care*, HEALTH AFF. Sept.-Oct., 2002, at 219.

66. 530 U.S. 1241 (2000).

67. Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001) (on remand for reconsideration in light of *Pegram v. Herdrich*), *cert. denied sub. nom*, U.S. Healthcare Systems of Pa., Inc. v. Pa. Hosp. Ins. Co., 122 S.Ct. 2618 (2002)).

68. *Pappas*, 768 A.2d at 1096.

69. *Id*.

70. *Id.*

errors always are, under state medical malpractice law.[71] The court purported to follow the combined instructions of *Travelers* that "ERISA does not preempt state law that regulates the provision of adequate medical treatment", and *Pegram* that "an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice."[72]

The task of applying ERISA to an era of managed care never envisioned by its framers is made more difficult by the lack of consistent signals from the Supreme Court.[73] While the *Pegram* Court hinted that expanded state tort liability was possible, it also explicitly acknowledged the legitimacy of managed-care practices aimed at rationing care and cautioned that the judicial

71. *Id.* Not all courts agree with this revolutionary reading of the *Travelers-Pegram* line of cases. The United States Court of Appeals for the Fifth Circuit rejected it, stating without detailed analysis that "we do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." Corporate Health Ins., Inc. v. Texas Dep't of Ins., 220 F.3d 641 (5th Cir. 2000), *vacated and remanded for reconsideration in light of* Rush Prudential HMO v. Moran, 122 S.Ct. 2151 (2002), *reinstated as modified*, 314 F.3d 782 (5th Cir. 2002) (holding that independent review provisions regulate the business of insurance and are not preempted as to insured ERISA plans, but declining to reconsider other aspects of its earlier opinion). By way of limitation, the Fifth Circuit offered, "[I]t may be that state causes of action persist only for actions based in some part on malpractice committed by treating physicians. If so, state causes of action against HMOs for the decisions of their utilization review agents would still be preempted." *Corporate Health Ins., Inc.*, 220 F.3d at 643 n.6. The court declined to make "additional inferences" noting that *Pegram* did not "exhaustively discuss the specific kinds of state causes of action that it implied were not preempted." *Id.* A different panel of Fifth Circuit judges has expressed doubt about the continuing validity of *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), following the Supreme Court's decisions in *Traveler* and *Pegram*. Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002). The *Roark* court held that state-law claims challenging an HMO's mixed eligibility and treatment decisions were not completely preempted by ERISA. *Id.* at 308-09. Even for pure eligibility decisions, the court appeared inclined to find no pre-emption, but the panel of judges who heard *Roark v. Humana, Inc.* felt constrained to follow the *Corcoran* precedent: "If we were writing on a clean slate, or deciding this en banc, the Roarks would have a strong case against ERISA preemption. But, as a panel we are bound by *Corcoran.*" 307 F.3d 298, 315 (5th Cir. 2002). One court, the Third Circuit, chose to interpret *Pegram* as invoking the more familiar quantity/quality distinction, discussed above. Lazorko v. Pennsylvania Hosp., 273 F.3d 242 (3d Cir. 2000).

72. *Pappas*, 768 A.2d at 1095.

73. The most recent signal of the Court's curtailment of ERISA preemption came in a case giving an expansive reading to the ERISA savings clause, which permits the state regulation of insurance, banking, and securities. Rush Prudential HMO v. Moran, 122 S.Ct. 2151 (2002). Because the case is not relevant to state law court challenges to managed care organization's decisions, a complete discussion is beyond the scope of this paper. *See* E. HAAVI MORREIM, ERISA TAKES A DRUBBING: IMPLICATIONS OF RUSH PRUDENTIAL FOR HEALTH CARE (unpublished manuscript on file with author).

branch should generally leave judgments of social value to the legislative branch.[74]

As lower federal courts attempt to follow the Supreme Court's mixed directions, an uneasy analytical approach to ERISA preemption is beginning to emerge in the few cases decided post-*Pegram*. That analysis begins with an acknowledgement that HMOs, and some other managed care organizations, fulfill two roles with respect to their enrollees: an insurer or administrator of a health benefit plan and a provider or "arranger" of health care services.[75] In the first role, the health plan decides only questions of payment; in the second role, it also decides whether and how treatment should be delivered. ERISA preempts state law causes of action that challenge the first function, but not the second.[76] Under this analysis, courts have determined that an enrollee's state law claim alleging that an HMO was negligent in imposing a greater patient load on a primary care physician than he could adequately monitor was not preempted,[77] but state law challenges to an HMO's administrative decision to use physician financial incentives to reduce care were preempted.[78]

In sum, in the view of some courts, ERISA preemption turns on the quantity/quality distinction, in the view of others, the payment/treatment distinction is key, and still others focus on the mixed/pure eligibility distinction. Regardless of the particular nuances, a number of potential

74. Pegram v. Herdrich, 530 U.S. 211, 233-34 (2000) ("If Congress wishes to restrict its approval of HMO practice to certain preferred forms, it may choose to do so. But the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure").

75. *See* Bui v. American Tel. & Tel. Co., 310 F.3d 1143, 1153 (9th Cir. 2002) ("ERISA does not preempt claims of medical malpractice against medical services providers for decisions made in the course of treatment or . . . evaluation. This is true even if those medical services providers also serve, at other times, as administrators.") *Cf.* Rubin-Schneiderman v. Merit Behavioral Care Corp., 163 F. Supp. 2d 227 (S.D.N.Y. 2001) (distinguishing medical necessity determinations made by an HMO in its role as a medical provider with similar decisions made by a PPO in its role as an administrator that gives patients the ability to choose how to manage their own care by offering differing levels of coverage).

76. *Compare* Hammerich v. Aetna U.S. Healthcare, Inc., 209 F. Supp. 2d 1282 (M.D. Fla. 2002) (HMO acts as health care provider when it fails to inform patient or physician of the result of a colorectal screening test sent by the HMO to its enrollees), *and* Bui v. American Tel. & Tel. Co., 310 F.3d 1143 (9th Cir. 2002) (company that advised employee to stay in a foreign country for medical treatment was acting as a health care provider), *with* Pryzbowski v. U.S. Healthcare Inc., 245 F.3d 266 (3d Cir. 2001) (HMO acts as plan administrator when it delays in approving benefits but acts as a provider when it adopts a policy to discharge newborns from the hospital within twenty-four hours).

77. Miller v. HealthAmerica Pa., Inc., 50 Pa. D. & C.4th 1, 27 (Pa. Ct. Com. Pl. 2000) ("When an HMO makes staffing arrangements for the doctors who provide the actual medical treatment . . . the HMO is acting in its capacity as the 'arranger' of medical treatment, and is not performing its administrative function.").

78. Bordlemay v. Keystone Health Plans, Inc., 789 A.2d 748, 752-53 (Pa. Super. Ct. 2001).

avenues have emerged for circumventing ERISA preemption in liability suits based on core managed care techniques. This approach is in stark contrast to an earlier analysis in which ERISA was held to preempt any state law claim challenging the actions of a managed care organization offered through an ERISA plan.[79] The variety of inroads, coming simultaneously from different lines of cases, is what creates the impression that ERISA preemption is eroding.

Despite this erosion, however, ERISA preemption remains a hill that plaintiffs must climb. For direct liability theories, one experienced lawyer we interviewed said that the concern about erosion is "much worse than the reality," based on the actual precedents. Several lawyers noted that decisions finding ways around ERISA are still localized to a few prominent jurisdictions, principally the Third Circuit, whereas in other circuits, such as the Tenth and the Fifth, the ERISA barrier remains much stronger.[80] Most defense lawyers we spoke to thought that the recent Supreme Court rulings reaffirm preemption "at its core" and raise questions or set limits only at the boundaries. One experienced defense lawyer thought ERISA was "still a great defense" and bragged that he had not seen a managed care liability complaint that he could not remove, at least, to federal court for a preliminary preemption ruling.

Thus, at the moment, although ERISA pre-emption is far from absolute, it creates substantial uncertainties in the ability of plaintiffs to bring state law actions, due to the difficulties in drawing the lines required by the evolving analysis. For example, reasonable minds could differ regarding the classification of a health plan's assignment of patients to a physician or its enforcement of gatekeeping requirements. These features are crucial to arranging for care, but they also are a means to administer a plan that pays for health care services. Therefore, even if one of these lines of tenuous analysis should take hold, much will remain to be refined as the courts struggle to determine when an HMO is acting as an administrator and when it is acting as a health care provider.

D. A Horizon without ERISA Preemption

Most analysts view ERISA preemption as entirely accidental and thoughtless as it applies to managed care liability. (It makes more sense for

79. *See, e.g.*, Corcoran v. United Healthcare Inc., 965 F.2d 1321 (5th Cir. 1992) (Louisiana wrongful death statute); Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 2981 (8th Cir. 1993) (tortious interference with contractual relationship, medical malpractice, and breach of contract).

80. *See* Corporate Health Ins., Inc. v. Texas Dep't of Ins., 220 F.3d 641 (5th Cir. 2000), *vacated and remanded for reconsideration in light of* Rush Prudential HMO, Inc. v. Moran, 122 S.Ct. 2151 (2002), *reinstated as modified*, 314 F.3d 702 (5th Cir. 2002) (interpreting Texas right-to-sue law to exclude a cause of action for medical necessity determinations); Moffett v. Haliburton Energy Servs., Inc., 291 F.3d 1227 (10th Cir. 2002) (state tort of insurance bad faith preempted by ERISA and not saved as a regulation of insurance).

improper administration of pension funds, which is the primary focus of the ERISA statute.) However, there are those who would defend ERISA preemption as potentially embodying an efficient or fair restriction on liability.[81] Even if preemption were lifted as a matter of federal law, state courts would still need to consider whether arguments in favor of preemption justify limiting managed care liability under common law. A brief analysis of common law justifications for limiting tort liability generally, however, indicates that managed care organizations would not fare well if they were forced to look to the common law for protections in the absence of ERISA preemption.

The most current guidance on the common law comes from the proposed Restatement of the Law Third. There, the American Law Institute recognizes that "special problems of principle or policy" can justify decisions not to impose liability on an actor.[82] Using its analysis, the limitations on liability that the managed care industry enjoys might be justified based on the conflict between tort liability and the public policy considerations from another domain.[83] ERISA embodies public policy considerations of national uniformity in administration of employee benefits. However, absent ERISA's legislative mandate, it is completely unconvincing that national uniformity is a sufficiently strong policy objective for state courts to relinquish their traditional roles in developing tort law. Moreover, even if uniformity were an overriding goal, it would be achieved equally either by uniform liability or immunity. Uniformity by itself does not support setting aside liability.

A stronger public policy justification would be the potential for liability to deter the expansion of managed care and the development and implementation of cost containment techniques. For example, Peter Jacobson has compared the favorable treatment afforded to the managed-care industry in its formative years to that enjoyed by the early railroad industry.[84] While the early railroads did not have complete immunity, they enjoyed favorable legal treatment under negligence as opposed to a strict liability regime. Some scholars posited that such favorable judicial treatment was afforded as a means to facilitate the industry's evolution during a time when it was key to national economic

81. *See, e.g.*, Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, Class Actions, and the Patient's Bill of Rights*, 30 J. LEGAL STUD. 625 (2001) (acknowledging that ERISA preemption of managed care liability is a tough sell, and withholding judgment on whether, ultimately, preemption is justifiable, but observing nonetheless that there are some reasons to support preemption).

82. RESTATEMENT (THIRD) OF TORTS § 7 (Tentative Draft No. 2, 2002).

83. *Cf. id.* § 7 cmt. d ("negligence-based liability might interfere with another area of [common] law").

84. *See* PETER D. JACOBSON, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 79-83 (2002).

growth.[85] However, this historical precedent does not support lifting liability altogether, and this justification loses force as the industry in question matures and becomes more established.

Another possible justification that can be drawn from the proposed Restatement Third is deference to discretionary decisions of other branches of government.[86] For instance, one example the Restatement offers is deference to governmental decisions that allocate resources or make other policy judgments.[87] Managed care organizations engage in cost containment initiatives at least in part as a result of the federal government's decision not to allocate health care resources through a system of universal coverage, and instead as a matter of national policy, to leave the allocation of health care resources to the private sector. Many of the practices in which managed care organizations currently engage, including clinically based coverage determinations, were specifically authorized in the federal Health Maintenance Organization Act of 1973 and its implementing regulations.[88] The analogy between managed care and governmental allocation decisions, however, is not a perfect one. Governmental authorization of an activity does not demand deference to every private action taken in pursuit of that activity. Holding managed care organizations legally accountable for harm caused by the lawful methods they adopt does not require the review of a substantive governmental decision. The managed care industry, not government, is allocating societal resources, and it is doing so without social consensus or governmental mandate concerning either the procedure or the substance of rationing decisions.

Finally, the proposed Restatement gives "administrability" as a possible ground for lifting tort liability. Negligence-based liability might be waived when a category of case poses particular difficulties for courts in gathering evidence or drawing doctrinal lines.[89] However, these concerns should not be overdrawn. Virtually all areas of tort law, and law generally, present problems of administrability to some degree. Certainly, they exist in the realm of managed care liability, which must wrestle with the overlap between tort and contract, that is, between coverage and treatment, and must correctly allocate responsibility among insurers, providers, employers, and patients. After thorough analysis, some of these concerns do convince us to limit liability in certain ways but others are hurdles the law can overcome. It is not possible to reach a complete understanding of these issues, however, until we give careful

85. *See id.*

86. RESTATEMENT (THIRD) OF TORTS § 7, cmt. g (Tentative Draft No. 2, 2002).

87. *Id*.

88. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e-300e-17 (2000); 42 C.F.R. §§ 417.100-417.166 (2002).

89. *See* RESTATEMENT (THIRD) OF TORTS § 7, cmt. f (Tentative Draft No. 2, 2002). The comment offers the recent disputes over the manufacture of handguns as a specific example. *E.g.*, Hamilton v. Beretta U.S.A. Corp., 750 N.E.2d 1055 (N.Y. 2001).

consideration to what is currently known about how liability functions in the managed care arena, and how it might function in a horizon beyond ERISA preemption. It is these broad inquiries to which we now turn.

III. THE RISKS AND BENEFITS OF LEGAL ACCOUNTABILITY IN THE MANAGED CARE INDUSTRY

A. Deterrence and Costs in Theory

The shortcomings of the present-day tort system are well known, and will not be reiterated here.[90] Suffice it to say that the twin goals of compensation and deterrence are imperfectly served by tort liability in the health care industry. Malpractice litigation is an expensive, time consuming and imprecise mechanism to identify the injured individuals who deserve recovery for harm resulting from medical negligence.[91] Nor can the shortfalls in meeting the compensation goal be justified by effective deterrence. Despite the easy availability of significant amounts of data, leading researchers have largely abandoned the effort to *prove* that medical malpractice litigation deters medical errors.[92] To the extent there is deterrence, others claim that it is excessive, taking the form of so-called "defensive medicine," but this, too, is difficult to prove.[93] Even if a general deterrent effect could be proved, that effect would be lessened by the uncertainty of sanction for harm resulting from the undesirable behavior and the possibility of sanction for harm unrelated to bad acts.

There is no reason to believe that expanding malpractice liability to managed care organizations will overcome the well known shortcomings of the malpractice regime as applied to physicians and other caregivers. Under theories of vicarious liability, effective use of malpractice liability would

90. *See, e.g.*, David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (if Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1640-46 (2002).

91. The number of claims filed is significantly smaller than the number of injuries suffered, and the claims resulting in recovery are not always supported by good evidence that negligence occurred. *See* Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991) (comparing incidence of injury with incidence of lawsuits claiming negligence and negligence awards). The modern day malpractice system, briefly described, is one in which some individuals harmed by negligence are compensated some of the time; some individuals who suffer bad outcomes are compensated despite a lack of proved negligence. And many who are not injured, such as lawyers and their experts, share in the compensation otherwise intended for the unfortunate victim of medical error.

92. *See* Hyman, *supra* note 90, at 1646 (reporting on researchers' difficulty in proving that tort liability deters medical negligence).

93. *See* Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1609 (2002) (studies are inconclusive).

require creating more accurate and efficient quality improvement incentives than those created by tort actions against hospitals, physicians, and other caregivers. In the arena of coverage determinations, the aim is for liability to cause health plans to do a better job in allocating limited resources to competing medical needs. There is not yet any evidence to show that either branch of managed care liability would have these desired effects. The public backlash against the managed care industry provides some reason to suspect that, if tort law doctrines are not carefully crafted and directed by an unbiased judiciary, the fit between socially undesirable conduct and legal sanction could become worse.

At present, national health care policy delegates the function of controlling health care costs to the managed care industry. Managed care organizations ration health care services in private corporate boardrooms, because society avoids doing so in public statehouses.[94] Cost control in health care is an unpopular, if essential, task, and one that is easy to second-guess with Rashomon-like hindsight when a medical outcome is bad. Relying on common-law adjudication of liability related to cost containment initiatives will place judge and jury in the position of social policy-maker, in the absence of clear social consensus about the appropriate means of allocating health care resources. Therefore, the courts inevitably will influence the evolution of managed care practices;[95] how well or wisely they do so remains to be seen. The specter of tort liability could chill innovation in techniques to manage care and cost or could lead the managed care industry to abandon the cost-control function entirely without another mechanism in place to fulfill that function.

B. Deterrence and Costs in Practice

1. Direct Costs

To learn more about whether any of these possibilities have occurred so far, we inquired in our interviews about the costs of litigation and whether liability threats affect core managed care strategies. Quantifiable costs are difficult or impossible to obtain. One measure is to look at aggregate costs of liability insurance. However, much of this liability exposure is self-insured and cannot be quantified in this fashion. For the portion that is insured, health plans report their rates have "sky rocketed" in recent years and coverage is sometimes hard to find at any price. Therefore, larger health plans have had to

94. *See* David Orentlicher, *The Rise and Fall of Managed Care: A Predictable "Tragic Choices" Phenomenon*, 47 ST. LOUIS U. L.J. 411 (2003) (managed care is only the latest of the mechanisms that American society has used to avoid making tragic choices in a public forum).

95. *See* Peter D. Jacobson & Scott D. Pomfret, *Establishing New Legal Doctrine in Managed Care: A Model of Judicial Response to Industrial Change*, 32 U. MICH. J.L. REFORM 813 (1999).

increase substantially the level of liability risk that they retain or self-insure. One large insurer currently has a deductible of $3 million per case and expects this amount to rise; other health plans reported that their deductibles doubled in recent years. One staff model HMO said that it has to self-insure entirely for vicarious liability because, due to the large number of childbirths it covers under a managed Medicaid program, its cost of coverage had increased so much. Other HMOs are too small to retain substantial risk, and they are forced to pay substantial increases in liability premiums. One defense lawyer noted that health plans he represents have "huge" liability limits that make no sense to him, such as $100 million per case.

Most defense-oriented lawyers attributed the increased costs and difficulties in finding liability coverage to the class action lawsuits and the handful of very large punitive damage awards, both noted above. Several knowledgeable lawyers, however, opined that difficulties with liability coverage are due more to general trends in the property and casualty insurance industry than to the experience with managed care specifically. They noted general financial problems at Lloyds of London, industry consolidation leading to a shortage of liability insurers in the market and the tendency of insurers' to alternate between artificially low rates to "buy business" and substantial premium increases to recover from the losses that result.

For cases that are self-insured, the most direct measure of liability costs is the average cost of litigating and settling cases, referred to jointly as "case severity." Several defense lawyers explained that liability risk causes health plans to settle claims for substantial amounts, even when the health plan believes it is not at fault, to avoid the potential for very large verdicts. One health plan lawyer explained that his company is eager to "get rid of cases early" because it prefers to deal with certainty. "Certainty is something that business people can evaluate; they can't evaluate the risk of an open-ended judgment that could be in the millions." This same health plan said its case severity (average cost to resolve) had increased 33% in a year. This health plan lawyer and other lawyers also noted, however, that the cost of resolution is also driven by legal costs, which have increased due to the increasing difficulty of having to defend ERISA pre-emption issues.

2. Indirect Costs

As significant as these direct costs might be, of greater importance are the *indirect* costs or benefits of liability caused by the deterrence, possibly excessive, of managed care techniques designed to contain health care expenditures or improve quality. Overall, the predominant view in our interviews was that liability is not a primary driver of how managed care activities are conducted. Even a number of those who thought that liability exposure was high felt that massive verdicts are too unpredictable to form the basis for making major strategic or operational decisions. "There isn't much

you can do about" these cases, "they just come out of the blue." Several subjects thought that the negative publicity from lawsuits was as much or more threatening than the actual liability, but that health plans would face the "moral liability of the press" in any event, regardless of the degree of legal liability.

Accordingly, the formation of networks, the credentialing of providers, the use of financial incentives and the management of utilization all appear to be driven mainly by market forces, regulatory constraints and general public reactions, rather than by liability. For instance, virtually no subject said that liability deters the use of financial incentives, or induces health plans to abandon gatekeeping or to change their network strategy by creating either smaller more tightly managed networks or larger unmanaged ones. Although many of these changes are occurring, they are attributed to market or regulatory forces rather than liability concerns.[96]

There was a much more deeply divided reaction about liability's impact on utilization management. A number of subjects felt that, here too, liability is not a major driver of behavior or change. Several health plan officials said that liability concerns are not on their minds at all when making coverage decisions. One experienced health plan lawyer explained that liability is often one of many factors that health plan managers have to balance in making decisions about business operations, but it is rarely determinative. Often there are "strong feelings" or a "real passion" internally about programs they think "add real value," so they go ahead despite liability concerns, although they might make a "few changes" to lessen the liability risk. For instance, no interview subject said that liability is a major deterrent to increased use of disease management programs, which target chronic illnesses such as asthma or diabetes where poor care increases costs and morbidity. And, liability was not given as a reason for delegating utilization management functions to independent contractors, perhaps because there is little confidence that doing so will insulate the health plan from liability.[97] Despite the large differential that exists in the actual liability exposure for these market segments, coverage processes and criteria are acknowledged, almost uniformly, to be the same for purchasers covered by ERISA preemption and those who are not. One health plan said that even enactment of a federal liability bill, which would overturn ERISA preemption, would not cause it to make significant changes in its

96. One experienced health lawyer said that liability has a "huge chilling effect" on the willingness of large provider groups to take on full insurance risk through global capitation, since this exposes them to the same liability as health plans. "When the lawyers explain it that way, . . . these provider organizations [ask themselves] if they really want that kind of exposure." However, this same lawyer said that these large provider contracting organizations are "falling apart" for other, financial reasons, not due to liability. Therefore, global capitation would be on the wane regardless of liability concerns.

97. Some subjects noted that this allows health plans to seek indemnification from another party if they are found liable.

utilization management practices because it feels like it has a good system in place already.

A second group of health plan representatives said that liability concerns were "on the back of their minds" when making coverage decisions and caused them to be "a little gun shy" or to exercise "a lot more caution" in denying coverage. One patient advocate thought that liability makes it easier to get the health plan's attention when trying to resolve a coverage issue since, before the liability statute in the advocate's state, HMOs thought they were "bullet proof." One representative of a health plan, that has been hit with a major verdict, claimed that its "nurse managers approve everything now" because "they're afraid of" both lawsuits and negative press from another bad case. Another observer felt that health plan medical directors are more affected by the threat of professional discipline than by liability, but still they are more conscious now than before about being held personally responsible for bad outcomes. One health plan lawyer somewhat surprisingly said that liability had positive effects by making health plans more careful about "getting it right." He thought that, "always, some good comes out of being sued" because it makes people more diligent. Therefore, "there are some benefits to putting the horn in the meat grinder." One insightful lawyer explained that big lawsuits, although rare, have a pronounced impact on investors and, therefore, on stock prices. Since managers of large publicly traded health insurers "run the business to please Wall Street," they are especially eager to avoid giving plaintiffs' lawyers reason to sue them. In this lawyer's view, "every once in a while an MCO should say 'no, we aren't covering that,' and take the risk of the lawsuit, but they don't want Wall Street getting shaken up."

The deterrent effect of liability was noted both on the processes and the substance of coverage decisions. Regarding process, subjects from several points of view said that the need to defend coverage decisions in court has caused health plans to rely more on objective medical criteria that can be documented in the medical literature, rather than on the subjective opinion of medical directors. One health plan said that the liability threat makes its medical director more likely to consult an outside expert to back up a coverage denial he thinks might be challenged in court, and another health plan said that liability made them "more serious" about meeting deadlines for making and reviewing coverage decisions. Another health plan was prompted by large punitive damage awards to review its practices and criteria thoroughly to see if it was doing any of the things that produced these verdicts, and to make some adjustments that would allow it to better defend its decisions in court. The health plan created a "concierge service" or "member advocacy program" to intervene earlier in cases that have a higher likelihood of producing a dispute, so they can work out compatible solutions earlier in the process before the case gets too far "downstream." The goal is to "infuse medical criteria" more thoroughly, consistently and earlier in the coverage determination process.

However, a lawyer with this health plan was unable to identify any specific substantive coverage criteria that have been changed primarily due to liability concerns. The changes were predominantly procedural. Another plan said it reviewed and improved its processes when a managed care liability statute was first enacted in the state because it originally thought the statute would produce a lot of litigation. The changes remain in place, even though little litigation has ensued.

Regarding the substance of coverage decisions, the difficultly in defining when it is or is not "prudent" for patients to go to the emergency room (under the statutorily required "prudent layperson" standard in most states)[98] has caused many health plans to routinely approve coverage for virtually all emergency visits. Furthermore, many health plans are reluctant or unwilling to deny coverage for high-dose chemotherapy with autologous bone marrow transplantation (HDCT-ABMT) for breast cancer, due to a prominent set of mixed results in court,[99] even though recent clinical trials have, in the minds of most experts, proven the procedure to be ineffective.[100]

Liability also affects how health plans exercise the discretionary authority they may have to deviate from contractual coverage limitations. One experienced lawyer said that, due to liability concerns, health plans are more willing to settle coverage disputes "extra-contractually," that is, agree to pay for something they believe is not covered by the insurance policy, especially where the patient has already incurred the cost at his physician's recommendation. A health plan gave as an example its willingness to pay for one patient's referral to a specialist in Europe, after concluding that treatment would not cost more than in the U.S. Other lawyers, however, said that health plans are less willing to make exceptions for "sympathy reasons" for fear that this will set a precedent that will later be held against them as an indication of being "arbitrary and capricious" when they deny the same procedure for another patient, a point that was reiterated by some health plan officials.

Beyond these particular components of managed care, some subjects commented on liability's more global effect on managed care, as part of the

98. David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409 (1998).

99. Mark A. Hall & Gerard Anderson, *Models of Rationing: Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992); Richard S. Saver, *Reimbursing New Technologies: Why Are the Courts Judging Experimental Medicine?*, 44 STAN. L. REV. 1095 (1992); William Giese, *Adjudication of Third Party Payment for High Dose Chemotherapy and Bone Marrow Rescue in the Treatment of Breast Cancer*, 1 DEPAUL J. HEALTH CARE L. 205 (1997).

100. Marc E. Lippman, *High-Dose Chemotherapy plus Autologous Bone Marrow Transplantation for Metastatic Breast Cancer*, 342 NEW. ENG. J. MED. 1119 (2000); Edward A. Stadtmauer et al., *Conventional-Dose Chemotherapy Compared with High-Dose Chemotherapy plus Autologous Hematopoietic Stem-Cell Transplantation for Metastatic Breast Cancer*, 342 NEW. ENG. J. MED. 1069 (2000).

overall climate of anti-managed care "backlash." One knowledgeable lawyer was particularly forceful in observing that liability is one factor that has caused most major national health plans to move away from managing care as their primary means of adding value to the insurance product. Instead, they are embracing the principle of enhancing consumer choice, which entails increasing patients' responsibility for paying more of their costs out of pocket:

> Managed care organizations are looking ahead and concluding that the risk is such that this isn't a place they want to be in the market anymore. They weren't intending to be a deep pocket for creative plaintiffs' lawyers. That is not the "benefit of the bargain" they thought they were getting when they wrote managed care policies. . . . You're dealing with the whole litigiousness of society and a particularly unpopular [image]. If you're a CEO of an insurer/MCO, you don't want to put your shareholders in harm's way. . . . When the bad events occurred in managed care, the industry didn't want to stand up and say, "we screwed up." Instead, they made like "wounded animals in a corner." . . . People got really upset about that because the MCOs were trying to duck when they really made a mistake. Insurers are finally waking up and realizing that the managed care model might not be a good model these days. Plaintiffs' lawyers can make pretty compelling cases. Even if liability is warranted, it will be assessed because MCOs are so unsympathetic.
>
> The move away from [utilization review and medical necessity denials] is both market-driven and driven by fears of liability. . . . Employers are hearing a lot about choice; some of what they are being told might be reliable. But, overall, employees are joining the consumer-empowerment approach. They want to make decisions about their own care. And plans are making decisions to avoid potential liability. There are two flows that have come together that have really pushed some of the changes in the marketplace.

This viewpoint was confirmed by another knowledgeable health lawyer, who said that both liability and market forces are behind the shift in recent years away from HMOs benefit designs and towards PPOs, which entail fewer managed care restrictions. He also attributed the current level of interest in moving from comprehensive coverage to much higher deductibles and co-payments to a combination of market forces and liability concerns.[101] He noted that if a treatment decision goes wrong due to the patient's own concerns about costs, the health plan couldn't be blamed. Despite a role for liability concerns in recent shifts in benefit design, this subject felt that market forces are the main drivers of these changes.

101. James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design,* HEALTH AFF., May 2002, at 16; Victor R. Fuchs, *What's Ahead for Health Insurance in the United States?* 346 NEW ENG. J. MED. 1822 (2002); Jason S. Lee & Laura Tollen, *How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing,* HEALTH AFF., June 2002, at 11 *at* www.healthaffairs.org/WebExclusives/Lee_Web_Excl_062902.htm (last visited Sept. 23, 2002).

Other health plans have not backed away from utilization management, gatekeeping or financial incentives either for liability or for economic reasons. One health plan lawyer was especially forceful in stating a "real passion" for the value that managed care can bring to health insurance. In her view, there is no reason to be in the business if patient protection laws, including liability provisions, are seen as making it impossible to engage in programs such as disease management for reduction of asthma in inner city children. She sees it as "unfortunate" that lawyers have to "stand over the shoulders" of medical directors who undertake these "really neat, innovative" programs to remind them about aspects of the initiatives that could increase the plan's liability exposure. So far, her colleagues have gone ahead and done what they think is "the right thing to do" despite liability concerns, which she "hopes" will continue to be the case.

3. In Search of Optimal Deterrence

In resolving these competing considerations, two distinct realms must be clearly differentiated: secondary liability for the negligence of treating physicians and primary liability for harm caused by managed care restrictions such as wrongful coverage denials.

Vicarious Liability. Regarding health plans' liability for physicians' medical negligence, legal scholars have staked out two polar positions. At one extreme, some scholars, including Patricia Danzon and Richard Epstein, argue that health plan liability would be redundant and add unnecessary costs, because physicians are already on the line for liability and are well insured.[102] Contractual arrangements between physicians and managed care organizations can reallocate this liability if it is efficient to do so. However, courts should not adopt a default position that assumes that health plans are well positioned to monitor, improve and take responsibility for the quality of care delivered by physicians in their networks.

At the other extreme, scholars including Clark Havighurst and Bill Sage argue that managed care organizations should be not only fully liable but, in the case of Sage, exclusively liable, for physician negligence.[103] This view is consistent with the Institute of Medicine's recent report, *To Err is Human*,

102. *See, e.g.*, Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491 (1997) (liability for negligent care should rest solely with caregivers and health plan liability should be based on contract); Richard A. Epstein, *Vicarious Liability of Health Plans for Medical Injuries*, 34 VAL. U. L. REV. 581 (2000).

103. *See* William M. Sage, *Enterprise Liability and the Emerging Health Care System*, 60 LAW & CONTEMP. PROBS. 159 (1997) (recommending legislatively imposed enterprise liability); Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7 (2000) (absent a different contractual agreement, health plans should be vicariously and exclusively liable for torts committed by health care providers with whom they contract).

which identified health care systems as the most effective means to address the inevitable failings of individual caregivers,[104] and supported by indications that managed care organizations are not taking their quality control role seriously.[105] The potential for vicarious liability for health care services provides an incentive for managed care organizations to take steps to minimize the opportunity for medical errors.

We take an intermediate position in the vicarious liability debate.[106] For staff model HMOs, there is no justification to depart from normal rules of respondeat superior that apply to any type of employee, including physician employees. For preferred provider organizations (PPOs), which allow patients free movement within and outside of broad networks composed of independent contractors, it is very difficult to justify a strong position of enterprise liability, and no courts have gone this far. In between these extremes are a host of hybrids that partake in different degrees of the respective policies and precedents that inform these two polar positions. These hybrids include: provider based HMOs where smaller networks of independent hospitals and physicians are closely affiliated with the HMO; traditional HMOs that use the gatekeeping concept but with extensive provider networks; direct access HMOs, which require patients to stay within the network, but remove the gatekeeping feature that requires permission before going to a network specialist; and point-of-service plans, which, like PPOs, allow patients to opt out of the network, but like HMOs, may impose gatekeeping if patients choose to stay in the network. Added to this complexity are a variety of different contractual and ownership arrangements between managed care organizations and provider organizations, such as "delegated networks," in which large provider groups assume most of the financial risk of health care services for a defined population through global capitation.

104. COMMITTEE ON QUALITY HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000).

105. The Office of Inspector General of the Department of Health and Human Services has suggested that managed care organizations were not taking quality control duties seriously, basing this assertion in part of a finding that managed care organizations do not notify the National Practitioner Data Bank of adverse actions taken against physicians with whom they contract. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, MANAGED CARE ORGANIZATION NONREPORTING TO THE NATIONAL PRACTITIONER DATA BANK: A SIGNAL FOR BROADER CONCERN (2001).

106. Our position is similar to, but distinct from, the position that Haavi Morriem develops in her recent book, in which she distinguishes between resource allocation decisions that are subject only to contractual standards, and issues of medical expertise, which are subject to tort standards. MORRIEM, *supra* note 73. We question whether this distinction can be drawn as cleanly as it needs to be for this approach to be workable. Also, even for pure resource allocation decisions, a contractual approach requires the development of tort-like standards of liability when breach of contractual obligations leads to personal injury.

The most sensible way to deal with the daunting complexity and variety of these arrangements is to continue to allow common law to evolve principles of vicarious liability on a case-by-case basis. This evolution is not being hampered by ERISA preemption; therefore, this area of law is not crying out for legislative reform. The only obstacle to an orderly evolution based on organizational structure are some archaic precedents in a few states that hold HMOs immune from vicarious liability under the corporate practice of medicine doctrine. The states that initially adopted this position, either by statute or case law, have now reversed it through one or the other means.[107] Therefore, for now, we opt to leave well enough alone.

Coverage Denials. Liability for coverage denials is quite another matter. This area cries out for legal reform due, on the one hand, to ERISA's interference with common law development, and, on the other hand, to extraordinary punitive damages approaching $100 million that juries have awarded in several cases so far not covered by ERISA preemption. Neither state of affairs is sustainable.

Managed care organizations cannot justify being exposed only to contractual damages for blatant breaches of their obligation to authorize essential medical care for individual patients.[108] If liability exposure were to be increased for core managed care activities, deterrence could lead to system-wide improvements in cost containment efforts. Managed care organizations could minimize the risk of liability through the adoption of scientifically valid standards to establish coverage policy and guide clinically based benefit determinations in individual cases.[109] Managed care organizations might be encouraged to select skilled and careful clinical decision-makers, supply them with proper information and tools, assign them to areas within their expertise, and monitor their performance. The development and use of quality assurance programs for clinically based benefit determinations and coverage policy could detect defects in design or implementation of managed-care cost-containment systems.[110]

The concern that some liability exposure might over-deter cost-containment activities should not be overstated. There is some reason to believe that managed care organizations are better positioned to process liability signals than are individual clinicians. Actuarial projections of liability

107. *See supra* text accompanying notes 37-39.

108. *See supra* text accompanying notes 80-89.

109. *See* Eleanor D. Kinney, *The Brave New World of Medical Standards of Care*, 29 J.L. MED. & ETHICS 323, 326-27 (2001) (discussing the role of medical standards in managed care).

110. Moreover, if disclosure and consent were an affirmative defense to challenges to cost containment initiatives, the risk of liability could encourage transparency in system design and incentives. *See* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, & ECONOMICS OF RATIONING MECHANISMS 194-98 (1997) (discussing disclosure of rationing mechanisms during insurance enrollment).

can be more precise with the larger volume of patient encounters involved in a managed care enterprise than with individual physicians. The economic signals sent by judgments against managed care organizations, therefore, should not be as distorted as those sent by the medical malpractice system against individual caregivers. Although physicians are widely believed to engage in over-deterrence through the so-called defensive practice of medicine as a result of their fear of medical malpractice actions, managed care organizations are in the business of spreading risk, and, with time and experience, should be more able to gauge their response to the increased risk of liability. In addition, the available evidence indicates this over-deterrence has not yet become the dominant explanation for increasing medical costs.[111] The managed care industry, however, cannot serve the resource allocation mission assigned to it by society, and many individual companies could not survive in any form, if ERISA preemption were lifted entirely and massive punitive awards became commonplace.

A compromise is needed. Although a middle course could evolve through common law adjudication, legislative intervention is more likely to achieve a well-considered balance by crafting a rule of liability for clinically based coverage denials that imposes accountability for the personal injury that can result from a managed care organization's malfeasance, but that does not excessively deter setting limits that are necessary to honor the contractual terms of affordable insurance coverage. As the next section reveals, recent legislative initiatives have not yet achieved that goal.

IV. LEGISLATIVE INITIATIVES

Both state and federal legislatures are actively engaged with attempting to formulate optimal liability rules for managed care. Congress has twice attempted, but has yet to enact legislation to moderate the effects of ERISA preemption.[112] Since 1997, eleven states have enacted variants of laws that create a "right to sue your HMO."[113] Although ERISA preemption remains a

111. *See* discussion *supra* Part II.B.2.

112. In the 106th Congress, the House of Representatives passed the Norwood-Dingell Managed Care Improvement Act of 1999, but the Senate failed to act, and Congress adjourned without enacting managed care reform. Until the events of September 11 changed the 107th Congress' priorities, Congress was again moving toward legislation that would expand managed care liability and clarify ERISA preemption of state law. On June 29, 2001, the Senate passed patient protection legislation. Bipartisan Patient Protection Act, S. 1052, 107th Cong. (2001). On August 2, the House of Representatives passed its version. Bipartisan Patient Protection Act, H.R. 2563, 107th Cong. (2001). The events of September 11 delayed further consideration and attempts at reconciliation of the House and Senate enactments.

113. *See* PATRICIA BUTLER, KEY CHARACTERISTICS OF STATE MANAGED CARE ORGANIZATION LIABILITY LAWS (2001), *available at* www.kff.org (citing and discussing ten such laws; North Carolina has since become the eleventh state to enact right-to-sue legislation).

major uncertainty,[114] these laws are receiving a lot of attention. Similar legislation has been pending in Congress for several years which, if enacted, would resolve the ERISA preemption issue and create a combined federal and state liability regime. For purposes of this Article, two aspects of these right-to-sue laws are germane: the *scope* of activities for which a managed care entity can be held liable, and the *standard* of care against which the managed care entity's conduct will be measured. In general, these statutes are aimed at coverage determinations rather than vicarious liability for the quality of care, and they require "ordinary care" rather than a professional or medical standard of care. They leave the precise parameters of "ordinary care" to common law adjudication.

A. Scope of Activities and Standards of Care

Texas was the first state to enact right-to-sue legislation in 1997.[115] The statute imposes a duty on managed care organizations to "exercise ordinary care when making health care treatment decisions."[116] In an apparent attempt to take advantage of the quality/quantity distinction noted above, the Texas legislature defined a health care treatment decision as a determination made when medical services were provided that affected the quality of those services.[117] Regarding the standard of care, the statute contains a subtle, but important, distinction, according to whether the actor is the managed care entity, or is an individual professional acting for the organization. "Ordinary care" for the entity is to be measured against "ordinary prudence" by a managed care entity in the same or similar circumstances, but "ordinary care" for an individual decision-maker is defined by reference to a standard of care

114. This uncertainty arises from an unresolved conflict in ERISA's two sources of pre-emption. The primary pre-emption clause saves from pre-emption state laws that regulate insurance, and, after the Court's decision in *RushPrudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002), it seems clear that these liability statutes meet the test for regulating insurance. However, another part of ERISA creates an exclusive federal remedy to enforce rights under ERISA, which the Court has construed as a jurisdictional bar to remedies in state court. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 48 (1987). It is unclear which provision trumps the other. In *Rush Prudential*, the Court reserved judgment on this question, but four justices clearly would find preemption, and the other five conceded, at least in dictum, that preemption is suggested by prior decisions.

115. Texas averted ERISA preemption by asserting that its scope was limited to claims of vicarious liability for negligence of plan physicians, despite the plain language of the statute that appears to envision broader liability. Corporate Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526 (5th Cir. 2000), *reh'g denied* Corporate Health Ins., Inc. v. Texas Department of Ins., 220 F.3d 641 (5th Cir. 2000), *vacated and remanded for reconsideration in light of* Rush Prudential HMO, Inc. v. Moran, 122 S.Ct. 2151 (2002), *reinstated as modified*, 314 F.3d 782 (5th Cir. 2002). *See infra* text accompanying notes 141-42.

116. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2002).

117. *Id.* § 88.001(5).

for other professionals of the same type.[118] Coupled with the doctrine of respondeat superior, this distinction would have the effect of holding managed care organizations that employ their physician-medical directors to the medical professional standard of care. Maine, North Carolina and Oklahoma later adopted substantially similar statutes, imposing a duty of ordinary care on managed care entities making health care decisions.[119] Those statutes, however, did not include a standard-of-care distinction for employed medical directors.

Other states have relied on the managed care entity's role as insurer in their attempt to justify an ability to regulate the industry in a manner that might escape ERISA preemption. California, for example, referenced its authority to regulate the business of insurance[120] when it imposed a duty of "ordinary care" on managed care entities arranging for the provision of medically necessary services and created a private right of action for individuals harmed by denial, delay, or modification of care that resulted from a managed care entity's breach of its duty.[121] Although "delay and denial" are terms more common to insurers than caregivers, the California legislature stated that the duty it imposed and the remedy the law provided were "necessary to protect the health and safety" of state residents.[122] Only enrollees who suffer "substantial harm" are eligible to sue.[123] New Jersey also used language common to insurers in imposing liability for a managed care entity's "negligence" in denying or delaying approval of medically necessary covered services. Arizona law created a variant of a common-law bad faith denial of coverage claim. It provides a private right of action for individuals harmed by health care insurers' delay or failure to authorize medically necessary services, but only in

118. *Compare id*. § 88.001(10) ("Ordinary care" for an employee or agent of a managed care entity making the health care treatment decision is measured against the "degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice . . . in the same or similar circumstances."), *with* ME. REV. STAT. ANN. tit. 24-A, § 4301-A (West 2001) (ordinary care for both the health plan and its agents defined by reference to ordinary prudence under the same or similar circumstances).

119. ME. REV. STAT. ANN. tit. 24-A, § 4313 (West 2001) (carrier has "the duty to exercise ordinary care when making health care treatment decisions that affect the quality of diagnosis, care or treatment"); N.C. GEN. STAT. § 90-21.51 (2001) (managed care entity has "the duty to exercise ordinary care when making health care decisions"); OKLA. STAT. ANN. tit. 36, § 6593 (West 2002) ("managed care entity . . . has the duty to exercise ordinary care when making health care treatment decisions").

120. 1999 CAL. STAT. 536 § 2(a)(1) ("all managed care entities regulated under the [Act] are engaged in the business of insurance in this state").

121. CAL. CIV. CODE § 3428 (West 2001).

122. 1999 CAL. STAT. 536 § 2(b), *codified* at CAL. CIV. CODE § 3428 (West 2001).

123. CAL. CIV. CODE § 3428(b) (West 2001) (substantial harm includes loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physician pain, or significant financial loss).

circumstances in which the insurer "knew that it acted without a reasonable basis or failed to perform an investigation or evaluation adequate to determine whether its action was supported by a reasonable basis."[124] A managed care entity can defend against such claims by asserting that its conduct was "inadvertent or unintentional."[125]

Two states, Georgia and Washington, purport to measure managed care liability against a medical professional standard. Washington requires a "health care carrier [to] adhere to the accepted standard of care for health care providers . . . when arranging for the provision of medically necessary health care services to its enrollees."[126] Similarly, Georgia requires entities that administer benefits or review or adjust health care claims to act in accordance "with the practices and standards of the profession of the health care provider generally."[127]

Both the House and the Senate bills that were passed (but not enacted) in the 107th Congress would expand the potential liability of managed care organizations for their own actions and permit monetary damages for personal injuries resulting from negligent benefit determinations for ERISA plan beneficiaries. The Senate bill would accomplish this result by creating a new cause of action against ERISA plans for negligent benefit denials that are based on the terms of the coverage contract.[128] Managed care entities offered through ERISA plans could be held liable if they failed to exercise "ordinary care" in making decisions about eligibility or coverage. Ordinary care would be measured against the care, skill, and diligence exercised by a "reasonable and prudent individual."[129] The Senate bill would eliminate ERISA preemption of state law causes of action challenging coverage determinations that are based on clinical criteria, so-called medically reviewable decisions.[130] This action would put ERISA plan beneficiaries on equal footing with other managed care enrollees. While these claims could be brought under state law, they would be subject to federal damage limits.[131]

124. ARIZ. REV. STAT. § 20-3153(A)(2) (2001).

125. *Id.* § 20-3153(B)(2).

126. WASH. REV. CODE § 48.43.545(1)(a) (2002).

127. GA. CODE ANN. § 51-1-48(a) (2000).

128. S. 1052, 107th Cong. § 402 (2001) (amending § 502 of ERISA).

129. *Id.* § 402 (amending § 502 of ERISA by adding (n)(4)(A)).

130. *Id.* § 402(b) (amending § 514 of ERISA by adding (d)) ("PREEMPTION NOT TO APPLY TO CAUSES OF ACTION UNDER STATE LAW INVOLVING MEDICALLY REVIEWABLE DECISIONS"). Medically reviewable decisions would include claim denials based on an evaluation of medical facts about a specific patient, including, but not limited to, determinations of medically necessity or appropriateness and experimental or investigational determinations. *Id.* § 104(d)(2).

131. *Id.* § 104(d)(1).

The House bill would create a cause of action for ERISA plan beneficiaries harmed by benefit determination,[132] but it also would prohibit courts from classifying disputes about coverage determinations as challenges to the quality of medical care under state tort law.[133] Like the Senate version, the House bill would impose a standard of ordinary care measured against a reasonable and prudent person, although unlike the Senate bill, this standard would apply to all benefit determinations including those based on evaluation of clinical information.[134] Presumably, the House version would require the development of a federal common law of negligence to address benefit determinations based on clinical criteria. How the differences between the two proposals will be resolved, and more fundamentally whether any federal legislation will be enacted, remains uncertain.

B. Initial Impact of State Laws

The state right-to-sue laws have not been on the books long enough for lawsuits to make their way through the courts in any number. Therefore, it is too early to know what impact the state laws will have. To date, however, there is no evidence of the much ballyhooed "flood of litigation" that was predicted when the ERISA shield began to erode and states enacted right-to-sue laws.[135] According to Texas lawyers we interviewed, from the time of its enactment in 1997 until July 2001, when the first jury verdict was handed out, only about a dozen lawsuits were filed under the Texas right to sue law, and the stream of cases since then has "gone down to almost nothing," far less than anyone ever expected. The first case filed, *Plocica v. NYLCare Health Plans Inc*, was settled in 2000, and the first jury verdict exonerated the HMO.[136] A second jury verdict awarded $13 million (including $10 million in punitive damages) against Cigna for prematurely discharging a nursing home patient

132. Bipartisan Patient Protection Act, H.R. 2563, 107th Cong. § 402(1) (2001).

133. *Id*. § 402(a) (amending § 502 of ERISA by adding (n)(9)) ("A cause of action that is based on or otherwise relates to a group health plan's determination on a claim for benefits shall not be deemed to be the delivery of medical care under any State law . . . . Any such cause of action shall be maintained exclusively under [the amended section of ERISA]").

134. *Id*. § 402(16)(E) (defining ordinary care). ERISA plan participants could file challenges to benefit determinations in either federal or state court, but such claims would be adjudicated under federal law.

135. *See* Jake Tapper, *The Healthcare Disaster that Wasn't, at* SALON.COM (July 17, 2001) (quoting then Governor George W. Bush on the potential for the legislation to drive up costs and increase the number of law suits). For further explanation of why this has not occurred, see Carole Gresenz, et al., *A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries*, RAND CORP. ISSUE PAPER (1999), *available at* http://www.rand.org/publications/IP/IP184/.

136. *See* Mary Alice Robbins, *Defendants Score in First Test of Texas Health Liability Act*, LEGAL INTELLIGENCER, July 19, 2001, at 4 (reporting on both the earlier *Plocica* settlement and *Brewer v. Chang*, the first case to reach a jury).

who died.[137] Other cases were settled, dismissed based on ERISA preemption, or are still pending. Only a handful of suits have been filed in all the other states combined with these statutes, and, to the knowledge of the experienced lawyers we interviewed, several of these states have had no suits filed yet.

Lawyers on both sides of the table reported that the state right-to-sue laws have not yet made a large difference in managed care liability. Defense lawyers view them as merely "another arrow in the quiver" of plaintiffs' lawyers. Health plan lawyers consistently said they were not "quaking in their boots," but were taking a "wait and see" attitude toward the statutes. Although there was at first "a lot of worry," one lawyer said, "after more sober cost-benefit analysis," health plans do not see these statutes creating any major new source of liability. For their part, most plaintiffs' lawyers reported that the plaintiffs' bar was not suddenly saying "let's attack HMOs now." While plaintiffs' lawyers were interested in seeing the statutes tested, most of the ones we spoke to, including some who reviewed several hundred potential cases of malpractice each year, reported that they had not yet seen the right set of facts for a test case, one that clearly pointed to the health plan as a primary wrongdoer. Even the most active plaintiffs' lawyer in Texas said that he turns down about twenty cases for every one he takes.

Many patient advocates agree with these lawyers' assessment that the state statutes have had only a marginal impact on managed care liability. One advocate from New Jersey said that, even though the New Jersey statute had been "waived around as another great consumer protection" and characterized as a version of liability that was stronger than that contained in a pending federal bill, nothing had happened under the statute in its first year. However, a patient advocate in Texas thought that the right to sue is still an important protection, even if it is rarely used, because it is a patient's only recourse if injury has already occurred from a treatment denial.

The dearth of litigation activity was attributed to several factors in the interviews we conducted.[138] Few lawyers see the right-to-sue statutes as creating any fundamentally new theories of liability. At their core, most of these statutes create a form of liability akin to liability for "bad faith" denial of insurance benefits.[139] A few states seemingly intended to create a medical

137. *Jury Awards $13 Million Against HMO For Forcing Patient From Nursing Home*, 11 BNA HEALTH L. REP. 1005 (July 11, 2002) (reporting on *Pybas v. Cigna HealthCare*, the first plaintiff's verdict under the Texas legislation).

138. Notably, however, this is not due to the various limitations or qualifications in these statutes that some might view as creating hurdles to suing. For instance, plaintiffs' lawyers said that the list of more serious health conditions one must have in some states to bring suit is not limiting since no plaintiffs lawyer would want the case anyway unless the patient had one of these conditions. As one lawyer put it, "I wouldn't waste the court's time on whether to have toenails trimmed."

139. *See supra* text accompanying notes 116-23.

malpractice type action against the managed care organization for erroneous clinical determinations made by its employed medical directors.[140] However, most interview subjects had a difficult time distinguishing these theories of liability from what was already available, at least in theory, under common law.[141] Although many states lack a clear precedent on point applying these types of general tort theories to managed care organizations, most lawyers we spoke to thought that it was "just a matter of time, given the right set of facts" before courts would be willing to "hold [managed care organizations] responsible for their own decisions." State statutes that recognize a right to sue health insurers are viewed, for the most part, as merely codifying existing state common law theories of liability, not as creating brand new theories of liability.[142]

The major legal functions of these statutes then will be to establish a standard of care for managed care organizations and to attempt to circumvent ERISA preemption by invoking the states' right to regulate insurance or the quality of medical care. Until definitive rulings on ERISA preemption emerge, lawyers see a great deal of uncertainty about whether the latter goal will be accomplished.

Uncertainty about ERISA is not the only reason for the absence of state litigation under the right-to-sue laws. It is possible that fewer potential cases exist than some might have predicted. One experienced plaintiffs' malpractice lawyer explained that, in most cases the lawyer reviewed, there was no clear cut denial of coverage or interference by the health plan; instead, physicians sometimes claimed they failed to offer treatment thinking that it would not likely be approved. If this experience is generalized, it suggests that the liability threat is diminished by the simple fact that managed care

140. *See supra* text accompanying notes 112-17.

141. For instance, some noted that "ordinary care" is not necessarily a lowering of the standard from "bad faith," since bad faith is used to justify punitive damages, whereas compensatory personal injury damages are (or might be) available already under common law simply for failing to honor the terms of insurance coverage, whether or not this was done in bad faith.

142. The major exception to this statement is in the few states such as Texas that previously had ruled that HMOs were immune from suit for medical errors based on the statutory prohibition on corporations practicing medicine. For a discussion of corporate-practice of medicine defense, see *supra* text accompanying notes 37-39. Texas lawyers said that a major impact of the Texas statute is to "put a nail in the coffin" of the corporate practice defense to liability. Even these states, however, would likely have recognized liability for injury caused by wrongful denial of insurance benefits, which is all that many of the newly enacted state statutes address. Interview subjects in Texas explained, contrary to the conventional wisdom that the corporate practice defense barred liability in their state, the defense was seldom successful in court prior to the liability statute, and in fact the corporate practice argument was often turned against HMOs, as a theory of liability, by arguing that engaging in the illegal corporate practice of medicine constituted negligence per se.

organizations' clinically based coverage determinations may be much less intrusive on the course of treatment than is commonly believed. One prominent medical malpractice lawyer thought that the absence of "egregious facts" in the cases he screens indicates that the few "horror stories" one hears are not "typical day in and day out" cases but instead are "one in a million" "anecdotes." Another plaintiffs' lawyer, who also commented that he does not see the kinds of "abuses" he used to read or hear about, speculated this is because HMOs have "tweaked the system" to eliminate their "worst practices," under pressure from providers and the public backlash. This observation is consistent with other reports that health plans in recent years have lessened many managed care controls, such as greatly reducing the number of procedures that require prior authorization or allowing patients to go directly to specialists without seeking prior approval.[143]

Finally, when disputes that implicate a health plan do arise, lawyers explained that they are less likely to result in a liability suit as a result of the external review programs that have been adopted by most states in recent years.[144] External review procedures allow patients to appeal coverage denials to an independent physician or panel of physicians with relevant qualifications. A number of interview subjects from different perspectives (including health plans) felt independent external review was a preferable form of dispute resolution, one that prevents the harm from occurring in the first place by correcting health plan mistakes before they cause harm and that provides a speedy and trustworthy resolution of disputes when they arise. This procedure dampens the need for a dissatisfied enrollee to consult a lawyer and seek redress in court. Some defense and plaintiff's counsel opined that mandating external review would also limit the liability exposure for coverage denials to any harm caused during the time that external review is pending.

These views are based only on initial interpretations of these statutes and could change dramatically if early court rulings come out differently than anticipated. An experienced health plan lawyer observed that predicting how courts will interpret these statutes is difficult, as courts sometimes adopt readings that are "surprising."[145] As one health plan executive stated,

143. *See* James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001).

144. For a discussion of state external review laws, see KAREN POLITZ ET AL., ASSESSING STATE EXTERNAL REVIEW PROGRAMS AND THE EFFECTS OF PENDING FEDERAL PATIENTS' RIGHTS LEGISLATION, *available at* http://www.kff.org/content/2002/3221/externalreviewpart2rev.pdf.

145. For example, she pointed to the Fifth Circuit's apparently reading the Texas statute as applying only to claims of medical negligence by treating physicians despite the fact that the statute imposes a duty on "*managed care entit[ies]* . . . [to] exercise ordinary care when making health care treatment decisions." Corporate Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526, 534 (5th Cir. 2000) (emphasis added), *vacated and remanded for reconsideration in light of* Rush Prudential HMO, Inc. v. Moran, 122 S.Ct. 2151 (2002), *reinstated as modified*, 314 F.3d 782 (5th

"everyone is still trying to figure out" what these statutes will mean, and it's possible they may "end up being a non-event." One major issue that will determine the impact of these statutes is how courts develop the standard of care that applies to personal injury damages resulting from a managed care organization's clinically based decisions.

V. REACHING THE MERITS OF CHALLENGES TO BENEFIT DETERMINATIONS

It is axiomatic that managed care organizations owe their enrollees a duty of care. The measure of that duty, or the requisite standard of care against which it will be assessed, is considerably less clear. Some commentators have suggested that private insurance contracts should play the major role in defining payors' obligations.[146] For example, contracts might limit coverage for rehabilitative services to thirty sessions in a contract year, without regard to whether an enrollee could benefit from or will be affirmatively harmed by the withholding of additional sessions. Certainly, such absolute limits should be honored and failure to grant exceptions should not be the basis for personal injury liability. Tort suits should not become vehicles for rewriting coverage documents that are clear and precise. However, this approach does little to resolve the core issues because coverage within the prescribed limits is defined according to open-ended and judgmental concepts such as medically necessary, non-experimental, non-custodial and non-cosmetic. Therefore, insurance contracts unavoidably will give insurers discretion to determine uncertain issues that require the application of individual clinical assessments.[147] If, ultimately, it is concluded that the insurer's judgment was arbitrary, unreasonable or simply not correct, the liability that results from any misfeasance raises issues cannot be resolved without resort to concepts from the domain of tort law.

Cir. 2002). To be fair, the Fifth Circuit had the assistance of counsel for the State in reaching this rather strained reading of the statute. *Corporate Health Ins., Inc.* 215 F.3d at 534 ("We agree with Texas' interpretation of the Act. When the liability provisions are read together, they impose liability for a limited universe of events. . . . [T]he Act would allow suit for claims that a treating physician was negligent in delivering medical services . . . ."). Earlier, we noted our speculation that counsel for the State asserted this reading in an attempt to stave off a finding of ERISA preemption. *See supra* note 115.

146. *See generally* Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1784 (1992) (urging greater reliance on private contract to ration health care services); E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE (2001) (arguing that health plans should not be liabile in tort for clear limitations in coverage).

147. *See* Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J.L. MED. & ETHICS 253, 256-57 (2001) ("[T]he contract itself will never be adequate to describe what that care should be in an individual case. What the consumer is buying . . . is . . . [a] reasonable judgment about patient care."); *see generally* HALL, *supra* note 110.

A. Lessons from Wickline *and* Wilson

The first reported case alleging that a payer's decision to withhold payment or medical services on the ground that they were not medically necessary for the insured was decided little more than fifteen years ago.[148] It arose when Lois Wickline sued the California State Medicaid program (MediCal) alleging that it negligently refused to authorize payment for an eight-day extension of inpatient treatment as requested by her physicians, and, instead, agreed to pay for four additional days of hospitalization. At the conclusion of the four-day extension Mrs. Wickline's physicians discharged her from the hospital. Shortly thereafter, she developed complications that eventually necessitated the amputation of her right leg. The state court of appeal reversed a jury verdict in Mrs. Wickline's favor, concluding that the cost limitation decision did not "corrupt medical judgment."[149] In reaching its decision, the court noted that payers could be held "legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms" but that physicians who complied without protest with limitations imposed by third-party payers' decisions "cannot avoid ultimate responsibility for harm suffered by the patient."[150]

MediCal's payment determination undisputedly *changed* the treating physician's decision about when to discharge Mrs. Wickline from the hospital. "Corrupt," the term used by the appellate court, however, has a decidedly negative connotation: not merely to change, but to change from good and sound to bad or unsound.[151] The court concluded that the physician's discharge decision, while changed as a result of the denial of payment, was not itself negligent.[152] Accordingly, the court was not forced by the facts and procedural posture to operationalize this vernacular term into a legal standard. Perhaps because of its conclusion that the discharge decision was not negligent, the court did not evaluate in any detail the "design or

148. Wickline v. State, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

149. *Id.* at 820.

150. The court was later to repudiate this statement in *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990). The court characterized the *Wickline* court's statement about a treating physician's ultimate responsibility as dicta, and rejected it, holding that a treating physician would not have sole liability for harm caused by a hospital discharge that resulted from the payer's decision not to approve payment. *Id.* at 879. The *Wilson* court's approach is consistent with the tort doctrine of joint and several liability.

151. Webster's Third New International Dictionary defines "corrupt" as "to change from good to bad" or "to degrade with unsound principles." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE UNABRIDGED 512 (1993).

152. However, this finding was not fully litigated. The only physicians who testified at trial were physicians associated with the MediCal program and Mrs. Wickline's own physicians. *Wickline*, 239 Cal. Rptr. at 815. Neither group was likely to testify that the care provided was substandard, even though the treating physicians maintained that it was not optimal and that the deficit in care caused Mrs. Wickline's injury. *Id.* at 815-16.

implementation" of MediCal's cost containment mechanisms, to explain why they were or were not "defective" or what would constitute an actionable defect.

The uncertainties reflected in the *Wickline* case were not resolved by a subsequent California decision, *Wilson v. Blue Cross of Southern California*, which allowed a similar set of facts to go to trial.[153] That decision reasoned that liability would exist if the plaintiff proved that a utilization review firm improperly denied coverage for psychiatric hospitalization and if this denial was a "substantial factor" in causing the patient's suicide. However, the key fact on which the allegation of illegality was based is unlikely to recur: the insurance contract at issue seemingly failed entirely to authorize utilization review or the delegation of utilization review to a third party,[154] a defect that, if true, could be, and has been, quickly fixed in future insurance contracts. This case too sheds little light on what types of defects in process will give rise to tort liability. Moreover, the decision is silent about the standard of medical care that gives rise to liability, since no facts had been developed to indicate whether the care that was provided was negligent.

Despite these shortcomings, *Wickline* and *Wilson* can provide an analytical framework for articulating the standard of care for managed care liability. They indicate that we need to consider both a substantive professional standard regarding the quality of medical care that was delivered (that is, whether medical judgment was "corrupted"), and a more procedural standard of how the insurer went about deciding whether to pay for the requested treatment. Each standard of care formulation has both sound underpinnings and significant shortfalls in assessing individual coverage decisions that are based on clinical factors. Accordingly, the following two sections analyze alternative ways to articulate a standard based on substance and one based on process, and concludes by considering how the two types of standards should relate to each other.

B. The Professional Medical Standard

1. Influencing or Arranging for Negligent Care

Mrs. Wickline's attending physicians testified that if she had remained in the hospital, the complication following surgery would have been identified more promptly and her leg could have been saved by surgical intervention.[155] That a better medical outcome might have resulted, of course, is not the test for

153. *Wilson*, 271 Cal. Rptr. at 876. The patient committed suicide after the insurer's utilization review firm refused to authorize extending his stay in a psychiatric hospital to the full thirty days requested by his physician and covered by his insurance. *Id.* at 877-78.

154. *Id*. at 880-81.

155. *Wickline*, 239 Cal. Rptr. at 816.

medical negligence. Rather, the usual question is whether the physician complied with minimally acceptable professional medical standards. In *Wickline*, the court accepted the medical testimony that a four-day extension of the patient stay satisfied the prevailing standard of care, although a longer extension might have been optimal and might have prevented the amputation.[156] The court held that MediCal was not liable as a "matter of law."[157] Is this the correct result?

In our view, the standard of care depends on whether the gravamen of the complaint is the health insurer's refusal to pay for covered benefits, or instead whether the plaintiff claims that the health insurer influenced or interfered with the independent medical judgment of treating physicians. *Wickline* had elements of both, but the court focused more on the latter than on the former. Although MediCal initially approved only four days rather than the eight days requested, the treating physicians failed to ask for an extension when the four days expired, feeling this would be futile considering how MediCal conducted its utilization review activities. Therefore, the court framed the issue as "the legal responsibility that a third party payor . . . has for harm caused to a patient when a cost containment program is applied in a manner which is alleged to have affected the implementation of the treating physician's medical judgment"[158] and "the effect of cost containment programs upon the professional judgment of physicians to prescribe."[159] In short, the court focused on whether the payer had "corrupted" physicians' medical judgment.

Framed this way, it is correct to apply a medical professional standard of care. There is no basis for holding the health insurer to a higher standard of care than the physicians themselves. This is the essence of the principle that applies to hospitals when they allow unqualified physicians onto their medical staffs. Hospitals are not held to a standard of strict liability for any less-than-ideal outcome for patients of unqualified physicians. Instead, liability attaches only when such physicians themselves commit malpractice.[160] Similarly, a managed care function that results in a clinical course of conduct that is not negligent should not be actionable merely because of a bad outcome. Some bad outcomes are inherent risks of treatment procedures, and others, while avoidable, are not *ipso facto* the result of negligence. If a treatment recommendation would not have been negligent, then that same recommendation couched as a coverage determination should not be

156. The *Wilson* Court, in an attempt to clarify the opinion in *Wickline*, stated that the court there found "as a matter of law, the discharge decision met the standard of care for physicians." 271 Cal. Rptr. at 879.

157. *Wickline*, 239 Cal. Rptr. at 820.

158. *Id.* at 811, 820.

159. *Id.* at 811.

160. MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 441 (forthcoming 6th ed. 2003).

considered a breach of duty merely because it is different from the physician's initial recommendation, unless the health plan has actually promised a higher standard of care.

Several courts have indicated that the medical standard of care will be applied to managed care organizations when they are acting as providers or arrangers of health care services.[161] This, in essence, creates a "case within a case," since, to find the health insurer liable, it is necessary first to show that the treating physicians or other care providers were negligent, and then establish the legal basis for holding the health insurer responsible for this negligence. The standard for evaluating the quality of care that patients receive is not the hard question, however. Instead, courts need to decide what conditions justify holding the health insurer responsible. When a health insurer is held responsible vicariously for the care provided by caregivers, the issue is not so much a standard of care question as it is an application of principles of agency, a complex and subtle topic that is not our primary focus in this article. Instead, we are focusing on liability arising from denial of coverage based on judgmental factors involving clinical determinations.

Simply denying coverage as legally permitted by the terms of the insurance policy should not, standing alone, constitute grounds for holding health insurers liable when patients receive substandard care. Some other basis for legal responsibility would need to be established, such as actual or ostensible agency. This is an obvious point if the denial of coverage is based on clear and absolute terms, such as limiting coverage for psychiatric hospitalization to thirty days a year. If this limitation in coverage were to influence a physician or hospital to cease treatment that is medically required by the minimum standard of care,[162] there is no doubt that only the provider would be responsible. Doubt arises only when the insurer's coverage limitation is not certain because it is written in judgmental terms, such as "medically necessary," that are subject to differences of opinion. We next consider what standard should govern interpretation of these terms.[163]

161. *See, e.g.*, Hammerich v. Aetna U.S. Healthcare, Inc., 209 F. Supp. 2d 1282, 1285 (M.D. Fla. 2002) (when an HMO is acting as a health care provider, it is subject to the prevailing standard of care); Morton v. Mylar Pharmaceuticals, No. 99-4896, 2000 WL 340196 (E.D. Pa. 2000) (same); Tiemann v. U.S. Healthcare, Inc., 93 F. Supp. 2d 585, 598 (E.D. Pa. 2000) (same); *In re* U.S. Healthcare, 193 F.3d 151, 164-65 (3d Cir. 1999) (allegation that HMO breached the medical standard of care when it failed to arrange for a nurse in a timely fashion).

162. *See, e.g.*, Muse v. Charter Hosp. of Winston-Salem, Inc., 452 S.E.2d 589, 595 (N.C. Ct. App. 1995) (finding a psychiatric hospital liable for discharging a suicidal patient because his insurance coverage ran out).

163. We assume for purposes of the following discussion that the insurer was both contractually entitled to limit coverage to medically necessary services and entitled to make the medical necessity determination.

2. Denying Coverage for Medically Necessary Care

When the dispute centers on whether the insurer was legally authorized to deny coverage, the argument is stronger for invoking a professional medical standard if the operative coverage concepts are ones such as medically necessary or experimental, which by their own terms invoke professional medical norms. Managed care organizations retain the services of physicians to make these judgmental determinations, and these physicians have been found to be "practicing medicine" when they serve in this utilization review capacity.[164] Under normal agency principles, managed care organizations would be responsible when their physician-agents make legally actionable errors in coverage decisions that require medical training and experience. The argument, then, is that the validity of coverage decisions based on judgmental medical criteria should be determined by the same standard of care as that which is applied to treating physicians. This would bring physician liability and insurer liability into sync, avoiding the difficulty that arises when physicians are forced by their liability considerations to provide care that insurance will not cover.

This argument has superficial appeal, but it deceptively conflates two types of liability for coverage denials: contractual and tort. If the question is how to interpret medical necessity and similar terms for purposes of claiming contractual benefits, then certainly a minimum professional medical standard should apply. Indeed, some regulators and legislatures have gone much further to require that an *optimal* or *maximal* professional standard should govern insurance contract enforcement, rather than a minimally acceptable professional standard.[165] Under this stance, if there is a legitimate difference of opinion between the insurer's physician and the treating physician (e.g., four vs. eight days of hospitalization), both of which are supported by scientific evidence or professional opinion, it is the treating physician's judgment that should govern.[166] Others are highly critical of this limitation on the freedom to contract for alternative and more cost-effective styles of medical practice.[167]

164. *See* Murphy v. Bd. of Med. Exam'rs, 949 P.2d 530, 535 (Ariz. Ct. App. 1997); State Bd. of Registration for the Healing Arts v. Fallon, 41 S.W.3d 474, 478 (Mo. 2001) (en banc).

165. Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, LAW & CONTEMP. PROBS., Winter 2002, at 169.

166. Sara Rosenbaum et al., *Who Should Determine When Health Care Is Medically Necessary*?, 340 NEW ENG. J. MED. 229, 232 (1999).

167. *E.g.*, Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 398 (2001). Based on our interviews, however, health insurers for the most part appear willing to live with this heightened contract standard as the price for making peace with the public, in response to the managed care backlash. Most health plan executives interviewed in this study did not complain that mandatory definitions and

The issue here, however, is not simply how best to interpret the insurance contract or which benefits insurers should be required to cover. Instead, the issue is whether personal injury and punitive damages should be awarded for harm resulting from the illegal refusal of covered benefits. Both kinds of disputes, the one sounding in contract and the other in tort, turn on the application of medical judgment through terms such as "medically necessary." Nevertheless, a medical professional standard is not the correct standard for determining tort liability. Although using medical custom as the measure of the duty owed by managed care organizations has some intuitive appeal, a close examination reveals factual inaccuracies, doctrinal weakness and procedural problems with the use of this substantive standard.

First, the analogy between managing care and practicing medicine is not a perfect one.[168] Physicians examine patients and make differential diagnoses; they discuss treatment options and attendant risks with their patients in deciding on a course of treatment; and they rely on technical skills to perform diagnostic testing and treatment. Managed care organizations and the physician-agents who make clinically based coverage determinations on their behalf do none of these things.[169] Therefore, if managed care organizations are practicing medicine, they are doing so within a much narrower range of professional responsibilities. A decoy looks a lot like a duck; it serves a useful purpose; but it cannot be expected to quack and lay eggs. How well it fulfills its function might be better judged by a closer examination of what that function is. The same could be said of managed care organizations that engage the services of clinicians to make coverage determinations but not to diagnose, advise and treat.

Reliance on medical custom as the standard of care has been questioned even in the cases in which it has its origins, those involving allegations of medical malpractice against treating physicians. "Medical custom" as a legal standard of care is based on a fallacy: that there exists one single correct medical response to every clinical problem and moreover that this single correct response is, and should be, determined without reference to cost.[170] The one-right-way approach has necessitated the evolution of additional legal

interpretations of medical necessity unduly hampered their cost containment objectives or their contractual options in the marketplace.

168. Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 439-40 (1988).

169. They have even fewer attributes of a true treatment relationship than do physicians who examine patients for employment purposes, for instance, and these employment physicals have been held not to create a professional duty of care. Payne v. Sherrer, 458 S.E.2d 916, 917 (Ga. Ct. App. 1995).

170. *See* James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Healthcare Marketplace?*, 11 ANNALS HEALTH L. 125, 130-31 (2002).

doctrines, including the respectable minority and two schools of thought rule, to account for this clinical reality.[171] The cost-is-no-object aspect of medical custom causes medical malpractice law to deviate from the wider body of tort law that encompasses a risk-utility analysis. In a recent body of work, Professor Philip Peters has shown that judicial deference to medical custom is eroding in favor of traditional tort principles of reasonable care under the circumstances presented.[172] Whether juries will consider cost as one of the circumstances remains to be seen. Therefore, this area of law would not be well served by expanding an uncertain and questionable common law doctrine to an increasing circle of actors.

More troubling still is the possibility that applying a medical professional standard would result in holding health insurers liable for tort damages for honest differences of opinion, when juries might conclude that damage resulted from the insurer initially opting for the less protective of two professionally justifiable courses of action. Studies document that medical custom often varies over a surprisingly wide range, sometime much wider even than the four vs. eight days of hospitalization in *Wickline*.[173] Many or most tort suits for denial of coverage would come to court only after the question of contract interpretation has been resolved through administrative appeal mechanisms, such as the external review process discussed above.[174] These contract disputes are likely to be governed by a more demanding version of medical custom, such as the optimal or maximal professional standard. Having established entitlement to coverage under this standard for contract interpretation, it would be very difficult, applying a similar standard, for juries to then distinguish the lower, minimally acceptable level of care that governs a suit for tort damages. In theory, health insurers would be entitled to argue what is essentially a "respectable minority" or "two schools of thought" rule. However, framing the tort issues this way tends to improperly shift the burden of proof regarding the standard of care to the insurer since the plaintiff's prima facie case will appear to have been established by the victory in the contract dispute, only under a more demanding version of a custom standard. Moreover, courts in some jurisdictions might allow juries to reach their own

171. *See generally* Hal R. Arkes & Cindy A. Schipani, *Medical Malpractice v. The Business Judgment Rule: Differences in Hindsight Bias*, 73 OR. L. REV. 586, 587 (1994).

172. *See* Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 164 (2000) (tracing the erosion of medical custom as the legal standard of care); Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 911 (2002) (the role of jury when medical custom does not define the legal standard of care).

173. *See* John E. Wennberg & Philip G. Peters, Jr., *Unwarranted Variations In The Quality Of Health Care: Can The Law Help Medicine Provide A Remedy/Remedies?*, 37 WAKE FOREST L. REV. 925 (2002).

174. *See supra* text accompanying note 144.

conclusions on the contract coverage issue, even when the external reviewer has ruled in favor of the health insurer. In our interviews, one health plan lawyer noted that this would constitute virtual strict liability for any harm caused by a coverage denial with which an external review physician or jury happens to disagree. She argued forcefully, "you can't run a business that way."

If minimally acceptable medical custom were to be the gauge of tort liability, courts would have to take special care to ensure the independence, expertise and lack of bias of the physicians who asked to testify about the decisions of managed care organizations.[175] As *Wickline* illustrates, physicians might ratchet up their views of what constitutes minimally acceptable care as a means to push back against managed care restraints. Courts might be better served by objective evidentiary sources, including scientifically valid, current clinical guidelines or Medicare standards based as much as feasible on medical outcomes.

As Professor Morreim observes,[176] a clinically based coverage determination is more accurately characterized as a medical *resource* decision than a medical *treatment* determination. In managed care cases, juries are asked to determine the reasonableness of a resource allocation decision, also known as a medical rationing decision. This is a class of decisions that this nation has taken great pains to hide from public view[177] and that is ill suited for judicial resolution.[178] Judges, therefore, will also have to take special care to guard against hindsight bias as a result of the backlash against the managed care, especially if the medical profession and the managed-care industry are permitted to play out their power struggle in the courtroom.[179]

In the final analysis, the strongest argument for applying a medical professional standard of care is the following doctrinal argument: the insurance contract invokes medical professional concepts in defining coverage, and any

175. For a discussion and example of the risk of practicing physician bias against managed care decision-makers brought to fruition, see Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341, 400-05 (2001) (discussing Murphy v. Board of Medical Examiners, 949 P.2d 530 (Ariz. Ct. App. 1997)).

176. MORREIM, *supra* note 146.

177. *See generally* GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES (1978); Orentlicher, *supra* note 94.

178. Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1711-12 (1992); Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358 (4th Cir. 1997). "Despite rumors to the contrary, those who wear judicial robes are human beings, and as persons, are inspired and motivated by compassion as anyone would be. . . . The temptation to go about, doing good where we see fit, and to make things less difficult for those who come before us, regardless of the law, is strong." Bechtold v. Physicians Health Plan of Northern Indiana, 19 F.3d 322, 324 n.3 (7th Cir. 1994).

179. *See* Randall R. Bovbjerg & Robert H. Miller, *Managed Care and Medical Injury: Let's Not Throw Out the Baby with the Backlash*, 24 J. HEALTH POL. POL'Y & L. 1145 (1999).

error in applying these terms that results in injury should be compensated according to the normal rules for consequential personal injury damages that flow from the breach of contractual obligations. This is a substantial argument. The major objection is the feasibility of distinguishing between the minimally acceptable professional standard that should govern personal injury damages and the higher standard of optimal care that tends to influence coverage determinations. A jury trial is not institutionally well suited to make this differentiation reliably.

Moreover, there appears from our interviews to be no pressing need or desire to sue health insurers in these circumstances simply in order to have a solvent source of compensation for patients' injuries.[180] This does not serve the deterrence function, but that might be advanced either in third party claims brought by physicians against insurers, or by punitive damages suits against insurers when their departure from contractual standards was egregious. Plaintiffs' lawyers we interviewed also acknowledged that obtaining punitive damages is the major strategic reason to add a health insurer to what otherwise is an ordinary medical malpractice suit against the physician. However, punitive damages point more to the bad faith concept from insurance law, a different standard of care, one that is based more on the process of making coverage decisions than on the substance of the medical judgment rendered. Indeed, it is conceivable that violation of a process standard might result in liability for bad medical outcomes even if the treatment rendered is not professionally substandard. Therefore, we next turn to different formulations of a process standard of managed care liability.

C. Process-based Standard of Good Faith in Following Contractual Standards

The absence of established legal doctrine presents an opportunity for the law to develop in ways that respond to the present day realities of the medical marketplace. Medical custom is a product of a legal system that blamed individual decision-makers for wrongful results, while contemporary thinking is that errors are more likely to be prevented through a systems approach.[181] State and federal law support control of health care spending and cost conscious clinical decision-making.[182] In the present-day cost-constrained

180. As discussed above, when liability turns in any event on showing that substandard care was delivered, most of the plaintiffs' lawyers we interviewed think it makes the case unnecessarily complex and expensive to sue both the physicians and the insurer, so they prefer to sue only the physician.

181. *See* Randall R. Bovbjerg et al., *Paths to Reducing Medical Injury: Professional Liability and Discipline vs. Patient Safety—and the Need for a Third Way*, 29 J.L. MED. & ETHICS 369 (2001) (good process prevents more errors than individual sanction).

182. The court in *Wilson* explained that the result in *Wickline* should be attributed to a "clearly expressed public policy in the California [statutes] which mandated the use of a

environment, which lacks a viable alternative to the managed-care industry to control spending, the risks of hindsight bias and the potential chilling effect on efforts to contain costs point to a standard of care that can provide a prospective and concise guide to industry conduct. Taken together, these factors support the development of a procedural standard of care as a means to assess the conduct of a managed care organization implementing a cost-quality tradeoff through a clinically based coverage determination.

A process-based standard would evaluate both the substance and the process of the insurer's coverage determination. Tort-type liability would attach, not simply for any decision that later was determined to be incorrect as a matter of contract or statutory law, but instead, in the words of *Wickline*, only if an incorrect coverage decision was caused by "defects in the design or implementation of the [coverage determination] mechanisms."[183] This begs the question of what the standard of care should be for the process of making coverage determinations that depend on medical criteria and judgment. We will explore two possibilities: industry custom, or a reasonable person standard.

To illustrate, in *Wickline*, a registered nurse employed by the payer reviewed a standard form setting forth the treating physician's reasons for requesting an extended stay.[184] When the nurse could not approve the request under the payer's guidelines, the nurse referred it to the next available physician reviewer, and physician reviewers were assigned cases for review without regard to the nature of the patient's problem or the reviewer's field of expertise.[185] In Mrs. Wickline's case, the decision to authorize half the extended stay requested by the attending physician was made by a general surgeon solely on the basis of a telephone call with the nurse-reviewer, without review of the completed form, the patient's record or consultation with the attending physician or a vascular surgeon with expertise in conditions like the one from which Mrs. Wickline suffered.[186] The physician-reviewer testified later that he must have concluded that Mrs. Wickline was progressing satisfactorily because the standard form did not contain any information about

utilization review process," and to a state statute that "provided for the denial of benefits . . . when to do so was 'in accordance with the usual standards of medical practice in the community.'" Wilson v. Blue Cross of S. Cal., 271 Cal. Rptr. 876, 884 (Cal. Ct. App. 1990) (citation omitted). A clearly expressed public policy in favor of utilization management and cost control does not differentiate *Wickline* from any contemporary managed-care liability case. The Federal Health Maintenance Organization Act of 1973 and states' HMO acts authorize utilization review and other managed care practices and provide persuasive evidence of a public policy in favor of cost containment in health care. *See, e.g.*, 42 C.F.R. § 417.103(b) (1998) (mandating that federally qualified HMOs have "effective procedures to monitor utilization and control cost").

183. Wickline v. State, 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986).

184. *Id.* at 813-14.

185. *Id.*

186. *Id.*

abnormalities in her temperature, her diet or her bowel function, none of which are necessarily implicated as complications of vascular surgery.[187] From the absence of this information, the physician-reviewer testified he probably concluded that all must be normal and, therefore, that she must be progressing satisfactorily.[188] Although there were places on the form to indicate the recommendation and the reason for disapproval, they were left blank.[189] There were no contemporaneously created records to memorialize the physician-reviewer's clinical conclusions on the basis for them, and he said he did not have clear recall of the case.[190]

It is, at least, debatable that this process was defective in design or implementation. The question, however, is according to what standard? Under an industry custom, Medicaid might be absolved if it followed what it and other Medicaid or private utilization review firms usually do. Under the reasonable person standard, the state would need to convince a jury that this is an acceptable way to run a utilization review program. We analyze both possibilities.

1. Industry Custom

An industry custom standard is suggested by extension from physician liability. Because this is the approach generally taken for matters of liability relating to medical care, it might make sense to judge managed care practices according to what most other managed care plans usually do, constrained as they are by market forces and regulatory oversight. For instance, *Jones v. Chicago HMO Ltd. of Illinois* envisioned the adoption of a managed-care industry standard, by noting that an HMO fulfills its duty of care when it acts as a "reasonably careful" HMO would under the circumstances.[191]

It is important to recognize, however, that defining the standard of care by prevailing custom is a rarity in tort law generally.[192] The reasonably-prudent-actor standard guards against a race to the bottom that could result from collective adoption of unreasonable customs. The factors that support an exception for physician negligence do not apply very strongly to insurers' *processes* for making coverage decisions.[193] Judging physicians by medical

187. *Id.*

188. *Wickline*, 239 Cal. Rptr at 814.

189. *Id.*

190. *Id.*

191. 730 N.E.2d 1119, 1128 (Ill. 2000).

192. *See, e.g.*, The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932), *cert. denied*, 287 U.S. 662 (1932) ("a whole calling may have unduly lagged in the adoption of new and available devices").

193. We stress that this analysis applies only to the process component of the standard. Elsewhere, one of us maintains that the substance of what constitutes minimally acceptable medical care should be allowed to evolve according to professional, and perhaps industry,

custom is sometimes attributed to the complexity of medical practice and the layperson's difficulty in assessing it, and coverage determinations are also complex and technical enterprises, but this argument proves too much. Other complex human endeavors outside common knowledge, like structural engineering and industrial design, do not enjoy such judicial deference.

Deferring to collective medical judgment can be explained more accurately by a historical social judgment about physicians' selfless commitment to patient welfare and public service.[194] Regardless of whether extra space that social judgment was ever sound for physicians, the managed care industry cannot plausibly proclaim a single focused, other-serving mission. Instead, health insurers have multiple competing loyalties—to patients' economic as well as medical interests, to employer purchasers as well as patient members and to shareholders as well as customers. These conflicting duties to multiple stakeholders counsel against a standard that defers blindly to industry custom, especially custom defined the way it is for physicians, namely, the lowest common denominator among a range of professional practices and opinions.

Rejecting an industry custom standard is consistent with other choices the law has made with respect to the regulation of medical practice. The privilege of self-regulation had been historically afforded to the medical and legal professions as one means of legal oversight of their activities. The American Medical Association promulgated the first formal code of medical ethics in 1847.[195] And, every state has established a state medical board, typically dominated by physician members, to oversee the practice of medicine within its borders.[196] In contrast, self-regulation within the managed-care industry has a short history; the National Committee for Quality Assurance conducted its first site visits in the early 1990s.[197] And, the industry's voluntary accreditation efforts have not been afforded self-regulatory status. In contrast to the medical profession, outside regulatory scrutiny is the legal norm for the managed care industry.[198]

Reliance on professional custom and self-regulation is based on public trust that the self-regulating profession will set high standards and that the risk

custom. *See* Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containmen*t, 17 LAW, MED. & HEALTH CARE 347 (1989).

194. *See* Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium,* 57 WASH. & LEE L. REV. 163, 193-95 (2000) (recounting the historical basis for medical custom in tort law).

195. Sheldon F. Kurtz, *The Law of Informed Consent: From "Doctor Is Right" to " Patient Has Rights*", 50 SYRACUSE L. REV. 1243, 1244 (2000).

196. *See generally* CARL F. AMERINGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION (1999).

197. For a history of NCQA, see its website, *at* www.ncqa.org (last visited October 4, 2002).

198. Most states give the department of insurance regulatory authority over managed care organizations. *See* Sloan & Hall, *supra* note 165.

of professional sanction will cause individuals to comply voluntarily with professional norms to avoid social sanction.[199] The managed care industry is not afforded the degree of public or individual trust that characterizes the medical profession.[200] Bureaucracy does not engender a sense of public confidence or individual trust. The individually unidentifiable corporate constituents that determine corporate conduct have less to fear from individual social sanction than to personal physicians and, therefore, are likely to be less motivated by these psychological and reputational forces.

Finally, the argument that market forces will assure that industry behavior is, on the whole, reasonable does not carry as much weight in this setting as it might in other consumer-driven markets. This is true not only due to the difficulty consumers have in evaluating these complex issues, but also because of the agency problems introduced when purchasing decisions are made by someone other than those who receive the services: employers vs. employees.[201]

2. Process-based reasonable person standard

Rather than an open-ended "reasonable person" standard, we proposed the following process standard:

> A managed care organization would be liable for its share of a patient's injury caused by an incorrect coverage denial only if the plaintiff proved that the applicable cost containment procedure was (a) not designed to acquire and consider relevant clinical factors or to base coverage determinations on one or more sources of externally developed, scientifically valid, current medical information, or (b) the cost containment procedure otherwise meeting (a) was not implemented substantially according to its own terms,[202] and (c) the coverage determination was the proximate cause of plaintiff's harm.

This more precise formulation of a standard of care sets more workable constraints on juror discretion than an unbounded "reasonableness" standard.[203]

The proposed standard is designed to facilitate good decisions by requiring good procedure.[204] Factors indicating good procedure might include reliance

199. *See* Peters, *supra* note 194.

200. Mark A. Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463, 516 (2002).

201. Sloan & Hall, *supra* note 165.

202. Non-material deviations should not be punished.

203. *See* Jeffrey O'Connell & Andrew S. Boutros, *Treating Medical Malpractice Claims Under a Variant of the Business Judgment Rule*, 77 NOTRE DAME L. REV. 373, 424-25 (2002) (making an analogous suggestion about lowering the standard of care or raising the standard of proof in medical malpractice cases).

204. *See* Lynn A. Stout, *In Praise of Procedure: An Economic and Behavioral Defense of* Smith v. Van Gorkom *and the Business Judgment Rule*, 96 NW. U. L. REV. 675, 677 (2002) (better decision making procedures increases the likelihood of a better outcome).

on a decision maker with competence and training in the relevant practice area, or in the absence of expertise, consultation with an expert; consideration of patient-specific factors including relevant medical records and other reasonably available sources of medical information; and sharing of clinical criteria and reasons for coverage denials with the attending physician to ensure a full and fair consideration of the patient's medical needs. State legislatures that prefer not to leave development of procedural standards to the common law could adopt statutory standards or empower a state agency to establish procedures.[205] These statutes might follow the model of the Health Care Quality Improvement Act of 1986 that encouraged peer review and due process in medical staff decision making by conditioning a qualified immunity on compliance with statutory standards or their functional equivalent and an absence of evidence of bad faith.[206] They might also provide a deemed status for those managed care organizations that are accredited by a specified national private accrediting agency, much as the federal Medicare program permits hospitals to prove their compliance with the program's conditions of participation through accreditation by the Joint Commission on Healthcare Organizations.[207]Other possible sources for safe harbor protection include Department of Labor regulations under ERISA and regulations governing Medicare HMOs.[208]

The proposed standard encourages not only the adoption of good procedures, but compliance with those procedures in individual cases. Good procedures will not shield a managed care organization that does not follow them, absent justification for deviating in a particular case. Inadvertent or unjustified failure to follow applicable procedures gives rise to compensatory damages. Moreover, proof of bad faith non-compliance with established procedures or reckless disregard for a patient's medical needs could give rise to punitive damages.[209] However, health plan managers should have reasonable leeway to respond in good faith to unusual situations by deviating

205. The plight of national managed care organizations would be eased considerably by a federal enactment of standards for cost containment procedures, but Congress's inability to enact major health legislation make this course unlikely.

206. 42 U.S.C. §§ 11101-11152 (2000).

207. HALL ET AL., *supra* note 160, at 1094.

208. *See* Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 63 Fed. Reg. 48390 (Sept. 9, 1998) (to be codified at 29 C.F.R. pt. 2560); *see also* Medicare Program; Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, 62 Fed. Reg. 23368 (Apr. 30, 1997) (to be codified at 42 C.F.R. pt. 417).

209. *Cf.* Poling v. Wis. Physicians Serv., 357 N.W.2d 293, 297 (Wis. Ct. App. 1984) (evidence showed wanton disregard of duty by plan administrator); Hughes v. Blue Cross of N. Cal., 263 Cal. Rptr. 850 (Cal. Ct. App. 1989) (insurer breached covenant of good faith by failing to investigate claim and using standard significantly at variance with community standard).

from normal procedures when this is appropriate. The proposed standard is intended to allow for this flexibility.

The causal element of the proposed standard, and the reference to shared liability, are intended to reflect the limited scope of the managed-care organization's duty with respect to determining the actual care that patients receive.[210] If the coverage determination does not alter the clinical course, the requisite causation would not be proved. Also, courts will have to assess the probability that a requested medical intervention would have produced a better outcome. Finally, as *Wickline* held, if the ultimate course of treatment was substandard, the treating physician will share in the ultimate responsibility. These elements reflect that clinically based coverage determinations, no less than treatment decisions, are complex and uncertain, and are part of a web of decisional authority over what treatment patients ultimately receive.

How might this approach work in practice? In *Wickline*, the only evidence on this issue that is revealed in the appellate opinion is testimony that is biased, or at least self-interested. One of Mrs. Wickline's treating physicians testified that "the Medi-Cal Consultant's rejection of the requested eight-day extension . . . and his authorization of a four-day extension in its place did not conform to the usual medical standards," and that "in accordance with those standards, a physician would not be permitted to make decisions regarding the care of a patient without either first seeing the patient, reviewing the patient's chart or discussing the patient's condition with her treating physician."[211] The treating physician, of course, was not disinterested and nothing in the reported opinion suggested that he was qualified as an expert in utilization review procedures. In contrast, the Chief Medi-Cal Consultant testified that "it was the practice . . . for Medi-Cal Consultants not to review other information [beyond that contained on the standard form]" and that "Medi-Cal Consultants did not initiate telephone calls to patient's treatment doctors because of the volume of work."[212] The Medi-Cal consultant, whose testimony might provide some evidence of industry standards, also had a stake in the litigation. There was seemingly no evidence or testimony from unbiased, objective expert witnesses concerning whether the procedures used by the state Medicaid program, in reaching its decision to approve half the requested extension of hospital stay, were consistent with the standard of a reasonably prudent third-party payer conducting prospective utilization review.

Better sources of evidence would include standards of practice drawn from regulatory and accreditation sources. This is how courts, for instance, determine the process standards for hospitals alleged to have negligently approved the credentials of physicians applying for medical staff

210. *See supra* notes 164-65 and accompanying text.

211. Wickline v. State, 239 Cal. Rptr. 810, 817 (Cal. Ct. App. 1986).

212. *Id.* at 818.

membership.[213] In *Wickline*, the state Medicaid cost containment program would not appear to satisfy contemporary voluntary accreditation standards established by the National Committee for Quality Assurance, the principal accrediting agency for managed-care organizations.[214] Those standards would have required that the physician-reviewer consider "relevant clinical information and consult[] with the treating physician."[215] They would also require that the reasons for the denial be communicated to the physician and the patient and documented by the reviewer.[216] There should also have been a procedure in place for the general surgeon physician-reviewer to consult, if necessary, with a board-certified vascular surgeon in making the determination to deny the treating physician's request.[217]

However formulated and administered, a reasonableness standard for the process of coverage determinations should not allow second-guessing or hindsight bias of coverage guidelines and criteria that are based on sound medical evidence simply because they take into account the cost as well as the effectiveness of proposed and alternative treatments. While cost-effectiveness is a legitimate and appropriate factor in determining insurance coverage, we envision that clinically based coverage policy will also have some basis of medical or scientific legitimacy.[218] The process standard we propose here is intended to encourage the use of sound decision-making *criteria* as part of sound procedures. Therefore, the standard should not be satisfied by coverage criteria that are based solely or primarily on cost considerations unless the criteria can be supported by some scientific evidence when it is reasonably available, or informed unbiased medical opinion if it is not. However, the

213. *See, e.g.*, Johnson v. Misericordia Comty. Hosp., 301 N.W.2d 156 (Wis. 1981).

214. The National Committee for Quality Assurance began its operations in 1990, and conducted its first accreditation site visits in 1991. *See* http://www.ncqa.org/about/timeline.htm (last visited October 4, 2002).

215. NATIONAL COMMITTEE FOR QUALITY ASSURANCE, STANDARDS FOR ACCREDITATION OF MCOS 55 (1999) (Standard UM 5).

216. *Id.* at 56 (Standards UM 6 and 6.1).

217. *Id.* at 53 (Standard UM 3).

218. Clinical guidelines vary widely in the rigor applied to their development. Some have been developed solely for payment purposes, to demand as well as to deny insurance coverage. *See* NATIONAL HEALTH LAWYERS ASSOCIATION, COLLOQUIUM REPORT ON LEGAL ISSUES RELATED TO CLINICAL PRACTICE GUIDELINES 12-14, 21-27 (1995) (One author, Gail Agrawal, was a participant in this colloquium and contributed to the report.). Some critics have charged that one frequently used set of managed care coverage guidelines lacks medical validity based on current scientific evidence or informed unbiased medical opinion. *See* Laura B. Benko, *Not by the Numbers, Please; Physicians Rebel Against Milliman & Robertson's National Insurer Care Standards*, MODERN HEALTHCARE, May 8, 2000, at 34 (professor of pediatric infectious diseases characterizes proposed pediatric-care guidelines as "outrageous" and "dangerous" and brings defamation and fraud action against standard issuer for listing his name as an author of them). Although we express no opinion on this claim, we believe that, if the allegation were proved, use of the challenged standard should not satisfy the standard we propose here.

failure to use the best available medical criteria should not be automatic grounds for liability. A factfinder should not be allowed to substitute its judgment for that of a managed care organization choosing among acceptable decision-making criteria. Beyond these caveats, we have not fully reconciled how this substantive component of the process standard should be articulated, so we leave this for the evolutionary processes of the common law.

3. Combining the Two Standards

In summary, a medical profession standard should govern vicarious liability and other theories of liability that seek to hold health insurers responsible for the quality of care rendered other than simply their role in making coverage decisions. In such cases, the difficult issue will be what attributes of managed care justify holding the health insurer responsible for substandard care by providers. In cases seeking personal injury damages for wrongful coverage determinations, however, the main focus is a process standard, one that looks at whether the health insurer had an acceptable system in place, and followed it, for making reasonable determinations of clinical factors that determine what the insurance policy covers. What we finally need to consider is whether, in coverage decision cases, there is also a substantive standard. In other words, is a breach of the process standard resulting in injury sufficient for tort liability, or is it also necessary to show that the care delivered fell below minimally acceptable professional medical standards?

In our view, liability for coverage decisions should attach if each of the elements we propose is established, even if care that is rendered or that the insurer did approve is minimally acceptable under a professional medical standard. In other words, we propose a process standard that is both necessary and sufficient for liability. This is not to say that issues of substance are irrelevant. It is still necessary to show that the patient was in fact entitled to coverage for the care that was requested. When this question turns on medical criteria, then issues of medical substance will be presented, but those should be examined through the contract lens, in terms of what the insurance policy covers by its own terms. An additional element of defective process is then needed to use the contract breach as a basis for tort damages. However, tort damages from coverage denials do not depend on meeting a substantive tort standard for the quality of medical care. In short, that the physician cannot be found liable for rendering substandard care should not be a defense to the health insurer's independent duty to make sound coverage decisions in good faith.

V. CONCLUSION

Despite the length and complexity of this article, we have gone down only the first stretch of road beyond ERISA preemption. If, due to erosion of

preemption, a reversal of Supreme Court precedents, or legislative enactments, there comes a time when indeed you can sue your HMO, the basic theory of liability and the core standard of care will be only the first two questions one must answer. Courts will also need to wrestle with allocating liability between physicians and insurers, and, even more problematic, between insurers and employers, especially employers who choose to retain authority over managed care functions. This article does not touch, or only scratches the surface of, these additional difficult questions. Therefore, it falls far short of a complete roadmap for managed care liability.

This article has a more modest aim. The first step is to distinguish between theories that seek to hold health insurers responsible for the actions of treating physicians, and those that challenge the health insurer's own decisions. This distinction cannot always be clearly drawn, but maintaining it in some form is essential for keeping legal categories coherent. The second is to identify cases that can be resolved within the four corners of the contract and those that are based on judgmental factors, especially factors that require medical expertise. Cases where health insurers wrongly deny coverage present a complex set of considerations. When a contractual violation is clear, ordinary tort principles would impose liability for personal injury that foreseeably results, but whether a breach has occurred is often not clear due to the open-ended way in which health insurance coverage is typically defined.

Courts have not been called on to resolve what standard should govern the award of tort-type damages because this path has been blocked by ERISA preemption, but ERISA preemption is evolving. It is now generally conceded that ERISA preemption does not apply to theories of vicarious liability, and, in some jurisdictions, ERISA does not apply to any form of liability attacking the quality of care. Even though the common law has been free to evolve along with the changing interpretation of ERISA preemption, little evolution has occurred because most trial lawyers have been reluctant to complicate medical malpractice cases by naming health insurers as additional defendants.[219] In most instances, practicing lawyers think that it is not necessary or worth the effort to sue a managed care entity under a theory of managed care liability that depends in part on showing that the physician was negligent and that introduces the complications of an institutional defendant and the uncertainties of ERISA preemption.

If the ERISA bar were lifted, new state statutes suggest a standard of "ordinary care," but it is unclear whether this term refers to the substance of the medical judgment that is used to interpret coverage terms, or, instead, to the process for determining coverage. We opt for a process standard for several reasons. A medical professional standard might be correct for specific

219. Of course, there are exceptions. Most of the lawsuits filed under the Texas right-to-sue law, for example, have been filed by the same lawyer. *See* Robbins, *supra* note 136.

enforcement of insurance contracts, but it is too open to legitimate differences of opinion to serve as the basis for tort liability or punitive damages. Moreover, the medical standards that are likely to govern contract enforcement are much more demanding than the minimal standards used to determine physicians' tort liability. Excessive second-guessing of the substance of coverage decisions could over-deter insurers' socially beneficial efforts to contain costs. In contrast, evidence so far indicates that health insurers' effort to improve the process of coverage determinations is a socially constructive response to tort law's deterrence signal.

A process standard would hold managed care organizations liable for consequential personal injury if, in determining health insurance coverage based on medical criteria, they use a procedure that is not designed to acquire and consider relevant clinical factors, or if they depart materially from normal procedures without adequate justification. Following industry standards or meeting regulatory requirements would not constitute an absolute defense, but a process standard should defer heavily to well considered and unbiased social or governmental assessments of what are and are not acceptable managed care practices.

If health insurers do not use reasonable procedures in making coverage decisions, they should be held responsible for the harm that results, even if the medical care that is rendered meets acceptable professional norms. Health insurers have a duty to their members independent of the duty of treating physicians, and the standard of care that governs each duty is distinct. The standard we propose does not hold health plans strictly accountable for achieving perfect results. It does demand that health plans base medical judgments on medical criteria that have professional and scientific credibility.