ARTICLES

Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*

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Prelude

The delivery of health care services is an intensely personal activity. Patients necessarily place their physical well-being in the hands of other persons, either physicians or other providers. Because health care technology and the science of medicine\(^1\) have progressed so swiftly over the past hundred years, the focus and direction of the relationships among the parties involved in the delivery of health care have changed dramatically. As technology and science developed, the cost of transferring skills and services from the provider to the patient grew geometrically. In the days when the physician-patient relationship was considered more art than science, delivery consisted of a one-to-one transfer of skills. The physician looked at the patient, listened to a description of the patient's symptoms, conducted a few very simple tests, prescribed drugs or conduct that the physician believed might help, and promised to return later to see if, in fact, she had helped. Today, as medicine moves more toward science and technology, the physician is likely to use looking and listening only as a starting point. She then refers the patient for sophisticated machine testing of many varieties and for more looking and listening by other providers having narrow specialties. The end result is a final diagnosis that takes into account the expertise of perhaps dozens of people.

As these changes have made the practice of medicine more and more complex, the cost of health care delivery has increased and has become a national concern. At some point, the cost becomes greater than the benefit. We are now involved in a search for a new means of determining when, to whom, and how much of such services we, as a nation, should provide. This

\(^1\) As opposed to the art.
search has been characterized as the need for cost containment. It is being carried out in many ways and in many areas of the health care industry. One view of acceptable limitations on the delivery of health care is called "managed care." But managed care, like other programs in the past, has become so focused on the problem of cost that it may very well be losing sight of what should be the overriding purpose of health care — the well-being of the patient. After all, the patient is the *raison d'être* for the entire system. The patient's well-being is not directly aided by cost containment, but the patient's well-being is the focus of other important health care issues, such as quality of care and access to care. The manner in which cost containment, quality of care, and access to care interact and the priorities given to them will determine the future structure of our nation's health care system.

We now seem to be entering into a new phase of health care delivery. A hundred years ago, the physician-patient relationship was the core of the health care system. That relationship remained central to any health care delivery changes taking place until around 1970. Even with the introduction of third-party payers in the form of insurance plans, the physician-patient relationship remained unaffected. The physician determined what services would be delivered to the patient; the patient received the services, having paid premiums (or having premiums paid for his benefit) to the third-party payer; the third-party payer either reimbursed the patient or paid the physician directly. The third-party payer simply had no right to affect the physician-patient relationship and, in fact, did not affect that relationship.

After 1970, however, a new triangle of relationships came into being. In this triangle, the third-party payer not only contracts with the patient to finance the patient's health care needs, it also contracts with physicians and other providers to provide those health care needs. Two problems arise from this second contractual relationship. First, through "utilization review," the third-party payer assumes the right to direct the means and methods of providing the health care services. Second, through its contracts with providers, the third-party payer induces compliance with utilization review by means of financial rewards and penalties, or financial "risk shifting."

These two new aspects of health care relationships, utilization review and financial risk shifting, create the possibility
that patients may be injured in totally new ways. Before the new relationships were created, the only way a patient could be medically injured was through the physician's conduct. With the advent of the new relationships, patients may be indirectly medically injured because decisions may be made based on some statistical norm, not on the patient's individual condition. Further, the patient may be medically injured by conduct of the physician, not because of the physician's own decision, but because of a third-party payer's guidelines, with which the physician is trying to comply. For example, consider the cases of Kim, Brad, and Barbara.

Kim needs an operation on her knee. Through her employer, Kim has health insurance with a preferred provider organization (PPO). One doctor, a member of the PPO, recommends an operation. Another doctor recommends a procedure that is more expensive but will require less healing time. Kim cannot go to the second doctor, who is not a member of the PPO, because she cannot afford to pay for the operation herself. When she has the operation recommended by the PPO doctor, she takes two months longer to heal than if she had the more expensive operation.

Brad, a teenager, is suicidal. Through their employer, Brad's parents have insurance for him. His doctor wants to admit Brad to a psychiatric hospital. The insurance company, however, requires preapproval of any nonemergency hospital admission and denies approval. Because Brad's parents cannot afford the twenty-one day proposed hospital stay, they decide to have him treated as an outpatient. Five days later, Brad commits suicide.

Barbara, a single mother, is pregnant. She works for minimum wage, but qualifies for government health insurance. Because the government health insurance pays doctors significantly less than what they would receive from other patients, there is no doctor in her immediate community who will accept her health insurance. The nearest doctor is one hour and two bus transfers away. Because of the three or four hours she would have to miss from work, Barbara does not receive adequate prenatal care. Her baby is born premature and has a low birth weight.

These three hypotheticals illustrate situations in which individuals may have adequate insurance but may not have adequate health care. As illustrated by the above stories, pri-
vate insurers and government health insurance programs ration care by restricting choice, denying services, and decreasing availability. They perform utilization review and financial risk shifting through managed care products such as health maintenance organizations and preferred provider organizations. Prior to the advent of the new triangle of relationships, none of the problems illustrated above would have arisen in exactly the same way they now arise.

I. INTRODUCTION

The escalation of health care costs has put the words "cost control" on everyone's lips and has forced society to reevaluate the American health care system. Early reimbursement plans rewarded physicians for providing expensive and sometimes unnecessary treatment. Third-party payers and government then developed alternative market-driven plans, which economically penalized physicians for providing what was perceived to be unnecessary care.

In particular, third-party payers have depended on managed care products, which revolutionize the relationship among third-party payers, physicians, and patients. Under managed care products, the risk of financial loss shifts from third-party payers to physicians. The clear problem with this approach is that physicians, concerned that they will be left to cover costs that patients would normally cover, find themselves choosing treatment options which are not in the best interest of their patients.

2. Each player probably means something different by the term "cost control." Patients mean price; third-party payers mean cost.

3. Between 1960 and 1983, per capita health care rose from 5% to nearly 11% of the gross national product (GNP). E. Haavi Morreim, Cost Containment and the Standard of Medical Care, 75 Cal. L. Rev. 1719, 1720 (1987). In 1989, health costs consumed 11.6% of the GNP, up from 11.2% in 1988 and up by nearly a point in just three years. Health Law News Rep., Feb. 1991, at 3; see also Clifford Ossario, Increasing Costs Are Pressuring the Entire Health Care Industry, 9 Whittier L. Rev. 197, 197 (1987). In 1989, total health care expenditures were $604 billion, up by $60 billion or 11% from 1988. Health Law News Rep., supra, at 3. For most employers, health care expenditures are approaching 10% of payroll costs. Ossario, supra, at 197. In fact, the total worth of the Fortune 500 today is less than the commitment of those companies to health care expenditures for their retirees. Id. at 197-98.

These escalating costs have been attributed to several factors including price inflation, the graying of America, new technologies, and the growth in the number of hospitals. Morreim, supra, at 1720; William B. Schwartz, The Inevitable Failure of Current Cost-Containment Strategies, 257 JAMA 220 (1987).

4. There are many health care providers (e.g., nurses and chiropractors) to whom this same analysis applies. For the sake of simplicity, this Article refers only to physicians. Similarly, although there are many types of organizations that provide health care (e.g., hospices and nursing homes), this Article refers only to hospitals.

5. See infra part II.C.
for which the third-party payer refuses reimbursement, will cut necessary services and will leave patients almost completely out of the decision-making process.\footnote{6}

Without proper controls, the zeal of third-party payers to lower costs encourages physicians not only to eliminate unnecessary care, but to eliminate beneficial care as well. Furthermore, risk shifting has the potential to worsen problems of access to health care service.\footnote{7} The actual impact of managed care products on physician behavior is unknown, and the uncertainty makes the product dangerous to the patient. Because the patient is left with significantly less control over health care decisions than was previously available, the danger is unreasonable.\footnote{8}

Third-party payers use techniques for risk shifting that are designed to encourage physicians to push their practices to the outer limits of acceptable medical standards.\footnote{9} Because quality measurement\footnote{10} is difficult at best, such actions may make it hard to decide where acceptable medical practice ends and malpractice begins. Moreover, if managed care products are allowed to determine the standard of care, how can injured patients support claims against those products for physician negligence? In other words, will cost containment efforts imposed by third-party payers constitute a defense to medical malpractice claims?

While the goal of financial risk shifting is to reduce unnecessary care and so-called "marginally helpful care," without appropriate safeguards the potential exists for withholding necessary and potentially helpful care. If a person is injured because the physician failed to provide marginally helpful care, what legal standard of care applies? Will the standard of care be based on whether the unprovided service was "medically necessary"? Will the definition of "medically necessary" be based on the statistical person or on the individual patient?

\footnote{6}{See infra part III.C.}
\footnote{7}{See infra part III.C.3.}
\footnote{8}{While it is true that patients have never had complete control over health care decisions because of their lack of knowledge of the medical system and treatments available, patients exercise control when there are competing therapies with different risks and different outcomes, or when the cost of the preferred treatment exceeds a patient's financial capabilities. Managed care products would remove from the menu of options available to patients those therapies and treatments that the managed care products view as unnecessary.}
\footnote{9}{See infra part III.B.}
\footnote{10}{See infra part III.C.1.}
The courts have not yet allowed financially interested providers to redefine the medical standard of care. There is some risk, however, that such a self-serving redefinition may indeed occur and result in uncompensated injury to patients. It is this potential risk of uncompensated injury from which patients must be protected. Traditionally, the law affords significant respect for the physician-patient relationship, a relationship that must be based on trust. If society chooses to allow third-party payers to tamper with the physician-patient relationship, society must force those third-party payers to take responsibility for the injuries that occur.11

It will serve this society little if lower health care costs are achieved by means of uncompensated injuries to individuals. It will serve this society little if—in the interest of reducing government taxes or increasing profits or market share for third-party payers—society adopts a system in which the rule is "caveat patients." It will serve this society little if a market-based system aggravates inherent class differences.

Managed care products are potentially dangerous to individual patients and to society. The entities that can minimize that danger are the third-party payers who design, plan, and benefit from managed care products. Yet, because of the peculiar nature of the relationships among patient, physician, and third-party payer, current legal theories are inadequate to promote safety, to shift the risk, and to spread the burden.12 Tort theories put an extraordinary burden on the plaintiff in areas where the defendant has the more complete knowledge, often the only knowledge. Tort theories are also inadequate because of the effect of utilization review and financial risk shifting, which recasts injury-producing decisions that would previously have been analyzed in terms of negligence as nonnegligent judgmental conduct.13

The tort system produces a significant element of chance, heavy transactional costs, inadequate compensation recovery, enormous malpractice premiums, and ineffectual deterrents. Furthermore, even if tort theories could provide an adequate remedy, the Employee Retirement Security Act of 1974

11. This Article does not address tort liability for interference with the physician-patient relationship. This Article assumes that there has been no tortious interference but that there has nevertheless been injury.

12. See infra part IV. This Article is limited to a discussion of tort theories of liability. It does not discuss contract theories of liability.

13. See infra part IV.
Compensating for Health Care Injuries

(ERISA)\textsuperscript{14} restricts or denies coverage for injuries based on utilization review activities and financial risk shifting.\textsuperscript{15} Given society’s desire to control health care costs through cost containment activities, alternate mechanisms should be developed to compensate the victims who are injured by such activities. A medical injury compensation fund could provide appropriate compensation, not only to the victims of cost containment activities, but also to others receiving medical injuries.

This Article examines current tort remedies for personal injury claims and explores the problems that arise when these remedies are applied to physicians’ actions that are directed by third-party payers. Part II of this Article explores the organization and historical development of managed health care products. Part III considers the past and present uses of the utilization review process and financial risk shifting. Part IV explores the applicability of traditional theories of tort liability to third-party payers, including direct liability of third-party payers who market managed care products. Part V considers the barriers that ERISA presents to compensating patients for cost containment injuries. Part VI proposes a no-fault medical injury compensation scheme as a legislative remedy for cost containment and other medical injuries.

II. HISTORICAL BACKGROUND

Those who cannot remember the past are condemned to repeat it.

George Santayana\textsuperscript{16}

Over the last one hundred years, America’s health care system has undergone several major changes. It has moved from a home-based system to a hospital-based system. It has moved from a nursing care-based system to a technology-based system. It has moved from a patient-driven system to a provider-driven system. Each change introduced not only advances in health care, but also perverse negative aspects. Perhaps, the negative features that were introduced into the system might have been avoided if more attention had been paid to the down side of changes occurring in the health care system. The health care

\textsuperscript{15} See infra part V.
\textsuperscript{16} Paul R. Torrens, Historical Evolution and Overview of Health Services in the United States, in INTRODUCTION TO HEALTH SERVICES 3, 3 (Stephen J. Williams & Paul R. Torrens eds., 1980).
system is again undergoing major changes as it moves from a provider-driven system to a third-party payer-driven system. As the new system is being designed and implemented, it is important to understand how the current systemic problems developed. Only then can actions be taken to avoid analogous pitfalls in this new third-party payer-driven system. Section A of this Part provides an overview of the historical development of third-party payers. Section B discusses the impact third-party payers have had on health care delivery. Finally, Section C considers the development of managed care products as a response to cost containment issues. Together these sections are designed to help us remember the past so that we will not be condemned to repeat it.

A. Overview of Historical Development

1. From Home to Hospital

From the 1700s to the mid-1800s, those who became sick or injured and could pay stayed at home for treatment. Only the lowest class person went to the hospital, which was often only a separate wing on the almshouse, jail, or pesthouse. In the late 1700s, at the urging of European-trained physicians, a few communities established the first community-owned or voluntary hospitals. Although these hospitals admitted both the poor and paying patients, it was not until the late 1800s that hospi-


18. Moderate-sized cities had almshouses, which were also called poorhouses. These institutions primarily provided food and shelter for the homeless. Medical care was generally only a secondary function. Pesthouses operated as quarantine stations for persons with contagious illness. Usually, mentally ill persons received care at home, at the almshouse, or at the jail. See, e.g., id. at 126-28.

19. Among the first voluntary hospitals were Pennsylvania Hospital, opened in Philadelphia in 1751; New York Hospital, New York City in 1773; Massachusetts General Hospital in 1816. Id. at 128. During the same time, governmental agencies established city, county, and state mental health hospitals, including ones at Williamsburg, Virginia in 1773; Lexington, Kentucky in 1817; and at Columbia, South Carolina in 1829. Id.

20. Id. at 127-28. Voluntary hospitals were run as private charities. They were generally crowded and dirty. Most of the persons using them had contagious diseases, and nurses were usually former patients. Unpaid physicians worked out of a mixed sense of charity and the opportunity to practice their cures. Doctors charged medical students for medical training, and the students worked without pay, practicing and learning on the poor. Steven R. Owens, Pamperin v. Trinity Memorial Hospital and The Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency, 1990 Wis. L. Rev. 1129, 1131-32.
tal stays became widely accepted. As late as 1873, there were only 178 hospitals with a total of 35,064 beds in the entire United States.\(^{21}\) Only thirty-six years later, in 1909, the number had grown to 4,359 hospitals with 421,065 beds, and by 1929 to 6,665 hospitals with 907,133 beds.\(^{22}\)

2. The Coming of the Blues

The Great Depression caused a dramatic change in the economic state of hospitals as patients unable to pay for health care simply stayed away. As early as 1930, average hospital receipts fell from $236.12 per patient in the 1920s to $59.26, bed occupancy dropped from 71.28% to 64.12%, and hospital deficits rose dramatically.\(^{23}\) Hard hit by the depression, the American Hospital Association (AHA) developed the Blue Cross concept to assure stable revenues.\(^{24}\)

The Blue Cross plans simply guaranteed payment of hospital costs, albeit in an environment of limited technology and patient self-rationing. Given the general economic state, the popularity of the plans was predictable. The plans, however, covered only hospital costs. Physicians, through the American Medical Association (AMA), sought to keep coverage limited. The AMA took the position that medical ethics permitted only insurance that was paid directly to patients.\(^{25}\) The AMA feared that if third-party payers became intermediaries, they would eventually play a significant role in determining medical treatment.\(^{26}\) Specifically, the AMA feared that third-party payers who paid physicians directly would eventually require the physicians to make medical decisions based on the third-party payers' interest rather than on the patients' interest.\(^{27}\)

Nevertheless, under increasing political pressure, some state

\(^{21}\) Dowling & Armstrong, supra note 17, at 128.

\(^{22}\) Id.

\(^{23}\) See SYLVIA A. LAW, BLUE CROSS: WHAT WENT WRONG? 6 (1974); see also Dowling & Armstrong, supra note 17, at 131.

\(^{24}\) The hospital industry developed the model state legislation necessary to create local nonprofit, tax-exempt corporations for prepayment of hospital services. See Law, supra note 23, at 6-9; Dowling & Armstrong, supra note 17, at 131.

\(^{25}\) See PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE, 215-16 (1982) (describing organized medicine's resistance to health insurance because of the potential for insurers to place themselves between patients and physicians).

\(^{26}\) Id.

\(^{27}\) Id. at 216-17.
medical societies approved medical service benefit plans called Blue Shield.\textsuperscript{28}

Like Blue Cross, Blue Shield proved extremely popular. Over the last sixty years, the Blue Cross and Blue Shield plans have become the largest providers of private medical insurance.\textsuperscript{29} The current interest in managed care plans, which emphasize controlling physicians' behavior, indicates that physicians' historical fears of third-party payer control of medical practice decision making were well founded.\textsuperscript{30}

3. World War II and Beyond

With the coming of commercial insurance after World War II, the health insurance industry experienced significant growth. As medical technology advanced, reliable access to medical services became increasingly important. This led employers to begin to use health care benefits as a part of employee compensation. This, in turn, led to an increasing demand for health insurance as a standard benefit of employment,\textsuperscript{31} which brought commercial insurance companies into competition with the Blue Cross and Blue Shield plans.\textsuperscript{32}

Unlike early Blue Cross and Blue Shield plans, commercial policies offered an indemnity benefit.\textsuperscript{33} To compete, Blue Cross and Blue Shield adopted similar provisions and abandoned,

\begin{footnotesize}
\begin{enumerate}
\item Id. at 306-09.
\item In 1980, the Blue Cross and Blue Shield plans provided surgical coverage to 74 million individuals while all other companies insured about 101 million. In 1984, commercial insurers collected $43.6 billion in premiums and paid $33.3 billion in claims. During the same period, the Blue Cross and Blue Shield plans had $39.9 billion in subscription income and paid $35.7 billion in claims. Therefore, the commercial insurers paid 76.3 cents in claims of each dollar they collected in premiums. The Blue Cross and Blue Shield plans paid 90 cents of each dollar. Sylvia A. Law & Barry Ensminger, Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism), 61 N.Y.U. L. Rev. 1, 7-8 n.31 (1986).
\item See Minutes of the Eighty-Fifth Annual Session of the American Medical Association, 102 JAMA 2191, 2201 (1934) (recommending that there be "no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession").
\item Starr, supra note 25, at 313-15.
\item An indemnity benefit pays patients directly. The insurance company sets premiums based on risk experience, allowing it to charge lower premiums to groups of reasonably healthy people.
\end{enumerate}
\end{footnotesize}
among other things, service benefit and community rating.\textsuperscript{34} Because of the higher cost of insurance that is individually rated, the Blue Cross and Blue Shield abandonment of community rating and adoption of an individualized rating system left many people who could not afford the premiums unprotected.\textsuperscript{35} Thus, an increasing health care access gap began to develop between those who had either health insurance or wealth, and consequently could afford the cost of health care services, and those who did not.

4. Medicare and Medicaid

In 1965, Congress responded to the medical insurance crisis by creating Medicare\textsuperscript{36} and Medicaid\textsuperscript{37} programs. To counteract initial opposition by the AMA and to assure physician participation, Congress gave Blue Shield the administrative responsibility for reimbursement of physicians. Medicare was to reimburse physicians on the basis of "customary, prevailing, and reasonable charges."\textsuperscript{38} For Medicaid, state governments determined how physicians were to be paid.\textsuperscript{39} Today, about one-half of the states pay physicians based on fee sched-

\begin{itemize}
  \item \textsuperscript{34} Blue Cross plans negotiated payment rates with participating hospitals. To the subscriber, the plans charged a single community-wide premium rating (community rating). The hospitals were guaranteed payments for the provision of selected services to the subscribers (service benefit).
  \item \textsuperscript{35} STARR, supra note 25, at 331-34.
  \item \textsuperscript{37} Medicaid, a cooperative state-federal program, provides health insurance to income-eligible individuals and families. 42 U.S.C. § 1396 (1988).
  \item \textsuperscript{38} Social Security Act, 42 U.S.C. § 13951(a) (1988). Reasonable charges are the lesser of the actual billed charge, the individual physician's customary charge, or the prevailing charge in the community. 42 C.F.R. § 405.502(a) (1993).
  \item \textsuperscript{39} 42 U.S.C. § 1302 (1988). The states' Medicaid payment levels to physicians may not exceed Medicare's reasonable charges. See Johnson's Professional Nursing Home v. Weinberger, 490 F.2d 841 (5th Cir. 1974) (upholding limitation of Medicaid payments to Medicare standard of reasonable costs). Regulations require physician reimbursement to be "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." 42 C.F.R. § 447.204 (1993).
\end{itemize}
ules. The remainder provide some form of charge-based reimbursement.

Since 1965, Medicare and Medicaid have grown significantly. Medicare currently accounts for approximately thirty-five percent of national health care expenditures and forty percent of hospital revenues. Yet, Medicare's impact extends well beyond the program itself. For example, other institutional purchasers of health care, such as private insurers, typically follow Medicare's lead in medical technology and payment schedules.

B. Impact of Third-Party Payers on Health Care

By 1986, seventy percent of payments to providers were made by public or private insurance. The insurers' reimbursement methods introduced into the health care system complex, often irrational economic incentives. The traditional reimbursement method of private insurers was the fee-for-service model, while government insurance reimbursed on a cost

40. Law & Ensminger, supra note 29, at 13. Under a fee schedule, Medicaid sets the fees that it will pay. Relevant to the range of physician fees, schedules can be set high, by using the higher physician fees, or low, by using the lower physician fees. States can adjust fees to account for the patient's diagnosis; the service provided; the physician's training, experience, and specialty; and whether the care was given in a hospital or an ambulatory setting. Id. at 12.

41. Id. at 13. Charge-based reimbursement bases the payment to the provider on recent historical charges by the individual provider and his colleagues. Private insurance calls this "usual, customary, and reasonable reimbursement (UCR)," and Medicare calls it the "customary, prevailing, and reasonable charge method (CPR)." Id. at 12. When insurance pays charge-based reimbursement, it pays the least of the provider's actual billed charge, the median amount that she customarily charges for that procedure, or some percent of customary community charges for the medical specialty and geographic locality. Id.


43. Costs of the Medicare Program, supra note 42, at 23.


45. The fee-for-service system, euphemistically called the "free lunch" system, has delivered medical care without regard to cost containment and sometimes without regard to medical necessity. Under the fee-for-service system, third-party payers pay health care providers for each discrete item of service. In 1980, 50% of active physicians were compensated by fee for service, approximately 20% were salaried, and the remaining 30% received a mixed form of compensation. Sunny Yoder, Physician
or charge basis. Both of these forms of reimbursement created powerful incentives for all players in the health care system to intervene excessively with overpriced procedures. No one had an incentive to economize.

An individual who contracted with Blue Cross through an employer for eighty percent of the usual, customary, and reasonable cost (UCR) of medically necessary care lacked the incentive to economize because no matter what the cost of health care, the individual would be paying only twenty percent. Because the insurance cost was shared with the employer, the individual was not likely to scrutinize medical expenditures to avoid future premium increases. Furthermore, because insurers did not base health care insurance premiums on “experience rating,” a patient’s health care use would not directly influence the cost of the insurance to the employer. Thus, the patient was not likely to realize the full financial impact of treatment decisions.

Nor were hospitals and physicians motivated to economize. Because most insurers guaranteed providers eighty percent of their customary charges, fee-for-service or cost-based charges had an opposite and perverse influence on health service delivery. Providers earned more under both reimbursement systems when they treated more. This phenomenon had two effects: First, physicians and hospitals tended to de-emphasize preventive care, which was not as lucrative as treatment services. Second, because insurers paid for discrete procedures, not

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46. Under cost-based or charge-based reimbursement, third-party payers reimburse providers for most of the costs or charges incurred in treating covered patients.


48. When insurance induces a person to use more medical care than she would use if she were paying for the services directly, then the insurance is a “moral hazard” with respect to the person’s indifference to cost. Mark A. Hall & Ira Mark Ellman, Health Care Law and Ethics 8 (1990).

49. “Experience rating” means that the annual recalibration of premiums will reflect each insured group’s actual claims experience for the prior period. Mark A. Hall & Gerald F. Anderson, Models of Rationing: Health Insurers’ Assessment of Medical Necessity, 140 U. Pa. L. Rev. 1637, 1671 n.131 (1992). With experience rating, the insurer has less incentive to refuse payment because all amounts it pays are recouped in next year’s premium increases.

50. See Capron, supra note 47, at 710-11 (stating that the payment system offers incentives for excessive intervention with overpriced procedures).
time spent with patients, providers tended to place excessive reliance on the use of medical technology.

The insurers' methods of calculating fees to be paid further complicated the picture. The practice of covering the UCR allowed the provider to charge whatever the insurer would pay.

When the maximum payments available under usual and customary became public knowledge, there was a natural tendency on the part of physicians . . . to move to the maximum available. . . . Once that was done, the whole concept of usual and customary, based on physicians' pricing as an independent entity unaffected by their peers or others in the community, was gone. The whole program changed its nature both as to Medicare and as to private, usual and customary. Prices rose dramatically. . . . [The doctor] could find [the maximum UCR] out very readily by simply testing the system by raising his fees until he hit the upper limit, and they did.51

From the patient's point of view, insurance removed the need to ration health care dollars, thus creating the moral hazard problem.52 From the insurer's point of view, a payment system that had worked well for auto and life insurance would seem to make sense. Thus, health care indemnity plans were designed and implemented on the basis of faulty assumptions and expectations by all parties: the insurers' failure to recognize the problem of moral hazard and the providers' and patients' failure to recognize the need to continue to ration health care.53

For over fifty years, the cost of health care was hidden from most of the participants in the system. However, as the cost of health care has spiraled upward, employers,54 government,55

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52. See supra notes 45-49 and accompanying text.
53. See supra notes 48-52 and accompanying text.
55. The spiraling health care costs are pushing governmental programs to the brink of disaster. For example, it is predicted that by the mid-1990s Medicare will face bankruptcy. Board of Trustees Report, A Proposal for Financing Health Care of the Elderly, 256 JAMA 3379, 3379 (1986). State Medicaid programs consume excessive portions of limited state funds. Morreim, supra note 3, at 1720.
and third-party payers have gained strong incentives to restrain costs.\textsuperscript{56} Employers and third-party payers desire to protect their profits, and the government wants to reduce the deficit by decreasing health care expenditures. Because of their profit interest, third-party payers are rigorously looking for ways to control the untamed beast. During the early 1970s, major employers began to self-insure to reduce costs,\textsuperscript{57} and the government switched to using diagnosis-related groups as its method of paying hospitals.\textsuperscript{58}

These efforts have had limited effectiveness. While self-insurance helped employers avoid the problem of increased premiums, it did little to control the actual cost of health care.\textsuperscript{59} Similarly, Medicare and Medicaid's use of diagnosis-related groups for prospective payment of hospital services has not proved effective in controlling costs.\textsuperscript{60} In a second-stage effort to control health costs, third-party payers redesigned health benefit plans to pass on increased costs to the employee by eliminating "first-dollar" coverage and significantly increasing deductibles.\textsuperscript{61} It is predicted that by 1995, ninety-eight percent of major employers will have eliminated first-dollar coverage.\textsuperscript{62}

\begin{small}
\begin{thebibliography}{99}
\item 56. See Jon Gabel et al., \textit{The Emergence and Future of PPOs}, 11 J. HEALTH POL. POL'Y & L. 305 (1986). In 1989, private insurance and other private payers paid 37% of health care bills, government programs paid 42%, individuals paid 37% (premiums), and business paid 30% of the bills. \textit{Health Law. News Rep.}, supra note 3, at 3. During that year, 39% of the money went to hospitals, 19% to physicians, and 8% to nursing homes. \textit{Id}.
\item 58. See Alexander M. Capron & Bradford H. Gray, \textit{Between You and Your Doctor}, \textit{WALL ST. J.}, Feb. 6, 1984, § 1, at 24; see also \textit{infra} note 60 and accompanying text.
\item 60. Medicare classifies each patient's hospital admission into one of 468 diagnostic groups. Medicare then multiplies the average price and "weight" of the procedure to predetermine the reimbursement the hospital will receive for the care given the patient. Michael Tichon, \textit{Current Issues in Reimbursement: Medicare and Medicaid}, 6 WHITTIER L. REV. 851, 851 (1984). From that payment, the hospital keeps, as profit, moneys not spent on patient care; alternatively, the hospital absorbs any loss. On the positive side, diagnosis-related groups limit hospitalization and the use of costly technologies. See Bruce C. Vladeck, \textit{Medicare Hospital Payment by Diagnosis-Related Groups}, 100 ANNALS INTERNAL MED. 576 (1984). However, profit or loss potential creates an incentive for hospitals to discharge patients earlier and perform fewer interventions. Some providers have begun to stabilize the effect by "unbundle" care. See generally Arnold M. Epstein & David Blumenthal, \textit{Physician Payment Reform: Past and Future}, 71 MILBANK Q. 193 (1993).
\item 61. Bischoff, \textit{supra} note 57, at 3.
\item 62. \textit{Id.} at 4.
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Elimination of first-dollar coverage would appear to give the patient economic incentives to control the use of health care services. However, some individuals may respond to the incentives by significantly underutilizing services, thus adversely affecting their health.63

Current cost containment efforts shift the risk of financial loss for health care in whole or in part to the providers of that care.64 Physicians are offered economic incentives to act as the third-party payer’s agent—the gatekeeper to health care services.65 As gatekeepers, physicians are concerned with limiting access to health care services so that third-party payers do not find excessive utilization. If a third-party payer determines that a physician has ordered too many services, the third-party payer financially penalizes the physician.66 Consequently, physicians are motivated to order services for patients within third-party payer guidelines. Thus, gatekeeping shifts the focus of the health care system from the physician-patient relationship to the relationship between the physician and third-party payer. Ultimately, the physician and the third-party payer will determine the quality of care received by the patient and the patient’s access to that care.67

63. Eliminating first-dollar coverage has had limited effect on most patients. In general, unless the deductible is very high, the patient merely incorporates into her decision making only that portion of health costs that she is required to bear. Thus, if the patient must bear the first $300, only that amount affects her overall health care decision making. Such behavior is rational and predictable. Consider how our eating habits would differ if we had to pay only one fifth of our food costs.

64. Despite the historical opposition by providers to risk shifting, the position of physicians and hospitals has been weakened by the current economic situation. One third of total hospital capacity is permanently idle, and patient days dropped from 280 million in 1980 to 240 million in 1984. By the mid-1990s, it is predicted that the number will drop to 120 million. There are now 2.2 physicians per 1,000 persons, 1.2 physicians more than needed. By the year 2000, it is predicted that we will have 1.5 more physicians than needed. Galen D. Powers, Allocation of Risk in Managed Care Programs, in MANAGED HEALTH CARE: LEGAL AND OPERATIONAL ISSUES FACING PROVIDERS, INSURERS, AND EMPLOYERS, at 279 (PLI Commercial Law and Practice Course Handbook Series No. 393, 1986), available in WESTLAW, TP-All File.


66. See infra part III.B.

67. The gatekeeping role is not new to physicians. They have used their position in several ways. For instance, physicians have used their authority as health care gatekeepers to resist hospitals’ and insurers’ efforts to influence medical treatment. Furthermore, they have generally used their role to obtain more services for the patient, not fewer. Now, however, they use their position to save money for third-party payers by ordering fewer services. See STARR, supra note 25 at 26-27; Capron, supra note 47, at 747. Thus, the fundamental change in the basic ethical concern of the system is revolutionary—from the “best interest of the patient” to “cost containment.”
As employers, government, and other third-party payers more aggressively seek market share and profits, the health care marketplace is driven by fierce competition for enrollees. At the same time, third-party payers demand experience rating and utilization data on the services they are purchasing. Third-party payers attempt to limit their costs by reducing the amount a physician or hospital receives for the average patient’s care. Third-party payers have developed plans that limit the amounts and types of services that can be used. They have sought to restrict physicians’ decision-making power. In short, third-party payers have entered the managed care business, with management in the hands of the third-party payer, not the physician or the patient.

C. The Development of Managed Care Products

The third-party payer-driven system can look deceptively like the provider-driven system. The traditional contractual relationships between patient and third-party payer, and between physician and patient, continue to exist. However, a new relationship between the third-party payer and the physician now exists. Thus, in the payer-driven system, there is a triangular relationship. The physician is legally and professionally obligated to act in the patient’s best interest. The third-party payer is contractually obligated to pay for services rendered by the physician. The physician is contractually obligated to provide services under the guidelines set by the third-party payer if the physician wishes to be paid for the medical services. Thus, the physician manages the patient’s health care for the third-party payer—leading to the term “managed care

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68. Ossario, supra note 3, at 198; see Marc P. Freiman, Cost Sharing Lessons from the Private Sector, HEALTH AFF., Winter 1984, at 85, 86.
69. For instance, insurance carriers increasingly attempt to identify inappropriate medical interventions. See, e.g., Capron, supra note 47, at 715.
70. Essentially, third-party payers reduce provider pay by refining current payment methods, using explicit fee schedules, or bargaining for prices. Refining current payment methods, because it involves only modifying the calculation of the fee paid, provides the least radical change in third-party payer reimbursement. Explicit fee schedules have been used for basic medical expenses, and use of the schedules for provider pay would merely extend their current use. The third-party payer pays the lesser of the actual fee or the scheduled amount for the service. Under an explicit fee schedule, the provider is paid directly. Id. at 718.
71. Third-party payers attempt to limit their payment for medical services by “bundling” services for reimbursement purposes. By using this payment method, third-party payers attempt to avoid the present excessive incentives to overtreat. Id. at 722.
72. See Bischoff, supra note 57, at 4-5.
products." The two basic forms of managed care products are health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

1. Health Maintenance Organizations

An HMO is an organized system of health care delivery for both hospital and physician services in which delivery and financing functions are offered by one organization. HMOs provide both services to an enrolled membership for a fixed and prepaid fee. The traditional HMO structure completely shifts the financial risk from the third-party payer to the provider. This shift means that HMOs can obtain cost savings only by controlling both utilization and expenses. They do so by encouraging fewer hospital admissions, more outpatient procedures, and fewer referrals to specialists.

In Oklahoma in 1929, the Farmer's Union started the Cooperative Health Association using the familiar "farmer's co-op" pooled financing structure. Around the same time, in Los Angeles, Drs. Ross and Loss started a prepaid group health delivery plan with comprehensive services.

The AMA slowed the development of managed care by labeling the concept "socialized medicine" or "communism." "The medical profession was unremittingly hostile [to managed

73. DOUGLAS D. BRADHAM, HMO AND PPO OVERVIEW: HISTORY, DEVELOPMENT AND DEFINITIONS (Florida Bar 1989). There are five models of HMOs. The staff HMO model delivers services by a physician group that is employed by the HMO, with the hospital usually owned by the HMO plan. The group HMO model delivers services through an outside physician group under contract. Hospital services are usually contracted for as well. While the primary care network HMO model has multiple contracts with physicians, it is the primary care physician who controls all specialty referrals. The Individual Practice Association (IPA) HMO model delivers services through independent practices. These practices can be solo or group practices that have organized to pool the financial risk. The open-ended HMO allows enrollees to select services outside the HMO provider staff, network, or IPA, but coverage is at the traditional indemnity rate and is typically less comprehensive and more expensive than the HMO's standard package. Id. at 1.5-1.6. Methods of payment to a provider are based on the model used. Staff models use salary-based payment almost exclusively; IPA models use both capitation and fee for service; network models use capitation; group models are split among all three. See id.

74. Id. at 1.2.

75. Id. at 1.1. But see Sarah Glazer, The Failure to Contain Medical Costs, 2 EDITORIAL RES. REP. 510, 511 (1988) (giving Dr. Michael A. Shadid the credit for establishing the first prepaid group practice in 1927, also in Oklahoma).

76. BRADHAM, supra note 73, at 1.1. The Ross-Loss Health Plan is the oldest HMO still in existence. Milton H. Lane, LEGAL RELATIONSHIPS AND RESPONSIBILITIES IN HMOs, HEALTH CARE MGMT. REV., Fall 1983, at 53.

77. BRADHAM, supra note 73, at 1.1.
care], and by the end of the [1930s] succeeded in convincing most states to pass restrictive laws that effectively barred [managed care] plans from operating. Because of this opposition, HMOs developed haphazardly in response to the needs of specific communities. In the early 1970s, when skyrocketing health care costs were front page news, the AMA position weakened. Conservatives were certain that market competition in the health care system would reduce costs.

In 1973, in response to increasing pressure, Congress passed legislation that required businesses with more than twenty-five employees to offer their employees at least one federally qualified HMO as an alternative to conventional insurance. With federal grant and loan money in hand, the HMO industry experienced a steady growth between 1974 and 1983.

Though the government discontinued federal loans, HMOs experienced another growth spurt between 1983 and 1988, probably caused by the expansion of health maintenance cover-

78. Glazer, supra note 75, at 511 (quoting Starr, supra note 25, at 302).
79. For instance, in the 1930s, in response to a shortage of medical facilities for construction workers, Kaiser Health Foundation Plan originated an HMO in connection with the construction of an aqueduct near Los Angeles, California. The HMO started as a series of capitation agreements with area physician groups under which the group was paid $1.50 per month for each covered employee. As of March 1988, it was the largest prepaid plan in the United States with 4,904,768 members in five states. Jack F. Monahan & Michael Willis, Special Legal Status for HMOs: Cost Containment Catalyst or Marketplace Impediment?, 18 STETSON L. REV. 353, 359 n.21 (1989).
80. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e-300aaa (1988). An HMO is defined under the legislation as an organization that provides health services to members in specific geographic areas in return for periodic, fixed prepayment. Id. § 300e. The prepayment is fixed without regard to frequency, kind, or duration of service. Id. § 300e(b)(1). An HMO must (1) assume full financial risk on a prospective basis for the services provided to its members; (2) maintain a "fiscally sound operation"; (3) protect its members from liabilities of the organization; and (4) provide commercial members a comprehensive package of health services, which was specifically prescribed in the legislation. Id. § 300e. Until the HMO Amendments of 1988, Pub. L. No. 100-517, 102 Stat. 2578 (1988), HMOs were required to use community rate premiums for commercial members. Since 1988, however, HMOs are permitted to develop premiums on the basis of their revenue requirements for providing services to individuals and families of a group. 42 U.S.C. §§ 300e-300q (1988); 42 C.F.R. § 417.104 (1992). Finally, the HMO Amendments of 1988 require employers to make an equal contribution to HMO and other health benefit options and forbid employers to financially discriminate against employees who enroll in an HMO. 42 U.S.C. § 300e-9 (1988). Nothing, however, prevents an employer from financially discriminating against an employee who does not enroll in a managed care product.
81. Monahan & Willis, supra note 79, at 359.
82. The number of HMOs rose from 290 to 648 between 1983 and 1988, and enrollment expanded from 13.7 million to 31 million members, averaging a 25% increase per annum. Id. at 360 n.27.
age to Medicaid and Medicare eligibles. In 1982, former President Reagan signed a bill that expanded the definition of contracting entities to include entities other than federally qualified HMOs and authorized Medicare payment on either a prospective, per capita basis or on a reasonable cost basis.

Other roadblocks to the growth of HMOs were also removed during that period. For instance, many states had laws that forbade the corporate practice of medicine. Consequently, many states had to enact enabling statutes because HMOs required some kind of corporate practice.

With Medicaid authorization and state legal clearance, the number of HMOs increased dramatically—about 900% in fifteen years. While recent market consolidation has resulted in an actual decrease in the number of operating HMOs, the overall enrollment continues to climb.

2. Preferred Provider Organizations

As HMOs stabilized as a cost control mechanism, third-party payers pushed to find more efficient cost control methods. The push resulted in the proliferation of other managed care arrangements, most notably PPOs. PPOs contract directly with an employer through the employer's health benefits department or indirectly through an insurance carrier to provide health

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84. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 924 (codified as amended at 42 U.S.C. § 300e (1988)). This Act delineates the requirements an HMO must meet to become federally qualified according to organizational structure, health care benefits, and the manner of conducting business. Though federal qualification is not intended to represent that the HMO is financially viable, qualification is necessary to receive federal subsidies under the Act. Compliance also serves as a means to demonstrate publicly that the HMO has complied with a federally uniform standard.


87. Monahan & Willis, supra note 79, at 361.
care services from a preselected group of providers. The limited list of providers means that the overall expense to the patient is lower than the expense of traditional insurance. Physicians entering into provider contracts with PPOs agree to accept both utilization review controls and financial risk shifting structures. Third-party payers give consumers economic incentives to use the PPO physicians through reduced fees for services. Generally, local market conditions determine the organization of a PPO. Most PPOs consist of a provider panel made up of preferred hospitals and physicians. The PPO employs fee schedules and utilization reviews that create a monetary incentive for consumers to choose the PPO provider, while leaving consumers free to choose their own providers. A common feature among PPOs is the ability to efficiently process provider claims. PPOs, however, can be organized in almost any form, and they are essentially unregulated. Despite the lack of definition, PPOs are classified according to sponsorship categories. Another distinguishing feature is


89. Greg de Lissovoy et al., Preferred Provider Organizations: Today's Models and Tomorrow's Prospects, 23 INQUIRY 7, 7-8 (1986). Monetary incentives to the patient effectively obviate freedom of choice. If a patient is unable to pay the difference, she will have no choice but to utilize the preferred provider. Approximately 20 states have attempted to resolve this issue by passing laws that limit the reimbursement differential between PPO and non-PPO utilization. It is unclear whether such limitations protect freedom of choice, as the protection limits the effectiveness of managed care products. Norman Payson, A Physician's Viewpoint on PPOs, 6 WHITTIER L. REV. 699, 699-705 (1984).


91. Nine states (California, Florida, Indiana, Louisiana, Michigan, Minnesota, Nebraska, Virginia, and Wisconsin) have laws that permit prepaid health plans that limit choice of provider. Fifteen states have pending legislation. Congress is also considering legislation that would override state laws inhibiting managed care health plans. Capron, supra note 47, at 721 n.39.

92. De Lissovoy et al., supra note 89, at 7.

93. Of the 51 jurisdictions, only 20 states have a regulatory scheme for PPOs. E.g., LA. REV. STAT. ANN. §§ 40:2201-40:2205 (1992); NEB. REV. STAT. § 44-4106 (1988); N.C. GEN. STAT. § 58-65-1 (1991). Some states have indirectly regulated managed care products. For example, Indiana enacted a law that forbids an insurer from unreasonably discriminating against providers not willing to meet the terms of the agreement offered to them. IND. CODE § 27-8-11-3 (1992). California forbids exclusion from membership based on the category of the license. CAL. INS. CODE § 10133.6 (West 1993).

94. A 1986 national survey of PPOs classified them as (1) hospital sponsored (including corporate hospital chains and joint sponsorships by hospitals and physicians); (2) physician sponsored (including physician groups); (3) commercial
the amount of risk that the PPO shifts to the provider. For example, in most full-risk PPOs, the PPO assumes the role of insurer and takes on all risk of loss. The PPO charges the employer a premium and covers all the services provided to the enrollee, including services offered at nonparticipating hospitals.\(^95\) On the other hand, limited-risk PPOs assume only a portion of the financial burden and shift part of the risk of the enrollee's care to the provider.\(^96\)

**D. Summary**

Managed care products allocate financial risk in several ways, from the complete risk shifting of the health maintenance organization (HMO) to the varied risk shifting of the preferred provider organization (PPO). Nevertheless, both forms have the same goal: to reduce costs and increase profits by altering the practice behavior of providers.\(^97\) Third-party payers reward or penalize providers based on the services they deliver, without regard to the quality of those services. Thus, there is a strong incentive for providers to control, for the financial benefit of the third-party payers, the care received by the covered patient. Whether that control will be detrimental to the overall quality of care remains to be seen. But, without a doubt, managed care products will be detrimental to some patients.

In 1980, managed care products were begging for providers to enter into agreements with them. Today, it is not uncommon to see this situation completely reversed.\(^98\) At least sixty percent of individuals with employer-sponsored health care plans

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95. Powers, supra note 64, at 290-91.

96. Id. at 290; see infra part III.B.

97. Initially, managed care products were perceived as a combination of providers offering discounts from customary charges and retrospective utilization review programs for medical procedures and ancillary testing. Richard A. Hinden & Douglas L. Elden, Liability Issues for Managed Care Entities, 14 SeTOn HAll LEGIS. J. 1, 2 (1990). Although a significant portion of the marketplace still views managed care as discount medicine, today's managed care products have evolved into entirely different entities where the organization actively sets the parameters of medical practice. Id. at 2-3.

are enrolled in managed care products. 99 Furthermore, all types of individuals and entities are developing these products. 100 Acute-care hospitals develop them as a device to maintain or increase their market share. 101 Physicians develop them to retain some control over health care delivery. 102 Insurers develop them to keep profits up and to protect market share. 103 Employers also develop managed care products to control costs. 104 Finally, entrepreneurs develop managed care products because "it appears to be a business in which one can make a profit." 105 Perhaps the only group not developing managed care products is the group most affected by the delivery of health services—patients.

Efforts to control costs through limiting providers' expenditures will be magnified in the future because health care is an increasingly business-oriented activity. In the face of a third-party payer-driven delivery system, there is a need for either legal theories or a compensation system that particularly reflects institutionalized profit-seeking behavior. Otherwise, a third-party payer-driven system seems destined by its very structure to proceed at the expense of the patient's best interest. 106

99. Id.

100. One author has commented with dismay on the number of "inexperienced people" entering the "business" of managed care. Ossario, supra note 3, at 198.


102. Id. at 692-93. The fact that physicians control the managed care organization does not change the underlying analysis regarding liability. The underlying purpose to control cost remains and the physician's behavior will be essentially the same as other owners.

103. Id. at 693.

104. Id.

105. Id.

106. For example, on legal and operational issues facing providers, insurers, and employers, one commentator noted that changing physician practice patterns is more important than thwarting outliers. Joseph J. Martingale, Cost Containment Mechanisms: The Tools of the Managed Health Care Revolution, in MANAGED HEALTH CARE: LEGAL AND OPERATIONAL ISSUES FACING PROVIDERS, INSURERS, AND EMPLOYERS (PLI Commercial Law and Practice Course Handbook Series No. 393, 1986), available in WESTLAW, TP-All File. Outliers are services or patterns of practices that fall outside established norms. In general, outliers are statistical observations that are so far away from the rest of the sample that they should be disregarded in statistical calculations. See THOMAS H. WONNACOTT & RONALD J. WONNACOTT, INTRODUCTORY STATISTICS 417 (1972).
III. THIRD-PARTY COST CONTAINMENT MEASURES

As discussed, many entities and individuals are designing and implementing managed care products. The identity of the organizers of a particular managed care product may have profound effects on the quality of care under the product and on the techniques used to shift the risk to the physician, hospital, or other provider. Yet, there is a common focus for all managed care products: To succeed in reducing health care costs and generating profits, the managed care product must consistently maintain effective cost containment efforts.\(^{107}\) Cost containment effectiveness depends on implementing a strict utilization review process enforced by appropriate risk-shifting techniques.\(^{108}\) Section A of this Part defines utilization review and outlines utilization review structure. Section B describes the way managed care products employ strict enforcement of utilization review, through financial risk shifting, to control cost. Section C outlines the effects of cost containment measures on health care, including problems of assuring quality of care in the managed care product and maintaining the ethical basis of health care. Together, these sections provide an overview of the structure, operation, and effects of managed care products that is necessary to appreciate the need for a compensation system that encompasses managed care injuries.

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107. One recent study of 222 employers noted that utilization review efforts can reduce total medical expenditures an average of 8.3%. Bishoff, supra note 57, at 9 (citing Glenn Ruffenbach, Employers Can Cut Health-Care Costs With “Utilization Review,” Study Finds, WALL ST. J., May 19, 1988, at A38). In 1988, another study concluded that nearly 10% of the 800,000 hospital Medicare admissions were not “medically justified.” Id. However, it may be that utilization review can provide only temporary relief and not a cure for increased costs. Id. at 10. That position would seem to be supported by employers’ perceptions of the major obstacles to health care cost management: 76%—physician and hospital charges; 70%—costs of sophisticated medical technologies; 59%—an aging population; 49%—an inability to enforce medical performance standards; 42%—a failure of managed care to achieve projected savings. Only 37% and 30% respectively believed that utilization of outpatient care and utilization of inpatient care were major obstacles to health care cost management. Id. at 10. These perceptions would indicate that utilization review is a minor player in health care cost containment. Despite what may be a limited effectiveness of utilization review, the lack of a utilization management program or an inefficient system without supporting data probably disqualifies an entity from being a managed care system. Hinden & Elden, supra note 97, at 50-51.

108. Boland, supra note 90, at 503.
Utilization review (UR) is the process by which an organization determines if medical services are appropriate and necessary. Managed care products perform UR by examining providers' authorization and furnishing of services to detect variations from the norm that may indicate unnecessary or inappropriate care. When the third-party payer detects variation, it either does not pay the provider's charges (retrospective UR) or refuses to authorize the provision of the service (concurrent UR and prospective UR).

Utilization review takes several forms:

1. Preadmission review for scheduled hospitalization,
2. Admission review for unscheduled hospitalization.

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110. Retrospective utilization management programs analyze data on hospital admissions, patterns of treatment, and utilization of certain procedures. See Bischoff, supra note 57, at 14-15 (providing examples of retrospective review).

111. Concurrent review (or length of stay certification) determines the medical necessity of a continued hospital stay. Hinden & Elden, supra note 97, at 52. A concurrent review is conducted by a nurse reviewing the patient's treatment plan. The nurse conducts the review at the hospital using established medical criteria. If the nurse judges the treatment plan to be appropriate, she approves the stay until the next review cycle or the patient is discharged. If she does not approve the treatment plan, the nurse refers the case to a physician advisor who either confirms the need for continued treatment or suggests alternate treatment. Bischoff, supra note 57, at 14.

112. Under a prospective review system, most nonemergency hospital admissions must receive prior approval and an initial approved length of stay is assigned. Hinden & Elden, supra note 97, at 52.

113. Preadmission review is a form of prospective review. Preadmission review determines the medical necessity of a scheduled inpatient admission, expensive procedures, or outpatient procedures. The initial determination is made by a nurse review coordinator using established criteria. A registered nurse usually conducts off-site preadmission certification. If there is a scheduled admission prior to hospitalization, the patient's physician completes a review form. She describes the patient's medical condition and the treatment plan, and forwards the form to the nurse review coordinator. The nurse notifies the physician, patient, and hospital of her decision regarding the appropriateness of admission and length of stay. Bischoff, supra note 57, at 13-14.

114. Admission review is a form of concurrent review. Admission review determines the medical necessity of unscheduled inpatient admissions or other admissions not covered by preadmission review. Most managed care products use admission review. The primary exception is hospitals that are paid based on diagnosis related groups.
(3) second opinions for elective surgery,\textsuperscript{115}
(4) concurrent review,\textsuperscript{116}
(5) gatekeeping by primary physician,\textsuperscript{117} and
(6) retrospective claims review.\textsuperscript{118}

Despite all the current interest, utilization review is not new. In the 1970s, Congress established Professional Standards Review Organizations (PSROs).\textsuperscript{119} These PSROs were composed of physicians and were responsible for monitoring Medicare quality of care and conducting utilization review of Medicare services.\textsuperscript{120} Medicare’s PSROs, however, had limited effectiveness. In 1982, Congress reorganized the PSRO program, replacing PSROs with utilization and quality control Peer Review Organizations (PROs).\textsuperscript{121}

2. Utilization Review Structure

Utilization review may be conducted by providers, third-party payers, or independent agencies. The provider who conducts utilization review has a legal or a moral obligation to prevent overutilization, but a financial desire to fill the beds.\textsuperscript{122} From the third-party payer’s point of view, the physician often appears to be the least concerned with cost effectiveness because the physician is likely to authorize more services than appear necessary to the third-party payer. On the other hand,

\textsuperscript{115} Except by commercial insurers, second-opinion surgery is used much less often. In 1985, commercial insurers required second opinions in nearly twice as many programs as any other sponsor. De Lissovoy et al., supra note 89, at 11.
\textsuperscript{116} See supra note 111.
\textsuperscript{117} See supra notes 64-67 and accompanying text.
\textsuperscript{118} Retrospective review disallows payments of claims for utilization. Because retrospective review disallows payment after the service has been received, it is not as effective as prospective or concurrent review. Consequently, the use of retrospective claims review is declining. However, it is useful as a tool to research provider claims. For example, it would be useful in determining whether the objective laboratory data (e.g., biopsy) and subjective data (e.g., surgeon notes) are consistent with the length of stay or the length of surgery. See Bischoff, supra note 57, at 15. Consequently, retrospective review can be a very important tool in a managed care product such as an HMO.
\textsuperscript{119} See ANNAS et al., supra note 44, at 193.
\textsuperscript{120} Id.
\textsuperscript{121} 42 U.S.C. §§ 1320c to 1320c-12 (1988); ANNAS et al., supra note 44, at 193.
\textsuperscript{122} Interestingly, some commentators believe that allowing the provider to do the utilization review is letting the “foxes guard the hen house.” Burgess, supra note 94, at 283-84. In reality, no review organization is independent. All review organizations are directly or indirectly concerned about encouraging overutilization or underutilization. Hospitals enter PPOs primarily to remedy a decline in patient volume, so they may not be inclined to conduct stringent utilization review, which might further reduce patient volume. De Lissovoy, supra note 89, at 9.
with a strong incentive to cut costs, the third-party payer may err on the side of denying needed services. Not even independent agencies are truly independent when third-party payers are paying the bills for the agencies’ services. The agencies’ incentive is to maintain their contractual relationships with the third-party payers. Thus, with the possible exception of the provider, all entities who conduct utilization reviews focus on a desire to decrease the use of medical services, not on a desire to increase the quality of care.

It is empty and unrealistic to declare that the physician must act and be accountable for the patient’s best interest while society allows, even encourages, the physician to act in the best interest of third-party payers. If “a man cannot serve two masters,” neither can the physician. One need not be a clairvoyant to know which master will dominate.

The transaction between physician and patient becomes a commodity transaction. The physician becomes an independent entrepreneur or the hired agent of entrepreneurs and investors who themselves have no connection with the traditions of medical ethics. The physician begins to practice the ethics of the marketplace, to think of his relationship with the patient, not as a covenant or trust, but as a business and a contract relationship. . . . Medical knowledge becomes proprietary; the doctor’s private property to be sold to whom he chooses at whatever price and conditions he chooses.

Yet, the utilization review process is not the real culprit. Risk-shifting mechanisms cause the physician to change her pattern of practice from overutilization to appropriate utilization at best and underutilization at worst. Without financial risk shifting, utilization review would be nothing more than a guard dog without teeth.

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124. While it is possible to have effective utilization review and high quality health care, without a focus on quality it is more likely that utilization review will work to the detriment of quality care. See infra part III.C.2.


B. Strict Enforcement Through Financial Risk Shifting

Third-party payers seek to manipulate provider behavior by shifting the risk of financial loss from the third-party payers to providers. Financial risk shifting can arise in a variety of arrangements: ownership interest, joint venture, or a bonus arrangement. 127 The risk shifting can also be in the form of rewards, 128 penalties, 129 or both. 130 The degree of risk assumed by the provider varies with the type of payment arrangement. Traditional fee-for-service practices are at one end of the spectrum (no risk shifted), and traditional HMOs are at the other (full shifting of the risk). 131 PPOs fall in the middle.

The most common means used by third-party payers to spread financial risk to providers 132 are capitation (set fee per enrollee), 133 withholding (retaining a percentage of payment


128. Rewards can be a predetermined fixed dollar amount, a fixed percentage of the surplus distributed among the risk pool, a bonus based on a physician's productivity, or a combination of methods. Alan L. Hillman, Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?, 317 NEW ENG. J. MED. 1743, 1746 (1987). The methods also include increasing fee schedules and allowing practitioners to become investors.

129. Third-party payers often provide for a portion of payments to providers to be withheld. Other mechanisms used to place the provider at risk include (1) increasing the percentage of payment withheld the following year, (2) placing liens on future earnings, (3) decreasing the amount of the capitation payment the following year, (4) excluding the provider from the program, (5) reducing the distributions from surplus, and (6) requiring providers to pay either the entire amount of any deficit or some set percentage of the deficit. Id. at 1745.

130. For example, approximately 40% of managed care products require primary care physicians to pay for outpatient laboratory tests directly out of their capitation payments. Id. at 1746. HMOs also use peer pressure as a significant motivator. They develop a reporting system that informs providers of their performance compared with that of their peers. The reporting identifies areas of excessive costs and service intensity. Bischoff, supra note 57, at 12-13.

131. Powers, supra note 64, at 289-90.


133. A provider, or provider group, is paid a capitation fee per enrollee. The provider group then provides all necessary physician services. Primary care physicians are the gatekeepers to specialists and hospital services and are financially responsible for utilization. Because the amount of payment to the provider group is independent of the actual services rendered, the group takes on the risks of an insurer. Powers, supra note 64, at 298-99; Capron, supra note 47, at 726.
due to reward or punish use trends at year-end),\textsuperscript{134} discounted fees for services (provider required to give a discount to the third-party payer on amounts due),\textsuperscript{135} per diem payments (flat fee per day per patient),\textsuperscript{136} and profit sharing.\textsuperscript{137} To shift the risk to hospitals, third-party payers also use per case mechanisms\textsuperscript{138} and capitated payments per patient.\textsuperscript{139}

While the form may vary, the penalties have similar effects. For instance, third-party payers indirectly penalize physicians by giving them less profit or directly penalize them by reducing capitation payments each time they make inappropriate referrals. Not all risk-shifting mechanisms, however, have the same impact. Some have a greater potential than others to cause the physician to act inconsistently with the patient's best interests.\textsuperscript{140} For instance, mechanisms like physician diagnosis-related groups and capitation require the physician to bear indi-

\textsuperscript{134} Managed care products can shift the risk by withholding part of the provider's periodic fee-for-service payments for a claim period. The managed care products usually withhold from 5% to 20%. At the end of a claim period, a medical claim trend is determined and compared to a target medical claim trend. If the actual medical claim trend is lower than the target, the withheld funds are paid to the providers. If the actual medical claim trend exceeds the target, the withheld funds are paid to the third-party payer. Powers, supra note 64, at 293-84, 300-301.

\textsuperscript{135} The managed care product assumes the risk that the third-party payer's premium will be sufficient to cover hospital charges. However, there is no participation by hospitals in profits of the managed care products. Third-party payers that contract with hospitals without a discount may pressure those hospitals for a discount, but discounted charges may be insufficient to cover the hospital's actual costs. \textit{Id.} at 294.

\textsuperscript{136} Hospitals are paid a flat rate per patient per day, which must cover all necessary services. The advantage of per diem payments is that the hospital is not at risk for the length of stay. However, if the managed care product also has an emphasis on early discharge, the hospital's total income may be reduced. This reduction can occur when the predetermined per diem payments are too low for the hospital to cover its costs and the managed care product requires discharge of the patient before the hospital can break even by averaging cheaper end-of-stay days with the more expensive beginning-of-stay days. \textit{Id.} at 294-95.


\textsuperscript{138} Case mechanisms are similar to diagnosis-related groups. See supra note 60. Based on the diagnosis, a predetermined amount is paid to the hospital for each admission. The hospital is then at risk for the treatment and the length of stay. Powers, supra note 64, at 295-96.

\textsuperscript{139} A hospital is paid a lump sum per enrollee in the hospital's service area to provide all covered hospital services required by those enrollees. Because the hospital's payments are independent of the actual services rendered by the hospital, the hospital assumes the role of an insurer. \textit{Id.} at 296-97.

\textsuperscript{140} All methods of payment implicitly involve financial incentives. The fee for service method provides as much incentive to overutilize as withholding can provide to underutilize. Alan L. Hillman et al., \textit{How Do Financial Incentives Affect Physicians'}
Consequential

Because many diseases and health conditions have wide
variation in treatment, the loss to the physician can be signifi-
cant. Consequently, these methods produce the greatest risk of undertreatment.

On the other hand, if the financial risk shifting places
the risk on the organization employing the physician, that risk
shifting is less likely to interfere with the physician's attempts
to act in the patient's best interest. Finally, cost contain-
ment efforts that place explicit restrictions on the physician's
decision making are less likely to result in injury than cost con-
tainment efforts whose effects may be hidden from the patient,
from the physician, and from society.

Most plans do not place providers at individual risk. Nev-
ertheless, third-party payers encourage competition among
providers by basing the provider's financial rewards or penal-
ties on the utilization experience of the individual provider in
relation to the group.

At what point does a financial incentive create a conflict of
interest, in which physicians' behavior may be motivated sub-
stantially by pecuniary self-interest rather than by the
patient's best interest? As [managed care products] con-
tinue to grow and as more physicians continue to sign con-
tracts with them, these concerns will intensify.

C. Effects of Cost Containment Measures on Health Care

Cost containment activities affect health care systems in
several ways. First, cost containment can affect the quality of
care received by patients. Second, financial risk shifting
changes the fundamental ethical basis of the health care sys-
tem. Finally, cost containment potentially restricts access not
only to types of services but to minorities, underserved popula-
tions, and others who already have limited access.

141. See supra note 60 and accompanying text.
142. See Capron, supra note 47, at 735-36 (noting the wide variations in
treatment).
143. Id. at 749-50.
144. Id. at 750.
145. Hillman, supra note 128, at 1744.
1. Assuring Quality Care in the Managed Care Product

Quality health care requires a high level of health care services that assist an individual in remaining free from physical and mental incapacity while maximizing social capacity. In a third-party payer-driven market, the main challenge is structuring quality assurance activities to protect quality care in the face of counterproductive financial incentives.\(^\text{146}\) The Council on Medical Service for the AMA (the Council) defines high-quality care as that which "consistently contributes to improvement or maintenance of the quality and/or duration of life."\(^\text{147}\) Another definition of quality care is the "component of the difference between efficacy and effectiveness that can be attributed to care providers, taking into account the environment in which they work."\(^\text{148}\) Both definitions are strikingly nonspecific and create, rather than solve, problems of definition. In an effort to help clarify its definition, the Council established eight factors that it believes are necessary for quality care delivery:

1. the production of optimum improvement in the patient's physical condition and comfort;
2. the promotion of prevention and early detection of disease;
3. the timely discontinuation of unnecessary care;
4. the cooperation and participation of the patient in the care process;
5. the skilled use of necessary professional and technological resources;
6. concern for the patient's welfare;
7. efficient use of resources; and
8. sufficient documentation of medical records to ensure continued care and for evaluation of the care by peer review.\(^\text{149}\)

Physicians have long had a concern for quality care.\(^\text{150}\) Many believe that the quality of care must suffer to achieve cost

\(^{146}\) Ossario, supra note 3, at 199-200.
\(^{147}\) Burgess, supra note 94, at 289 (quoting AMA Council on Medical Service, Quality of Care, 256 JAMA 1032 (1986) [hereinafter Quality of Care]).
\(^{148}\) Id. at 289 n.120 (quoting Quality Medical Care: Empiricism v. The Gestalt, in National Health Lawyers Association 1987 Health Law Update 1.3 (1987)).
\(^{149}\) Id. at 289 (citing Quality of Care, supra note 147, at 1032).
\(^{150}\) For instance, physicians reviewed the competence of their peers through state agencies and local medical societies. Similarly, hospitals monitored medical staff performance to maintain accreditation and minimize liability. Betsy A. Rosen, Comment, The 1985 Medical Malpractice Reform Act: The New York State Legislature Responds to the Medical Malpractice Crisis with a Prescription for Comprehensive
control. Unfortunately, there is very little information available about quality assurance in managed care products. The absence of well-defined standards in an industry bent on cutting costs poses serious problems for patients. Historically, we have seen how the profit motive worked to increase utilization. There is no reason to think that similar dysfunctions will not occur in a system designed to enhance profits by decreasing utilization. Cost containment is the raison d'être for third-party payers. Without comprehensive utilization review and financial risk shifting, third-party payers cannot contain costs. But if cost containment becomes simply an excuse for sacrificing quality care, those whose benefit should be the focus of the entire system—the patients—will suffer.

To argue that patients have a choice and can seek care outside the plan is unrealistic and even irrational. In reality, many individuals must forego uncovered treatment because of financial constraints. Furthermore, providers influenced by financial concerns may not even offer uncovered treatment to particular patients.

Some argue that if society intends to influence provider behavior and thus create a risk to the individual patient, reasonable behavior based on that influence should be a defense to a medical malpractice claim. If reasonable cost containment

Reform, 52 BROOK. L. REV. 135, 144-45 n.49 (1986); see Quality of Care, supra note 147, at 1032.


152. See Burgess, supra note 94, at 288-91. This is in part due to the difficulty of defining and measuring quality. As a result, managed care products have had substantial flexibility in setting quality assurance standards. Id. at 292.

153. Id.

154. For instance, a California study found that for-profit hospitals had the highest rate of repeat Cesarean sections. HEALTH LAW. NEWS REP., supra note 3, at 5.

155. Burgess, supra note 94, at 292. In fact, insufficient financial incentives have been connected with the breakdown of several managed care products including SAFECO's United Health Care Experiment. See generally Steven S. Sharfstein, Financial Incentives for Alternatives to Hospital Care, 8 PSYCHIATRIC CLINICS OF N. AM. 449-60 (1985).


157. Id.

158. E.g., Morreim, supra note 3, at 1719 (arguing that the presumption of a unitary standard of care be refutable by appropriate evidence of economic constraints).
was a valid defense to malpractice, however, what would happen to the patient injured by cost containment efforts? It is unfair to both encourage and entice providers to practice cost control and then to hold them individually responsible for consequent injuries. But it is no more fair to allow the injuries of innocent patients to go uncompensated. Current legal theories are neither adequate to encourage third-party payers to act cautiously, nor are they adequate to shift the burden of proof.\textsuperscript{159} Thus, if legal theories remain unchanged, it appears inevitable that the quality of care will change, resulting in significant burdens on patients and providers. These burdens will appear unless third-party payers are held responsible for structuring systems that maintain quality care while containing costs.

Yet, these quality care systems do not appear to be developing.\textsuperscript{160} An overwhelming obsession with cost containment has caused developers of managed care products to essentially ignore quality assurance. The products, specific and detailed in their utilization requirements, generally address the issue of quality care in a vague and nonspecific manner. For instance, typical contract language states that “the provider is solely responsible for the quality of services rendered to a member.”\textsuperscript{161} This shifting of total responsibility for quality to providers is unacceptable. Third-party payers are using financial incentives to deliberately influence providers' behavior to emphasize cost containment, possibly at the expense of quality care, while at the same time contractually passing the buck for the consequences of that emphasis. The government has made only minimal efforts to regulate managed care products. Instead, because managed care products focus on cost containment, the

\textsuperscript{159} See infra part IV.

\textsuperscript{160} HMOs are required to administer comprehensive quality assurance to meet statutory and regulatory requirements. Burgess, supra note 94, at 289. Consequently, the National Committee for Quality Assurance (NCQA), incorporated in 1979, has established standards to measure HMOs. Id. at 289-90. However, those standards tend to be targeted on organizational issues and administrative and clinical problems. Id. at 289-91. Another method suggested for monitoring and assessing quality of care is the use of audit reports. Independent physicians examine the managed care products' medical records after the patient is discharged. Id. at 290; see Arnold Milstein et al., \textit{Auditing Quality of Care: An Employer Based Approach}, \textit{Bus. & Health}, July-Aug. 1986, at 10. While audits may provide performance snapshots of quality of care, they do not necessarily identify what the quality of care should be. The AMA has proposed that the Joint Commission on Accreditation of Hospitals be given the sole authority to develop standards of care for the health care industry. Burgess, supra note 94, at 290-91.

\textsuperscript{161} Stevens, supra note 98, at 9 (emphasis omitted).
government has encouraged their growth and is reluctant to regulate.\textsuperscript{162}

If society desires to reduce costs by changing providers' behavior, it must also establish legal safeguards to deal with predictable adverse consequences of that altered behavior. Several consequences are predictable: (1) Third-party payers will place increasingly effective utilization review and risk-shifting requirements on providers to cut costs and to increase profits; (2) Some third-party payers will attempt to increase profits by placing increasingly severe penalties and incentives on providers;\textsuperscript{163} (3) Some providers will respond to the risk-shifting incentives by cutting out not only unnecessary services but also by eliminating some marginally necessary services and even some medically necessary care; and (4) Some determinations by utilization review agencies will be made arbitrarily or solely on the basis of cost. It is also predictable that some individuals will be injured because they do not receive necessary care. Given these predictable problems, we should not allow a system to develop that places the risk of injuries from cost containment on the individual rather than on society.

2. Maintaining the Ethical Basis of Health Care

There is a danger that financial risk shifting will undermine the fundamental ethical basis of the health care system. Historically, the health care system has been based on a belief in the sanctity of the physician-patient relationship. Physicians have had an ethical and legal responsibility to act in the patient's best interest. In addition, although access has not been actually assured, Americans have often articulated a belief that access to health care is a fundamental right.\textsuperscript{164} Any risk shifting by third-party payers to physicians and hospitals will necessarily impact these beliefs.\textsuperscript{165} Yet, the third-party payers'...
inducements to physicians are, as one author has stated, "blatantly unethical."\textsuperscript{166}

Without a mechanism for quality control, it [is] blatantly unethical to entice physicians to alter their approach to patient care through either the prospect of personal financial gain or peer-group pressure. A patient comes to a physician to receive an expert opinion—an objective assessment of a particular problem or the best therapy. To have that opinion colored by external incentives . . . creates an unethical conflict of interest that is potentially dangerous to the patient. In addition, [it] further [deteriorates] the medical profession in the public opinion. . . .[The] patient's welfare must be the physician's main concern.\textsuperscript{167}

The ethical basis of the health care system is necessarily founded on a certain amount of trust.\textsuperscript{168} When a patient seeks care from a physician, the patient must believe that the physician will act in the patient's best interest and will not put other interests before that of the patient. The patient usually does not have the training to judge the reasonableness of the physician's decisions about her health care needs and alternative means of meeting those needs.\textsuperscript{169} Thus, the physician, not the


\textsuperscript{167} Id.


Implicit in such a contract is that the physician can be trusted to treat the patient's health needs and interest as central, thus minimizing the need for the patient to be defensive or to withhold information. Both the status of the physician and the ethical bases of his practice facilitate the patient's willingness to put his health in the hands of the physician with little demand for detailed explanations or monitoring of the physician's decisions. This is not to imply that physicians have always conformed to these ethical mandates or that patients have generally been docile, but only that the physician's authority has been assumed to be part of the ordinary understanding of relationships between physicians and patients and their respective responsibilities.

David Mechanic, \textit{Therapeutic Relationship; Contemporary Sociological Analysis}, in \textit{Encyclopedia of Bioethics} 1688 (Warren T. Reich ed., 1978), \textit{quoted in} Capron, supra note 47, at 737 n.113. The courts have also recognized this trust relationship: "The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject." Canterbury v. Spence, 464 F.2d 772, 782 (D.C. Cir. 1972).

\textsuperscript{169} Capron, supra note 47, at 738.
patient, combines the components of care into treatment. It is essential that the patient trust that the physician will *primum non nocere*—first do no harm.\textsuperscript{170}

This trust will clearly be undermined by cost containment efforts.\textsuperscript{171} Even the suspicion that physicians no longer act in patients' best interest will cause anxiety and increase distrust. When there are actual injuries, the distrust will be reaffirmed and intensified. As the distrust becomes more and more significant, distrust may further exacerbate any unfavorable health outcomes.

3. Maintaining Access to Health Care

Changing the payment structure and the underlying system motivations not only affects quality and the physician-patient relationship, it also negatively affects access to health care. This is no small issue because access to health care is already a significant problem for many Americans.\textsuperscript{172}

Access problems caused by cost containment efforts occur in several ways. The first occurs when plans have systemic variations in the level of financial protection for the individual against health care costs.\textsuperscript{173} Under those circumstances, access will be affected as patients' ability to afford health care changes. Furthermore, as plans further shift financial risk to providers, patient access will be affected as providers who are intent on avoiding cost containment penalties or obtaining cost containment rewards do not order services for patients.\textsuperscript{174}

\textsuperscript{170} See id. at 737-38.  
\textsuperscript{171} See id. at 738.  
\textsuperscript{172} At any one time, up to 25 million Americans lack health insurance. That amounts to about 11% to 12% of the noninstitutionalized population. Because of loss of coverage or change of employment status, in any given year over 16% of Americans will not have insurance. Id. at 740-41 n.119.  
\textsuperscript{173} Individuals and agencies engaged in utilization review traditionally maintain that they make their decisions for the limited purpose of determining payment, not for the purposes of determining the course of treatment or access to care. Hinden & Elden, *supra* note 97, at 54. "Just because we refuse to pay for the service," the argument goes, "does not mean the patient cannot get whatever treatment she desires." Even if that argument had any validity, the reality is that for many people a denial of payment is a denial of treatment. Id. Thus, a health care system based on third-party payers that ration health care resources on the basis of ability to pay will exacerbate the problem of access. Morreim argues that these changes in the health care delivery system will more heavily burden the indigent. She argues that the problem is not so much one of "pervasive resource shortage" but of "stratified scarcity." Morreim, *supra* note 3, at 1722.  
\textsuperscript{174} If different cost containment programs produce markedly different financial rewards for physicians, then physicians are likely to refuse to participate in programs or
Thus, the effectiveness of a plan's cost containment efforts will affect the patients' ability to obtain certain health care services. In addition, third-party payers can control costs by severely limiting the availability of certain resources. Finally, access will be limited by differences in the quality of services. If patients perceive a managed care product to provide poor services, they are likely to forego the services, even though no other services may be available.

175. Alternative sources of care cannot be expected to fill the gaps of access created by the withdrawal of physicians who do not believe that a particular program rewards them sufficiently. As noted by one author, "patients with 'substandard' third-party reimbursement rates have difficulty commanding the attention, much less the loyalty of many physicians." Id. at 747; see also Peter H. Elias, Physicians Who Limit Their Office Practice to Insured and Paying Patients, 314 New Eng. J. Med. 391 (1986) (letter to editor). Cost containment measures that shift financial risks of treating patients from the third-party payer to the provider may have an effect on access to care that other types of cost containment efforts will not have. Capron, supra note 47, at 751-53. Providers might overcome price-lowering efforts by increasing the number of service units. However, they can only beat risk shifting by excluding high risk patients from their practice. See id. at 728. But see Harold S. Luft, Health Maintenance Organizations and the Rationing of Medical Care, 60 Milbank Memorial Fund Q. 268, 299 (1982) (arguing that providers' disinclination to serve certain populations might be overcome if a higher premium is charged for those enrolled). For example, some cost containment efforts have disincentives that penalize the physician for accepting the sickest and poorest patient, "the very ones who have the hardest time obtaining health care." Capron, supra note 47, at 752.

176. See Capron, supra note 47, at 742.
A utilization review’s prospective decision is fundamentally different in its impact on the beneficiary than a retrospectively made decision.\textsuperscript{177} While in both instances, patients theoretically know what treatments their plan will pay for, the plans’ effects on patient behavior are significantly different. In the retrospective system,\textsuperscript{178} a patient makes a decision about medical care and receives the medical care with only a potential risk of disallowance.\textsuperscript{179} On the other hand, in a prospective system,\textsuperscript{180} a patient knows in advance of treatment that the third-party payer will not pay for the recommended treatment. The patient’s only chance of recovering the cost of that recommended treatment, if she can now even obtain it, is in a challenge to the third-party payer’s decision.\textsuperscript{181} Thus, a patient in the prospective system is less likely to pursue treatment options not authorized by the plan.\textsuperscript{182}

By shifting incentives and creating the disincentive that results from having one’s own finances at risk, the new methods of provider reimbursement turn providers into gatekeepers for the health care system. Their decisions would no longer be based on medical criteria alone (i.e., “does this medicine have something to offer this patient?”) but would now take into account their own financial risk if they admit patients into the system whose care costs more than insurance will pay.\textsuperscript{183}

These considerations may undermine both the patients’ trust in the system and the patients’ access to care.

\textbf{D. Summary}

No matter how risk shifting reimbursement schemes are viewed, they will eventually alter the perceptions and expectations of society, physicians, patients, and third-party payers about what is owed to whom, what treatments are appropriate in what circumstances, and even what qualifies as a disease.\textsuperscript{184} These altered perceptions may create a denial of access on the ground that a patient’s condition is not meaningful in cost con-

\begin{itemize}
  \item \textsuperscript{177} Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992).
  \item \textsuperscript{178} See supra note 110 and accompanying text.
  \item \textsuperscript{179} Corcoran, 965 F.2d at 1332.
  \item \textsuperscript{180} See supra notes 111-112 and accompanying text.
  \item \textsuperscript{181} Corcoran, 965 F.2d at 1332.
  \item \textsuperscript{182} Id.
  \item \textsuperscript{183} Capron, supra note 47, at 753.
  \item \textsuperscript{184} Id. at 749.
\end{itemize}
tainment terms, without regard to an assessment of whether the patient’s condition is individually meaningful. If a denial of appropriate medical care results in injury because of cost contain-ment efforts, who shall bear the burden? If cost contain-
ment is an important social goal, then the cost of injuries created by it should be spread throughout society.185 Unfortunately, traditional tort theories of liability are inadequate to spread the cost throughout society, promote safety, or compensate patients.

IV. TRADITIONAL THEORIES OF LIABILITY

Third-party payers using managed care products induce, through utilization review and financial risk shifting, health care providers to make health care decisions based on economic pressures. If those decisions result in injury to the patient, under what theory, if any, can a third-party payer be held liable? If theories producing liability exist, a more important issue is whether they will have the effect of promoting safety and spreading the cost of injuries. There are several theories of liability for injury that might be adaptable to cover the problems created by the peculiar relationships among providers, patients, and third-party payers.

Both insurance and managed care products are in perverse relationships with providers in that they can cause providers to act in unacceptable ways. With insurance, the problem of moral hazard exists. Insurance causes the physician to provide services without regard to cost. Managed care, on the other hand, may cause providers to deny services without regard to need because they act in the best interest of the third-party payer. In a health care system that emphasizes acting in the patient’s best interest, current legal theories are adequate. But these theories are inadequate when applied to the perverse relationship between providers and third-party payers. Current legal theories fail to cause third-party payers to act with care when designing utilization review programs or when giving financial incentives to providers to act in the third-party payers’ best interest. Furthermore, because patients infrequently recover

185. Soon third-party payers will routinely withhold (or decline to pay for) interventions that might benefit certain patients but that simply cost too much because society collectively may choose not to “check on physicians’ temptation to place their own interest ahead of their patients’ interests. Instead society [attempts] to use physicians’ selfish motivation to restrain full pursuit of patients’ interest.” Id. at 749.
from third-party payers under current theories, the theories fail to meet the goal of spreading the risk to those who create it.

This Part discusses the inadequacy of four traditional theories as they might be applied to cost containment efforts. Section A discusses negligence or direct liability for utilization review and financial risk shifting activities. Section B considers the effectiveness of the corporate negligence doctrine in compensating for cost containment injuries. Section C contemplates the use of the doctrine of respondeat superior. Section D describes the use of the ostensible agency doctrine to compensate for cost containment effects. These traditional theories of liability are inadequate when applied to cost containment efforts because they fail to adequately promote safety, spread the risk, and compensate patients.

A. Negligence (or Direct Liability) for Injuries Caused by Cost Containment Measures

A party can be held liable for injuries caused by its failure to conform to a standard of care, that is, when the party has been negligent. Negligence, as a theory, has proved inadequate as a risk spreader in health care primarily because medical practice is as much an art as a science. Consequently, the current tort system has difficulty distinguishing between medical judgment and negligent conduct.

Should a CAT scan be performed to detect the unlikely tumor, even though such a test is expensive and carries with it a small risk of complications including death? Should the physician forego the test if the best clinical judgment so dictates, or is the doctor better off ordering the test anyway to protect against a malpractice suit in the event a tumor actually is present?

By deferring to professional practice, negligence theories allow the profession to define the standard of care. Thus, the negligence approach places the patient at a theoretical disadvantage because distinguishing between a judgment call and negligence depends in large part on for whose benefit an expert witness is testifying. Consequently, many injured patients do not file negligence claims, in part because of the problem of

187. Id.
proving negligence. Of those who actually file suit, many patients are not able to establish fault. Finally, even if the injured patient wins at trial, it usually takes many years of litigation before she is compensated. Thus, under the present negligence scheme, compensation resembles a tort lottery. As such, negligence theory is an unreliable source of compensation for patients, including those injured by third-party cost containment efforts.

Third-party cost containment efforts further complicate this situation because they push more of the provider’s practice from clearly negligent behavior to judgment calls. As cost containment measures become more and more prevalent, a component of the standard of reasonable care will necessarily be whether the physician acted in reliance on reasonable cost containment efforts. The leading case as to third-party payer liability for cost containment through utilization review and financial risk shifting activity is Wilson v. Blue Cross.

In Wilson v. Blue Cross, Mr. Wilson, the decedent, had an insurance contract with Alabama Blue Cross, which was administered by Inter-plan Service Benefit Bank. California Blue Cross provided the benefits of the insurance contract between Alabama Blue Cross and Mr. Wilson. The contract provided inpatient hospital benefits as follows:

INPATIENT HOSPITAL SERVICE.

While a Member is covered under this Contract and is a registered bed patient in a Hospital, and during such time (subject to the limitations, exclusions, and conditions prescribed elsewhere herein) as the Member’s attending physician determines that hospitalization is necessary, such

188. Id. at 243.
190. Personal injuries are adjudicated in an average of seven years. Only half of all malpractice cases are closed within 18 months after they are opened, and 10% remain open over 6 and a half years. Tan, supra note 186, at 243 n.13.
193. Id. at 880.
194. Id. at 878.
Member shall be entitled to the following benefits, herein referred to as Hospital Service. . .

Benefits for mental and nervous disorders were provided as follows:

**BENEFITS FOR MENTAL AND NERVOUS DISORDERS OR FOR PULMONARY TUBERCULOSIS.**

Benefits hereunder for mental and nervous disorders or for pulmonary tuberculosis shall be limited to an aggregate of thirty (30) days during any period of twelve (12) consecutive months.196

Nothing in the insurance contract permitted review by an outside entity of an attending physician's conclusion that hospitalization was necessary.197 In 1983, Western Medical, a utilization review consulting firm, contracted with California Blue Cross to perform "utilization review of the 'medical necessity'" of hospitalization.198 Western Medical did not have a contract with Alabama Blue Cross.199

Mr. Wilson suffered from major depression, drug dependency, and excessive weight loss. He was admitted to College Hospital on March 1, 1983.200 His treating physician, Dr. Taff, decided that Mr. Wilson needed three to four weeks of inpatient care at the hospital.201 Western Medical performed a "concurrent review" using federal Medicare regulations and decided that the hospitalization was not medically necessary.202 Ten days later, Mr. Wilson's insurance company refused to pay for any further hospital care.203 Because neither Mr. Wilson nor his family could afford to pay for any further inpatient hospital care,204 Dr. Taff discharged him without appealing Western

195. Id. at 880 (emphasis added).
196. Id.
197. Id. at 881.
198. Id.
199. Id.
200. Id. at 877, 881.
201. Id. at 882.
202. Id.
203. Id.
204. When Mr. Wilson was informed that he would "not be covered financially by his insurance company and that the liability [for hospital costs] would then be his," he cried while talking to an aunt. Id. Mr. Wilson's aunt said that the family did not have enough money to pay for the cost of inpatient hospitalization and that Dr. Taff told her "to come and get him." Id. Further, she testified that Dr. Taff told Mr. Wilson's mother and father that Western Medical "terminated his [the decedent's] stay" and that this was a "problem" that had occurred on other occasions. Id.
Medical's utilization review.\textsuperscript{205} On March 31, 1983, Mr. Wilson committed suicide.\textsuperscript{206}

In a suit brought by Mr. Wilson's father, the trial court issued summary judgment for Blue Cross on the ground that \textit{Wickline v. State}\textsuperscript{207} controlled. The appellate court reversed and remanded, holding that a triable issue existed as to whether the conduct of Blue Cross was a substantial factor in causing the decedent's death.\textsuperscript{208} \textit{Wickline}, the appellate court reasoned, erred in relieving the third-party payer from liability.\textsuperscript{209} The \textit{Wilson} court reasoned correctly. The purpose of utilization review is to affect providers' decisions regarding medical services. When the system works appropriately, third-party payers reap the cost containment benefits. Having initially injected cost containment into medical decision making, third-party payers should not be allowed to cloak themselves with immunity merely because the providers acceded to the cost containment decision of the third-party payer.

\textit{Wickline} involved three key components, legal and factual, that the \textit{Wilson} opinion specifically distinguished. First, \textit{Wickline} held that as a matter of law, the discharge decision by the attending physician met the medical standard of care for physicians.\textsuperscript{210} The \textit{Wilson} court distinguished \textit{Wickline} on this point

\begin{itemize}
\item \textsuperscript{205} \textit{Id.}
\item \textsuperscript{206} \textit{Id.} at 878.
\item \textsuperscript{207} 239 Cal. Rptr. 810 (Ct. App. 1986). In \textit{Wickline}, Ms. Wickline's physician requested an eight-day extension of her stay in the hospital. Medi-Cal denied the request and authorized an additional four days of hospital stay beyond the originally scheduled discharge date. Complying with the limited extension authorized by Medi-Cal, Ms. Wickline was discharged on January 21, 1977. At Ms. Wickline's discharge, her leg did not appear in any danger. Ms. Wickline began to experience pain and discoloration soon after arriving home. Nine days after the discharge, she was admitted to the hospital for cloting in the right leg, no circulation to that leg, and an infection at the graft site. After unsuccessful attempts to treat Ms. Wickline's conditions, the doctors amputated her leg above the knee. \textit{Id.} at 814-17. The court in \textit{Wickline} held that a person can recover from a third-party payer only if medically inappropriate decisions result from defects in design or implementation of cost containment mechanisms. \textit{Id.} at 819-20. Such defects are limited to requests for services that are arbitrarily ignored, unreasonably disregarded, or unreasonably overridden. \textit{Id.} The court held that the state had not unreasonably overridden the physician's decision to discharge Ms. Wickline because the physician had not pursued every avenue of appeal and complied with the third-party payer's decision without protest. \textit{Id.} The physician could be held responsible for the injury because he failed to protest the third-party payer's decision through all possible steps. \textit{Id.}
\item \textsuperscript{208} \textit{Wilson}, 271 Cal. Rptr. at 885.
\item \textsuperscript{209} \textit{Id.}
\item \textsuperscript{210} \textit{Id.} at 883. The Medi-Cal standard for determining whether to provide acute care was essentially the same as the medical standard of care. \textit{Id.} at 879.
\end{itemize}
by noting that no evidence indicated that the discharge decision was within the medical standard of care.\footnote{211} To the contrary, Dr. Taff testified that reasonable treatment required inpatient treatment on March 11, 1983, and that had Mr. Wilson completed his planned hospitalization, there was a reasonable medical probability that he would not have committed suicide.\footnote{212}

Second, in \textit{Wickline}, the funding process was based on the state's statutory rather than contractual duty to provide funds.\footnote{213} \textit{Wilson} is distinguishable because, in \textit{Wilson}, neither a statute nor a regulation affected the duty owed by Blue Cross. Blue Cross's duty to Wilson was based on contract, while in \textit{Wickline}, a specific statute allowed the denial of benefits to a person seeking acute hospital care when the denial was "in accordance with the usual standards of medical practice in the community."\footnote{214}

Finally, in \textit{Wickline}, the court held that the Medi-Cal review process did not "corrupt medical judgment."\footnote{215} In \textit{Wilson}, Blue Cross argued that, as in \textit{Wickline}, the physician had sole responsibility for medical treatment decisions.\footnote{216} The \textit{Wilson} court rejected that argument, stating in dicta as follows:

[T]he argument is likewise invalid because it misconstrues the test for joint liability for tortious conduct. The test for joint tort liability is set forth in section 431 of the Restatement (Second) of Torts, which provides, "The actors' negligent conduct is a legal cause of harm to another if (a) his [or her] conduct is a substantial factor in bringing about the harm, and, (b) there is no rule of law relieving the actor from liability because of the manner in which his [or her] negligence has

\footnote{211} See id. at 881-82.
\footnote{212} Id. at 882.
\footnote{213} Under the California Civil Code, "(e)very one is responsible, not only for the result of his [or her] willful acts, but also for an injury occasioned by another by his [or her] want of ordinary care or skill." \textit{Wickline}, 239 Cal. Rptr. at 810 (citing \textit{Rowland v. Christian}, 443 P.2d 561 (Cal. 1968)). As rephrased by the \textit{Wickline} court, "All persons are required to use ordinary care to prevent others being injured as a result of their conduct." \textit{Id.} "In the absence of statutory provision [sic] declaring an exception to the fundamental principle enunciated by section 1714 of the Civil Code, no such exception shall be made unless clearly supported by public policy." \textit{Id.} at 818. In \textit{Wilson}, however, the Welfare and Institutions Code and Title 22 of the California Administrative Code constituted an exception to the usual standard of tort liability specified in Civil Code § 1714. \textit{Wilson}, 271 Cal. Rptr. at 878.
\footnote{214} \textit{Wickline}, 239 Cal. Rptr. at 819 (citation omitted).
\footnote{215} Id. at 820.
\footnote{216} \textit{Wilson}, 271 Cal. Rptr. at 883.
resulted in the harm." Section 431 correctly states California law about the issue of causation in tort cases.217 Thus, the court held that a third-party payer is responsible when that third-party payer's actions are a substantial factor in bringing about the injury.218

The Wilson appellants argued that "public policy considerations which favor the use of the concurrent utilization process should alter the normal rules of tort liability."219 The court rejected the argument, noting that in Wickline the California Administrative Code and the Welfare and Institutions Code mandated the use of utilization review processes.220 A specific statute provided for denial of benefits "in accordance with the usual standards of medical practice in the community."221 The court found no "similar clearly expressed public policy that applies to [Mr. Wilson's] contract with Alabama Blue Cross."222

Finally, Western Medical argued that Dr. Taff had the responsibility to pursue avenues of appeal when insurance benefits were denied because of the utilization review process.223 The Wilson court again rejected the Wickline dicta stating that the doctor who "complies without protest with the limitations imposed by a third-party payer, when [her or] his medical judgment dictates otherwise, cannot avoid his [or her] ultimate responsibility for her [or his] patient's care."224 The court distinguished Wilson as involving a claim by a decedent's estate and relatives directly against insurance companies and their agents, not against a physician, and stated that the informal policy allowing for reconsideration by Western Medical did not warrant granting summary judgment.225 Thus, summary judgment should not have been granted for Western Medical because there were "triable issues of material fact as to Western Medical's liability for tortious interference with the contract of insurance between [Mr. Wilson] and Alabama Blue Cross and its role in causing the wrongful death of [Mr. Wilson]."226

217. Id. (citation omitted).
218. Id.
219. Id.
220. Id. at 879.
221. Id. at 878 (quoting Wickline, 239 Cal. Rptr. at 810).
222. Id. at 884.
223. Id.
224. Id. (quoting Wickline, 239 Cal. Rptr. at 810).
225. Id.
226. Id. at 885.
By rejecting Wickline, the court brought the issue of third-party payer liability into focus: Did the third-party payer substantially cause the injuries to the plaintiff, either negligently or intentionally (tortiously)? This is the issue that all courts should address because, if courts adopt the Wilson reasoning, a significant step in the right direction would be made. Nevertheless, because most courts continue to focus on the character of the decision-making conduct rather than the inevitability of effects on the individual patients, the problems of burden of proof continue to prevent liability from attaching.

The problems surrounding the burden of proof are particularly severe when third-party payers can make the tort system ineffective by redefining the reasonableness of their behavior in their favor. This problem is evidenced by the retrial of Wilson, when the jury found that Blue Cross had not been negligent. Thus, even direct liability does not adequately address the goals of risk spreading and compensation. Such goals can be met only through an alternative theory of third-party payer liability.

B. Corporate Negligence Doctrine

A health care organization can be held liable not only for its own negligence causing harm to a patient, but also as a corporate entity when it fails to adequately protect a patient from harm by others. In the last hundred years, the primary organizational structure for the delivery of health care has been the hospital. A hospital’s legal duty to patients was based on the view that a hospital was analogous to an innkeeper in providing facilities for physicians to practice medicine. While the hospital might be liable for harm caused by its physical facilities or

227. Wickline, supra note 1.
228. Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 258 (II. 1965) (holding that hospitals could be found liable for the negligent selection and supervision of medical staff members). Whether a physician is an employee or an independent contractor depends on a number of factors including the degree of control, method of payment, and the ownership and provision of instrumentalities used by the physician. Restatement (Second) of Agency § 220 (1958); David J. Oakley & Eileen M. Kelley, HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs, 23 Tort & Ins. L.J. 624, 627-29 (1988); Catherine Butler, Note, Preferred Provider Organization Liability for Physician Malpractice, 11 Am. J.L. & Med. 345, 350-54 (1985).
229. Hinden & Elden, supra note 97, at 26.
its employees, it was deemed powerless to prevent harm at the hands of the physician. Corporate negligence theory replaced that traditional view with the view that a hospital owes the patient a separate and independent duty to protect her from harm. The hospital's responsibility to the patient extends beyond merely refraining from causing harm. The duty includes a number of responsibilities: to provide proper overall surveillance of the quality of patient care services; to properly review and investigate the credentials and expertise of medical staff applicants before granting privileges; to protect patients from malpractice by members of its medical staff when, through reasonable care, it should have known that malpractice was likely; to use reasonable care in maintaining the facility.


231. See generally Hinden & Elden, supra note 97 at 26-27. But see Rhoda v. Aroostook Gen. Hosp., 226 A.2d 530 (Me. 1967) (holding that the nonliability rule of charitable immunity extends to shelter a hospital corporate charity from liability for its own corporate negligent acts, including the selection, training, and supervision or control of its personnel or employees).

232. Fridena v. Evans, 622 P.2d 463 (Ariz. 1980) (finding that a hospital's duty includes an obligation to take reasonable steps to monitor and to review the treatment being received by a patient); Poor Sisters of St. Francis Seraph of the Perpetual Adoration, Inc. v. Catron, 435 N.E.2d 305 (Ind. Ct. App. 1982) (holding that a hospital can be held liable for negligence when a nurse or other hospital employee follows a doctor's orders despite knowledge that the doctor's orders are not in accordance with normal medical practice).

233. Jackson v. Power, 743 P.2d 1376 (Alaska 1987) (finding a duty by a hospital to ensure that physicians granted hospital privileges are competent and to supervise medical treatment provided by members of its medical staff); Insinga v. LaBella, 543 So. 2d 209 (Fla. 1989) (holding hospital liable for its negligent decision to grant staff privileges); Joiner v. Mitchell County Hosp. Auth., 186 S.E.2d 307 (Ga. Ct. App. 1971) (finding that a hospital may be held liable for negligent selection of new staff physicians, but not when it selects authorized physicians in good standing), aff'd, 189 S.E.2d 412 (Ga. 1972); Copithorne v. Framingham Union Hosp., 520 N.E.2d 139 (Mass. 1988) (holding hospital liable for the failure to withdraw staff privileges when it has received notice of the misconduct of a staff physician); Blanton v. Moses H. Cone Memorial Hosp., Inc., 354 S.E.2d 455 (N.C. 1987) (holding that a hospital owes duty of care to its patients to ascertain that a doctor is qualified to perform an operation before granting him the privilege to do so); Corleto v. Shore Memorial Hosp., 350 A.2d 554 (N.J. Super. Ct. Law Div. 1975) (holding a hospital liable for negligent selection and retention of a staff physician when the physician's incompetence was obvious); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981) (holding hospital liable when it failed to exercise reasonable care to determine whether physician was qualified to receive privileges).

234. Joiner, 186 S.E.2d at 307; see also Sewell v. United States, 629 F. Supp. 448 (W.D. La. 1986) (stating that a hospital can be held liable for a physician's failure to consult a specialist where the failure was below the appropriate standard of care); Ingram v. Little Co. of Mary Hosp., 438 N.E.2d 1194 (Ill. App. Ct. 1982) (holding that a
and providing medical instruments and equipment; and to use care in selecting and supervising medical personnel.

In Darling v. Charleston Community Memorial Hospital, the first and most widely followed corporate negligence case, the court recognized the hospital's obligation to oversee the quality of patient care services.

Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and [interns], as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

While hospitals are not guarantors of adequate health care, establishing hospital corporate negligence does not turn on the relationship between the physician and the hospital. A primary justification for the corporate negligence doctrine is the hospital may be liable for a physician or an agent's misconduct as well as a violation of its duty to review and supervise medical care).

235. Emory Univ. v. Porter, 120 S.E.2d 688 (Ga. Ct. App. 1961) (holding that a hospital could be held negligent for failing to furnish adequate equipment); Hamil v. Bashline, 485 A.2d 1204 (Pa. 1982) (holding that a hospital is under a duty to adequately procure and maintain equipment).


237. 211 N.E.2d 253 (Ill. 1965). In Darling, a plaintiff who broke his leg while playing in a college football game was awarded $150,000 by a jury after his leg was amputated because of the attending doctor's negligence. Id. at 255. The court rejected the historical view of a hospital's limited duty. Id. at 257.

238. Id. (quoting Bing v. Thunig, 143 N.E.2d 3, 8 (N.Y. 1957)).

239. See Purcell v. Zimbelman, 500 P.2d 335, 340-41 (Ariz. Ct. App. 1972). In Purcell, Dr. Purcell, a private practitioner, was selected by Mr. Zimbelman to perform an abdominal surgical procedure for cancer. As a result of the doctor's negligence, Mr. Zimbelman lost a kidney, lost sexual function, had a permanent colostomy, and had urinary problems. Id. at 339-40. The hospital knew that Dr. Purcell's two prior operations for abdominal cancer using the same procedure had resulted in lawsuits, and that two other surgical procedures performed by Dr. Purcell had also resulted in lawsuits. Id. at 343. Even though Dr. Purcell was clearly an independent contractor and no evidence was presented indicating that he may have been an actual or apparent agent of the hospital, the hospital was ultimately responsible for the quality of care provided in the institution. See id. at 341.
hospital's custody of the patient. Although a managed care product does not have custody, the duty to protect from harm may nevertheless arise from the process of selecting physicians or other medical personnel for the managed care product. This is particularly true when the managed care product restricts a patient's choice of provider. Thus, as with hospital liability, a managed care product should be liable for failing to properly review and investigate the credentials and expertise of provider panel applicants, and for failing to protect its subscribers from malpractice by provider panel members when it knew or should have known, through reasonable care, that such malpractice was likely.

The court in Harrell v. Total Health Care, Inc. discussed the extension of the corporate negligence doctrine to independent practice association model managed care products.

A subscriber to Total Health Care, or to any other prepaid medical services plan, expects and assumes that the plan will cover the expenses of medical care. To realize the benefit of the Total Health Care plan, the subscriber must, under the plan terms, accept treatment by physicians that Total Health Care has approved. Although Total Health Care argued otherwise, the evidence shows that a subscriber does not have unlimited choice of a specialist physician. To be assured that payment of the charges will be made by Total Health Care, the subscriber must go to the physician referred by his primary care physician and the specialist must have contracted with Total Health Care. Because the subscriber

240. See Reed E. Hall, Hospital Committee Proceedings and Reports: Their Legal Status, 1 Am. J.L. & Med. 245, 252 (1975) (describing the premise of corporate negligence as being that the hospital, by virtue of its custody of the patient, owes a duty to exercise care in the construction, maintenance, and operation of the hospital).

241. Harrell v. Total Health Care, Inc., No. WD 39809, 1989 WL 153066, at *4 (Mo. Ct. App. Apr. 25, 1989) (The corporate negligence doctrine "is not a theory limited to claims against hospitals. . . . The duty of care to protect patients from foreseeable risk of harm, however, finds a common ground" in both hospitals and IPA model HMOs.).


243. See supra note 234 and accompanying text.

244. 781 S.W.2d 55 (Mo. 1989). In Harrell, the plaintiff brought an action against a health service corporation alleging damages resulting from alleged malpractice. The trial court entered summary judgment for the health service corporation. Id. at 60. The Missouri Supreme Court held that (1) a former statute that exempted health service corporations from some forms of liability for injuries to patients applied to a patient's action that alleged that the corporation was negligent in its selection of the surgeon who treated the patient and (2) the statute was not unconstitutional. Id.
may select another doctor and pay for the services outside the Total Health Care coverage is irrelevant.\textsuperscript{245}

Although the court dismissed the case by using a technical aspect of Missouri law,\textsuperscript{246} the court’s conclusion in \textit{Harrell} is an appropriate extension of the corporate negligence doctrine to HMOs. The court concluded that the plaintiff made a case of liability for corporate negligence based on proof that (1) Total Health Care conducted no investigation of the physician’s competence, (2) the physician’s record of malpractice claims was such that a prudent person would recognize the physician’s lack of competence, and (3) Total Health Care did not discharge its duty to the plaintiff as a subscriber to its services to prevent a foreseeable risk of harm.\textsuperscript{247}

Because many third-party payers market their managed care products with claims that they determine provider panel competency, continuously evaluate the physician panel, monitor provider performance, and take corrective action, courts may readily extend the corporate negligence doctrine to them. Even if extended, however, the doctrine suffers from several problems. For instance, besides establishing organizational negligence, the plaintiff must also prove that the physician was negligent and that the physician’s negligence was the proximate cause of the plaintiff’s injuries.\textsuperscript{248} Thus, the plaintiff faces the difficulty of proving two concurrent negligent acts to establish liability. The focus, therefore, is on the negligent conduct of the physician and not on the utilization review process or financial risk shifting.

Thus, even if applied, the corporate negligence doctrine would do little to promote safe utilization review processes and limit financial incentives. If the utilization review process is not negligently designed or conducted, but merely defective, there will probably be no liability under this doctrine. Under traditional theories of tort liability, managed care products tend to decrease physician liability because economic considerations and the deference given to professional judgment make physicians’ actions seem more reasonable. In addition, because

\textsuperscript{246} Id.
\textsuperscript{247} Id. at *5-*6.
\textsuperscript{248} Ferguson v. Gonyaw, 236 N.W.2d 543, 550 (Mich. Ct. App. 1975) (finding that the plaintiff failed to prove that staff privileges would have been denied if the hospital had used reasonable care in evaluating the physician).
third-party tortfeasors have always been more difficult to hold liable, managed care products are rarely viable alternative sources of recovery. The results are more injuries to patients and fewer successful lawsuits. As a practical matter, only twenty jurisdictions have adopted the corporate negligence doctrine. Consequently, even if a managed care product is defective, the doctrine would have limited effect.

C. Respondeat Superior Doctrine

Another possible theory of liability is the doctrine of respondeat superior, which holds an entity liable for the negligent acts of an employee arising in the course of his or her employment. Historically, hospitals, as the primary organizations for health care delivery, were immune from liability for the negligent acts of physicians. Even after the demise of the doctrine of professional skills and the doctrine of charitable immunity, hospitals continued to enjoy immunity from liabil-


250. Under the doctrine of professional skills, courts held that because of a physician's professional skills, a physician was considered an independent contractor for whose acts a hospital could not be held liable. See Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 92-93 (N.Y. 1914), overruled by Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957). The New York Court of Appeals overturned the old rule of nonliability, noting that "[t]he rule of nonliability is out of tune with the life about us, at variance with modern day needs and with concepts of justice and fair dealing. It should be discarded." Bing v. Thunig, 143 N.E.2d 3, 9 (N.Y. 1957). Other courts began to reject this doctrine as they began to recognize hospitals as highly-integrated systems for the delivery of health care. See Ybarra v. Spangard, 154 P.2d 687, 691 (Cal. 1944) (finding that hospitals operate under highly-integrated systems of medical health care); Moore v. Board of Trustees, 495 P.2d 605, 608 (Nev.) (holding that hospitals are highly integrated community health centers whose sole purpose is to make available the highest possible quality care to patients), cert. denied, 409 U.S. 879 (1972).

251. Historically, hospitals maintained as charitable institutions could not be liable for the negligence of their physicians and nurses in the treatment of patients. See, e.g., Schloendorff, 105 N.E. at 92-93 (finding no liability though the patient made some payment to help defray the cost of board); Gartman v. City of McAllen, 107 S.W.2d 879, 880 (Tex. Comm'n App. 1937, opinion adopted by the Texas Supreme Court) (holding that city hospitals operating solely for public benefit could not be held liable). However, later courts have uniformly rejected the doctrine. See, e.g., Flagiello v.
ity for the negligent acts of physicians. It was not until 1965 that courts began to extend liability to hospitals on some theory other than the doctrine of respondeat superior.

Up until that time, liability turned on the character of the physician-hospital relationship, that is, whether the physician was an independent contractor or an employee. Hospitals were not liable for the conduct of physicians who were independent contractors or who lacked an apparent employment relationship with the hospital. More recently, courts have held a hospital liable, under certain conditions, for the negligence of a physician who was an independent contractor. The line of respondeat superior cases begun in 1965 holds, for example, that a hospital that negligently selects or retains an independent contractor may be directly liable for injuries resulting from the negligence of that independent contractor. Further, a hospital may be vicariously liable for the negligence of an independent contractor performing nondelegable duties. In recent years, such vicarious liability has also been found under the doctrine of ostensible agency.

Pennsylvania Hosp., 208 A.2d 193, 208 (Pa. 1965) (holding that the negligence of a charitable hospital's employees must be treated the same as the negligence of any other employer's employee); Pierce v. Yakima Valley Memorial Hosp. Ass'n, 43 Wash. 2d 162, 174, 260 P.2d 765, 771-75 (1953) (finding charitable hospital liable if its negligence is the proximate cause of injury); Adkins v. St. Francis Hosp., 143 S.E.2d 154, 163 (W. Va. 1965) (abolishing charitable immunity doctrine, thereby making hospitals liable for negligent acts committed there).

252. Schloendorff, 105 N.E. at 94 ("The true ground for the [hospital's] exemption from liability is that the relation between a hospital and its physicians is not that of a master and servant. The hospital does not undertake to act through them but merely to procure them to act upon their own responsibility.").

253. See supra part IV.B.

254. A basic principle of tort law is that employers are not liable for the negligence of an independent contractor. Restatement (Second) of Torts § 409 (1965).


257. Id.

258. Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 257 (Ill. 1965); Arthur, 405 A.2d at 446; Albain, 553 N.E.2d at 1044; Capan, 430 A.2d at 643-49; Adamski, 20 Wash. App. at 111, 579 P.2d at 977. But see Greene v. Rogers, 498 N.E.2d 867 (Ill. App. Ct. 1986). The Greene court specifically refused to apply apparent agency to a hospital and emergency room doctor relationship. "The absence of the power to control the decision making of the emergency room physicians demands that the
As a theory of liability for cost containment conduct, the doctrine of respondeat superior might subject a third-party payer to liability if a physician were employed by the managed care product and the physician made negligent decisions based on utilization review or financial risk shifting. Increasingly, courts are applying theories of vicarious liability to third-party payers. This is true where the managed care product limits a patient's choice of providers to those who have contracted to provide care to its beneficiaries.269

The doctrine presents several problems, however. First, many managed care products, such as preferred provider organizations, do not directly employ physicians.260 Second, even for employed physicians, many injury-producing decisions fall within a gray area in which the decision, though motivated by considerations other than the patient's best interests, is arguably within the appropriate standard of care. Under such circumstances, third-party payers would escape liability for resulting injuries. Furthermore, cost containment measures move more physician conduct from the clearly negligent arena into the nonnegligent (or judgment) arena, resulting in compensation for fewer injured patients. Consequently, the doctrine of respondeat superior would not be effective in spreading the cost of cost containment injuries to all responsible parties.

D. Ostensible Agency Doctrine

Ostensible agency liability is a type of vicarious liability under which a health care organization can be held liable for a health care provider's negligence.261 The liability of the organi-

independent relationship between the hospital and emergency room physician be recognized." Id. at 871.


260. Mitte v. H.I.P., 478 N.Y.S.2d 910, 911 (App. Div. 1984) (rejecting the theory of respondeat superior and finding in favor of a staff model HMO in a medical malpractice suit on the grounds that the HMO "does not treat or render medical service or care to anyone"). But c.f. Schleier, 876 F.2d at 174 (holding an HMO responsible for the acts and omissions of a consulting physician who had no contractual relationship to the HMO).

261. Courts have used various labels to hold hospitals vicariously liable: "ostensible" or "apparent" agency, or "agency by estoppel." Although the terms are often
zation is based on appearances that have "led [a] patient to reason-
ably believe that [the health care provider] was in [the health care organization's] employ and under its control." Thus, reasonable reliance of the patient may determine liability, even though no employment relationship exists.

In order to find a hospital liable for the negligent acts of an independent physician with staff privileges, courts have generally required the following:

(1) The plaintiff must show that the hospital or its agent acted in a way that would lead a reasonable person to conclude that the negligent physician was operating as an agent under the hospital's authority;

(2) Where the acts of the agent create the appearance of authority, the plaintiff must prove that the hospital had knowledge of and acquiesced in them; and

(3) The plaintiff must have acted in reliance on the ostensible agency relationship.

used interchangeably, they are not theoretically identical. The ostensible or apparent agency theory is based on § 429 of the Restatement (Second) of Torts, which provides as follows:

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

RESTATMENT (SECOND) OF TORTS § 429 (1965). In contrast, agency by estoppel is based on § 267 of the Restatement (Second) of Agency, which provides as follows:

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

RESTATMENT (SECOND) OF AGENCY § 267 (1958). Thus, § 429 of the Restatement (Second) of Torts requires that the employer hold out the independent contractor as its own employee, and that the injured person reasonably believe that the services are being rendered by the employer or its agents. In contrast, § 267 of the Restatement (Second) of Agency requires actual reliance on the representations of the employer by the injured person. Some jurisdictions cite § 267, others cite § 429, and still others cite both.


Thus, ostensible agency turns not on the issue of control, as in the *respondeat superior* doctrine, but on the appearance of the relationship between the physician and health care institution.

Courts that have looked at this issue generally have accepted the ostensible agency doctrine on two grounds. First, the courts recognize that the changing role of the hospital in society creates a likelihood that patients will look to the institution and not to the individual physician for care. Second, the courts say that ostensible agency liability should attach when the hospital holds out the physician as its employee.

Will the ostensible agency doctrine be extended to third-party payers? If applicable, will the doctrine be an effective tool to promote safety, to protect the physician-patient relationship, and to minimize access problems? The managed care product market is changing radically and expanding rapidly. This rapid change and expansion, coupled with an increase in the number of inexperienced people who develop and manage managed care products, would seem to create fertile ground for litigation. The courts have heard several cases under the doctrine of ostensible agency. The leading cases are *Boyd v. Albert Einstein Medical Center* and *Williams v. Good Health Plus, Inc.*

264. See Grewe, 273 N.W.2d at 433.

265. A “holding out” occurs “when the hospital acts or omits to act in some way which leads the patient to a reasonable belief he is being treated by the hospital by one of its employees.” Adamski v. Tacoma Gen. Hosp., 20 Wash. App. 98, 115, 579 P.2d 970, 979 (1978).


269. Id. ("Just the fact that there are so many new HMOs and the fact that they are expanding so rapidly creates tremendous problems.").


1. Boyd v. Albert Einstein Medical Center

Mrs. Boyd died after being treated by physicians who were participants in the "HMO of PA." In his lawsuit, Mr. Boyd contended that the HMO advertised that its physicians and medical care providers were competent and had been evaluated for up to six months before being selected as HMO providers. He further contended that he and Mrs. Boyd relied on the HMO's representation of quality care in choosing Drs. Rosenthal and Dorstein as their primary care physicians, and that HMO of PA's documents showed both that those doctors were designated care providers and that HMO of PA guaranteed the quality of care.

The trial court granted HMO of PA's motion for summary judgment on the ground that Mr. Boyd failed to establish that the theory of ostensible agency, based on the facts applied to hospitals, applied to the HMO. On appeal, the Pennsylvania Superior Court considered whether the theory of ostensible

273. Boyd, 547 A.2d at 1230. At the time of Mrs. Boyd's death, she and her husband were participants in the Health Maintenance Organization of Pennsylvania (HMO of PA), a managed care product. The third-party payer limited Mrs. Boyd's choice of physician to the names provided in a directory. In June 1982, Mrs. Boyd saw Dr. Rosenthal, whom she selected from the directory. Dr. Rosenthal referred Mrs. Boyd to Dr. Erwin Cohen, a participating HMO of PA surgeon as required by the subscription agreement. Dr. Cohen performed a biopsy of Mrs. Boyd's breast tissue on July 6, 1982. During the surgery, he perforated Mrs. Boyd's chest wall with the biopsy needle. Mrs. Boyd was discharged, but continued to have complaints for weeks afterward. On August 19, Mrs. Boyd awoke with chest pain. Dr. Rosenthal examined Mrs. Boyd and diagnosed Tietz's Syndrome. Tietz's Syndrome is an inflammatory condition affecting the costochondral cartilage in women between 30 and 50 years old. He set up a subsequent appointment for tests to be done at his office. Following a series of tests in his office, Dr. Rosenthal sent Mrs. Boyd home. Her symptoms persisted and worsened. That same afternoon, Mr. Boyd discovered Mrs. Boyd dead in their bathroom from a heart attack. Id. at 1229-30.

In his lawsuit, Mr. Boyd contended that Mrs. Boyd exhibited symptoms of cardiac distress and that Dr. Rosenthal should have sent her to the hospital rather than negligently ordering the tests on Mrs. Boyd at his office. Id. at 1230 n.5. The reasons the test occurred at Dr. Rosenthal's office were disputed. The HMO maintained that the tests were done at Dr. Rosenthal's office because Mrs. Boyd would have been more comfortable. Mr. Boyd maintained that they were done at the office because the HMO required them to be done there to keep medical fees within the HMO. Id. at 1230 n.4. Mr. Boyd contended that the safer practice would have been to perform the tests at the hospital where the results would have been more quickly available and that this negligent treatment caused Mrs. Boyd's death. Mr. Boyd maintained that HMO of PA should be liable for the negligence of its participating physicians because those physicians acted as ostensible agents for the HMO. Id. at 1231.

274. Id.
275. Id.
276. Id.
agency should be applied to an independent association practice model HMO operating with independent contractor physicians.\textsuperscript{277}

The Boyd court acknowledged that Pennsylvania recognized the theory of ostensible agency and had applied it to hospitals.\textsuperscript{278} It then outlined factors that other courts had considered in determining that an independent contractor could be an agent of a hospital.\textsuperscript{279} Among those factors were the likelihood that "patients will look to the institution rather than the individual physician for care" and whether the HMO held out the physician as an employee.\textsuperscript{280}

Considering these factors, the Boyd court concluded that ostensible agency should apply if Mrs. Boyd had submitted herself to the care or protection of the primary care physicians in response to an invitation from the HMO.\textsuperscript{281} The court decided that there were grounds for an inference that the HMO extended such an invitation to Mrs. Boyd.\textsuperscript{282} Furthermore, several facts demonstrated that Mrs. Boyd reasonably could have looked to the HMO for her medical care and that she reasonably could have believed that the physician treating her was an HMO of PA employee.\textsuperscript{283} HMO of PA's marketing materials represented to enrollees that its program guaranteed the quality of care.\textsuperscript{284} It required enrollees to select a primary care physician from a limited list of physicians approved by the HMO.\textsuperscript{285} Finally, HMO of PA employed a gatekeeper system.\textsuperscript{286} The court reasoned that "because [Mrs. Boyd] was required to follow the mandates of HMO [of PA] and did not directly seek the attention of the specialist, there is an inference that [she] looked to the institution for care and not solely to the physicians."\textsuperscript{287}

\textsuperscript{277} Id. at 1234.
\textsuperscript{278} Id. at 1231.
\textsuperscript{279} Id. at 1232.
\textsuperscript{280} Id.
\textsuperscript{281} Id. at 1234-35.
\textsuperscript{282} Id. at 1235.
\textsuperscript{283} Id.
\textsuperscript{284} Id. at 1232 n.6 (noting that in a document entitled "Why Offer HMO-PA?," HMO of PA represented to employers that it "[a]ssumes responsibility for quality and accessibility" of health care).
\textsuperscript{285} Id. at 1235.
\textsuperscript{286} Id. at 1233; see supra notes 64-67 and accompanying text.
\textsuperscript{287} Boyd, 547 A.2d at 1235.
The Boyd court concluded that "an issue of material fact [existed] as to whether the participating physicians were the ostensible agents of HMO [of PA]."288 Thus, the court reversed the trial court's grant of summary judgment to HMO of PA and remanded the ostensible agency question to the trial court.289 The court, however, did not decide whether Drs. Rosenthal and Dornstein acted negligently nor whether HMO of PA would be liable if they did.

2. Williams v. Good Health Plus

In Williams v. Good Health Plus, Inc.,290 Ruth Williams maintained that her right thumbnail had to be surgically removed after it became infected because of Good Health Plus's and HealthAmerica's negligence. She claimed that the defendants permitted unsanitary conditions to exist in the treatment areas where the nail was treated, and that the defendants placed her on a drug without previously performing necessary tests.291

The Williams analysis (unlike Boyd) was based on state laws governing the practice of medicine and governing HMOs.

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288. Id.
289. Id.
291. Id. at 374. The Williamses provided the following statement of each act or failure to act:
   Failure to listen to patient complaints and failure to diagnose and properly treat nail staph infections and systemic [lupus [erythematous], refusal of treatment. Failure to order the usual and customary lab work for a person taking the medications prescribed to monitor well[being of patient and to decrease chance of side effects. Mismanagement of ca[r]e of the nail to the point that correct management of systemic lupus was impossible due to the fact steroids could not be given appropriately.

Id. at 374-75. HealthAmerica Corporation (HealthAmerica) was the legal successor to Good Health Plus, Inc. Southwest Medical Group (Southwest) was the physician group that gave medical services to Mrs. Williams. The medical services agreement between HealthAmerica and Southwest stated that "under this agreement, physicians 'shall be totally responsible for all medical advice to and medical treatment of members and for performance of medical services within the service area.'" Id. at 376. HealthAmerica did not select the physicians who treated Mrs. Williams, and HealthAmerica did not have the right to direct or control "the work or practice of medicine" of the physicians who treated Mrs. Williams. Id. at 377. Neither HealthAmerica nor Good Health Plus employed, paid, or supervised any physicians. In Mrs. Williams's medical records, many progress notes were written on forms provided by Southwest and bore the professional association mark, "Southwest Medical Group, P.A." Id. at 378. Finally, when Mrs. Williams sought care from the "Southwest Medical Group, P.A.," she signed a Consent to Procedure form that contained the following language: "I hereby authorize [the Southwest Group physician] and whomever he may designate as his assistants, to perform upon myself the following procedure . . . ." Id.
The Texas Medical Practice Act\textsuperscript{292} prohibited the corporate practice of medicine and required individuals to satisfy specific licensure requirements to practice medicine.\textsuperscript{293} The Act did not provide any means for a corporation such as HealthAmerica to be licensed to practice medicine.\textsuperscript{294}

The Texas Health Maintenance Organization Act\textsuperscript{295} stated that the Act shall not be construed to

(a) authorize any person, other than a duly licensed physician or practitioner of the healing arts, acting within the scope of his or her license, to engage, directly or indirectly, in the practice of medicine or any healing art, or

(b) authorize any person to regulate, interfere, or intervene in any manner in the practice of medicine or any healing art.\textsuperscript{296}

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293. \textit{Williams}, 743 S.W.2d at 375. The provision provided as follows: [It] shall be unlawful for any individual, partnership, trust, association, or corporation by the use of any letters, words, or terms as an affix on stationery or on advertisements, or in any other manner, to indicate that the individual, partnership, trust, association, or corporation is entitled to practice medicine if the individual or entity is not licensed to do so.


Under the corporate practice of medicine doctrine, a lay corporation cannot "employ a doctor, charge for the doctor's services, pay the doctor a salary, and then keep the profit that is left over." Anthony Hunter Schiff, \textit{Provider Discounts, 9 Whittier L. Rev.} 249, 250 (1987). A professional corporation owned by a physician is the only type of corporate entity that can practice medicine and retain profits. \textit{Id.} However, a corporation can provide health services to employees if it does not charge for the services. \textit{Id.} The corporate practice of medicine rule generally prohibits corporate entities from employing physicians. The most significant exception to the rule is health maintenance organizations. See Cynthia M. Combe & Neil Krugman, \textit{Design and Pricing of the PPO and EPO Products, in Managed Health Care: Legal and Operational Issues Facing Providers, Insurers, and Employers, at 114-16} (PLI Commercial Law and Practice Course Handbook Series No. 393, 1986), \textit{available in Westlaw, TP-All File} (discussing the prohibitions against the corporate practice of medicine). This prohibition is based on legal and policy considerations. Legally, statutory licensure requirements for physicians include certain age, educational, and moral character requirements that are "incapable of being met by an artificial [entity] such as a corporation." \textit{Id.} at 114. Policy considerations include a concern that corporations may control medical decision making to "an unacceptable degree and interfere with the quality of patient care," and that treatment decisions may be "based upon economic considerations, such as shareholder interests, rather than upon patient need." \textit{Id.} at 114-15; see also \textit{Cal. Bus. \& Prop. Code} § 2400 (West 1990) (stating that "corporations and other artificial legal entities shall have no professional rights, privileges or powers").

294. See infra notes 295-298 and accompanying text.


296. \textit{Williams}, 743 S.W.2d at 375 (quoting \textit{Tex. Ins. Code Ann.} § 20A.29 (West 1981)).
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The Texas Health Maintenance Organization Act provided that "[n]othing in this Act shall be construed as permitting the practice of medicine as defined by the laws of this state." 297 Perhaps most important was the provision of the Health Maintenance Organization Act that limited the powers of HMOs to the following:

the furnishing of or arranging for medical care services only through physicians or groups of physicians who have independent contracts with the health maintenance organizations; the furnishing of or arranging for the delivery of health care services only through providers or groups of providers who are under contract with or employed by the health maintenance organization. 298

Based on the court's interpretation of the relevant Texas statutes and the facts, HealthAmerica established that, as a matter of law, it was entitled to summary judgment. 299 The court reasoned that HealthAmerica could not be subjected to liability for any of the alleged negligent treatment because HealthAmerica could not practice medicine. 300 The court gave no credence to the argument that HealthAmerica represented or held out the physicians as its agents. 301 The court did not examine previous cases construing the ostensible agency theory of liability.

3. Analysis of Boyd and Williams

While a third-party payer was liable in Boyd, but not in Williams, Boyd and Williams are not inharmonious. Taken together, the cases demonstrate why ostensible agency, though theoretically applicable to third parties, is a weak doctrine. First, the applicability of the doctrine relies on facts within the third-party payer's control that can be easily manipulated. Boyd and Williams were decided under very different factual circumstances. For instance, in Boyd, HMO of PA was more involved in medical decision making, while the third-party payer in Williams exercised very little specific direction and

297. Id. (quoting Tex. Ins. Code Ann. § 20A.06(a)(3) (West 1981) (alteration in original)).
298. Id.
299. Id. at 379.
300. Id. at 378.
301. Id.
control over the physicians who treated the plaintiff.\textsuperscript{302} Furthermore, the Williams court did not rule out the possibility that under the right fact pattern, it might apply the ostensible agency analysis. If true, the alleged acts and omissions of misdiagnosis and medical mistreatment would mean that HealthAmerica engaged in the practice of medicine.\textsuperscript{303} HealthAmerica submitted a motion for summary judgment and affidavits establishing that, as a matter of law, HealthAmerica could not practice medicine. When Williams did not respond with additional facts that would establish ostensible agency,\textsuperscript{304} the court held that she was "not entitled to claim, in the absence of a response to the motion for summary judgment or any other evidence in the record, that HealthAmerica may be liable on some theory of holding-out or ostensible agency."\textsuperscript{305} Thus, it is likely that given the right facts (and possibly better lawyering), Texas, like Pennsylvania, will apply the ostensible agency doctrine.

Even if applied, however, the doctrine is flawed in its capacity to promote safety, to spread risk, and to minimize the negative effects of cost containment efforts. Because of the holding out requirement, third-party payers can easily restructure their programs to avoid the appearance of agency.\textsuperscript{306} The key factor underlying Boyd was that Mrs. Boyd looked to the HMO corporate institution, not to the individual physicians.\textsuperscript{307} A well-developed managed care product and a skilled attorney could remove such appearances. For example, how would the Boyd case have turned out if HMO of PA had not promised any quality of care, had given Mrs. Boyd the option of seeking care outside the plan,\textsuperscript{308} and had required a disclosure consent acknowledging that the physicians were independent contractors\textsuperscript{309} and not agents of the plan?\textsuperscript{310}

\textsuperscript{302} It is unclear, however, from the facts of Williams whether Mrs. Williams selected Southwest's doctors or was required to use them. Part of the problem with Williams may be in how the plaintiff's attorney formed the case.
\textsuperscript{303} Id. at 375-76.
\textsuperscript{304} Id. at 378.
\textsuperscript{305} Id. at 379.
\textsuperscript{306} See Gnessin, supra note 132, at 410 (advising managed care organizations to inform and to disclose to the patient the exact relationship between the health care provider and the HMO as an effective defense against ostensible agency).
\textsuperscript{308} See id. (indicating that Mrs. Boyd had no choice as to which specialist to use).
\textsuperscript{309} "A hospital would not be held liable for the negligence of a doctor (whether on staff or not) if the patient was aware of the actual relationship between the doctor and
Second, the effectiveness of the ostensible agency doctrine can be statutorily negated, as it was in Texas. The court in *Williams* relied on Texas law that provided that HMOs are not exempt from the corporate practice of medicine rule. That law is unique among laws governing HMOs. Most other states offer HMOs an exemption from the prohibition against the corporate practice of medicine.311 Thus, courts in most other jurisdictions will make a common law negligence analysis or an ostensible agency analysis and not a statutory analysis.312 Still, the issue of HMO liability is new, so future decisions are not clearly predictable.

Finally, the ostensible agency doctrine is applicable only to some forms of managed care products.313 It is, for example, inapplicable to managed care products that hire staff physicians.314 More importantly, the doctrine of ostensible agency is


310. A court could find that even where an individual knew that the managed care organization (MCO) physicians were independent contractors, and not MCO employees, an individual requiring care lacks a meaningful choice because of the financial restraints placed on individuals who opt out of the MCO plan. Under those restraints the court might find ostensible agency despite the knowledge of the individual. See *Martell v. St. Charles Hosp.*, 523 N.Y.S.2d 342, 351 (Sup. Ct. 1987) (holding that even where a patient has the knowledge of emergency room physicians' status as independent contractors, the hospital can be held liable under ostensible agency theory).


313. The diverse organizational structures make the application of traditional malpractice theories more difficult. See generally Gregory G. Binford, *Malpractice and the Prepaid Health Care Organization*, 3 *Whittier L. Rev.* 337 (1981); *Monahan & Willis, supra* note 79, at 353; *Oakley & Kelley, supra* note 228, at 624.

314. See *Ossario, supra* note 3, at 197-98 (distinguishing IPA for-profit HMOs from nonprofit group staff models of the past decade by noting the difference in management controls and financial incentive arrangements). In *Boyd*, the defendant HMO was an independent practice association model HMO. *Boyd v. Albert Einstein Medical Ctr.*, 547 A.2d 1229, 1232-33 (Pa. Super. Ct. 1988).
applicable only when physician negligence exists. Because cost containment activities are not considered when determining liability, there is little incentive for third-party payers to change cost containment activities that result in injuries. Under the ostensible agency doctrine, a court will view physician malpractice as an aberration, not as a symptom indicating a need for systemic change. Furthermore, because not all persons injured by defective cost containment measures can establish ostensible agency, the doctrine is ineffective as a risk spreader.

E. Summary

The tort system has developed several theories to facilitate compensation for injuries caused by another. Negligence will compensate for behavior that falls below a standard of reasonable care. Corporate negligence will hold an organization liable for the negligent conduct of a provider when the organization was negligent in hiring or supervising the provider. Respondeat superior will hold an employer liable for the negligent acts of an employee provider even though the employer itself has not acted negligently. Ostensible agency will hold an organization liable for the negligent act of a provider who, even though not an employee, has been held out as an agent of the organization.

As discussed, negligence, corporate negligence, respondeat superior, and ostensible agency are all inadequate to meet the goals of compensating victims, promoting safety, and spreading the risk. These theories fail to include injuries created by managed care organizations in their cost containment efforts of utilization review and financial risk shifting. To meet these goals, an alternative compensation system must be developed. This is particularly crucial because even if a patient proves a tort claim for injuries, ERISA would raise an additional barrier to recovery.

V. ERISA as a Barrier to Compensation for Injuries

The most significant barrier to recovery for injuries caused by cost containment activities may be the Employee Retirement Income Security Act of 1974 (ERISA).

A. Background

ERISA was enacted by Congress in 1974 to bring uniformity to the state laws governing private pension and benefit plans.\footnote{Senate Comm. on Labor and Pub. Welfare, Retirement Income Security for Employees Act of 1973, S. Rep. No. 127, 83d Cong., 1st Sess. 29 (1973).} ERISA establishes minimum standards regulating the content of pension plans with respect to participation, benefit accrual, vesting, benefit payment, fiduciary status and conduct, reporting and disclosure, and funding.\footnote{29 U.S.C. §§ 1001-1145 (1988).} In addition, ERISA requires nonpension employee benefit plans (e.g., employer provided health insurance) to comply with ERISA's fiduciary, reporting, and disclosure requirements.\footnote{Id.} Finally, ERISA empowers participants, beneficiaries, and fiduciaries to initiate civil actions in federal court to enforce the requirements of ERISA or to enforce the terms of a pension or welfare plan.\footnote{Id. § 1144(c)(2).}

While states enjoy concurrent jurisdiction in actions to enforce the terms of a plan, in all other actions the federal courts have exclusive jurisdiction.\footnote{Id. § 1132(e)(1).} The principal purpose of ERISA was "to protect . . . the interests of participants in employee benefit plans . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies . . . and ready access to the Federal courts."\footnote{Id. § 1001(b).}

ERISA also contains an explicit preemption clause, which provides that ERISA supersedes all state laws that apply to employee benefit plans.\footnote{29 U.S.C. § 1144(a) (1988).} Notwithstanding several exemp-
tions, the Supreme Court has held that the clause is to be construed broadly. In particular, preemption is extended to state laws whenever they have a connection with or reference to an employee benefit plan.

Where there has been a violation of ERISA, the beneficiary is ordinarily entitled to recover only contractual damages. ERISA, however, provides for "other appropriate equitable relief":

(a) A civil action may be brought . . . (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan . . . .

Nevertheless, whether extracontractual or punitive damages are available to a beneficiary under ERISA is still an open question. Consequently, without extracontractual or punitive damages, a plaintiff injured by a utilization review activity through the denial of services can recover only contract damages—the cost of the denied service or substituted services.

United States; and (4) public employer plans, church plans, and workers compensation plans. Id. § 1144(a)-(d). Thus, without an explicit exemption, ERISA applies to any state law that regulates medical benefit plans.


324. See generally Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 133 (1990) (cause of action allowing recovery from employer when discharge is premised on an attempt to avoid contributing to pension plan is preempted); Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829-30 (1988) (statute explicitly barring garnishment of ERISA plan funds is preempted); Dedeaux, 481 U.S. at 47-48 (common law tort and contract causes of action seeking damages for improper processing of a claim for benefits under a disability plan are preempted); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983) (statute interpreted by state court as prohibiting plans from discriminating on the basis of pregnancy is preempted); Christopher v. Mobil Oil Corp., 950 F.2d 1209, 1218 (5th Cir.) (common law fraud and negligent misrepresentation claims that allege reliance on agreements or representations about the coverage of a plan are preempted), cert. denied, 113 S. Ct. 68 (1992).


B. Corcoran v. United HealthCare

Although the concept of imposing liability on third-party payers for utilization review activities and financial risk shifting is only beginning to be explored,\textsuperscript{328} Corcoran v. United HealthCare, Inc.\textsuperscript{329} raised the issue of the limitations imposed by ERISA on claims against third-party payers and utilization review organizations.

Mrs. Florence Corcoran was a long-time employee of South Central Bell Telephone Company (Bell). Mrs. Corcoran was a member of Bell's Medical Assistance Plan (MAP).\textsuperscript{330}

She became pregnant in early 1989.\textsuperscript{331} This was Mrs. Corcoran's second pregnancy and, like the first pregnancy, several medical problems made the pregnancy high risk. Late in the pregnancy, her obstetrician recommended that she have complete bed rest during the final months of her pregnancy. As in the first pregnancy,\textsuperscript{332} he recommended that Mrs. Corcoran be hospitalized so that the condition of the fetus could be monitored twenty-four hours a day.\textsuperscript{333}

In accordance with MAP's requirements,\textsuperscript{334} Mrs. Corcoran applied to Bell for temporary disability benefits for the remainder of her pregnancy.\textsuperscript{335} Based on a utilization review performed by United Healthcare (United), Bell denied the disability benefits. Her obstetrician wrote Bell explaining Mrs. Corcoran's medical condition. Nevertheless, Bell denied the disability benefit a second time, even though a second opinion solicited by Bell suggested that "the company would be at considerable risk denying her doctor's recommendation."\textsuperscript{336} Despite the obstetrician's recommendation, United decided that

\textsuperscript{328} See supra part IV.
\textsuperscript{329} 965 F.2d 1321 (5th Cir.), cert. denied, 113 S. Ct. 812 (1992).
\textsuperscript{330} Id. at 1322, 1323. MAP was a self-funded medical benefits plan. The plan was administered by Blue Cross and Blue Shield of Alabama (Blue Cross) pursuant to an Administrative Services Agreement between Bell and Blue Cross. Id.
\textsuperscript{331} Id. at 1322.
\textsuperscript{332} In the first pregnancy, the fetus went into distress at the 36th week. The obstetrician had to perform a Cesarean section to successfully deliver the baby. Id. at 1323.
\textsuperscript{333} Id. at 1322-23.
\textsuperscript{334} Under the portion of MAP known as the "Quality Care Program" (QCP), participants were required to obtain precertification for overnight hospital admissions, and concurrent review or approval once they were admitted to a hospital. Failure of the plan's participants to obtain approval would affect the benefits to which they were otherwise entitled. Id. at 1323.
\textsuperscript{335} Id. at 1322.
\textsuperscript{336} Id.
hospitalization was not necessary and ten hours per day of home health care would suffice. During the time when the home health nurse was not on duty, the fetus went into distress and died.337

Mrs. Corcoran and her husband filed a state action alleging various claims, including wrongful death; the lost love, society, and affection of their unborn child; aggravation of a preexisting depressive condition; and the loss of consortium caused by that aggravation.338 The defendants removed the action to federal court on the ground that it was preempted by ERISA.339 They then moved for summary judgment. The defendants characterized the relationship between them and Mrs. Corcoran as existing solely as a result of an ERISA plan.340 According to the defendants, the plaintiffs’ cause of action was one of “improper handling of a claim” and therefore the claims were preempted by statute.341 The plaintiff, on the other hand, argued that (1) the case boiled down to one for malpractice against United HealthCare, (2) the claims pertained to state law of general application, and (3) preemption would leave them without a remedy and thus contravene the purpose of ERISA.342

The district court granted the defendants’ motion.343 According to the district court, the plaintiffs’ state law claim related to the employee benefit plan because “[b]ut for the ERISA plan, the defendants would have played no role in Mrs. Corcoran’s pregnancy.”344 On a motion for reconsideration, the plaintiffs did not ask the district court to reconsider its preemption ruling. Instead, they contended that the compensatory damages that they sought were within the civil enforcement mechanisms of ERISA as “other appropriate equitable relief.”345 Ignoring authority to the contrary,346 the district court denied the motion, indicating that “[t]he vast majority of federal appel-

337. Id.
338. Id. at 1324.
339. Id. at 1325; see also Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 66 (1987) (holding that ERISA preemption is so exhaustive that a preemption defense provides an adequate basis for removal to federal court).
340. All parties agreed that the plan was governed by ERISA. Corcoran, 965 F.2d at 1325.
341. Id.
342. Id.
343. Id.
344. Id.
345. Id. at 1325-26.
late courts have . . . held that a beneficiary under an ERISA health plan may not recover under . . . ERISA compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan."

On appeal, United argued that preemption applied because the decision it made was a health benefit decision made in its capacity as a plan fiduciary. All it did, it argued, was to determine whether Mrs. Corcoran qualified for the benefits. Consequently, the plaintiffs could not sue in tort to remedy injuries caused by plan benefit decisions. The Corcorans argued that preemption did not apply because United's decision was not an erroneous claims decision but an erroneous medical decision. Thus, their medical negligence claim was not preempted. The appeals court could not "fully agree with either United or the Corcorans":

Ultimately, we conclude that United makes medical decisions—indeed, United gives medical advice—but it does so in the context of making a determination about the availability of benefits under the plan. Accordingly, we hold that the Louisiana tort action asserted by the Corcorans for the wrongful death of their child allegedly resulting from United's erroneous medical decision is preempted by ERISA.

Finally, the court rejected an award of extracontractual damages under section 502(a)(3) of ERISA. Noting that the Corcorans proved neither a violation of the substantive provisions of ERISA nor a violation of the terms of the plan, the court

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(7th Cir. 1990); Warren v. Society Nat'l Bank, 905 F.2d 975 (6th Cir. 1990), cert. denied, 111 S. Ct. 2256 (1991).


348. Corcoran, 965 F.2d at 1329.

349. Id. at 1330. See generally Pilot Life Ins. Co. v. Dedecaux, 481 U.S. 41, 47-48 (1987). See also William A. Chittenden III, Malpractice Liability and Managed Health Care: History and Prognosis, 26 TORT & INS. L.J. 451, 459 (1991) (stating that claims of negligence for injuries caused by utilization review denial of medical services "can . . . be characterized as claims founded upon a constructive denial of plan benefits").

350. Corcoran, 965 F.2d at 1330.

351. Id. See generally Sommers Drug Stores, 793 F.2d at 1456.

352. Corcoran, 965 F.2d at 1331.

353. Id.

354. Id. at 1337.
went on to determine that damages for emotional distress and loss of consortium were simply not available.\textsuperscript{355}

Given the fundamental differences between prospective and retrospective utilization review decisions on access to care,\textsuperscript{356} the court had no difficulty characterizing United's refusal to approve hospitalization as the provision of medical services.\textsuperscript{357} Nor did it accept United's argument that it specifically told beneficiaries that medical decisions were ultimately up to the "beneficiary and his or her doctor."\textsuperscript{358} Nevertheless, the court viewed United's medical decisions as "part and parcel of its mandate to decide what benefits are available under the Bell plan."\textsuperscript{359} The court recognized that when a utilization review agency or a third-party payer makes a decision, it does so because of the financial ramifications.\textsuperscript{360}

Despite this view, the court reasoned that finding that the patient's claim was not preempted would undermine the goals of ERISA.\textsuperscript{361} If utilization review activities were not preempted, state courts might develop different substantive standards applicable to the same conduct.\textsuperscript{362} Plans and conduct would then necessarily be tailored to the law of each jurisdiction.\textsuperscript{363} Furthermore, without preemption, there is a significant risk that state liability rules would be applied differently to the same conduct of the same third-party payer with managed care products in different states.\textsuperscript{364} The court maintained that

\textsuperscript{355} Id. at 1335.
\textsuperscript{356} See supra notes 177-183 and accompanying text.
\textsuperscript{357} The court relied on the QCP booklet for "substantial support" for its view that the refusal was a medical decision. United's booklet says that it "assess[es] the need for surgery or hospitalization and determine[s] the appropriate length of stay for a hospitalization, based on nationally accepted medical guidelines." Corcoran, 965 F.2d at 1331. The booklet goes on to say that United "will discuss with your doctor the appropriateness of the treatments recommended and the availability of alternative types of treatments." Id. The booklet emphasizes that "United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care." Id.
\textsuperscript{358} Id. According to the court, the disclaimer only supports the conclusion that no physician-patient relationship existed between United and Corcoran. Id; see also Wickline v. California, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (declining to hold Medi-Cal liable but recognizing that it made a medical judgment).
\textsuperscript{359} Corcoran, 965 F.2d at 1332.
\textsuperscript{360} Id.
\textsuperscript{361} Id.
\textsuperscript{362} Id.
\textsuperscript{363} Id. at 1333.
\textsuperscript{364} Id.
the cost of complying with varying substantive standards would increase the cost of providing utilization review services, thereby increasing the cost to health benefit plans of including cost containment features such as the Quality Care program (or causing them to eliminate this sort of cost containment program altogether) and ultimately decreasing the pool of plan funds available to reimburse participants.365

The court ignored the argument that failure to impose liability on utilization review activities might actually increase the number of poor-quality medical decisions and medical injuries.366 Rather, as noted by one author, the court seemed to imply that because imposing liability would have only a mild "salutary effect of deterring poor-quality medical decisions," declining to impose liability would not be grave error.367 Nor did the lack of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a third-party payer's utilization review decision affect the court.368 The court ignored the fact that Congress implemented a comprehensive statute in a time when it could not have predicted the medical utilization review process and could not have contemplated that employee benefit plans would actually make medical decisions contrary to physicians' recommended treatment.369 The court also rejected the argument that preemption was inappropriate because a medical malpractice claim is an "exercise of traditional state authority rather than an area not traditionally regulated by the states."370

The court acknowledged that "fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employ-

365. Id.
366. Id. at 1332-33.
369. Corcoran, 965 F.2d at 1334.
However, it rejected the notion that it had any ability to make such changes. "Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators."  

ERISA preemption and the lack of extracontractual damages mean that individuals injured by third-party payers' utilization review activities have no remedy, state or federal. With no common law liability and no extracontractual damages, there is little pressure on third-party payers to avoid substandard medical decision making.

VI. THE MEDICAL INJURY COMPENSATION FUND—A PROPOSAL

The goals of the current tort system vis-à-vis medical malpractice are to compensate victims, deter substandard medical care, and spread the cost of injuries. It is questionable whether the tort system meets these goals for existing medical injuries. It is even more debatable whether the tort system can meet these goals for managed care. As an alternative, this Article proposes a medical injury compensation fund system that will meet the goals that the tort system fails to meet. In addition, the proposed fund system provides an effective way to spread the costs of medical care.

This Part begins by summarizing the problems with the current tort system in Section A. Then, in Section B, the elements of the alternative medical injury compensation fund are set out. Section C addresses the limitations and problems inherent in implementing a fund system like the one proposed. Section D, on the other hand, outlines the important benefits that would be provided by the proposed fund.

A. Problems with the Tort System

The tort system results in a significant degree of chance, heavy transactional costs, inadequate compensation recovery, enormous malpractice premiums, and ineffectual deterrents. A significant element of chance exists under the tort system.

372. Id.
373. Id. at 1338.
374. Id.
Recovery is speculative and has been equated to a lottery.\textsuperscript{376} Even though seventeen percent of adverse outcomes in medical patients are traceable to negligence\textsuperscript{377} under the current tort recovery system only ten percent of injured patients eventually file a claim, and only four percent actually receive compensation.\textsuperscript{378} The persons least likely to receive compensation are likely to be those least able to afford the injuries: the poor, women, and minorities. These groups have historically had inadequate access to the legal system, clearly affecting their ability to recover for cost containment injuries.

The tort system imposes heavy transactional costs. Even for those who actually receive compensation, the transactional costs created by the process are immense. Plaintiffs incur significant costs in time, money, and stress.\textsuperscript{379} The average medical malpractice claim takes over eighteen months to settle or adjudicate.\textsuperscript{380} Much of this time is attributable to delay as a defense maneuver.\textsuperscript{381} The costs of litigating malpractice claims are significant,\textsuperscript{382} and the psychological stress is real.\textsuperscript{383}

The tort system provides inadequate recovery. Even after investing the time, money, and stress, the plaintiff's recovery is still likely to be inadequate to compensate her economic losses. In fact, up to forty percent of any award goes to attorney fees.\textsuperscript{384} Thus, even if a patient overcomes the difficulty of recovering under the tort system and gets past the barrier of ERISA, compensation is likely to be inadequate.

The tort system breeds enormous malpractice premiums. Despite meager overall compensation, the extraordinary size of some tort recoveries has allowed insurance companies and others to create the impression of a medical malpractice crisis. This perception has allowed malpractice insurers to raise premiums astronomically.\textsuperscript{385} For example, high-risk specialists

\textsuperscript{376} Id.
\textsuperscript{377} Id.
\textsuperscript{378} Id.
\textsuperscript{379} Id.
\textsuperscript{380} Tan, supra note 186, at 243 n.13.
\textsuperscript{381} Starr, supra note 375, at 806-07 n.23.
\textsuperscript{382} Murray L. Schwartz & Daniel J.B. Mitchell, An Economic Analysis of the Contingent Fee in Personal Litigation, 22 Stan. L. Rev. 1125 (1970) (noting that the greatest expense for the plaintiff is the contingent fee).
\textsuperscript{383} Starr, supra note 375, at 806-07 n.23.
\textsuperscript{384} Id.
\textsuperscript{385} Stephen D. Sugarman, Doctor No, 56 U. Chi. L. Rev. 1499 (1991) (reviewing Paul C. Weiler, Medical Malpractice on Trial (1991)).
such as neurosurgeons and obstetricians in high-risk states such as New York and Florida pay annual medical malpractice insurance premiums of $100,000 to $200,000.\textsuperscript{386} During three years in the 1980s, total medical malpractice premiums skyrocketed from $2 billion to more than $5 billion.\textsuperscript{387} It is important to keep this in perspective: The average physician pays medical malpractice premiums of only $16,000.\textsuperscript{388} Nevertheless, the overall increase in expenditures for malpractice insurance translates into increases in the cost of health care for everyone.

The tort system provides ineffectual deterrents. Whether the tort system deters substandard care is, at best, speculative.\textsuperscript{389} The question is whether third-party payers will alter their behavior to conform to the legal standard for cost containment activities indicated by tort recovery. For instance, testing for glaucoma in persons under the age of forty was once seen as medically unnecessary because of the infrequency of the condition in that age group. But after Gates \textit{v. Jensen},\textsuperscript{390} physicians may have begun to test persons under forty more frequently as a form of defensive medicine—they test to avoid liability, not to diagnose a specific condition. Third-party payers would not necessarily react in the same way. They could view the court as wrong and not conform their behavior, or they could simply ignore the court altogether, confident that traditional liability theories would not reach them. After all, only theoretical possibilities have been articulated, and no real and substantial deterrent effect has been proved.\textsuperscript{391}

Consequently, whether viewed from the perspective of the nonrecovering patient, the premium-paying physician, or the damages-paying third-party payer, the present system is inadequate to handle the task of fairly distributing the cost of injuries. In addition to fairness problems, the present system exacerbates the cost of medical injuries through transactional costs, social costs of delay and disability, individual costs of fearful practitioners, and what may be developing as a systemic cost of defensive medical practice.

\begin{itemize}
\item \textsuperscript{386} Id.
\item \textsuperscript{387} I \textsc{American Law Institute}, \textsc{Reporter's Study}, \textsc{Enterprise Responsibility for Personal Injury} 3 (1991).
\item \textsuperscript{388} Sugarman, \textit{supra} note 385, at 1499.
\item \textsuperscript{389} Starr, \textit{supra} note 375, at 807-08.
\item \textsuperscript{390} 92 Wash. 2d 246, 595 P.2d 919 (1979).
\item \textsuperscript{391} See Starr, \textit{supra} note 375, at 808.
\end{itemize}
These problems are based on the preexisting system of health care delivery, which was based on the singular relationship between provider and patient. The new relationship between third-party payers and providers, developed through the introduction of managed care, will result in additional and new kinds of injuries to encumber and tax an already overburdened system. Because managed-care injuries have such difficult problems of proof and are so indirect in causation, those injuries widen the gap between injury and compensation. For these reasons, it would be wise to consider some alternative to the present tort system to allocate the burden for injuries.

B. Elements of a Medical Injury Compensation Fund

This Article proposes, in general terms, an alternative system of medical injury compensation analogous to the widely accepted workers' compensation system. Workers' compensation systems are based on the premise that injuries arising out of, and in the course of, one's employment should constitute an expense of doing business and that, therefore, the level of fault is irrelevant in most circumstances. Recovery for one's injury is certain, and proof problems are limited. On the other hand, the amount of recovery is less than full. The injured employee's medical expenses are fully covered, her rehabilitation expenses are usually fully covered, and her loss of earning capacity recovery is limited. Thus, the amount of money received by the injured employee does not make the employee whole. However, because the transactional costs to the injured employee are minimal, the employee may, in real dollars, recover at about the same level as if the employee went to trial. The objectives of the system are to get

394. 1 id. § 1.10.
395. 1 id. § 2.50.
396. 2 id. § 61.00.
397. 2 id. § 61.21.
398. 2 id. § 60.00.
399. 1 id. § 2.50.
the employee back on the job and to induce employers to avoid on the job injury.

Like workers’ compensation, the medical injury compensation fund would compensate quickly, correctly, and without regard to fault. An effective compensation scheme will deal with several issues: defining the compensable injury, determining the amount of compensation, financing the scheme, notifying the public of the existence of the fund and the performance of providers, defining exemptions, and covering legal fees for denied claims.

1. Defining Compensable Medical Injuries

The primary focus of the compensation fund would be on whether the patient incurred a medical injury. The fund would compensate for injuries arising out of, and in the course of, health care treatment. While the well-developed case law interpreting the workers’ compensation requirements could be used by analogy, there are unique definitional problems, the most significant of which is defining “medical injury” itself. Certainly not all consequences to a patient should be covered. In particular, those physical conditions that are the natural consequences of disease or the aging process would not be covered.

Essentially, compensable medical injuries would be composed of four categories: treatment injuries, drug injuries, cost containment injuries, and informed consent injuries. For example, in the area of drug therapy, treatment injuries would consist of injuries caused by giving the patient the wrong medication or the wrong dosage of medication, or by failing to give needed medication. Drug injuries would be caused by an injurious reaction to an otherwise appropriately prescribed drug. Cost containment injuries would be caused by the refusal of the third-party payer to authorize payment for an essential and expensive drug. Informed consent injuries would result from the failure to inform the patient of the probable side effects of an otherwise appropriately prescribed drug.

Because the possibilities of fraud in connection with claims of failure to inform are so great, it is proposed that these claims be left to the existing tort system. To include these claims in the compensation system would be inappropriate because the claims are peculiarly tied to conduct rather than status or cir-

400. A patient may typically say, “You may have told me but I obviously did not understand because I consented to the treatment, so my consent was not informed.”
cumstances. The focus for questions of causation in the other three categories is on the source of injury, as in a workers' compensation system, and not on the conduct of the actor.

Another problem is defining the point at which subsequent injuries become so attenuated that they should not be covered by the system. As in workers' compensation, a medical injury could result from a previous medical injury or from complications of an initial condition.

As noted, a medical injury compensation fund will have difficulty defining an injury. Unlike the tort system, however, problems of proof of causation are almost nonexistent. A person wishing to recover from the medical injury compensation fund will only have to prove that (1) there was a medical injury and (2) the injury occurred in the course of medical services.

2. Compensation

Compensation would be limited but adequate to meet the patient's economic need, which is not necessarily the same as her economic loss. While limited recovery is a necessary part of a compensation scheme, recovery should not be so limited that it fails to act as a deterrent to unsafe medical and managed care practice or causes an economic hardship to the injured patient. To meet these requirements, the fund would compensate for medical expenses, economic expenses, and disabling pain and suffering.

3. Financing the Fund

The fund would be financed by premium payments from all health care providers, health care institutions, and managed care organizations. All health care providers (e.g., physicians, hospitals, nurses, nursing homes, laboratories) licensed by a state to provide any kind of health care services would pay into the fund. The providers' payments could be based on a set premium or on a percentage of gross income from providing health care services.

401. A provider and a patient may agree, however, that the injuring provider may provide continued medical care at no cost and, if so, such medical care will not constitute part of recovery.
402. Lost wages, loss of earning capacity, etc.
403. Clinical proof of pain would activate a recovery schedule, with the amount of recovery based on the duration of disability and not on the intensity.
Whatever the initial mechanism, subsequent premiums would be adjusted on the basis of the injury experience in the particular medical field and on the basis of individualized claim experience. Physicians in high-risk specialties in high-risk states would pay the highest premiums, and individual physicians with high-claim experience would pay higher premiums. Similarly, third-party payers' premiums could be based on both the risk they undertake and their actual claims history. The fund can act as a deterrent to unsafe practice if premiums are based on actual claims history—both the number of claims and total amount paid out for the claims.

4. Duty of Public Notice

The authorizing statute of the fund would create a duty on the provider, institution, or organization to notify all patients of the fund's availability, benefits, and limitations. In addition, it would require publication of risk experience. These requirements would assure that patients were aware of their rights and could exercise those rights before the running of the statute of limitations. It would also provide patients with information that they could use to evaluate providers or procedures.\(^\text{404}\)

5. Exemptions

Intentional and malicious conduct would be exempted from the fund, and the patient would continue to have a tort cause of action, but without the defendant having any of the usual conduct defenses. Refusal or failure of the physician to participate in the fund would give the patient the option of recovery against the defendant (at three times the normal recovery) or recovery in tort without the defendant having conduct defenses.

6. Attorney's Fees

If the patient brings in an attorney because of a denial of a claim, a prevailing patient's costs of suit or administrative costs, excluding attorney's fees, would be payable by the defendant. The patient and the attorney could make any appropriate agreement concerning attorney's fees, but the department of medical injury compensation would have the authority to approve or disapprove any attorney's fee agreement. If the

\[^{404}\text{Starr, supra note 375, at 825.}\]
department disapproves, the attorney's services would be compensable under a statutorily set rate.

C. Problems of a Medical Injury Compensation Fund

Implementing a medical injury compensation scheme presents several difficulties. The first problem is the ability to maintain fiscal stability in the face of increasing participation. The second problem is curing and preventing the occurrence of fraud, abuse, and malingering. The third problem is state and federal constitutional challenges. Finally, because a scheme such as this would have to be enacted legislatively, the fourth problem is political feasibility.

1. Fiscal Stability

Any compensation scheme that proposes to include one hundred percent of medical injuries will face issues related to fiscal stability. Workers' compensation schemes continuously confront issues of continued fiscal viability.\textsuperscript{405} In general, the rising cost of medical care for the injured worker has placed workers' compensation systems in jeopardy.\textsuperscript{406} The state can absolutely control by statute the amount of benefits received by the injured worker herself, but cannot control medical costs. However, the definitions of temporary total disability, temporary partial disability, permanent total disability, and permanent partial disability have been altered by the courts over the years that workers' compensation systems have been in place, so that the length of recovery time allowed for any particular injury has expanded over time.\textsuperscript{407}

This problem precurses a decision that must be made in connection with a medical injury compensation scheme: whether to compensate on the basis of simple physical impairment, such as loss of bodily function, or the more complex loss of earning capacity. The issue of increasing costs of medical services should not be as significant in the case of a medical injury compensation fund because the additional compensation for medical injuries would be a quid pro quo to offset medical cost containment efforts, such as utilization review and financial risk shifting. These cost containment efforts should prevent the

\textsuperscript{405} Id. at 829 n.184.
\textsuperscript{406} H. Michael Bagley et al., Workers' Compensation, 44 Mercer L. Rev. 457 (1992).
\textsuperscript{407} See generally 2 Larson, supra note 393, § 10-57.
fiscal instability arising from runaway medical costs that have plagued workers' compensation systems.

2. Fraud, Abuse, and Malingering

In any system where compensation is made not on the basis of conduct but on the basis of status, the problems of fraud, abuse, and malingering are intensified.\textsuperscript{408} Ordinarily, a person who seeks medical treatment seeks the care for physical, mental (psychological), or social reasons. A compensation scheme adds an economic incentive. Physicians are trained to distinguish between physical, mental, and social causes for illness or articulated symptoms but are not necessarily adept at identifying economic causes. Thus, curing fraud, abuse, and malingering will be a problem with a medical injury compensation scheme just as it has been a problem with workers' compensation. Still, the benefit of providing compensation to the significant number of injured individuals who have been previously excluded outweighs any additional costs of overcoming fraud, abuse, and malingering.\textsuperscript{409}

3. Constitutionality

In workers' compensation, a takings issue arises because the employer forgoes its defenses and the employee gives up a right to full recovery, both of which are arguably property rights. In \textit{New York Central Railroad v. White},\textsuperscript{410} however, the Supreme Court held that the government has a right to add to, and subtract from, defenses as a right of sovereignty.\textsuperscript{411} The Court also held that because the workers' compensation system incorporated a quid pro quo (foregoing defenses in exchange for foregoing complete recovery), the scheme did not constitute a taking.\textsuperscript{412} A medical injury compensation scheme incorporates the same quid pro quo. Health care providers give up their

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408. For example, estimates by the General Accounting Office put the amount of welfare fraud and abuse at $1 billion per year. \textit{Fraud in Welfare Put at $1 Billion}, N.Y. TIMES, Dec. 7, 1987, at A25.

409. One study estimates that one percent of hospital patients receive an injury caused by physician negligence. Of those that are injured, only 2 out of every 15 file a claim. Of those who file a claim, only 50% are ever compensated. So only 1 in 15 injured patients ever receive compensation. Paul C. Weiler et al., \textit{Proposal for Medical Liability Reform}, 267 JAMA 2355, 2355 (1992) (reporting the results of a medical practice study performed at Harvard).

410. 243 U.S. 188 (1917).

411. Id. at 200.

412. Id. at 201.
\end{flushright}
defenses, and patients give up their right to full recovery. Over the last ten years, however, the Supreme Court has dramatically altered its view of what constitutes a taking, so that its attitude about workers’ compensation schemes may no longer hold.413

4. Political Feasibility

Only a few years ago, the political feasibility of instituting a medical injuries compensation scheme would have been questionable. There was little public concern about the so-called medical malpractice crisis and powerful opposition to such a scheme.414 Both attorneys and insurers had powerful lobbies that could effectively oppose any state or federal attempts to institute a medical injuries no-fault scheme.415 The recent focus on the need to reform the health care system to control cost may make a medical injury compensation scheme more appealing.416 In effect, the quid pro quo for instituting utilization review, financial risk shifting, and other cost containment measures should be the compensation of all medical injuries.

D. Benefits and Consequences of a Medical Injury Compensation Fund

A medical injury compensation fund would have several benefits. One benefit would be an overall reduction in administrative costs for medical injuries. Another benefit would be significantly increased participation in this recovery system over the tort system. As participation increased, however, potential monetary recovery would be reduced. The most significant benefit would be spreading the cost of managed care injuries to managed care products. The fund would avoid the problems that traditional tort theories present and would also avoid the barrier that ERISA presents.

1. Reduced Administrative Costs

Administrative costs would be reduced. The time and delay of traditional jury trials are not present in the typical workers'
compensation scheme and would not be present in the medical injury compensation fund.\textsuperscript{417} Instead, authorizing legislation would impose strict liability on health care providers and organizations.\textsuperscript{418} Thus, society's interest in preventing economic hardship and reducing transactional costs would be elevated over the attribution of fault. This elevation would allow for faster claim administration.\textsuperscript{419}

2. Increased Participation

Currently, of every one hundred patients who experience a medical injury, approximately six receive compensation.\textsuperscript{420} Under a medical injuries compensation fund, all one hundred would receive compensation. Although patients who cannot prove an injury or prove that an injury occurred in the course of medical care would still not recover, they by definition do not have a medical injury.

3. Reduced Monetary Recovery

Reduced monetary recovery by the patient is necessary to limit the economic liability of the health care providers and of society as a whole.\textsuperscript{421} The limits on societal resources require that some of the risks of medical treatment be apportioned to the patient.

Of every one hundred patients who suffer an injury during and related to medical treatment, seventeen have injuries falling within the present concepts of provider negligence.\textsuperscript{422} Of these, only four receive any compensation.\textsuperscript{423} Thus, a scheme compensating all one hundred injured patients could cost about twenty-five times as much as the present system; a scheme compensating only the seventeen injuries because of provider fault would cost about four times as much. Even assuming a dramatic increase in system efficiency, resulting in only thirty percent of the premium dollars being lost in transactional costs, the scheme would still cost three to seventeen times as much as

\textsuperscript{417} Starr, supra note 375, at 817.
\textsuperscript{418} Id.
\textsuperscript{419} Id.
\textsuperscript{420} Weiler et al., supra note 409, at 2355.
\textsuperscript{421} Starr, supra note 375, at 810.
\textsuperscript{422} Id. at 806 (citing CALIFORNIA MEDICAL ASS'N AND CALIFORNIA HOSP. ASS'N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY 65 (D. Mills ed., 1977)).
\textsuperscript{423} Id.
presently. Consequently, as noted by one author, "economic realities require patients to carry some of the risk of injury."  

4. Greater Spread of the Cost of Managed Care Injuries

Current tort theories are inadequate to encompass managed care injuries. The doctrines of corporate negligence, respondeat superior, and ostensible agency are all inadequate to spread the cost of managed care injuries because they focus on the negligent conduct of providers and not on the utilization review process or financial risk shifting. Attempts to hold the managed care product directly liable for utilization review and financial risk shifting have not been able to overcome the tendency of courts to focus on the character of the decision-making conduct rather than on the inevitability of effects on individual patients. Thus, when trying to hold managed care directly liable, the problems of burden of proof continue to prevent liability from attaching. These problems are overcome with a medical injury compensation fund, because all medical injuries, regardless of the source, would be covered.

E. Summary

The goals of the current tort system to compensate victims and to deter substandard medical care cannot be met for either existing medical injuries or managed care injuries. In contrast, a medical injury compensation system, like workers' compensation, could compensate quickly, correctly, and without regard to fault. Such a system would not only have the advantage of increasing compensation from four percent to one hundred percent for medical injuries, it would also be an efficient way of covering medical injuries caused by health care cost containment efforts, thus spreading the risk of cost containment throughout society.

VII. Conclusion

The health care system is undergoing drastic changes. One major change is in the relationships among physicians, patients, and third-party payers. Third-party payers are finding an increasing amount of their profit going to health care costs. As health care costs increase, third-party payers are

424. Id. at 810 n.43.
425. Id.
seeking ways to introduce cost containment into the equation. One way that managed care organizations effect cost containment is by shifting the risk of overutilization to the physician, thus inducing the physician to order fewer medical services and to refuse to treat high-risk patients.

The Hippocratic oath requires that the physician do no harm.\textsuperscript{426} Patients expect physicians to act in the patients' best interest.\textsuperscript{427} Third-party payers (particularly managed care products) now contract with physicians to act as gatekeepers to health care services, to avoid providing services that are minimally beneficial, and to protect the wealth of the third-party payers.

This new relationship between third-party payers and physicians introduces a new and different risk into the health care delivery system: A patient may be injured because a physician failed to provide services because of the financial pressures of third-party payers. Under this arrangement, third-party payers, as the new rule makers, are in the best position to promote safety and prevent injury. Thus, it is important that as the health care system changes, new systems of compensation or means of risk placement be developed based on the new relationships between physician, patient, and third-party payer.

Traditionally, third-party payers have not been held liable for the actions of health care providers. That standard was developed because no contractual relationship existed between the third-party payers and the health care providers. Now, third-party payers have contractual relationships with health care providers that require the physician to act as an agent for the third-party payer. These new contractual relationships obligate providers to provide care within the guidelines of the managed care products. Thus, third-party payers, not providers, set the standard of care. Yet, when patients are injured because of the standard of care, the third-party payers are insulated from liability. Thus, third-party payers unfairly avoid paying for injuries that their managed care activities cause, and patients are left with uncompensated injuries.

The legal system must apportion liability based on the risk that an actor has created. Managed care actors have introduced

\textsuperscript{426} Curley Bonds, The Hippocratic Oath: A Basis for Modern Ethical Standards, 264 JAMA 2311 (1990); see also Donald Konold, Codes of Medical Ethics: History, in ENCYCLOPEDIA OF BIOETHICS 162 (Warren T. Reich ed., 1978).

\textsuperscript{427} See supra notes 168-171 and accompanying text.
risks that individuals will be injured as providers are pressured to deny access to beneficial services. If cost containment is important to society, the injuries that result from lower health care costs should be spread throughout society. The injured patient should not be required to bear the cost alone, nor should the provider. The appropriate party to assume the risk is the entity that created the risk—the third-party payer. Thus, a medical injury compensation fund is a fair quid pro quo for cost containment measures that run the risk of increasing uncompensated medical injuries. It assures compensation for those injured, while spreading the cost to those generating the risk. Thus, a medical injury compensation fund can solve the problem of managed care cost containment injuries.