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Carl Giesler†

INTRODUCTION

A year ago this past November, Carley Christie of California attended her high school's homecoming dance.[1] This rite of passage represented a major milestone for the 14-year-old freshman since six years ago she was diagnosed with kidney cancer. Carley's HMO declined to pay for treatment by a surgeon with expertise and substantial experience in the removal of her particular cancer. After assessing Carley's condition, the HMO judged the specialized surgery as medically unnecessary. Instead, it directed her to a general surgeon.

Through their own means, Carley's parents persisted in their efforts to get a specialist. After four years of campaigning by the Christies, California fined the HMO half a million dollars and ordered reimbursement of medical expenses incurred. Carley's father now rejoices

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1. As recounted by Marilyn Chase, *New 'Bill of Rights' Makes a Modest Start At Protecting Patients*, WALL ST. J., Nov. 24, 1997, at B1.

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in her prognosis: "She's doing wonderfully."[2] American health care, in general, and managed care, in particular, are not supposed to work this way. As the Christies' trauma evidences, both remain works in progress.

Managed care[3] has significantly influenced the recent development of American medical care.[4] Despite first receiving widespread attention during the health care reform debates of 1992-94,[5] managed care has long been part of America's health care system.[6] Congress' failure to enact comprehensive national health care legislation did not slow the growth of managed care. Since 1993, the total number of managed care organizations (MCOs)[7] has expanded dramatically, and MCOs have spread to new markets. Millions of Americans have switched from traditional indemnity plans to managed care.[8] Today, nearly 75% of insured workers[9] receive their health care from MCOs, up from less than 30% in 1988.[10]

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2. *Id.* at B1.

3. There is no generally agreed upon definition of the term "managed care." However, "Broadly defined, it encompasses any measure that, from the perspective of the purchaser of healthcare, favorably effects the price of services, the site at which the services are received, or their utilization." Helene L. Parise, *The Proper Extension of Tort Liability Principles in the Managed Care Industry*, 64 TEMP. L. REV. 977, 979 (1991).

4. *See* FAMILIES USA FOUND., PREMIUM PAY: CORPORATE COMPENSATION IN AMERICA'S HMOs 1 (Apr. 1998).

5. In November 1993, President Clinton introduced the Health Security Act to Congress, H.R. 3600, 103d Cong. (1993). *See* The White House Domestic Policy Council, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE (1993). In considering the Act, Congress debated the merits of universal health insurance, community-rated insurance premiums, capitated payments, and various corporate structures designed to create a national health care system. *See* Victor R. Fuchs, *The Clinton Plan: A Researcher Examines Reform*, I HEALTH AFF. 102 (Spring (I) 1994).

6. Managed care began as a minor presence in 1929 and with the advent of the Kaiser Health Plan during World War II. *See* Manged Care Online, *Managed Care Primer* (last modified Oct. 15, 1997) <http://www.medicarehmo.com/mcprimer.htm>. Health maintenance organizations have existed since around the 1940s. *See id.* The Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (1973), encouraged their proliferation. *See* Laurie Zoloth-Dorfman & Susan Rubin, *The Patient as Commodity: Managed Care and the Question of Ethics*, 6 J. CLINICAL ETHICS 339, 339 (1995).

7. For simplicity, this article uses the term "managed care organization" as a general term to encompass a complex variety of managed care organizations. Two of the most well known types of MCOs are health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). HMOs and PPOs are also general terms; there are at least four types of HMOs, three types of PPOs, and hybrid forms exist. *See generally* James P. Freiburg, *The ABCs of MCOs: An Overview of Managed Care Organizations*, 81 ILL. B.J. 584, 584-88 (1993).

8. Over 165 million patients belong to coordinated care programs of networked-based health care systems. American Association of Health Plans, MANAGED CARE FACTS, 2-3 (1998). This represents a more than 120% increase since 1990. *See id.*

9. *See id.*

10. *See* Gail Jenson et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, 16 HEALTH AFF. 125, 134 (Jan.-Feb. 1997).

This growth in managed care stemmed, at least in part, from a growing sense that "health care costs . . . were spiraling out of control."[11] From 1985 until 1992, health care costs grew from $429 billion to $837 billion annually.[12] Respectively, these figures represent 10.3% and 13.4% of the United States' gross domestic product—a substantial jump both in absolute and percentage terms. Employers, legislators, and other policy-makers believed that the traditional fee-for-service medical system could not adequately contain these costs.[13]

However, as managed care has rapidly gained acceptance its popular perception has diminished.[14] The media regularly publishes accounts of MCO denials of care and reimbursements to enrollees.[15]

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11. FAMILIES USA FOUND., HIT AND MISS: STATE MANAGED CARE LAWS 1 (July 1998). *See also* Parise, *supra* note 3, at 977 (noting that "[t]he restructuring [in health care from fee-for-service insurance to managed care] is due primarily to the continual rise in health care costs.").

12. *See* Healthcare Financing Administration, *National Health Expenditures Table* (last modified Oct. 29, 1998) <http://www.hefa.gov/stats/nhe%2Doact/tables/+09.htm>.

13. *See generally* MARC A. RODWIN, MEDICINE, MONEY & MORALS: PHYSICIANS' CONFLICTS OF INTEREST 55-57 (1993). Professor Rodwin notes that insurance companies (third-party payors) pay for the vast majority of health care costs in the United States. Accordingly, consumers do not directly bear the costs of the medical services they receive and have little incentive to seek the most reasonably-priced physician. In addition, many consumers tend to seek health care in moments of crisis and will not consider cost to be the most important factor in selecting a physician. *See id.* at 13-14.

14. Public applause when actress Helen Hunt lambastes HMOs in the 1997 movie "As Good As It Gets" has been well documented. *See, e.g.,* Jacke Calmes, *Images Shape Debates Nationwide*, WALL ST. J., June 25, 1998, at A10; David S. Hilzenrath, *Art Imitates Life When It Comes to Frustration with HMOs*, WASH. POST, Feb. 10, 1998, at C1 (quoting Molly Ann Broide, director of special projects for the Henry J. Kaiser Family Foundation, as saying: "I think the [applause line in "As Good As It Gets"] has real implications. HMOs have become sort of the villain in our society."); Peter T. Kilborn, *Mounting Anger Over HMOs a Major Issue in Campaigns*, HOUSTON CHRON., May 17, 1998, at A12; Bennett Roth, *Texas Has a Big Stake in Health Care Debate*, HOUSTON CHRON., March 8, 1998, at A1.

15. *See e.g.,* David Moran, *Federal Regulation of Managed Care: An Impulse in search of a Theory?*, 16 HEALTH AFF. 7, 9 (Nov.-Dec. 1997); Alison Bass, *Therapists Say Insurer Gag Order Hurts Patients; Health Professionals Tell of a Blacklist*, BOSTON GLOBE, Dec. 20, 1995, at 1, *available in* 1995 WL 5966892; Susan Brink, *How Your HMO Could Hurt You: Managed-Care Doctors Concerned about Their Incomes Have an Incentive to Stint on Care*, US NEWS & WORLD REP., Jan. 15, 1996, at 62; Susan Brink & Nancy Shute, *Are HMOs the Right Prescription?*, US NEWS & WORLD REP., Oct. 13, 1997, at 60; George J. Church et al., *Backlash Against HMOs: Doctors, Patients, Unions, Legislators are Fed Up and Say They Won't Take it Anymore*, TIME, Apr. 14, 1997, at 32; Edward Dolnick, *Death by HMO—One Woman's Horror Story*, GLAMOUR, Feb., 1996, at 158; *For a Human Balance*, Editorial, N.Y. TIMES, March 19, 1996, at A22; Jeffrey M. Landaw, *Mr. Kafka, Call Your Office*, BALTIMORE SUN, Apr. 3, 1997, at 19A; Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 44; *The Rights of Patients, by Law*, Editorial, N.Y. TIMES, Nov. 22, 1997, at A14; Olmos Roan & Shari Roan, *HMO 'Gag Clauses' on Doctors Spur Protest*, L.A. TIMES, Apr. 14, 1996, at A1; Ellyn E. Spragins, *Beware Your HMO*, NEWSWEEK, Oct. 23, 1995, at 54; *Too Many HMOs Stint on Emergency-Room Care*, Editorial, USA TODAY, Apr. 9, 1997, at 10A (reciting "[t]ales from the crypt of managed care"). For a compilation of hundreds of such anecdotes, see GEORGE ANDERS, HEALTH AGAINST WEALTH:

Television has also exploited the dramatic potential of managed care.[16] One commentator has observed that:

> [P]ractically everybody covered by a managed-care health insurance plan has some story about a suffered indignity, petty or grand, foisted on him or her by a callous or ignorant health insurer.
>
> Even if one's annoyance is trivial, it makes a person inclined to nod one's head vigorously when hearing about the major-league horrors HMOs are alleged to inflict on helpless citizens. And one hears it a lot these days. Over the past several months, we have had newsmagazine covers and presidential pronouncements replete with anecdotal horror stories about treatments denied and 'gag rules' imposed by HMOs on their physicians to keep patients in the dark about the best treatment available to them.
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> . . . .
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> . . . In the time-honored journalistic tradition of championing the average guy against the rapacious big-money interests, it has become a mainstay for news editors to order stories on outrages among HMOs. Reading the stories and hearing the speeches, it is easy to believe that HMOs are all run by greedy and rapacious sadists concerned more about squeezing out an extra dollar of profit than providing basic aid and comfort to afflicted policyholders. And lots of distinguished people, including not just politicians but also physicians and hospital administrators, are saying just that.[17]

Reports of high MCO profits and generous MCO executive compensation only exacerbates public discontent with managed care.[18] In a

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HMOs AND THE BREAKDOWN OF MEDICAL TRUST (1996). *See also* Louise Kertesz, *Backlash Continues: Survey Finds Managed Care Is Still the Bad Guy in Many Americans' Eyes*, MOD. HEALTHCARE, Nov. 10, 1997, at 33 ("People seem to generalize from anecdotal reports in the news about problems with managed care. When asked about specific examples taken from news stories about the problems some people have reported . . . with managed care, the public's perception is that these are fairly common occurrences."); Maggie Mahar, *Time for a Checkup*, BARRON's, March 4, 1996, at 29 ("As if smelling blood in the water, newspapers and magazines have turned from cheerful if boring tales of HMO's ability to contain costs to horror stories about patients who requested a particular procedure were turned down by HMO administrators, and subsequently died.").

16. *See* Burkhard Bilger, *TV's Powerful Doctor Shows vs. the H.M.O.*, N.Y. TIMES, Dec. 22, 1996, at H41 (noting that television dramas use MCOs to "play the same role that Russians and Arabs used to play in movies: dark forces against which the forces of light must battle."); Barbara D. Phillips, Review, *He's No Giuliani*, WALL ST. J., Oct. 6, 1997, at A20 ("The big HMO and its employees are depicted as greedy at best, evil at worst—white-collar gangsters deserving of whatever federal threats and punishments can be brought to bear.").

17. Norman Ornstein, *HMO's Rightful Credo: No Pain, No Gain*, USA TODAY, March 24, 1997, at 15A.

18. In 1996, the 25 highest paid HMO executives had an average compensation, exclusive of un-exercised stock options, of more than $6.2 million. The median compensation exceeded $4.8 million. *See* FAMILIES USA FOUND., *supra* note 4, at 3; *see also* Andy Dworkin, *Compensation Averages $4.4 Million For Top HMO Executives, Study Says*, DALLAS MORNING NEWS, Apr. 2, 1998, at 2D; Milt Freudenheim, *Penny-Pinching HMOs Showed Their Generosity in Executive Paychecks*, N.Y. TIMES, Apr. 11, 1995, at D1.

recent survey, 69% of Americans considered HMO regulation very important to the nation.[19] Forty-five percent say that during the past few years, the quality of healthcare for patients with HMOs and other managed care plans decreased.[20]

The federal government is considering responses to the problems that have alarmed managed care consumers.[21] In 1997, President Clinton established a health care quality advisory commission "to find ways to ensure quality and to ensure the rights of consumers in health care are protected."[22] Also, in the last year Congress has considered competing Republican and Democratic bills imposing national regulations on managed care concerns.[23] To date, none has become law. Though the federal government has instituted some limited regulatory measures,[24] it has yet to establish a coherent system for managed care regulation.[25]

In contrast, state legislatures have responded more rapidly and concretely to public uneasiness with managed care.[26] By 1998, "[v]irtually all states [had] adopted one or more laws addressing different specific consumer concerns" about managed care.[27] The myriad of state approaches offer a variety of regulatory models that Congress could monitor and perhaps revise and adopt.

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19. Pew Res. Ctr. for the People & the Press, *Compared to 1994, Voters Not So Angry, Not So Interested*, (June 15, 1998) <http://www.people-press.org/june98rpt.htm> (surveying what news stories are attracting voters' interest and what issues people consider most important).

20. *See* The Henry J. Kaiser Family Found., *Is There A Managed Care "Backlash?,"* (visited March 7, 2000), <http://kaiser.bitwrench.com/content/archive/1328/mcarepr.html>.

21. At the time of publication the issue remains unresolved. On October 6, 1999, the House of Representatives passed H.R. 2990 by a vote of 227 to 205. The Senate amended the bill by substituting S. 1344 on October 14, 1999.

22. Exec. Order No. 13, 017, 3 C.F.R. 215 (1996).

23. *See* H.R. 4250, 105th Cong. (1998); H.R. 3605, 105th Cong. (1998).

24. Most notably, a law requiring coverage of forty-eight hour maternity stays. *See* Newborns' and Mothers' Health Protection Act of 1996, Pub. L. 104-204, 110 Stat. 2935 (codified at 29 U.S.C. § 1185 (Supp. III 1998)); 42 U.S.C. §§ 300gg-4 (Supp. III 1998); 42 U.S.C. §§ 300gg-51 (Supp. III 1998).

25. The Federal Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (1994 & Supp. III 1998), represented an effort by the federal government to facilitate the development of HMOs. It provided financial subsidies to HMOs, prohibited state laws or practices that inhibited the formation of federally-qualified HMOs, and required employers with more than 25 employees to offer an HMO as an option in its health benefits plan. While an HMO must accept several regulatory requirements in order to enjoy the Act's benefits, the Act does not represent a regulatory scheme meant to deal with the concerns consumers today have about MCOs. *See generally* Troyen A. Brennan & Donald Berwick, NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE 152-54 (1996).

26. *See* FAMILIES USA FOUND., *supra* note 11, at 35.

27. *Id.* at 2; *see also* Mary Lord, *Patience for a Bill of Rights: States Begin to Move on HMO Reforms While Congress Argues*, U.S. NEWS & WORLD REP. Oct. 5, 1998, at 74; Andrew Goldstein, *Ahead Of The Feds: How Some States Are Already Regulating Managed Care*, TIME, July 13, 1998, at 30.

Perhaps, no state has been more aggressive in its supervision of MCOs than Texas.[28] In 1997, the Texas Legislature passed the Texas Health Care Liability Act (THCLA),[29] directly imposing a legal duty on MCOs to exercise ordinary care when determining the medical necessity of a patient's proposed treatment.[30] A federal district court in *Corporate Health v. Texas Department of Insurance*[31] recently upheld Texas' imposition of this duty. It concluded that the Employee Retirement Income Security Act of 1974 (ERISA)[32] did not preempt the law's tort liability provision. Prior courts had generally ruled that ERISA preempts state laws that hold employer-sponsored health plans legally accountable for decisions that ultimately cause patient's harm by limiting care.[33]

This paper examines *Corporate Health* and argues the policy wisdom of imposing malpractice liability on MCOs. Part II chronicles the effective control MCOs exercise over medical care decisions. Part III discusses states' non-tort regulations of MCOs and their ineffectiveness in making MCOs accountable for that control.

Part IV then argues that the policy behind MCO tort liability makes sense and that Congress should clearly authorize states to impose malpractice liability on MCOs whose decisions negatively impact patients' medical treatment. Tort liability forces MCOs to consider the nonmonetary costs of negligent medical necessity decisions borne by man-

28. Ron Pollack, executive director of Families USA Foundation, a national organization for health care consumers, describes Texas' advancement: "The Texas example is cited frequently because Texas has the most far-reaching legislation. . . ." , Carol Marie Cropper, *In Texas, a Laboratory Test on the Effects of Suing HMOs*, N.Y. TIMES, Sept. 13, 1998, at A3.

29. TEX. CIV. PRAC. & REM. CODE ANN. § 88.001-.003 (Vernon 1997 & Supp. 1999).

30. Only two states—Texas and Missouri—have passed laws exempting managed care corporations from their laws against suing corporations for malpractice. In both states, this exemption had the practical effect of imposing tort malpractice liability on MCOs. Only Texas, however, has taken the additional step of creating a cause of action so individuals can sue their health plans. *See* FAMILIES USA FOUND., THE BEST FROM THE STATES II: THE TEXT OF KEY STATE HMO CONSUMER PROTECTION PROVISIONS (last visited Nov. 5, 1999) <http://familiesusa.org/best2.htm#sue>; Carla Rothouse, *Insurer Liability*, ISSUE PAPER (Health Policy Tracking Serv.), Oct. 1, 1998, at 3-4. In 1998, eighteen states have considered—but not passed—legislation to allow medical malpractice suits against MCOs (Alabama, California, Connecticut, Florida, Georgia, Hawaii, Maine, Maryland, Massachusetts, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Washington, and West Virginia). *See id.*

31. 12 F. Supp. 2d 597 (S.D. Tex. 1998).

32. 29 U.S.C. §§ 1001-1461 (1994).

33. *Compare* Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992) *and* Schmidt v. Kaiser Found. Health Plan, 963 F.Supp. 942 (D. Or. 1997) (both holding that ERISA preempts state tort claims arising from an ERISA MCOs benefit determinations) *with* Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) *and* Kampmeier v. Sacred Heart Hosp., 1996 WL 220979 (E.D. Pa. May 2, 1996) (both finding no ERISA preemption on claims arising from the provision of medical care as opposed to coverage administration).

aged care consumers and then incorporate them into their assessment of the trade-offs between health care cost and quality.[34] It also makes MCOs respect and adhere to the treatment quality levels demanded by society. The public has evidenced its desire to contain the rise in health care costs through its embrace of managed care. Nonetheless, by society's continued enforcement of standards of care through the imposition of malpractice liability on physicians and other providers, it has also revealed the level below which it does not want—and will not tolerate—health care quality to fall.

Though critics can debate whether custom-based standards of care make sense[35] and whether a tort regime is effective, no reason exists to exempt MCOs—the decisions of which affect patient care levels—from adhering to them while enforcing them against physicians and other providers.[36] Tort liability forces MCOs to respect those levels as they work to make health care more efficient and will not lead to unreasonable increases in malpractice litigation and health insurance costs. Part V reflects the recent trends in state legislation to address accountability and liability of HMOs. Part VI explains the Texas tort-based approach to MCO accountability for medical determinations, discussing the THCLA and its evaluation in *Corporate Health.*

Part VII concludes the paper with a call for Congress to enact legislation or amend ERISA so that states can unreservedly enforce medical negligence standards against MCOs. While courts have narrowed the extent of ERISA's preemption of state law, federal and state decisions on ERISA's implication for state MCO tort liability are inconsistent. Undoubtedly, the resulting uncertainty makes some state legislatures wary of imposing malpractice liability on MCOs. Clarification from Congress would likely embolden mores states to follow Texas' lead.

34. For example, the risk of having an illness or injury is exacerbated because of an MCO's delay or denial of treatment.

35. *See* Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care*, 26 J. LEGAL STUD. 491, 493 (1997) (arguing that "[t]he traditional custom-based standard of care has no basis in efficiency. On the contrary, it gives legitimacy to the standard of care that developed under indemnity insurance. Customary care under traditional insurance reflects severe moral hazard and hence overuse of costly services.").

36. *See* Peter B. Jurgeleit, *Note Physician Employment Under Managed Care: Toward a Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians*, 73 IND. L.J. 255, 292 (1997). ("Regardless of what HMO protocol holds is medically necessary or appropriate, a physician's duty of care is nevertheless that which a reasonable physician in the community would have provided.").

I. THE DISCONNECT BETWEEN MCO MEDICAL RESPONSIBILITY AND ACCOUNTABILITY

A. *MCO's Effect on Substantive Medical Care*

Managed care began as an effort mainly to improve access to preventive, primary, and coordinated care.[37] Recently, however, the widely perceived need to control America's rising health care costs[38] has spurred its expansion. Traditional fee-for-service plans offered powerful incentives for physicians and other providers to provide costly diagnostic tests, health procedures, and lengthy hospitalizations—even when of questionable benefit to patients.[39] By contrast, MCOs ideally control health care expenditures by working with physicians to provide only the most cost effective medically appropriate services.[40] Thus, managed care has the overarching policy goals of reducing wasteful medical treatment while generally promoting efficiency in the nation's health care system.[41]

However, MCOs' implementation of cost containment measures impinges on doctor-patient relationships and decisions. This erosion of the integrity of the physician-patient relationship and decision-

37. *See* FAMILIES USA FOUND., *supra* note 11, at 1. *See generally* David D. Griner, Note, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 874-80 (1991) (giving a brief description of the history of managed care).

38. *See* Sally T. Burner & Daniel R. Waldo, *National Health Expenditure Projections, 1994-2005*, HEALTH CARE FIN. REV., June 1, 1995, at 221. Revised projections indicate that health expenditures will reach 15.9% of the gross national product by 2000. *See id. See generally* Jenson, *supra* note 10 (discussing medical care inflation compared to general inflation).

39. *See* FAMILIES USA FOUND., *supra* note 11, at 1; Danzon, *supra* note 35, at 494.

> "In general, the physician knows more than the patient about the best treatment for the patient's condition and the quality of care actually delivered. This information asymmetry implies that providers appropriately play a key role as agents to guide patients in their use of medical services. However, these same agents/advisors often themselves implement, and therefore have a financial stake in, the recommended course of treatment."

Id.; *see also* Griner, *supra* note 37, at 881. (pointing out that each additional treatment represents extra income for the provider); Kenneth R. Pedroza, *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 410 (1996) ("[P]hysicians had an incentive to over-treat the patient. Procedures offering incremental benefits, no matter how small, were undertaken because both the doctor and the patient received benefits from the treatment.").

40. *See* Martin F. Shapiro & Neil S. Wenger, *Rethinking Utilization Review*, 333 NEW ENG. J. MED. 1353, 1353 (1995) (explaining that MCO policies should be employed to increase the cost effectiveness of medical care and optimize quality while reducing the use of resources); *see also* FAMILIES USA FOUND., *supra* note 11, at 1.

41. In aggregate terms, at least, MCOs have succeeded in their goal. "In 1997 national health expenditures amounted to $1.1 trillion, with per capita spending measured just shy of $4,000. Health spending as a share of gross domestic product fell slightly to 13.5 percent, the smallest claim of health spending on the nation's resources in the last five years." Health Care Financing Administration, *National Health Expenditures*, (last updated Oct. 30, 1998) <http://www.hefa.gov/stats/nhe%2Doact/hilites.htm>.

making process can affect the quality of patients' care. It overlays external cost and benefit calculations onto medical decisions.[42]

MCOs attempt to control health care costs by employing various cost containment policies and systems[43] that purposefully restrict and effectively control physician behavior. Indeed, managed care differs from traditional fee-for-service medicine primarily in that physicians in MCOs do not make independent treatment decisions with their patients. To avoid financing inappropriate medical treatments, MCOs regularly judge whether health care services prove "medically necessary" in determining patients' coverage. These determinations inject MCOs into the decision-making process historically reserved for physicians and their patients.[44]

MCOs employ both direct and indirect means to ensure that physician treatment recommendations meet their standards for medical and financial appropriateness.[45] MCOs supervise treatment perhaps most directly through prospective utilization management.[46] Through utili-

42. *See* Robert M. Goldberg, *What's Happening to the Healing Process?*, WALL ST. J., June 18, 1997, at A22:

> "Many managed care organizations maintain that limiting doctor autonomy eliminates wide differences in the amount and quality of care. They say that their systems will integrate care, providing better treatment at a lower cost than a lonely doctor in a traditional practice can. Several managed care plans, . . . have lived up to these claims. But they have taken great pains to preserve physician's autonomy and to encourage patients to become more involved in their treatment. Most plans, however, make it harder for doctors and patients to create such partnerships."

Id. Of course, physicians and other providers had incentives to render more care than perhaps necessary. These incentives tended to benefit the patient, rarely if ever resulting in a denial or rationing of necessary care. The patient and provider's interests aligned. By contrast, MCOs have a strong incentive to limit patient care. They, after all, must pay for it.

43. For an elaborate explanation of the various forms of organizational structures and cost-containment methods employed by MCOs, see generally, PETER R. KONGSTVEDT, THE ESSENTIALS OF MANAGED HEALTH CARE (1995) and THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH (1995).

44. Robert Blendon, professor of health policy and management at the Harvard School of Public Health, describes the interference: "All these plans have within them the phrase 'medically necessary and appropriate care.' Nobody told people that what that meant was their doctor might want to do something and the plan wouldn't permit it." Susan Brink & Nancy Shute, *America's Top HMOs*, US NEWS & WORLD REP., Oct. 13, 1997, at 60.

45. A defined benefits package generally has a central administration that oversees physicians who have contracted with the organization, disburses payment, and conducts utilization review. Additionally, an MCO may employ gatekeeper physicians—primary care physicians responsible for referring patients to specialists when necessary. *See* WILLIAM M. MERCER, INC., INTEGRATED HEALTH PLANS: MANAGED CARE IN THE 90s 4 (1990).

46. "Utilization review is arguably the measure that presents the greatest intrusion on provider autonomy. This measure subjects providers' proposed treatments to review before such services can be rendered to patients." Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STAN. L. & POL'Y REV. 433, 435 (1998). Another commentator has noted:

zation review, an MCO pre-screens major physician treatment decisions, retaining the power to authorize or deny payment for services such as hospital admissions, surgeries, referrals to specialists, and significant medical tests.

Similar to utilization review, MCOs have also designed and implemented treatment conventions and guidelines that outline approved medical services for various patient conditions.[47] For determining what constitutes medically appropriate and necessary care, most MCOs have established standards based on clinical information.[48] Authorization of treatment or inclusion of a procedure on guidelines depends not only on whether the MCO's health benefit plan covers a particular treatment but, more significantly, on whether the treatment meets the MCO's standard of "medically appropriate and necessary care."[49]

This latter determination essentially shifts the medical decision-making authority from the physician to the MCO.[50] The transfer of decision-making authority to the MCO can prove beneficial since MCOs, unlike most individual physicians, often have more accumulated experiential data from which to draw. Smart utilization review decisions and "carefully constructed guidelines . . . can [both] decrease costs and reduce [both] illnesses and deaths."[51]

II. PHYSICIAN COMPLAINTS

"Managed care physicians argue that [MCO] guidelines are often applied too rigidly, without consideration for the individual needs of patients."[52] They also criticize the quality of MCO reviewers, con-

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> Utilization review, particularly prospective . . . review, strikes at the heart of health care delivery: the physician-patient relationship. Because the basic purpose of utilization review is to influence treatment decisions, by its very nature it must affect or even overrule the physician's decisions.

Griner, *supra* note 37, at 885.

47. *See* Danzon, *supra* note 35, at 498.

48. *See* FAMILIES USA FOUND., *supra* note 11, at 28.

49. *See id.* at 27.

50. During Commerce Committee testimony in 1996, Dr. Linda Peeno, a former HMO medical reviewer, described the medical necessity determination as a health plan's "smart bomb capability." By retaining power to define what is and what is not medically appropriate, a plan can control health decision-making. Memorandum from Greg Ganske, Rep. of Iowa, U.S. House of Representatives, to Interested Members of Congress (July 21, 1998) (on file with author).

51. *Id.* For example, two cardiologists at the Minneapolis Heart Institute developed a protocol to determine which patients with chest pains should receive an angiogram—an expensive diagnostic procedure to detect coronary artery disease. By applying these standards, the physicians cut the number of unnecessary angiograms by more than 50%, saving about $2.1 million annually and lessening patients' exposure to unnecessary surgical risks. *See generally* Ron Winslow, *Heal Thyself: Two Doctors Saw That If They Were Going To Be More Efficient, They Were Better Doing It Themselves*, WALL ST. J., Oct. 23, 1997, at R15.

52. FAMILIES USA FOUND., *supra* note 11, at 30. Researchers found that, according to utilization review criteria, 80% of the reviewed cases did not warrant tube in-

tending that the reviewers sometimes have neither the requisite expertise nor sufficiently complete knowledge of the particular circumstances to make an appropriate medical judgment.[53] Furthermore, MCOs have an incentive to mask financial determinations as medical judgments.[54]

Regardless, when utilization review guidelines apply, the MCO—not the physician—makes the ultimate judgment on the care the patient receives. By assessing a physician's medical judgment for reimbursement purposes, MCOs effectively override doctor and patient decisions. The majority of patients often will—or must—refuse any treatment for which their benefit plan will not pay.[55]

MCOs also constrain physician medical decisions in less direct ways. For instance, MCO payment methods and financial incentives induce physicians to minimize—sometimes sub-optimally—the care rendered to patients.[56] Capitation[57] payment plans provide physicians a flat fee for each patient regardless of the medical care needed by the patient and rendered by the physician. This disbursement scheme imposes upon physicians some financial risk for their treatment of patients.

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sertions. By contrast, physicians with substantial expertise in the area concluded that only 31 percent of the tube insertions would prove unwarranted. *U.R. Criteria Found Much Stricter Than Physician Review*, MEDICAL UTILIZATION MGMT, Aug. 14, 1997, at 5.

53. *See* FAMILIES USA FOUND., *supra* note 11, at 30. Michael DeBakey, M.D., the pioneering heart surgeon, has lamented:

> If Americans want medicine to remain a humanitarian venture, they must be free to choose their physicians and must insist that health care decisions be made only by those medically qualified and personally familiar with the patient's clinical condition. We would not allow an unqualified clerk to recommend repairs for our car, so why would we settle for one when it comes to our own health?

Rx for the Health Care System, WALL ST. J., Oct. 8, 1998, at A18.

Both managed care consumers and providers have also lamented the time and effort involved in obtaining a utilization review decision. Additionally, patients have had difficulty obtaining the information they need on how a plan treats a particular disease or the clinical guidelines upon which an adverse utilization review decision rests.

54. *See id.* Arguably all MCO decisions are reduced to purely financial considerations. One HMO executive described MCO's views of patients as follows:

> We see people as numbers, not patients. It's easier to make a decision. Just like [automobile manufacturers], we're a mass production medical assembly line, and there is no room for the human equation in our bottom line. Profits are king.

Goldberg, *supra* note 42, at A22.

55. *See* Grosso, *supra* note 46, at 435 (fearing that "a majority of patients will refuse any treatment that is not covered under a benefits plan."); *see also* Danzon, *supra* note 35, at 498 (noting that "[i]n practice . . . insurance coverage may be necessary for the patient to afford high cost care").

56. *See* FAMILIES USA FOUND., *supra* note 11, at 16.

57. Capitation generally involves a fixed fee prepaid to physicians for each member in the plan, regardless of the volume or degree of services used. The MCO may also use incentive plans, in which physicians may receive bonuses for frugal use of resources; alternatively, they may have part of their salary withheld for excessive use of services.

When physicians assume this risk, they effectively act as both care providers and insurers. Therefore, they have a financial incentive to provide minimal care because they receive the same revenue irrespective of the time they spend and the expense they incur in rendering care.[58] In effect, withholding care increases the residual doctors can keep.

In addition to capitation, MCOs often employ other financial incentives and disincentives to encourage reduced care. Incentives include bonuses for physicians that keep certain medical service utilization below a certain level,[59] including, for example, specialist referrals, hospital admissions, and diagnostic tests.[60] Disincentives include withholding a portion of a physician's reimbursement and deducting the cost of non-basic medical care.[61] MCOs' "use of financial incentive arrangements to pressure physicians into keeping costs at a minimum . . . undoubtedly present conflicts of interests [among] patients, physicians, and payers."[62] Recently, the Texas Attorney General filed suit against several Texas MCOs alleging they illegally rewarded doctors who limited patient medical care and penalized those who did not.[63]

In addition to financial incentives and disincentives, MCOs sometimes employ non-financial mechanisms that affect physicians' medical judgment. So-called "gag-rules" restrict a physician's communication to and on behalf of patients.[64] Through these contrac-

58. *See* Parise, *supra* note 3, at 988 (stating that methods of physician payment have significant effects on rate of patient hospitalization); *see also* Danzon, *supra* note 35, at 499 (noting that "[w]hen the provider is paid a fixed amount per patient or episode, ordering extra services or tests entails additional costs but generates no additional revenue."). *See generally* Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations*, 321 NEW ENG. J. MED. 86 (1989); Paul J. Feldstein et al., *The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED., 1310 (1988).

59. *See* FAMILIES USA FOUND., *supra* note 11, at 16.

60. *See* Paul Gray, *Gagging the Doctors,* TIME, Jan. 8, 1996, at 50 (printing examples taken from U.S. Healthcare's own documents). Based on 925 patients, if a physician's referrals-to-specialists average less than $14.49 per month, per patient, the physician gets a bonus of $1,323 for the month; if the costs rise above $30.49 per patient, the doctor gets nothing extra. *See id.* If all of the doctor's patients collectively average fewer than 178 days in the hospital per year, the doctor receives a bonus of $2,063 per month; if patients collectively stay more than 363 days, the doctor receives nothing. *See id.*

61. For example, if a primary care physician is to receive a capitated rate of $11.25 per month, per patient, the MCO may withhold 20% or $2.25 per month, place that money in reserve, use that money to pay for non-basic medical treatment for all of the physician's patients, and at year's end give the physician whatever money remains. *See* KONGSTVEDT, *supra* note 43, at 79.

62. Parise, *supra* note 3, at 989.

63. Laura Goldberg, *Texas Sues HMOs, Claims Conflict of Interest in Care*, HOUSTON CHRON., Dec. 17, 1998, *available in* 1998 WL 16788133.

64. *See* FAMILIES USA FOUND., *supra* note 11, at 16. Such restrictions have been generically called "gag" rules. *See* Robert Pear, *Word for Word? HMO Contracts:*

tual provisions, a plan may enforce—explicitly or implicitly—practices that prohibit or discourage physicians from fully explaining to patients more costly treatment options, a health plan's utilization policies, and the financial incentive structures of the plan for the physician. Some MCOs may even terminate doctors who advocate on behalf of their patients against treatment denials.[65]

Through indirect controls such as fixed payment methods, financial incentives, and "gag clauses," MCOs may not actually determine the specific medical treatment rendered to a patient. Nonetheless, these mechanisms restrict the options which a physician will consider or discuss with a patient ultimately impacting the level of medical care received by the patient. Together with direct utilization review and clinical protocols, these indirect influences enable MCOs to determine effectively and substantively the care rendered to patients. Using such measures, MCOs "control the . . . what, when, where, and how of medical treatment."[66] As a Pennsylvania court recently observed, MCOs "involve themselves daily in decisions involving their subscriber's medical care."[67]

III. STATES' NON-TORT REGULATION

Managed care's success in curtailing the rise in national healthcare expenditures has proven unsettling for consumers.[68] "Many fear that

The Tricky Business of Keeping Doctors Quiet, N.Y. TIMES, Sept. 22, 1996, at D7. The U.S. General Accounting Office found little evidence of explicit gag rules in a review of HMO provider contracts. U.S. GENERAL ACCOUNTING OFFICE, GAO/HEHS-97-175, MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERNS REMAIN (1997). The GAO noted, however, that managed care plans may influence physician behavior through their ability to terminate contracts with physicians: "Physicians . . . pointed out that the increasing power of HMOs in the health care marketplace and their ability to bear on physicians to modify their practice patterns or discussions with patients, without relying on [gag] clauses." *Id.* Also, "two-thirds of responding plans and 60 percent of the contracts submitted had a non-disparagement, non-solicitation, or confidentiality clause that could be interpreted by physicians as limiting communication about all treatment options." *Id.*

65. *See* John P. Little, Note, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1443 (Summer 1997) (arguing that "[t]here are no other purposes for termination without cause clauses other than coercing physicians into restricting patient care and terminating those physicians whom the MCO considers to be non-compliant.")

66. David Sibley, *What the Texas Experiment Shows About H. .M.O. Liability*, N.Y. TIMES, Aug. 7, 1998, at A21. ("They decide who your doctor will be, what treatment you will receive, when you will receive it, where it will be delivered, and how it will be delivered."). Regarding the "who your doctor will be" decision, managed care plans generally restrict coverage to a network of contracted preferred providers. *See* Danzon, *supra* note 35, at 498.

67. Shannon v. McNulty, 718 A.2d 828, 835 (Pa. Super. Ct. 1998). The court held that the parents of a child that died following premature delivery made a prima facie case against their HMO for both vicarious liability and direct liability. *See id.* The court also noted that "[a] great deal of today's healthcare is channeled through HMOs with the subscribers being given little or no say in the stewardship of their care." *Id.*

68. *See* FAMILIES USA FOUND., *supra* note 11, at 1.

the reversal of economic incentives [from the fee-for-service system] will result in the denial of needed and appropriate care."[69] Stories of problems "ranging in severity from time-consuming bureaucratic red tape to life-threatening"[70] refusals of treatment have compounded consumer anxiety.[71] Accordingly, many state legislatures have passed regulations for MCOs.[72] By October 1998, most states enacted regulations that attempted either to preserve the integrity of the physician-patient relationship or to increase patient access to services, such as emergency care, prescription drugs, and specialists.[73]

Several types of state regulations aim to lessen MCO interference with the doctor-patient relationship.[74] These mandates seek to minimize business and financial considerations in a doctor and patient's medical treatment decisions rather than imposing any affirmative substantive medical obligations on MCOs. Thus, the regulations implicitly assume that if physicians and patients can interact as independently as possible, quality of care will meet or exceed society's custom-based standards. The most common non-interference regulations established by states include safeguards of doctor-patient communications, prohibitions against health plans' use of financial incentives to limit health care, and specifications of procedures through which patients can appeal denials of care by MCOs.[75]

69. *Id.* A recent survey by The Henry J. Kaiser Foundation and Harvard University's School of Public Health (Nov. 5, 1997) found that a majority of Americans (59%) believe managed care plans make it harder for sick people to see specialists. Over half of those surveyed (51%) say managed care has hurt the quality of care for sick individuals. *See* The Henry J. Kaiser Family Found., *Is There A Managed Care "Backlash?,"* (visited March 7, 2000) <http://kaiser.bitwrench.com/content/archive/1328/mcarepr.html>.

70. FAMILIES USA FOUND., *supra* note 11, at 1.

71. *See supra* notes 14-15 and accompanying text.

72. *See* FAMILIES USA FOUND., *supra* note 11, at 25. *See also* Milt Freudenheim, *HMOs Cope With a Backlash on Cost Cutting*, N.Y. TIMES, May 19, 1996, at A1 (stating [o]ver the last 18 months, at least 34 states have outlawed or curtailed methods that many health maintenance organizations have used to restrict patient care).

73. *See* FAMILIES USA FOUND., *supra* note 11, at 30.

74. *See generally* FAMILIES USA FOUND., *supra* note 11.

75. Other state regulations also work to maintain the integrity of the doctor-patient relationship and to shield doctors and patient medical decisions from MCO pressure. For example, more than one forth of states give seriously ill patients and pregnant women the right to continue receiving reimbursed care for a specified period of time from a physician whom an MCO has dropped. *See* FAMILIES USA FOUND., *supra* note 30, at 9-10. *See, e.g.*, N.J. ADMIN. CODE tit. 8 § 38-3.5(a)(4) (1997). These laws ensure that MCOs cannot arbitrarily disrupt the doctor-patient relationship. Also, two states—Maryland and Rhode Island—have enacted laws that prevent health plans from prohibiting patient participation in clinical trials if a doctor thinks the participation will help. *See* 1998 MD. LAWS § 1 (S. 137); R.I. GEN. LAWS § 27-41.2 (Supp. 1997).

A. *Anti-Gag Clauses*

Most states[76] have passed "anti-gag clause" measures designed to prevent MCOs from interfering with certain communications between doctors and their patients. These regulations respond to provisions contained in some contracts between MCOs and providers that limit the subjects that physicians may discuss with patients.[77] Most prohibit health plans from penalizing doctors for discussing more expensive treatment options with patients or for disclosing the plan's utilization policies and financial incentive structure as they relate to the patient.[78] In addition, some states have passed laws that specifically prevent health plans from terminating or refusing to renew provider contracts solely because physicians advocate on behalf of their patients, filed complaints against a plan, appealed a plan decision, or requested a hearing or review.[79] Kansas, for example, has established both types of prohibitions.[80] These "anti-gag clause" measures attempt to minimize corporate factors from influencing doctor-patient communication and to align the physician more squarely with the patient than with the MCO.

B. *Prohibiting Financial Incentives*

Nearly two out of every five states[81] have passed legislation to ensure that physician financial incentives do not adversely affect patient care.[82] Provisions of these laws vary. Some are quite vague, simply prohibiting plans from using financial incentives that will result in a denial of medically necessary care. Others have more specific and expansive statutes. One statute prohibits plans from making "specific payments directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the

76. Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. *See* FAMILIES USA FOUND., *supra* note 11, at 25.

77. *See supra* notes 64-65 and accompanying text.

78. *See* FAMILIES USA FOUND., *supra* note 11, at 25.

79. *See, e.g.*, N.J. STAT. ANN. § 34-19-3 (West Supp. 1999); R.I. GEN. LAWS § 27-41-46 (1998).

80. *See* FAMILIES USA FOUND., *supra* note 11, at 20 tbl.1; *see also* KAN. STAT. ANN. § 40-4604 (Supp. 1998).

81. Nineteen states have: Alaska, California, Georgia, Idaho, Kansas, Louisiana, Maryland, Montana, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Vermont, and West Virginia. *See* FAMILIES USA FOUND., *supra* note 11, at 25.

82. *See supra* notes 57-63 and accompanying text.

use of alternative treatment settings, or the use of a particular medication with respect to an individual patient . . . ."[83]

C. *Regulatory Procedures*

In addition to statutory prohibitions, many states have created regulatory procedures to ensure that patients and providers receive due process in their interactions with MCOs. In particular, some states have mandated that MCOs establish or strengthen grievance and appeal procedures .[84] Some new protections entail notice requirements and time lines for resolution of non-urgent claims,[85] mandatory expedited review of decisions affecting emergency care,[86] and the right to file grievances orally.[87] Some regulations attempt to inject independence into the appeal process by requiring either internal MCO review by professional peers not associated with the original care denial[88] or external review by a qualified independent decision-maker.[89] About one in three states[90] have taken the latter approach, permitting consumers to appeal to an external expert panel independent of the health plan. These appellate procedures further the integrity of the physician-patient relationship by trying to ensure that treatment denials rest on considered medical judgment rather than business caprice.

D. *Substantive Medical Obligations*

In addition to measures that work to minimize external MCO interference with the traditional physician-patient relationship, some states

83. R.I. GEN. LAWS § 23-17.13-3(B)(8) (1996).

84. Arizona, Connecticut, Florida, Hawaii, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, Pennsylvania, Rhode Island, Tennessee, Texas, and Vermont have adopted meaningful independent external review processes for managed care consumers. *See* FAMILIES USA FOUND., *supra* note 11, at 13.

85. Particularly, "protective laws require plans to respond to appeals for non-urgent care within a specified time frame. Texas, for instance, allows only 30 days for acknowledgment, investigation, and resolution of a complaint after an MCO receives the complaint." FAMILIES USA FOUND., *supra* note 11, at 12; *see also* TEX. INS. CODE ANN. art. 20A.12(d) (Vernon Supp. 1999).

86. "Most states have required an expedited appeals procedure for emergency and urgent care situations." FAMILIES USA FOUND., *supra* note 30, at 12. The specificity of their time frames vary, with some simply vaguely referring to the need for expedited review. Others give specific times. *See, e.g.,* NEV. REV. STAT. ANN. § 695G.210 (Michie 1997) (requiring 72-hour turn-around); 1998 MD. CODE ANN., INS. § 15-10A-2(b)(2)(i) (Supp. 1999) (requiring 24-hour turn-around).

87. *See* IND. CODE ANN. §27-13-10-5 (Supp. 1998); *see also* FAMILIES USA FOUND., *supra* note 11, at 13 ("An enrollee or a subscriber may file a grievance orally or in writing.") Other states mandate that MCOs must treat oral complaints about denials, reductions, and terminations as beginning the appellate process. *See id.*

88. *See, e.g.,* VA. CODE ANN. § 32.1-137.15 (Michie 1999).

89. *See, e.g.,* VT. STAT. ANN. tit. 8, § 4089f (Supp. 1998).

90. Fifteen have: Arizona, Connecticut, Florida, Hawaii, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, Pennsylvania, Rhode Island, Tennessee, Texas, and Vermont. *See* FAMILIES USA FOUND., *supra* note 11, at 25.

have imposed substantive medical obligations on MCOs. These states require that MCOs provide consumers access to specified services. Almost three-fifths of all the states[91] have passed laws establishing the right of patients to go to an emergency room and have the MCO pay for the resulting care if the person reasonably believed she had an emergency.[92] Nearly one-third of all the states[93] have entitled patients to receive reimbursement for health care from an out-of-network provider when a health plan's network proves inadequate.[94] About one-fifth of the states[95] have also required that persons with a chronic or serious illness or disability have the option of retaining a specialist as their primary care provider.[96] Some states[97] allow seriously ill persons to obtain standing referrals to a specialist,[98] while others[99] give women guaranteed direct access to an obstetrician or gynecologist.[100] Almost one in six states[101] have required MCOs to establish procedures that enable patients to obtain specific prescription drugs that are not on a health plan's formulary without bearing additional financial cost.[102]

91. Thirty-three have laws establishing a version of the "prudent lay-person" standard: Arkansas, California, Colorado, Connecticut, the District of Columbia, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin. *See* FAMILIES USA FOUND., *supra* note 11, at 23.

92. *See, e.g.*, GA. CODE ANN. § 31-11-82 (Supp. 1999). *See also* FAMILIES USA FOUND., *supra* note 30, at 2.

93. Colorado, Florida, Indiana, Kentucky, Maine, Missouri, Montana, New Mexico, New York, North Carolina, Ohio, Tennessee, Texas, Utah, and Vermont. *See* FAMILIES USA FOUND., *supra* note 11, at 23-24.

94. *See, e.g.*, CODE ME. R. CH. 850 § 7(A) (1997); 1998 Colo. Sess. Laws, § 10-16-704(2); *see also* FAMILIES USA FOUND., *supra* note 30, at 4, 6.

95. Indiana, Missouri, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Tennessee, Texas, and Vermont. *See* FAMILIES USA FOUND., *supra* note 11, at 24.

96. *See, e.g.*, N.Y. INS. LAW § 4804(c) (Consol. Supp. 1999); *see also* FAMILIES USA FOUND., *supra* note 30, at 6-7.

97. Alabama, California, Florida, Kansas, Minnesota, Missouri, New Mexico, New York, Ohio, Pennsylvania, Tennessee, and Vermont. *See* FAMILIES USA FOUND., *supra* note 11, at 24.

98. *See, e.g.*, OHIO REV. CODE ANN. § 1753.14(A) (Anderson Supp.1998); *see also* FAMILIES USA FOUND., *supra* note 30, at 7-8.

99. States requiring that women have direct access to obstetricians and gynecologists include: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and West Virginia. This list excludes states requiring access for only one annual visit. *See* FAMILIES USA FOUND., *supra* note 11, at 24.

100. *See, e.g.*, ALA. CODE § 27-49-4 (Supp. 1997); *see also* FAMILIES USA FOUND., *supra* note 30, at 8-9.

101. Arkansas, California, Georgia, Indiana, Missouri, Ohio, Oregon, and Vermont. *See* FAMILIES USA FOUND., *supra* note 11, at 24-25. This list excludes states that do not require plans to establish procedures for obtaining non-formulary drugs but do require procedures be disclosed if in place. *See id.*

102. *See, e.g.*, ARK. CODE ANN. § 23-99-409 (Michie Supp. 1997); *see also* FAMILIES USA FOUND., *supra* note 30, at 11-12.

These substantive access mandates have mitigated some of the more deleterious impacts managed care has had on health service quality.

IV. Inadequacy of Non-Tort Regulation

A. *Mitigating Factors*

Non-tort regulations, however, do not adequately make MCOs accountable for the medical decisions they effectively make. Anti-gag clause measures, prohibitions of certain physician incentives, and substantive access mandates attempt to mitigate MCO influence over care decisions thereby obviating the need for MCO accountability for those decisions. Anti-gag measures and incentive prohibitions free doctors and patients to consider a broader set of treatment options. Access laws give patients the right to certain medical services, irrespective of MCO policies.

To the extent that such mandates reduce the influence of MCOs in medical treatment decisions, they undermine—or at least dampen—the efficiency and cost reduction efforts that have made managed care popular with employers and policy-makers. Reducing MCO's sway over the doctor-patient relationship and their checks on access to costly services lessens the ability of MCOs to contain health care costs. Care-quality regulations on MCOs must enable managed care to limit unnecessary and inappropriate medical treatments. Non-interference and mandatory access statutes do not fit such criteria. Such quality-targeted mandates that remove MCOs' ability to assess the medical necessity and propriety of service options go too far.

Additionally, anti-gag clause measures, prohibitions on certain physician incentives, and substantive access mandates fail to fully eradicate MCOs from care determinations. Capitation payment structures and the mere threat of removal from a health plan's network strongly encourage physicians to comply with explicit and implicit medical and financial norms established by an MCO. Though limitations may exist on MCOs' power over care decisions under these non-tort regulations, they still have no accountability for how they exert that lessened power.

B. *Lengthy Appeals Process*

Appellate procedure mandates likewise fail to make MCOs sufficiently accountable for their control over medical decisions. Too often, appeal procedures prove inadequate. Enrollees may not know their rights. Plans may fail to inform them in writing that they can appeal denials, reductions, and terminations of care.[103] Moreover, appeal processes can prove cumbersome and require weeks, if not

103. With tort liability, plaintiff's lawyers will have an incentive to inform harmed consumers of their rights.

months, to reach resolution. The perceived likelihood of frustration and a long wait might discourage enrollees from even bothering to begin the process.[104] Moreover, long appellate procedures can endanger the health and even the lives of patients with urgent medical concerns. Furthermore, experts with sufficient understanding of the medical issues and particular circumstances at hand may not participate in the decision-making process.[105] Additionally, because the MCOs often govern the internal appeal processes[106] and can capture,[107] or at least strongly affect, bureaucratic review procedures, consumers may have no confidence in the fairness of the appeal process.

Perhaps most disturbingly, non-tort appeal processes—whether external or internal—generally under-deter MCOs from authorizing customary care. They offer consumers no recourse other than direct performance of the treatment. Financially, at least, MCOs still have incentive to withhold medical services before rendering them, resulting in patients enduring long appeals. The lack of punitive damages under-deters MCOs because MCOs would not have to pay for the care needed by those patients who choose to forego the trouble of appealing.[108] Also, non-tort appeal processes provide no remedy for consumers who have already suffered further injury or illness from an MCO's negligence in denying care. Non-tort processes fail to sufficiently encourage MCOs to authorize the level of care that society demands and enforces through its malpractice liability laws.

Physicians and other providers should not bear the burden of upholding custom-based medical standards alone. Non-interference, access, and appeal regulations all fall short of spreading the burden. Legislatures should place substantive medical responsibilities on MCOs that reflect the organizations' direct and controlling role in the provision and determination of health care services.

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104. Similar reasons may make consumers reluctant to use the tort process. That process, however, will give them recourse other than direct performance (e.g., compensatory or punitive damages).

105. The adversary process would ensure the introduction of the relevant expertise and information into a malpractice proceeding.

106. *See* Bennett Roth, *Senate GOP Health Care Bill Unveiled*, HOUSTON CHRON., July 16, 1998, at A1 ("There have also been questions about the impartiality of the . . . appeals, since the medical expert who would hear the case would be appointed and paid for by the health plan.").

107. "Theorists have reasoned that capture arises because [MCO] interests are concentrated, intense, and hence tend toward effective group action whereas consumer interests are dispersed, individually weak, and plagued by free rider obstacles to mutual action." John S. Wiley Jr., *A Capture Theory of Antitrust Federalism*, 99 HARV. L. REV. 713, 732 (1986).

108. *See generally* A. Mitchell Polinsky and Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 869, 887-96 (1998) (arguing that if a defendant can sometimes escape liability for the harm for which he is responsible, the proper magnitude of damages is the harm the defendant has caused, multiplied by a factor reflecting the probability of his escaping liability).

V. GOVERNMENTAL RESPONSE

Recognizing the indirect and insufficient accountability imposed by non-tort regulations, Texas and other states have begun to attempt to hold MCOs explicitly accountable for their medical determinations through tort actions. They have passed statutes that invalidate hold-harmless clauses and directly subject MCOs to tort malpractice liability. Several states, including Texas, have prohibited the use of indemnification clauses between MCOs and health care providers. These clauses in MCO-physician contracts require the physician to assume the liability inherent in medical decision-making, relieving MCOs of responsibility. In 1995, Connecticut,[109] Oregon,[110] and New Hampshire[111] became the first states to void such provisions.[112] Maryland,[113] Virginia,[114] Rhode Island,[115] and New York[116] followed with similar prohibitions in 1996.[117] By 1998, Texas and twelve other states also enacted measures invalidating hold-harmless clauses in provider contracts.[118]

Additionally, numerous states—with Texas having progressed the furthest—have considered directly providing consumers civil malpractice rights against MCOs.[119] In 1996, Governor Lawton Chiles vetoed legislation that would have made Florida the first state to allow malpractice suits against MCOs.[120] Twenty other states debated similar legislation in 1997.[121] By 1998, twenty-nine states had introduced bills allowing a patient to sue an MCO for malpractice.[122]

As of October 1998, only Missouri and Texas had actually enacted laws permitting consumer malpractice suits against MCOs.[123] Mis-

109. *See* CONN. GEN. STAT. § 38a-472a (Supp. 1999).
110. *See* OR. REV. STAT. § 743.803 (1999).
111. *See* N.H. REV. STAT. ANN. § 420-c:5-a (Supp. 1996).
112. *See* Rothouse, *supra* note 30, at 1.
113. *See* MD. CODE ANN., INS. § 15-117 (1997).
114. *See* VA. CODE ANN. § 38.3-5402 (Supp.1997).
115. *See* R.I. GEN. LAWS § 23-17.13-3(B)(8) (1997).
116. *See* N.Y. PUBLIC HEALTH LAW § 4324 (Supp. 1998).
117. *See* Rothouse, *supra* note 30, at 1-2.
118. The other states include Vermont, Louisiana, Missouri, North Dakota, South Carolina, Tennessee. As of October, 25 states had introduced hold-harmless bills in 1998. *See* Rothouse, *supra* note 30, at 2.
119. *See* FAMILIES USA FOUND., *supra* note 11, at 19.
120. *See* Rothouse, *supra* note 30, at 3.
121. *See id.* Rhode Island, for example, adopted S 837. That law created a special Senate commission to study the legal liability of HMOs in cases of inadequate care. *See id.*
122. As of October, 1998, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maryland, Maine, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, and West Virginia had proposed such measures. *See* Rothouse, *supra* note 30, at 4. Bills that would have created malpractice tort accountability for MCOs have officially failed in 19 states. *See id.*
123. *See id.* at 3-4.

souri passed House Bill 335, repealing its corporate practice of medicine prohibition.[124] This removal implicitly made MCOs accountable for their medical necessity determinations under a malpractice theory.[125]

Prior to Missouri's repeal of its corporate medicine prohibition, Texas passed the first statute establishing MCO tort accountability with the passage of the THCLA.[126] Like the Missouri legislation,[127] the Texas statute prohibits MCOs from claiming the prohibitions against the corporate practice of medicine as a shield to malpractice claims.[128]

The THCLA goes even further by making MCOs directly susceptible to malpractice claims for their decisions regarding the medical necessity of treatments.[129] The THCLA explicitly provides that patients can sue MCOs for malpractice when their health care treatment determinations do not meet the standard of ordinary care.[130] Additionally, the statute provides for an independent review process for MCO denials of care,[131] prohibits indemnification clauses in MCO-provider con-

124. *See supra* note 30 and accompanying text.

125. Insurers have used bars against the corporate practice of medicine to argue against malpractice suits. They have contended that because a state forbids them to practice medicine, they cannot have liability for malpractice. The argument strains logic: "It's like being stopped by a cop for speeding and you say 'Well, officer, I couldn't possible have been speeding because it's against the law in Texas to speed,'" says Elizabeth Kilbride, a Houston lawyer. *See* Cropper, *supra* note 28, at A3.

126. Codified at TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-88.003 (Vernon Supp. 1999) and TEX. INS. CODE ANN. arts. 20A.09, 20A.12, 20A.12A, 21.58A, 21.58C (West Supp. 1999). In announcing his decision to let S386 (THCLA) become law sans his signature, Texas Governor Bush explained: "Given the choice between doing nothing and doing something to address a significant problem that impacts the health of thusands of Texans, I have concluded the potential for doing good outweighs the potential for harm in S386." Wayne J. Guglielmo, *Sharp Shootin': Texas Doctors Put HMOs in the Malpractice Target Zone*, MEDICAL ECON., Dec. 22, 1997, at 98.

127. Missouri, too, has exposed MCOs to malpractice claims. Rather than enacting a law specifically making them susceptible to tort actions, however, Missouri simply made "it clear that HMOs practice medicine." Jane Bryant Quinn, *Holding Health Plans Accountable*, WASH. POST, Sept. 9, 1997, at 56.

128. *See* TEX. CIV. PRAC. & REM. CODE § 88.002(h) (Vernon 1997).

129. *See id.* § 88.002(a). This act only involves medical services covered by an MCO's health care plan. It does not require MCOs to provide services not covered under its plan. *See id.* § 88.002(d).

130. While the THCLA imposes liability on MCOs, it specifically exempts employers from liability when they do not participate in MCO care determinations. *See id.* at § 88.002(e). Also, a patient cannot ordinarily bring a liability action unless the patient has exhausted the internal appeals process of the MCO and the Independent Review Organization (IRO) mechanism authorized by the THCLA. If the patient has already suffered harm because of a treatment denial and a review would not benefit the patient, the patient can file suit without proceeding through the MCO appeals and IRO processes. *See id.* § 88.003.

131. *See id.* The legislation provides that a patient has the right to the review of a denial of medical services by an MCO in front of an IRO. The commissioner of insurance makes the assignment for review and sets the standards for certification. The review must occur within the earlier of 15 days after the date the IRO receives the necessary documents for review or 20 days after it receives a request for review.

tracts,[132] and forbids MCOs to retaliate against physicians and other providers that advocate on behalf of their patients.[133] In effect, the statute "recognizes that HMOs make medical decisions and forces them to answer for those decisions, just like doctors and hospitals."[134] By doing so, it represents "a watershed for state managed-care accountability."[135]

VI. THE ROLE OF *CORPORATE HEALTH*

Even before the THCLA took effect on September 1, 1997, it met legal challenge. On June 16, 1997, Aetna Health Plans of Texas[136] ("Aetna") filed suit against the Texas Department of Insurance seeking to have the law invalidated.[137] Aetna alleged primarily that the statute violated ERISA.[138] Aetna claimed that the federal law preempted the state statute's malpractice liability provision, its independent review process mandate, its prohibition of hold-harmless clauses, and its preclusion of physician termination for patient advocacy.[139] Judge Vanessa Gilmore held that ERISA did not preempt the malpractice liability portion of the statute but did preclude the other provisions.[140]

Judge Gilmore found that ERISA's insurance savings clause[141] did not except the Texas law from preemption.[142] Through it's savings clause, ERISA provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State, which reg-

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Ordinarily, a patient must first exhaust the internal appeals process of the MCO. In the event of a life threatening condition, the patient can skip the internal review process of an MCO and appeal directly to an IRO. The IRO review must conclude within the earlier of 5 days of receiving the necessary documents or 8 days after its receipt of the request for review. *See id.* § 88.002.

132. *See id.* § 88.002(g).

133. *See id.* § 88.002(f).

134. Sibley, *supra* note 66, at A21. Sibley has also commented: "The cornerstone of Senate Bill 386 was simply this: if the HMOs choose to make medical decisions—stand in the shoes of the doctor, as it were—they ought to stand in the shoes of the doctor in court, too." *See* Guglielmo, *supra* note 126, at 90.

135. Carol O'Brien, American Medical Association senior counsel, *quoted in* Guglielmo, *supra* note 126, at 89.

136. Along with Corporate Health Insurance, Inc., Aetna Health Plans of North Texas, Inc., and Aetna Life Insurance Company.

137. Corporate Health Ins., Inc. v. Texas Dep't of Ins., 12 F. Supp. 2d 597, 602 (S.D. Tex. 1998).

138. *See id.* at 602. Aetna also claimed that the THCLA violated the Federal Health Benefit Act (FEHBA) *See id.* This contention, though, proved minor in the case. Regarding the FEHBA preemption argument, Judge Gilmore concluded that a claim addressing the quality of a benefit would not relate to a FEHBA plan. *See id.* at 630.

139. *See id.* at 630.

140. *See id.*

141. *See* Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144 (b)(2)(A) (1994).

142. *See Corporate Health*, 12 F. Supp. 2d at 597.

ulates insurance, banking or securities."[143] The Supreme Court "delineated the requirements that a state statute must meet in order to come within the insurance facet of the savings clause" in *Metropolitan Life Insurance Co. v. Massachusetts*.[144] One necessary factor of that test considers whether the state regulation "is limited to entities within the insurance industry."[145] Judge Gilmore determined that the THCLA did not satisfy that requisite prong—and thus failed the *Metropolitan Life* test—because "on its face, the Act is obviously not limited to entities within the insurance industry."[146]

Having determined that the THCLA did not fall within the safe harbor of ERISA's savings clause, Judge Gilmore then concluded that the THCLA did not meet the "relates to" test for preemption in ERISA § 514(a).[147] That section provides that ERISA "shall supersede any and all State laws insofar as they . . . *relate to* any employee benefit plan. . . ."[148] Under ERISA preemption analysis, a state law "relates to" an ERISA plan if it "references" or has a "connection with" such a plan.[149]

In making these determinations, the United States Supreme Court has taken a practical approach. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*,[150] the Court noted that: "it must go beyond the unhelpful text [of § 514(a)] and the frustrating difficulty of defining its key term ["relates to"], and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive [preemption]."[151]

The Court asserted that the principle purpose of ERISA's "preemption clause . . . was to avoid a multiplicity of regulation in order to permit a nationally uniform administration of employee benefit plans."[152] Accordingly, the Court found that ERISA's "relate[s] to"

143. 29 U.S.C. § 1144(b)(2)(A).
144. 471 U.S. 724, 741-47 (1985).
145. *Id.* at 743 (quoting Union Labor Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982)). The savings clause test adopted in *Metropolitan Life* has been described as follows:

> First, the [C]ourt determined whether the statute in question fitted the common sense definition of insurance regulation. Second, it looked at three factors: (1)[w]hether the practice (the statute) has the effect of spreading policyholders' risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. If the statute fitted the common sense definition of insurance regulation and the court answered "yes" to each of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption.

Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 107 (5th Cir. 1993).
146. *Corporate Health*, 12 F. Supp. 2d at 607 (internal quotations omitted).
147. 29 U.S.C. § 1144(a).
148. *Id.* (emphasis added).
149. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983).
150. 514 U.S. 645 (1995).
151. *Id.* at 656.
152. *Id.* at 657.

language was not "intended to modify 'the starting presumption that Congress does not intend to supplant state law'" that falls within areas of traditional state regulation.[153] Those areas include "matters of health and safety."[154] Regarding the "reference" assessment, the U.S. Supreme Court has ruled that it is only "[w]here a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . that 'reference' will result in preemption."[155]

Judge Gilmore concluded that the THLCA did not suffer "reference" preemption. Aetna had argued that although the statute does not specifically refer to ERISA plans, certain statutory terminology such as "health care plan" and "health maintenance organization" warrants ERISA preemption. However, Judge Gilmore found that "the existence of an ERISA plan is not essential to the operation of the Act."[156] The statute does not "work immediately and exclusively upon ERISA plans."[157] Rather, the Texas law simply places a standard of ordinary care on health insurance carriers and MCOs regardless of whether their coverage occurs in an ERISA plan.[158] Accordingly, Judge Gilmore found that the THCLA "cannot be said to make a reference to ERISA plans in any manner."[159]

Judge Gilmore next examined whether the Texas law met the "connection with" ERISA test.[160] If a state statute has a "connection with" ERISA, the federal law may still preempt its application.[161] Aetna posited that the THCLA had several "connections with" ERISA, including the imposition of state liability laws on ERISA entities.[162] To support its claim, Aetna referenced *Corcoran v. United Healthcare Inc.*[163] In that case, the Fifth Circuit held that ERISA preempted a Louisiana tort action against an MCO for the wrongful death of an unborn child.[164] The court based its holding on the con-

153. De Buono v. NYSA-ILA Med. & Clinical Servs. Fund, 117 S.Ct. 1747, 1751 (1997).

154. *Id.* at 1751-52.

155. California Div. of Labor Standards Enforcement v. Dillingham, 519 U.S. 316, 325 (1997).

156. Corporate Health Ins., Inc. v. Texas Dep't of Ins., 12 F. Supp. 2d 597, 614 (S.D. Tex. 1998).

157. *Id.*

158. *See id.* at 612.

159. *Id.*

160. *See id.* The "connection with" test has been stated as: "To determine whether a state law has the forbidden connection, [a court must look]. . . both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive as well as to the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325 (quotations omitted).

161. *See Dillingham*, 519 U.S. at 325 (1997).

162. *See Corporate Health*, 12 F. Supp. 2d at 614.

163. 965 F.2d 1321 (5th Cir. 1992).

164. *See id.* at 1331.

clusion that ERISA bars recovery "for a tort allegedly committed in the course of handling a benefit determination."[165]

Judge Gilmore distinguished the THCLA controversy from *Corcoran*, finding that a suit under the Texas statute would relate to the quality of benefits from a managed care entity and not the withholding of benefits.[166] She also noted that after *Corcoran*, the U.S. Supreme Court had stated that an "indirect economic influence . . . does not bind a plan administrator to any particular choice and thus function as a regulation of an ERISA plan itself."[167] More specifically and relevantly, the Court has since held:

> [I]f ERISA were concerned with any state action—such as quality of care standards—that increased the cost of providing certain benefits, and thereby, potentially affected the choices made by ERISA plans, [then] we could scarcely see the end of ERISA's preemptive reach, and the words 'relate to' would limit nothing.[168]

Given these assertions by the U.S. Supreme Court, federal circuit courts have differentiated a claim about withholding benefits from a claim about quality of benefits.[169] In particular, the Third Circuit in *Dukes v. U.S. Healthcare, Inc.* held that ERISA did not preempt a medical negligence suit brought by beneficiaries against a HMO.[170] It noted that "[i]nstead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs . . . complain[ed] about the low quality of the medical treatment that they actually received. . . ."[171] The *Dukes* court held that ERISA did not preempt the latter type of claim—one concerning the quality of a benefit received.[172] Following the reasoning in *Dukes*, Judge Gilmore likewise concluded that ERISA does not bar the Texas regulations mandating standards for the "quality of benefits . . . actually provided."[173]

Aetna also alleged that the liability provision of the Texas statute "connected with" ERISA by improperly dictating the structure of plan benefits and their administration. It contended that the state law "imposes a 'negligence' standard of review on HMOs and PPOs . . . in

165. *Id.* at 1332.

166. *See Corporate Health*, 12 F. Supp. 2d at 617.

167. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 659 (1995).

168. California Div. of Labor Standards Enforcement v. Dillingham, 519 U.S. 316, 329 (1997).

169. *See, e.g.*, Pacificare of Okla., Inc. v. Burrage, 59 F.3d 151, 154 (10th Cir. 1995) (holding that medical malpractice claim not preempted by ERISA when issue of doctor's negligence required assessment of providing admittedly covered treatment or giving professional advice).

170. 57 F.3d 350, 357 (3d Cir. 1995).

171. *See id.*

172. *See id.*

173. Corporate Health Ins., Inc. v. Texas Dep't of Ins., 12 F. Supp. 2d 597, 620 (S.D. Tex. 1998).

contravention of the federally mandated abuse of discretion standard of review of a factual benefit determination under ERISA."[174] Judge Gilmore responded that, under the statute, a person may bring a suit that only challenges the quality of care received, not a benefit determination.[175] The former type of claim "would not implicate the abuse of discretion standard required under ERISA for factual benefit determinations."[176]

Judge Gilmore, nonetheless, agreed with Aetna's contention that "the provisions for an independent review improperly mandate the administration of employee benefits and therefore, have a connection with ERISA plans."[177] She reasoned that the independent review process provisions "concern the review of an adverse benefit determination and are therefore an improper mandate of benefit administration."[178] In *Travelers*, the U.S. Supreme Court held that "ERISA preempted state laws that mandate employee benefit structures or their administration."[179]

However, Judge Gilmore maintained that the independent review process provisions of the THCLA would not affect lawsuits challenging the quality of care an enrollee received since the provisions focus on the denial of benefit determinations, and not their quality.[180] Thus, Judge Gilmore upheld the quality of care liability clauses while ordering the severance of the independent review provisions.[181]

Additionally, Judge Gilmore struck the THCLA provisions prohibiting MCO retaliation against health care providers advocating on behalf of their patients[182] and forbidding hold-harmless clauses in managed care contracts with physicians. Judge Gilmore found that these mandates contractually bind employers and plan administrators to particular provider choices and affect the structure of health benefit plans. Like the independent review provisions, she declared these clauses severable from the rest of the statute.[183]

The result was that Judge Gilmore upheld the right for an enrollee to sue an MCO for damages resulting from that entity's failure to ex-

174. *Id.* at 621; *see also* Pierre v. Connecticut Gen. Life Ins. Co., 932 F.2d 1552, 1562 (5th Cir. 1991) (holding that "for factual determinations under ERISA plans, abuse of discretion standard of review is the appropriate standard.").

175. *See Corporate Health*, 12 F. Supp. 2d at 621.

176. *Id.*

177. *Id.* at 625.

178. *Id.* at 626.

179. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995).

180. *See Corporate Health*, 12 Fed. Supp. 2d at 626.

181. *See id.*

182. *See id.* at 627-28 (applying statutory restrictions in and citing TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon Supp. 1999)).

183. *See* Renae Merle, *Insurance Firm Seeks to Preserve HMO Review Law*, AUSTIN AM.-STATESMAN, Sept. 23, 1998, at B2.

ercise ordinary care when making health care treatment decisions.[184] The decision "opens the courthouse to injured patients and says that the HMO industry can no longer hide from state courts and juries."[185]

VII. THE WISDOM OF TORT-BASED ACCOUNTABILITY

A. *Pending Legislation*

The U.S. Congress should encourage other states to follow Texas' lead. The 105th session of Congress considered competing Republican and Democratic bills that would establish national regulation of managed care.[186] To a large extent, these conflicting proposals share a common ground. Both would implement many of the non-tort mandates already imposed on MCOs by the states.[187]

Most notably, however, the bills differ on the issue of whether states could subject MCOs to tort liability.[188] The Republican proposal would not provide states that option[189] while the Democratic one would. The latter bill would revise the ERISA doctrine by authorizing states to determine whether or not a health care beneficiary could raise a state malpractice action against health plan administrators. Also, like the THCLA, the Democratic bill would explicitly shield em-

184. Aetna appealed all of the court's holdings. Notice of Cross-Appeal, Civil Action No. H-97-2072, United States District Court for the Southern District of Texas, Houston Division, Oct. 16, 1998. The insurance company, however, wanted to preserve the independent review provisions of the legislation. *See* Renae Merle, *Insurance Firm Seeks to Preserve HMO Review Law*, AUSTIN AM.-STATESMAN, Sept. 23, 1998, at B2.

185. *See* Consumers for Quality Care, *Texas HMO Liability Law Upheld*, (Sept. 18, 1998) (press release) (on file with the Texas Wesleyan School of Law Library).

186. *See supra* notes 23-24 and accompanying text.

187. Both propositions would grant women direct access to obstetricians and gynecologists. Also, both bills would guarantee patients reimbursement for emergency care deemed necessary by a prudent lay-person and require full disclosure of medically available treatment options. Additionally, both proposals would authorize external review boards to review MCO treatment denials. The external review provision in H.R. 4250, however, results only in a recommendation that does not bind the MCO and would assess only whether the plan followed its own rules, not whether the patient actually needed the denied care.

188. The bills differ in other ways, as well. Unlike H.R. 4250, H.R. 3605 would mandate access to out-of-network providers, conditional use of specialists as primary care providers, conditional standing referrals to specialists, continuity of care when a physician leaves a plan, access to non-formulary prescription drugs, independent consumer assistance programs, and access to clinical trials. Also, only H.R. 3605 would prohibit MCOs from financially incenting doctors to reduce care.

189. In fact, H.R. 4250 might worsen states' ability to impose tort accountability on MCOs. Because it provides for expanded remedies under ERISA, federal judges could lose their current discretion to send certain cases back to state courts. *See* H.R. 4250, 105th Cong. (1998); H.R. 3605, 105th Cong. (1998). Moreover, this bill could codify in federal law that medical treatment decisions reduce to coverage decisions. This codification would effectively nullify states' utilization review regulations.

ployers from liability when they do not participate in coverage determinations of the MCOs that administer their health plans.[190]

The Democratic proposal, if made law, or some other federally legislated authorization of state malpractice liability for MCOs, would prove wise. From a policy standpoint, holding MCOs liable for malpractice makes sense, when their utilization review decisions, treatment protocols, payment arrangements with providers, or other contractual clauses result in treatment decisions that fail to meet the ordinary care standard. It requires MCOs to respect and adhere to the "tough trade-offs"[191] society has made between health care costs and quality.

Health care necessarily demands that society make "tragic choices."[192] It necessitates decisions involving the regrettable but inevitable tension between the social want of unlimited care for every patient and the constraints of available resources. Unfortunately, increased efficiency in health care often requires limits on the provision of costly treatment services while increased quality often necessitates spending more on services. Despite the persistence of the idea that economic interests should have no place in medical decisions and the American "optimism that all things are possible,"[193] an unavoidable trade-off between health care cost and quality exists. Economics *do* matter in the managed care system. Indeed, it *must* if society wants any limits at all on health care costs. Health care policy inevitably makes society face the "collision between basic goals—wanting more care for less."[194]

Society has implicitly decided on a balance between health care costs and health care quality.[195] The medical malpractice liability law

190. Doctors preferences for H.R. 3605 on the liability issue have proven strong enough for the American Medical Association, the nation's largest doctors' organization, to abandon its traditional support of Republicans. "While the AMA is a nonpartisan organization, its political arm awarded Republican lawmakers two-thirds of the more than $400,000 in contributions it has made in the most recent election cycle. [Its chairman] said he could not agree but that most doctors belong to the Republican party." Bennett Roth, *Doctors' Group Joins Push for HMO Plan*, HOUSTON CHRON., July 17, 1998, at A6.

191. *See* David S. Broder, *Unrealistic Solutions Won't Fix Health Care*, HOUSTON CHRON., July 19, 1998, at A24.

192. *Cf.* GUIDO CALABRESI & PHILLIP BOBBITT, TRAGIC CHOICES (1978) (exploring "the conflicts society confronts in the allocation of tragically scarce resources," not only in health care but in other arenas as well).

193. Robert J. Samuelson, *Having It All*, NEWSWEEK, Sept. 28, 1998, at 71, 72.

194. *Id.* at 72.

195. The choice has proven difficult. As Robert Samuelson explains:

> We have trouble discussing impersonal "trade-offs"—whether, for example, mammograms for all women over 40 are worth the cost. Most of us reject trade-offs for ourselves or our families. If we get sick, we want the best doctors, the newest drugs or the most advanced surgery. No questions asked. The trouble, of course, is that if we all have what we (or our doctors) deem desirable, health spending becomes uncontrollable. Someone has to impose

applicable to doctors and other providers strongly evidences that society demands certain baseline levels of care. While the past decade's rush to manage care[196] indicates a public desire to contain the growth in health care spending,[197] the negligence tort law applicable to providers indicates that society will permit controls on health costs to extend only so far. If the public desires enforcement of standards of care against physicians and other providers through malpractice liability, no reason—cost control or otherwise—exists for absolving MCOs from accountability for their decisions that affect patient care.

B. *Liability Issues*

Only tort liability will force MCOs to incorporate the socially determined standard of care levels into their medical service decisions. Currently, managed care consumers bear the costs of sub-standard care stemming from MCO treatment decisions.[198] Tort law would make MCOs suffer the consequences of their decisions that impinge on medical care, thereby transferring the costs of sub-standard care. Accordingly, MCOs would have to incorporate those costs in their calculation of whether the benefits of a particular treatment justify its expense.

On this point, a law and economics approach to tort actions is instructive. "In unilateral accident contexts, where only one party can make cost-justified investments in accident-cost reduction," that party should shoulder negligence liability.[199] Health care represents a unilateral process. When a consumer needs medical treatment to avoid exacerbating an illness or injury, only the medical decision-maker can determine[200] the necessary care investment to prevent the damage.[201] The investment often proves cost-justified in that the cost of the incre-

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limits on what kind of care people get, or who can get it. Thus, our dilemma: we want limits for society as a whole, but not for any of the individuals in it.

Id.

196. *See supra* notes 7-8 and accompanying text.

197. David Broder writes:

> Medical inflation in the 1980s scared Washington, and Medicare cost controls were imposed, but not quickly enough to halt the budget hemorrhage. But it got more action in corporate boardrooms, where runaway private health insurance costs were killing profit margins. Employers insisted that the insurers and providers manage those costs better. Thus, managed care came about from the pressure of the people paying for health insurance; it was imposed on patients, not chosen by them. And for a while, it worked.

Broder, *supra* note 191, at A24.

198. *See supra* note 34 and accompanying text.

199. Jon D. Hanson & Melissa R. Hart, *Law and Economics*, *in* A COMPANION TO PHILOSOPHY OF THE LAW AND LEGAL THEORY 311, 316-18 (Dennis Patterson ed., 1994).

200. When an MCO's decision impacts the care given. *See supra* notes 42-67 and accompanying text.

201. Rarely, if ever, can patients treat themselves.

mental treatment rarely exceeds the monetized value[202] of the worsened health of the patient stemming from a care denial. As only the medial decision-maker can prevent the injury by rendering or permitting appropriate treatment, "[i]mposing tort liability on [that] party will lead to efficient care-level investments."[203]

In managed care, an MCO often effectively acts as a controlling medical decision-maker.[204] Not all diagnoses or treatment decisions that result in a denial of care occur because of negligent provider medical judgment. Rather, the influence of MCO cost containment mechanisms on the physician-patient decision-making process regularly contributes—sometimes predominantly so—to the denials. Physicians and other providers "currently find themselves caught between two conflicting obligations—complying with an MCO's cost containment provisions [to avoid removal from the MCO's selected provider network] or ignoring such provisions to avoid malpractice liability."[205] Often the latter influence proves the more immediate, if not ultimately the more powerful.[206] In such situations, physicians should not solely bear the malpractice liability for making negligent decisions that they effectively lack the freedom not to make.[207]

Given managed care's transfer of medical decision-making responsibility from the patient and physician to the MCO, legal accountability for health care quality should correspondingly attach, at least in part, to health plan providers.[208] Otherwise, MCOs have insufficient incentive to include non-monetary costs incurred by patients from

202. "Many critics charge that focusing on money as a measure of damages oversimplifies the way human beings value certain goods. Valuing human life in dollar terms is said to offend and compromise the fundamental social norm of valuing human life infinitely. As Posner himself put it when discussing the sale of babies for adoption, 'economists like to think the unthinkable.' In response to this view, many defenders of the cost/benefit approach to policy-making point out that, like it or not, there is in everything we do an implicit monetary value that is placed on human life." Hanson & Hart, *supra* note 199, at 329. (quoting RICHARD POSNER, ECONOMIC ANALYSIS OF THE LAW 141 (3d ed. 1986)).

203. Hanson & Hart, *supra* note 199, at 326.

204. *See supra* notes 42-67 and accompanying text.

205. *See* Grosso, *supra* note 46, at 436.

206. MCOs can and often will terminate physicians who violate cost containment procedures. Today, because most physicians rely on MCOs for their patient supply, termination means bankruptcy. "If a particular MCO enrolls a substantial portion of a physician's patients, a physician could face an economic crisis if he is not enrolled with that plan or is terminated from that plan." Little, *supra* note 65, at 1427. This lack of effective freedom to exercise medical judgment has angered physicians. "[MCOs] should be accountable if they tie my hands and don't let me take care of the patients the way they need to be taken care of," complains Dan Boyle, an emergency room doctor. *See* Guglielmo, *supra* note 126, at 93.

207. *See* Jack K. Kilkullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7, 48 (1996) ("[A] physician's exposure to liability should not exceed that of an engineer at General Motors for the placement of a pick-up's gas tank.").

208. Under the previous Texas law, "injured patients [were] forced to sue physicians even when their actions are the direct result of managed care decisions." Polly

treatment denials into their care calculations.[209] As one commentator has put it: "Unless there are consequences to a HMO for denying expensive treatment, the financial calculus of 'managed care' will always weigh toward withholding and delaying costly care, no matter how sorely the treatment is needed or substantially it is justified by medical necessity."[210] The absence of MCO tort liability in effect establishes "a license for unscrupulous managed care plans to keep on endangering people's health by cutting corners on needed care."[211]

By altering MCO incentives, tort accountability will help ensure that the pressure for health care cost reduction does not intolerably cut into health care quality. MCOs can conduct actuarial assessments to determine which cost containment measures most effectively serve both cost control and quality goals. Tort liability will provide them the "incentive to review questionable procedures and to commit [their] resources to finding . . . safer approach[es] to treatment."[212] Some observers have already noted a positive change in MCO operations in Texas.[213]

C. *Encourage Cooperation*

Malpractice accountability will also likely improve care in another manner—by encouraging providers and MCOs to work closer together. If both MCOs and providers have exposure to malpractice liability, distrust between them may dissipate. Providers will feel more comfortable with MCO policies if they know that MCOs must also account for accidents resulting from those policies. Accordingly, MCO tort liability may encourage MCOs and physicians to "work to-

Ross Hughes, *Bush Won't Veto Bill Allowing Suits Against HMOs*, HOUSTON CHRON., May 23, 1997, at A1.

209. MCOs do have some non-tort incentive to treat patients efficaciously. As commentators have recognized, "[t]he integrated network has a competitive advantage [and incentive], for both statistical and economic reasons, in responding to consumers' demands for competition on quality and outcomes." Danzon, *supra* note 35, at 501. Doctors and other providers, though, have these same non-tort incentives. Still, society imposes tort liability on them.

210. Jamie Court, *Close the HMO's Favorite Loophole*, L.A. TIMES, Jan. 21, 1998, at B7.

211. Sen. Edward Kennedy (D-MA), *quoted in* Charles Ornstein, *Congress Divided on HMO Bill*, DALLAS MORNING NEWS, July 22, 1998, at D1.

212. Risa B. Greene, Note, *Federal Legislative Proposals for Medical Malpractice Reform: Treating the Symptoms or Effecting a Cure?*, 4 CORNELL J.L. & PUB. POL'Y 563, 594 (1995).

213. Opines Tommy Jacks, a Texas litigator: "I think that HMOs and other managed care companies have started changing their behavior toward enrollees, and I think that Judge Gilmore's decision [permitting Texas' tort liability law to remain in effect] will drive home the importance of doing that." Sarah Lunday, *State, Aetna Support HMO Review*, FORT WORTH STAR-TELEGRAM, Sept. 23, 1998, at C1. Also, Dr. Phil Berry, an orthopedic surgeon in Dallas has noticed more responsiveness by MCOs: "We have seen a much better attitude on the part of HMOs now as to recommendations we make for patients. They seem to be more willing to pay for what we ask for." *See* Cropper, *supra* note 28, at A3.

gether and share information to improve the quality of the treatment provided"[214] in a cost-effective manner.

D. *Critical Views*

In spite of these policy rationales for the imposition of MCO tort liability, critics remain. They have denounced tort law as too haphazard and too blunt an instrument for the regulation of institutional behavior and have argued against its expansion to new entities such as MCOs.[215] The current tort regime arguably compensates victims in an unpredictable and insufficient fashion. Harvard Law Professor Paul Weiler laments that "[t]ort benefits are doled out in a rather arbitrary manner to some—but not most—deserving victims, and also to those . . . who are not even 'deserving' within tort law's fault-based frame of reference."[216] Moreover, a recent study published in the New England Journal of Medicine evidences that the extent of a plaintiff's disability, rather than the degree of the provider's negligence, shows a significant statistical correlation with tort recovery.[217] Also, when negligently treated patients do recover, almost forty percent of any award immediately diverts to attorney's fees, irrespective of the lawyer's investment in the case.[218] Additionally, the average malpractice case may take eighteen months to adjudicate.[219] This duration often precludes recovery during periods when the victim's financial needs prove most acute.

Furthermore, tort accountability inefficiently deters tortious behavior. Since the tort system imprecisely assesses liability, courts sometimes fail to award damages for instances that actually warrant liability.[220] Such misses cause tort liability to under-deter.

Somewhat ironically, tort accountability may over-deter too.[221] To the extent potential malpractice defendants perceive courts' imposi-

214. Greene, *supra* note 212, at 590.

215. *See* Jeffrey O'Connell & James F. Neale, *HMO's, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL'Y 287, 297 (1998). *See generally* Danzon, *supra* note 35.

216. Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 915 (1993).

217. *See* Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1966 (1996).

218. *See* David S. Starr, *The No-Fault Alternative to Medical Malpractice Litigation: Compensation, Deterrence, and Viability Aspects of a Patient Compensation Scheme*, 20 TEX. TECH L. REV. 803, 806-07 n.23 (1989).

219. *See,* Comment, *The Medical Malpractice Crisis: Will No-Fault Cure the Disease?* 9 HAW. L. REV. 241, 243 n.13 (1987) (noting also that 10 percent of medical malpractice cases remain open for over six years).

220. *See* O'Connell & Neal, *supra* note 215, at 296.

221. *See generally* Israel Gilead, *Tort Law and Internalization: The Gap Between Private Loss and Social Cost*, 17 INT'L REV. L. & ECON. 589, 600 (1997).

tion of malpractice damages as "irrational [and] illogical"[222] and unconnected to their own negligence, tort liability will over-deter. This over-deterrence, critics of HMO tort liability fear, will lead to defensive medicine and the authorization of medically unnecessary care.[223] Tort liability would then inject unneeded costs into the health care system. These potential problems raise the question of "whether an already distressed tort system should bear the additional burden of resolving a rush of new malpractice claims against HMOs or whether an alternative might better serve society."[224]

Critics of tort liability for MCOs, however, sidestep the reality that society has chosen tort accountability as its main mechanism to ensure respect for customary medical care levels. More accurate, consistent, and efficient enforcement regimes may eventually prove practical and become established. Indeed, "in fifty years' time people [may very well] look back with some horror on tort law as [having existed] . . . too long."[225] Nonetheless, if the public wants its quality of care standards respected, it should subject all medical decision-makers—whether physician, hospital, or MCO—to the same enforcement system. No reason justifies freeing MCOs from having to take responsibility for the consequences of their judgments regarding medical care. Though the current medical malpractice regime has imperfections—to the extent it holds physicians and other providers accountable for their decisions affecting patients' health—it should hold MCOs equally accountable.

Additionally, critics' worries about an explosion in litigation and increased health costs will likely prove overstated and perhaps misplaced. Lawsuits probably would not rise dramatically with MCO tort liability. Since Texas enacted the THCLA, MCOs have suffered only one suit,[226] and of the cases that have gone before independent review boards, about half the decisions have favored MCOs.[227] Also, while

222. Josephine Y. King, *No Fault Compensation for Medical Injuries*, 8 J. CONTEMP. HEALTH L. & POL'Y 227, 235 (1992).

223. *See* Armand Leone Jr., *As Health Care Enterprise Liability Expands . . . Is ADR the RX for Malpractice*, 49 DISP. RESOL. J. 7, 10 (1994); Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, Q. J. OF ECON., May, 1996, at 353, 387-88 (suggesting that nationwide tort reform could produce savings of $50 billion annually without serious adverse health care consequences).

224. O'Connell & Neale, *supra* note 215, at 288.

225. JEFFREY O'CONNELL & C. BRIAN KELLY, THE BLAME GAME, INJURIES, INSURANCE AND INJUSTICE 139 (1987) (quoting Professor Patrick Atiyah).

226. *See* Plocica v. NYL Care of Texas, Inc., 43 F. Supp. 2d 658, 661 (N.D. Tex. 1999). Former Texas Trial Lawyer Association president Tommy Jacks concedes a rise in MCO suits might occur—not so much because of the THCLA as because of the increase in Texans enrolling in MCO health plans. *See* Megan H. Rhyne, *Plaintiffs Bar Doesn't Expect Suit Bonanza from HMO Law*, TEX. LAW., June 9, 1997, at 15.

227. As of Sept., 23, 1998, 114 cases of the 253 filed before a binding independent review board have been decided in favor of the MCO. *See* Lunday, *supra* note 213; *see also Poison Pills: Congress Should Not Undo State's Reform HMOs Staff*, Editorial, HOUSTON CHRON., July 18, 1998, at A32.

suits against MCOs may increase, the total number of medical liability suits probably will not rise much. Injured patients already routinely initiate suits against treating physicians, nurses, hospitals, and other providers. MCO tort liability would merely include MCOs in this proportional liability situation.[228] Furthermore, Congress could mirror the Texas legislature and condition a patient's right to sue an MCO for malpractice on completion of an independent review process.[229] Combining tort liability with a non-judicial screening process would "properly recognize the importance of maintaining patient rights without making HMOs the target of bad lawsuits."[230]

As the Texas experience indicates, health costs are not likely to rise significantly. Though the Texas Association of Business and Chambers of Commerce laments a return to the "indemnity insurance days where insurers paid for whatever the physician asked for," the evidence suggests otherwise.[231] Texas' full-service HMOs reported a six month increase of only 0.7% in the amount spent on medical expenses for each member per month since the THCLA took effect.[232] By comparison, they reported a 4.5% increase during the prior six months.[233]

Several accounting projections also show that MCO tort accountability will not substantially affect health care costs. Milliman and Robertson recently completed an actuarial study that estimated the cost of the Texas liability legislation to a Texas-based MCO at 34 cents per member per month.[234] Similarly, Price Waterhouse projected the likely premium increase from proposed California legislation would range from 0.1% to 0.4%.[235] The Congressional Budget Office estimated that the allowance of MCO tort liability in House Bill 3605 would only increase premiums for employer-sponsored health insurance by 1.2%.[236]

228. "The profound irony is that a physician operating within the rules set by the health plan can be punished when those rules lead to a bad outcome, while the plan itself goes scot-free." Beatrice Y. Motamedi, *Legal Brief: Showdown Over Malpractice: When a Managed Care Plan Thwarts Proper Treatment, Why Do Doctors Have to Pay the Price?*, 11 HIPPOCRATES 31, 36 (1997).

229. *See* Cropper, *supra* note 28, at 7.

230. *HMOs: Independent Reviews Should Be Restored*, Editorial, DALLAS MORNING NEWS, Sept. 22, 1998, at A14. David Sibley explains the rationale underlying the independent review mechanism in the THCLA: "We were looking for some way to make it more difficult to go to court. If people had to go through a review before they sued, that would winnow out the meritless lawsuits." Guglielmo, *supra* note 126, at 94.

231. *See* Cropper, *supra* note 28, at 7.

232. *See id.*

233. *See id.*

234. *See* THE CAMPAIGN FOR HEALTHCARE ACCOUNTABILITY, CLOSING THE MANAGED HEALTH CARE LIABILITY LOOPHOLE: A QUESTION OF SIMPLE FAIRNESS 5 (1998).

235. *See Will Right-To-Sue Provision Cost Just Pennies Per Month?*, MED. & HEALTH, April 12, 1998, at 1.

236. *See* CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE OF H.R. 3605/S. 1890 PATIENTS' BILL OF RIGHTS ACT OF 1998, July 16, 1998.

Each of these health care cost projections are conservative in that they ignore the non-monetary costs currently externalized by MCOs. Enrollees suffer the burden of increased risk in having an illness or injury exacerbated because their MCO does not have sufficient financial incentive to provide them medically necessary care.[237] Managed care liability would force MCOs to account for that non-financial cost in their calculations.[238] The resulting reduction in the non-monetary costs currently borne by consumers would offset most, if not all, increases in monetary costs to MCOs. While tort liability may raise costs to MCOs, it will not necessarily raise—and may even reduce—the monetary and other health care costs borne by society generally.

Moreover, even if health care costs are higher with MCO tort regulation, logic suggests it will lower expenses relative to non-tort MCO mandates. Tort accountability will more fully allow MCOs to continue containing health care expenditures. Removing managed care's check on decisions made by physicians and patients and generally mandating access to certain medical services without regard for particular need severely restricts MCOs' ability to manage health care costs. Such non-tort measures will indiscriminately make MCOs and providers do more, and "[r]equiring insurers and providers to do more inevitably means they will charge more."[239]

Tort regulations will also encourage MCOs to do more—but only when the standard of care dictates a need for additional treatment. Indeed, theoretically, tort liability will not affect MCO decision-making. MCOs currently review treatment decisions for their "medical

237. *See* Corcoran v. United Health Care Inc., 965 F.2d 1321, 1338 (5th Cir. 1992) (recognizing this dilemma).

> [The absence of tort liability] eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable [due to ERISA], there is theoretically less deterrence of substandard medical decision making. Moreover, if the cost of compliance with a standard of care . . . need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs.

Id.

238. Editorials have echoed this concern. *See*, e.g., Robert J. Provan, *Law Would Hold MCOs More Accountable*, SAN ANTONIO EXPRESS NEWS, May 19, 1997, at A19 ("MCOs claim that any accountability will cause the costs of health care to rise . . . . If so, that must mean MCOs are making many costly mistakes and that they are seeking to avoid paying the cost of those mistakes. So, who should bear them—the victim or the perpetrator?"). "While a price tag should never be put on a human life, there should be some reasonable compensation paid to patients and their families who are victims of medical malpractice. This is especially true when victims suffer their life-altering, if not fatal injuries due directly to the negligence of a plan executive attempting to save money." *Federal Initiatives on Quality of Care: Hearings on S. 449, S. 644 Before the Senate Comm. on Labor and Human Resources*, 105th Congress (1997) (Statements of Dr. William A. Reynolds, President of the American College of Physicians).

239. Broder, *supra* note 191, at A24.

necessity."[240] Rather than directly prohibit that cost containment practice, tort accountability will simply ensure that MCOs' definitions of "medical necessity" encompass society's tort-enforced standards of care.

Juxtaposition of the economic impact of tort regulation with that of non-tort mandates may explain why employers do not think health care premiums will rise substantially with MCO malpractice liability. In fact, sixty-one percent of small business executives support allowing patients to sue health plans.[241]

At bottom, Congressional authorization of tort liability similar to that in Texas would force MCOs to respect socially-determined care levels and likely would not have much negative effect on malpractice litigation and health care costs. As a Texas surgeon testified to Congress: "I am happy to report that despite a cry from insurance executives, the sky did not fall, premiums did not skyrocket, and there has not been a single lawsuit. The Texas law is working very well."[242]

CONCLUSION

Congress should amend ERISA or enact other legislation that unequivocally permits states to impose malpractice standards on MCOs. Managed care entities affect the actual medical care rendered to patients, and non-tort regulations insufficiently make them accountable for that control. Tort responsibility would force MCOs to consider the non-monetary costs of sub-optimal care decisions in assessing whether the benefits of a treatment warrant its expense. In doing so, MCOs are unlikely to reduce health care costs in ways that make socially intolerable sacrifices in care.

Authorization for states to institute MCO malpractice liability, however, must come from Congress. Judicial permission has proven unreliable as courts have struggled with the question of whether ERISA preemption doctrine precludes states from imposing tort liability on MCOs.[243] Nothing indicates that the judiciary can ultimately resolve this issue without legislative guidance.

Despite *Corporate Health*, federal courts in general have been inconsistent in their decisions on whether ERISA preempts states from holding MCOs liable for the quality of the benefits they provide. Since *Travelers* and *Dillingham*,[244] the extent of ERISA's protection

240. *See supra* notes 43-44 and accompanying text.

241. Survey by the Kaiser Family Foundation and Harvard School of Public Health, June 16, 1997.

242. Dr. Robert Sloane, *quoted in* Ornstein, *supra* note 211, at D1.

243. As former Labor Secretary Robert B. Reich admonished: "The situation [ERISA preemption of state tort claims] must be corrected. If the courts won't do it, Congress must." *Clinton Administration Considers Narrowing Scope of ERISA*, MANAGED CARE LAW OUTLOOK, Jan. 14, 1997, *available in* 1997 WL 9731157.

244. *See supra* note 155 and accompanying text.

of MCOs has undoubtedly eroded. Numerous courts have recognized the inequities of ERISA preemption of state malpractice claims against MCOs and have accordingly narrowed it. In *Dukes*, for example, the Third Circuit held a managed care plan liable for poor coordination and supervision of its contracted health care providers.[245] The court determined that ERISA does not preempt state regulation of the quality of the provision of health care services.[246] The Tenth and Seventh Circuits likewise determined that ERISA does not preclude state enforcement of medical standards against MCOs.[247] Also, Federal district[248] and state courts[249] have allowed claims relating to MCOs' direct roles in the negligent provision of medical care.

The architects of ERISA never contemplated that managed care concerns would integrate decisions to pay for care and medical judgments.[250] MCOs now determine the provision of care not only on the basis of whether a benefit plan covers such care but also on the basis of the "medical necessity" of such treatment.[251] When these medical necessity decisions lead to harm, ERISA allows patients only the cost of the benefit denied.[252] This remedy, while perhaps appropriate when a benefit plan denies an employee a pension benefit, proves in-

245. *See* 57 F.3d 350 (3d Cir. 1995).

246. *See id.*

247. *See* Pacificare of Oklahoma v. Burrage, 59 F. 3d 151, 155 (10th Cir. 1995) (holding that ERISA did not preempt a vicarious liability claim against an MCO for its physician's malpractice); Rice v. Panchal, 65 F.3d 637, 646 (7th Cir. 1995) (holding that ERISA did not preempt a handicapped patient's claim against an MCO under state law theory of respondeat superior).

248. *See, e.g.*, Kampmeier v. Sacred Heart Hosp., No. 95-7816, 1996 WL220979 at *3 (E.D. Pa. May 2, 1996) (holding an MCO directly liable for its procedures regarding the approval of reimbursement for diagnostic exams)

249. *See* Pappas v. Asbel, 675 A.2d 711, 718 (Pa. Super. Ct. 1996) (holding that ERISA did not preempt a direct negligence claim against an MCO for refusing to authorize a patient's transfer to a spinal cord trauma unit despite the treating physician's judgment that patient's neuralgic emergency immediately required it); Shannon v. McNulty, 718 A.2d 828, 831 (Pa. Super Ct. 1998) (holding that plaintiffs made a prima facie case against MCO for both vicarious liability and direct corporate liability).

250. The Third Circuit researched ERISA's legislative history, concluding:

> We find nothing in the legislative history suggesting that Section 502 (ERISA) was intended as part of a federal scheme to control the quality of benefits received by plan participants. Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation, and we interpret the silence of Congress as an intent that it should remain such.

Dukes v. U.S. Helathcare Inc., 57 F.3d 350, 357 (3d Cir. 1995). This determination comports with that of the U.S. Supreme Court: "[N]othing in the language of the act . . . indicates that Congress chose to displace general health care regulation, which has historically been a matter of local concern." New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1679 (1995).

251. *See supra* notes 37-63 and accompanying text.

252. *See* Employee Retirement Income Security Act of 1974 § 502(a), 29 U.S.C. § 1132(a) (1994); *see also* Berkeley Rice, *Look Who's on the Malpractice Hot Seat Now; But Don't Think Doctors Are Off the Hook*, MED. ECON., Aug. 12, 1996, at 200.

adequate with health care matters.[253] In health care, the cost of the benefit denied often proves only a fraction of the ultimate loss to the consumer.[254] Congress could not have intended for ERISA to limit a harmed patient's recourse in this inequitable manner.

Despite this legislative support for a narrow reading of ERISA's preemption of state tort claims, some courts have nonetheless upheld MCOs' defense of ERISA preemption. In *Schmidt v. Kaiser*,[255] the court conceded that an MCO's administrative functions often require it to judge the "medical necessity" of treatments. Nevertheless, the court held that ERISA preempted the plaintiff's negligent managed care claims. Resolution of conflicting interpretations of ERISA's preemption[256] along with more definitive case law on the issue will take time—perhaps too much time—to develop.

Until Congress clarifies the extent of ERISA's breadth, the 51 million Americans[257] who receive their health coverage from ERISA-governed employer "self insurers" have no guaranteed access to state managed care tort protections. MCOs will continue to lack sufficient incentive to avoid making medical decisions that might ultimately harm patients. They can argue ERISA immunity while leaving doctors and other health care providers as the sole possible defendants in lawsuits for medical negligence. Clearly, Congress should remove the perceived hindrance of ERISA to states' imposition of MCO medical malpractice liability.

Regardless of the action ultimately taken on managed care tort liability, Congress should not undermine Texas' progress. Ideally, federal legislation would clarify that ERISA does not preempt a state's privilege to enforce medical standards through health plan accounta-

253. "'The courts are seeing that the remedies provided under ERISA don't fit the bill [in health care matters],' says Joel Michaels, an attorney who has handled cases for the American Association of Health Plans." Motamedi, *supra* note 228, at 36.

254. For example, if a woman dies of breast cancer because her MCO negligently denied payment for a specialist's consultation and mammogram that could have saved her life, her estate could recovery only the cost of the denied care—perhaps $200.

255. 963 F. Supp. 942, 944-45 (D. Or. 1997).

256. *See* Corcoran v. United Health Care, Inc., 965 F.2d 1321 (5th Cir. 1992) (finding that utilization review denial of hospitalization to a woman with a high-risk pregnancy constituted a benefits determination and thus holding that ERISA preempted a suit challenging that decision). Note that the Fifth Circuit decided *Corcoran* prior to *Travelers*. Judge Gilmore in *Corporate Health* speculates that the Fifth Circuit might have decided *Corcoran* differently post-*Travelers*: "In light of the Supreme Court's recent mandate regarding ERISA preemption analysis, perhaps the Fifth Circuit would reach a different decision in *Corcoran* today." Corporate Health Ins., Inc. v. Texas Dep't of Ins., 12 F. Supp. 2d 597, 617 (S.D. Tex. 1998). Language from *Corcoran* supports her conjecture. The Fifth Circuit regretted the implication of its ERISA determination: "The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on thousands of medical decisions routinely made in the burgeoning utilization review system." *Corcoran*, 965 F.2d at 1338.

257. *See* FAMILIES USA FOUND., *supra* note 11, at 27.

bility. As Judge Gilmore implored in *Corporate Health*, "[i]f Congress wants American citizens to have adequate health care, then Congress must accept its responsibility to define the scope of the ERISA preemption. . . ."[258] In the alternative, Congress should at least designate Texas as a "pilot project"[259] for a number of years so that a future Congress can measure, assess, and ultimately benefit from the state's positive experience.

258. *Corporate Health*, 12 F. Supp. 2d 597, 616 n.7.

259. *See* Letter from John Smithee, Chairman, Tex. House Comm. On Ins., to the Tex. Congressional Delegation 1 (July 22. 1998) (on file with author).