

Notes

WIELDING THE WAND WITHOUT FACING THE MUSIC: ALLOWING UTILIZATION REVIEW PHYSICIANS TO TRUMP DOCTORS' ORDERS, BUT PROTECTING THEM FROM THE LEGAL RISK ORDINARILY ATTACHED TO THE MEDICAL DEGREE

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ABSTRACT

This Note identifies a discrepancy in the law governing the decisionmaking that directs patient care. Seeking treatment that a third party will pay for, a patient needs not only a physician-prescribed course of treatment but also an insurer's verification that the cost is medically necessary or otherwise covered by the patient's plan. Both of these decisions directly impact the ultimate care delivered to the patient, but are governed by two very different liability regimes. A patient who suffers an adverse outcome may sue his physician in tort, while a patient who suffers from a lack of coverage may generally sue his insurer only under contract. In other words, when a patient suffers from inadequate care, his potential remedies vary considerably depending on whether the physician or the insurer is the defendant.

This discrepancy in liability is the consequence of the federal law governing the administration of employer-sponsored health plans, and its extensive preemption of related state law. Many commentators

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have called for legal reform to address the distortion of managed care liability that results, arguing that managed care liability must be consistent or that wronged beneficiaries must have access to meaningful remedies. This Note argues that the federal law governing managed care organizations is problematic for a different reason and that the first step toward reform may be more elementary than previously suggested. Specifically, it suggests that the law governing insurers' coverage decisions is inconsistent with the law governing treatment recommendations. Patients suffer the same harm from error in both contexts—but because they can recover substantially more from treating physicians, doctors are named as defendants even when the insurers make errors. Further, this Note argues that simply aligning these two standards might offer a gateway to reform.

INTRODUCTION

Health-care costs ultimately arise from the accumulation of individual decisions doctors make about which services and treatments to write an order for. The most expensive piece of medical equipment, as the saying goes, is a doctor's pen.

—Atul Gawande¹

If the most expensive piece of medical equipment is the doctor's pen, then it is the stroke of this pen that is driving the American health care system into the ground. Collectively, the nation spends over two trillion dollars every year to provide mediocre medical care to only a segment of the population.² Individually, Americans pay premiums that are increasing four times faster than inflation.³ These ghastly fees go straight to third-party payers, most of whom “manage” care in an attempt to rein in the doctor's pen and contain costs that are now unsustainable.⁴ Predictably, one of the most effective ways to curb medical costs is to disagree with the doctor and simply refuse to cover the treatment his pen prescribes.

1. Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER, June 1, 2009, at 40.

2. OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, A NEW ERA OF RESPONSIBILITY: RENEWING AMERICA'S PROMISE 25 (2009) (noting that annual health care spending amounts to almost eight thousand dollars per person).

3. Kevin Sack, *Necessary Medicine?*, N.Y. TIMES, Dec. 14, 2008, § 4 (Week in Review), at 1.

4. Managed care is a unique type of insurance administration designed to reduce health care spending. See *infra* Part I.

When an insurer and a doctor disagree, the former usually wins: most people have health insurance precisely because they cannot afford the treatments they will need when they fall ill. Yet when a patient forgoes a denied treatment and later discovers that his doctor was *right*, he—or his estate—will likely seek a remedy for the harm he has suffered from this lack of care. Ironically, it is his doctor, and not his insurer, who most often pays the price.

This legal anomaly has been the subject of much debate; managed care organizations serve to contain costs by allocating treatments, but generally escape liability even when they fail to exercise due care in determining the medical necessity of one.⁵ The Employee Retirement and Income Security Act of 1974 (“ERISA”)⁶ preempts any state-imposed liability for employer-sponsored health plans relating to the administration of health benefits, but does not impose parallel federal liability in its place.⁷ As a result, most patients receive health care benefits from plans that are not subject to common or state law standards of care, and that offer no replacement recovery scheme for wronged beneficiaries. Managed care liability reform has been the outcry—to no avail—of many health law scholars who bemoan both the inconsistent legal regime that extensive state law preemption creates⁸ as well as the dearth of remedies it leaves to wronged plaintiffs.⁹

5. Extensive federal preemption applies to most managed care organizations, exempting them from liability under state laws. *See infra* Part II.

6. The Employee Retirement and Income Security Act of 1974, 29 U.S.C. §§ 1001–461 (2006).

7. *See, e.g.*, 29 U.S.C. § 1132(a); *see also infra* Part II.

8. *See, e.g.*, Gail B. Agrawal & Mark H. Hall, *What If You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS U. L.J. 235, 238 n.14 (2003) (“Within this patchwork system, it is nearly impossible to answer legal questions concerning managed care liability with any level of generality, other than ‘it depends.’” (quoting Peter J. Hammer, *Pegram v. Herdrich: On Peritonitis, Preemption, and the Elusive Goal of Managed Care Accountability*, 26 J. HEALTH POL. POL’Y & L. 767, 768 n.2 (2001))); Linda P. McKenzie, *Eligibility, Treatment, or Something In-Between? Plaintiffs Get Creative to Get Past ERISA Preemption*, 23 J. CONTEMP. HEALTH L. & POL’Y 272, 295–300 (2007) (discussing the pleading strategies used to avoid ERISA preemption).

9. *See, e.g.*, Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 535 (2003) (arguing that a reinterpretation of ERISA as it applies to health care would reduce the perceived need for a patients’ bill of rights); Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J.L. MED. & ETHICS 253, 265 (2005) (noting that ERISA’s provision allowing beneficiaries to seek injunction to enforce benefits is inadequate because “[i]t is unrealistic to expect patients who are sick and in need of rapid treatment to go to federal court to make sure that their health plans make

This Note provides an additional rationale for reform, arguing that the status quo of managed care liability is untenable because it is inconsistent with liability governing physicians. In medicine, contract and tort liability intersect and differently govern the conduct of two parties providing care to one patient. This Note illustrates that the imposition of these disparate standards of care has extremely negative implications for health care, and is a cause of unsustainable spending. Cost-containment efforts have failed and will continue to fail so long as this gap persists. Providers nearly always serve as the “deep pocket” for patients, even when it is the insurer who wrongly denied coverage.¹⁰ Consequently, physicians fear malpractice liability whenever an insurer exercises a cost-containment policy, and may refuse either to treat a patient or to alter a patient’s records to guarantee coverage. Only by eliminating the inconsistencies that the liability gap presents can health care costs be controlled in any meaningful way.

Managed care plays a critical role in health care cost-containment goals, and one that will grow as health care reform looks toward insurers to increasingly reduce spending. In the next year, managed care will undergo an unprecedented expansion: the uninsured 15 percent of the nation will carry coverage for the first time in history.¹¹ This tremendous opportunity for enrollment growth stems from a legislative assumption that managed care organizations are the appropriate vehicles for curbing costs,¹² as well as an increasing reliance on these entities to fulfill this role as access to care expands.¹³ For better or for worse, managed care is and will continue to be the conduit for containing costs.

timely, accurate decisions”); Shauhin A. Talesh, *Breaking the Learned Helplessness of Patients: Why MCOs Should Be Required to Disclose Financial Incentives*, 26 LAW & PSYCHOL. REV. 49, 75 (2002) (observing that *Pegram v. Herdrich*, 530 U.S. 211 (2000), represents a judicial shift from adopting a patient perspective to an MCO perspective).

10. See *infra* Part III.B.

11. OFFICE OF MGMT. & BUDGET, *supra* note 2, at 25.

12. None of the legislation set forth in the health care debate has proposed a novel method for containing costs. See generally HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: SIDE-BY-SIDE COMPARISON OF MAJOR HEALTH CARE REFORM PROPOSALS 19 (Oct. 15, 2009), http://www.kff.org/healthreform/upload/healthreform_sbs_full.pdf (comparing the various congressional health reform measures on a continually updated basis).

13. Senator Max Baucus, Chairman of the Senate Finance Committee, refused to grant advocates of a single-payer system a seat at health care reform meetings and ordered thirteen physicians and nurses to be removed when they arrived regardless. Victoria Colliver, *Local Supporters of Single-Payer System Head to Capitol Hill*, S.F. CHRON., June 3, 2009, at A8. House Representative Anthony Weiner proposed a single payer amendment, H.R. 676, to the

Yet despite its central role in accomplishing health care reform, managed care liability is strikingly absent from legislative discourse. In the entire health care debate, only one proposal has even mentioned managed care liability—and only tangentially so.¹⁴ Without addressing the present liability landscape governing managed care organizations, the current reform movement will rely heavily on managed care's cost-containment strategies without implementing an effective safeguard against overaggressive and medically inappropriate tactics.

The success of health care reform is far beyond the scope of this Note, which addresses only the movement's extensive reliance on managed care as the vehicle for curbing rising costs. Absent express legislative attention to the disconnect between the liability standards attaching to coverage and treatment decisions, this unprecedented dependence on the industry will create rippling negative effects on the quality of health care.¹⁵

This Note is divided into four parts. Part I reviews the role that managed care organizations play in making coverage decisions, and the extent to which these decisions overlap with treatment decisions traditionally left to the physician. Part I also briefly examines the legislative proposals for health care reform, and—finding that none of these proposals advocate changing the way third-party payers participate in the system—concludes that managed care's role in health care will not change. Part II sets forth the current liability scheme governing managed care organizations' coverage decisions. It

House health care reform bill. Press Release, Physicians for a Nat'l Health Program, House Vote on Single Payer Will Be Historic First, Doctor's Group Says (Aug. 5, 2009), *available at* http://www.pnhp.org/news/2009/august/house_vote_on_single.php. Representative Weiner withdrew this amendment before the bill went to a vote, stating that it would distract from attempts to create a public option. Press Release, Rep. Weiner Withdraws Single Payer Amendment from Current Health Care Debate (Nov. 6, 2009), *available at* http://weiner.house.gov/news_display.aspx?id=1368.

14. The House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200) proposes that Congress adopt standards for financial and administrative transactions to which managed care organizations would be held, including standard electronic transactions and timely and transparent claims and denial management processes. America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. § 164(a)(1) (as reported by H. Tri-Comm., Oct. 14, 2009) ("The Secretary shall adopt and regularly update standards . . . [that will] require timely and transparent claim and denial management processes, including tracking, adjudication, and appeal processing."); *see also* HENRY J. KAISER FAMILY FOUND., *supra* note 12, at 19 (comparing the various congressional health reform measures on a continually updated basis).

15. The different standards of care that attach to a physician's choice of treatment versus an insurer's decision to cover that treatment create a cascade of problems in health care delivery. *See infra* Parts II.B, III.A–B.

illustrates that, because of ERISA's preemptive effect,¹⁶ the majority of these entities escape any meaningful liability for failure to exercise due care in denying treatment coverage. Part III then contrasts this liability with the traditional tort regime governing physician behavior, arguing that two regimes governing utilization review and treating physicians create incompatible standards for care that is administered to the same patient. Finally, Part IV argues that these conflicting standards are antithetical to the goal of managed care: providing low-cost and high-quality health care.

I. MANAGED CARE: THE DE FACTO VEHICLE FOR COST CONTAINMENT

Managed care emerged as a method to control costs of the fee-for-service reimbursement system supported by insurance plans. Under a fee-for-service model, an insurer reimburses a health care provider for services rendered.¹⁷ The physician alone determines the "volume and kinds of services" he provides.¹⁸ Under a managed care model, however, an insurer reviews the care the physician provides—either prospectively or retrospectively—and reserves the right to approve or deny requests for coverage. The physician cannot provide and bill for endless services, thereby subjecting the patient to unnecessary care for his own financial gain.¹⁹ However, in their quest to eliminate coverage of superfluous care, insurers may also deny payments for medically *necessary* care, thereby precluding physicians from providing appropriate treatments. Therefore, the degree to which managed care and physician decisions conflict is important to understand.

Managed care replaced indemnity insurance in an effort to reduce the high costs realized under a traditional fee-for-service

16. 29 U.S.C. §§ 1001–461 (2006); *see also infra* Part II.

17. *Pegram v. Herdrich*, 530 U.S. 211, 218 (2000) ("Traditionally, medical care in the United States has been provided on a 'fee-for-service' basis. A physician charges so much for a general physical exam, a vaccination, a tonsillectomy, and so on. The physician bills the patient for services provided or, if there is insurance and the doctor is willing, submits the bill for the patient's care to the insurer . . .").

18. Arnold S. Relman, *Perspective, Doctors as the Key to Health Care Reform*, 361 *NEW ENG. J. MED.* 1225, 1225 (2009).

19. *Cf. id.* (noting that the fee-for-service payment structure creates a "strong financial incentive for [physicians] to maximize the elective services they provide").

reimbursement schedule.²⁰ Replacing a payment schedule that rewarded quantity over quality,²¹ managed care ideally controls spending by “managing” a patient’s treatment regime and thereby ensuring that the patient does not receive duplicative or unnecessary diagnostics or procedures.²² This process is called utilization review—insurers review the care a physician recommends, and determine whether it is within the patient’s plan.²³ This determination often hinges on whether the care is medically necessary.

Managed care coverage decisions conflict with physician decisions whenever an insurer denies coverage for a treatment the physician prescribes. The decision made in utilization review—whether a treatment is medically necessary—has traditionally been a decision reserved exclusively for the treating physician.²⁴ Therefore, when an insurer denies coverage of a treatment plan, managed care effectively trumps the physician’s treatment decisions and directly interferes with patient care.

At face value, obstruction of patient care appears inflammatory, but utilization review is not necessarily antithetical to quality care. When cost containment is a priority, managed care organizations are more effective than physicians at performing the utilization review

20. Patricia M. Danzon & Mark V. Pauly, *Health Insurance and the Growth in Pharmaceutical Expenditures*, 45 J.L. & ECON. 587, 593 (2002) (“In the 1980s and 1990s managed care insurance in its various forms . . . largely replaced traditional indemnity insurance for general health insurance.”).

21. See, e.g., *Pegram*, 530 U.S. at 218 (“In a fee-for-service system, a physician’s financial incentive is to provide more care, not less, so long as payment is forthcoming. The check on this incentive is a physician’s obligation to exercise reasonable medical skill and judgment in the patient’s interest.”).

22. See Danzon & Pauly, *supra* note 20, at 594 (noting that managed care organizations were able to expand depth of coverage by implementing highly effective “cost control strategies”).

23. See, e.g., *Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 2 n.1 (1st Cir. 1999) (“Utilization review refers to an external evaluation of the appropriateness of a given course of treatment based upon established clinical criteria.” (quoting *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 50 n.9 (D. Mass. 1997))); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 352 n.1 (3d Cir. 1995) (“HMOs often contain costs through a strategy known as ‘utilization review.’ Unlike traditional insurance policies, HMOs usually decide whether to reimburse patients for medical care prospectively—through utilization or ‘pre-certification’ review. The HMO may either perform the utilization review itself or assign the task to a third-party contractor.” (citations omitted)).

24. Barak Richman, *On Doctors and Judges*, 58 DUKE L.J. 1731, 1735 (2009) (noting that the “chore of making medical decisions and carefully allocating healthcare resources for all of society” has traditionally been a role of physicians).

role.²⁵ This becomes apparent as soon as one considers the divergent costs of medicine in different regions of the nation.²⁶ Spending levels are correlated neither with quality of care nor with medical experience, but rather differ based on the practice routines of a given region's physicians.²⁷ For example, the average annual cost of care provided to Medicare patients—which is one of the best approximations of total health care spending—ranged from just over six thousand dollars to over fifteen thousand dollars in different regions, but quality of care did not differ between those regions.²⁸ Physicians in high-cost regions provide up to 60 percent more care—more tests, procedures, specialist consultations, and hospital admissions—than physicians in low-cost regions, but do not produce healthier patients in doing so.²⁹ In fact, President Obama's budget director estimates that the government could reduce Medicare spending by nearly 30 percent if spending in high-cost regions was reduced to the levels in lower-cost areas.³⁰ The Supreme Court also has recognized the need for constraining costs, and views this as a function of managed care.³¹

In addition to constraining costs, managed care organizations could (but currently do not) serve as umbrellas in integrated systems of care.³² Integrated systems of care reduce costs and improve quality in two ways. First, by fostering collaboration and cooperation between health care providers in all specialties and at all levels of

25. See Ellen Wertheimer, *Calling It a Leg Doesn't Make It a Leg: Doctors, Lawyers, and Tort Reform*, 13 ROGER WILLIAMS U. L. REV. 154, 168 (2008) (noting that courts have treated cost-containment policies as “a necessary check on doctors' perceived tendency to recommend unnecessary and excessive treatment”).

26. Gawande, *supra* note 1 *passim*.

27. *Id.* at 40–41.

28. *Id.* at 36.

29. *Id.* at 38.

30. *Id.* at 39 (citing Peter Orszag, Budget Director for President Obama).

31. See *Pegram v. Herdrich*, 530 U.S. 211, 234 (2000) (“HMOs came into being because some groups of physicians consistently provided more aggressive treatment than others in similar circumstances, with results not perceived as justified by the marginal expense and risk associated with intervention.”).

32. For example, in Massachusetts, a state commission on health care payment issues has recommended the state manage its growing health care costs and improve quality of delivery by creating “‘accountable care organizations’ (ACOs), which would organize physicians into multispecialty teams with strong primary care staffing.” Relman, *supra* note 18, at 1226; see also Robert Steinbrook, Perspective, *The End of Fee-for-Service Medicine? Proposals for Payment Reform in Massachusetts*, 361 NEW ENG. J. MED. 1036, 1036–38 (2009) (describing the commission's proposal for payment reform in more detail).

training, integrated systems eliminate piecemeal physician decisionmaking, and thereby reduce repetition and error in patient care.³³ Second, by redistributing liability such that the third-party payers bear risk for adverse outcomes, payers assume accountability for the administration of all care delivered to its beneficiaries.³⁴ Delivery systems such as the Mayo Clinic and Kaiser Permanente have successfully coordinated patient care, but are outliers in a system dominated by disaggregated practice groups or individuals.³⁵ Furthermore, these integrated group practices do not rely on private insurers to make coverage decisions, and some argue that they could not do so without sacrificing quality of care.³⁶ Others assert that managed care can properly organize provider delivery *if* subject to enterprise liability.³⁷

Building systems of integrated care may be the ultimate goal,³⁸ but containing costs while expanding coverage is the only priority receiving legislative attention at the moment. Instead, health care reform legislation is focused both on expanding coverage³⁹ and

33. See Francis J. Crosson, Perspective, *21st-Century Health Care—The Case for Integrated Delivery Systems*, 361 NEW ENG. J. MED. 1324, 1325 (2009) (referring to studies “show[ing] that integrated care is positively correlated with improved quality”); Relman, *supra* note 18, at 1226 (proposing a health care delivery system based on multispecialty group practices).

34. Many argue that risk sharing between providers and payers would incentivize providers to exercise optimal care and payers to establish quality oversight. See Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1993–95 (2003) (arguing that entity level liability on the part of the managed care organization results in optimal levels of care by all parties); Crosson, *supra* note 33, at 1325 (“Kaiser Permanente’s history shows that risk sharing between the payer and the care delivery system can work quite well.”).

35. Crosson, *supra* note 33, at 1324; see also Relman, *supra* note 18, at 1226 (citing integrated systems such as the Mayo Clinic and Kaiser Permanente as models for reform).

36. See Relman, *supra* note 18, at 1227 (arguing that private insurers’ role in a system of integrated care should be limited to making capitated prepayments to the physician groups, “leav[ing] medical care decisions where they belong—in the hands of physicians and patients”).

37. Arlen & MacLeod, *supra* note 34, at 1993–95; see also Alice A. Noble & Troyen A. Brennan, *Managing Care in the New Era of “Systems-Think”: The Implications for Managed Care Organizational Liability and Patient Safety*, 29 J.L. MED. & ETHICS 290, 300 (2001) (suggesting that the threat of liability may encourage MCOs to improve quality).

38. The Chairman of the Council of Accountable Physician Practices argues that “rapid transition for established integrated delivery systems and gradual transition for the majority of physicians and hospitals” is necessary to improve quality of care while constraining spending. He notes that while this change may be spurred with “early forms of payment reform,” it is impossible to predict how long it would take to complete. Crosson, *supra* note 33, at 1324–25.

39. The Obama administration has made clear that increased access to care is a primary goal. OFFICE OF MGMT. & BUDGET, *supra* note 2, at 26 (“[M]oving to provide all Americans with health insurance is not only a moral imperative, but it is also essential to a more effective and efficient health care system.”).

reducing unsustainable costs.⁴⁰ These goals require extremely effective cost-containment strategies that physicians alone cannot offer.⁴¹ Without drastic reductions in health care spending, an unprecedented number of Americans will face bankruptcy merely by seeking necessary treatment.⁴² Thus, President Obama has called on Congress to reform health care “so that patients get the best care, not just the most expensive care.”⁴³ To this end, Congress seems to be relying on both reduced federal fee-for-service payments⁴⁴ and on managed care organizations’ ability to contain costs, and has rejected proposals that would alter this structure of compensation for care.⁴⁵ Furthermore, neither the House nor the Senate has considered altering managed care’s role in performing utilization review. For example, although numerous proposals focus on “reducing waste and inefficiency” and eliminating “unnecessary” or “repetitive” treatments and procedures, none sets forth the means to achieve these goals.⁴⁶ Therefore, managed care will increasingly serve to control health care spending.

Discord between managed care and physician treatment decisions is problematic when it involves disagreement over the rigor or quality of treatment a patient will receive. Whereas a physician’s treatment recommendation must meet a reasonable standard of care, a managed care organization’s refusal to cover that treatment need

40. The administration has promised to “reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added benefit.” HENRY J. KAISER FAMILY FOUND., *supra* note 12, at 19.

41. See Crosson, *supra* note 33, at 1324 (arguing that health care reform in Massachusetts is evidence that “near-universal coverage can be attained” but will only be “financially sustainable” if the unnecessary care resulting from fee-for-service payment of physicians is eliminated).

42. Between 2001 and 2007, the proportion of bankruptcies due to medical debt increased by 50 percent. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 744 (2009).

43. Barack Obama, President, Remarks by the President on Health Care and the Senate Vote on F-22 Funding (July 21, 2009), available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-on-Health-Care-and-the-Senate-Vote-on-F-22-Funding/.

44. Reducing Medicare reimbursement rates is one way legislators propose to reduce federal costs. Denis A. Cortese & Jeffrey O. Korsmo, Perspective, *Putting U.S. Health Care on the Right Track*, 361 NEW ENG. J. MED. 1326, 1327 (2009).

45. The most obvious alternative to managed care—a single-payer system—was quickly eliminated from consideration in the health care debate. See *supra* note 13.

46. See HENRY J. KAISER FAMILY FOUND., *supra* note 12, at 19–23 (summarizing proposals for cost containment).

not.⁴⁷ Because managed care organizations aspire to decrease expenditures, they deny coverage whenever possible⁴⁸ and escape liability even when a denial is negligent.⁴⁹ Moreover, because few patients can afford treatments their insurers refuse to cover, a managed care organization nearly always trumps a physician in defining medically necessary care. Thus, physicians occasionally are prohibited from providing care that is consistent with their professional and legal obligations. Part II describes the standard of care that managed care organizations must meet, and the liability vacuum many of them enjoy. Part III then illustrates the discrepancy between the standard of care governing the treatment decisions made in utilization review, and those made by the practicing physician.

II. THE EXISTING LIABILITY REGIME GOVERNING MANAGED CARE'S ADMINISTRATION OF UTILIZATION REVIEW POLICIES

Most managed care organizations operate in a legal vacuum. The preemptive force of ERISA shields an employer-sponsored health plan from state and common law theories of liability, including medical malpractice, even when it makes medical treatment decisions through utilization review. ERISA allows plan beneficiaries to challenge coverage decisions for breach of contract, but not for negligence.⁵⁰ Essentially, these plans make determinations about the medical necessity of a given treatment, but are not held to the professional standards of care a patient expects of his doctor.⁵¹ They can be liable for nothing more than the cost of benefits denied, even when a coverage decision resulted in irreversible injury or death.⁵²

47. Under ERISA, any employer-sponsored health plan is exempted from state law standards of care relating to the administration of benefits. *See infra* Part II.

48. *Cf.* Agrawal & Hall, *supra* note 8, at 250 (“Inevitably . . . managed care practices or incentives will cause or contribute to harm in some individual cases.”); Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB. POL’Y 245, 289 n.136 (2000) (“[I]n their zeal to control utilization, managed care plans may withhold appropriate diagnostic procedures or treatment modalities for patients.” (alteration in original) (quoting Council on Ethical and Judicial Affairs, AMA, *Ethical Issues in Managed Care*, 273 JAMA 330, 330–35 (1995))).

49. *See infra* Part II.

50. *See infra* note 58 and accompanying text.

51. *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 456 (3d Cir. 2003) (Becker, J., concurring), *quoted by* *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring).

52. *Id.*

This Part illustrates why most managed care organizations face little liability for their medical treatment decisions. Section A discusses the broad preemptive effects of ERISA. Section B then demonstrates preemption's practical effects on potential plaintiffs by highlighting the state law remedies that it forecloses.

A. *ERISA's "[E]xtraordinary [P]re-emptive [P]ower"*⁵³

Federal law usually preempts state and common law theories of liability applied to managed care organizations. The majority of individuals receive health insurance through their employers,⁵⁴ which places most managed care under the purview of ERISA. ERISA governs all pension plans offered by employers (with exception for some government employers and church plans).⁵⁵ Enacted to protect employee interests in pension and benefit plans from both plan default and plan mismanagement,⁵⁶ ERISA provides employee plaintiffs with a federal cause of action and several federal remedies.⁵⁷ At the same time, it preempts nearly all related state causes of action.⁵⁸ ERISA preemption is extremely broad; only one other

53. *Aetna Health*, 542 U.S. at 209 (quoting *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987)).

54. Nearly two-thirds of the population under sixty-five (the age at which Medicare benefits accrue) receive employer-sponsored health insurance. Mark W. Stanton, *Employer-Sponsored Health Insurance: Trends in Cost and Access*, RESEARCH IN ACTION, Sept. 2004, at 1, 1, <http://www.ahrq.gov/research/emspria/emspria.pdf>; see also TOM DASCHLE, SCOTT S. GREENBERGER & JEANNE M. LAMBREW, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 188 (2008) (noting that employers provide health care insurance for 60 percent of Americans, though this number is falling quickly as health care premiums rise).

55. BARRY D. ALEXANDER ET AL., FUNDAMENTALS OF HEALTH LAW 267 (4th ed. 2008).

56. *E.g.*, *McKenzie*, *supra* note 8, at 275.

57. 29 U.S.C. §§ 1131–35 (2006); see also *McKenzie*, *supra* note 8, at 279 (“[T]he Supreme Court has . . . construed [ERISA] section 502(a) to have extremely broad preemptive power. . . . [T]he Court has held that state contract, tort and statutory claims that could have been brought . . . are preempted A second and distinct type of preemption emanating from 502(a) is termed ‘complete preemption.’ . . . Complete preemption serves to re-characterize a state law claim into one arising under federal law. As such, the claim is removable by a defendant to federal court.” (footnotes omitted)).

58. Designed to provide uniformity in the administration of employee benefit plans, ERISA’s conflict and complete preemption clauses preempt any cause of action arising under a state law relating to an employee benefit plan. 29 U.S.C. § 1144; see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (interpreting Congress’s rejection of a limited preemption clause as evidence of intent to create sweeping preemption of state laws); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983) (“By establishing benefit plan regulation ‘as exclusively a federal concern,’ Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees.” (footnote omitted) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981))); *McKenzie*, *supra* note 8, at 278–

federal law, the Labor Management Relations Act, has similar preemptive power.⁵⁹

ERISA preemption is problematic in the context of managed care. Congress enacted ERISA before employee benefit plans encompassed health insurance, and before managed care dominated health care administration.⁶⁰ Thus, it fashioned civil remedies to allow beneficiaries to recover from the wrongful administration of ordinary pension, but not health care, benefits. In other words, ERISA allows beneficiaries to recover the cost of benefits denied but precludes recovery of compensatory or punitive damages. When a beneficiary is denied coverage of medically necessary care, however, he suffers not only economic loss, but also adverse health consequences (including death). Thus, recovery of the benefits denied is severely inadequate in the context of wrongful administration of health care benefits. Moreover, because ERISA remedies are exclusive, a wronged beneficiary may not turn to state law to recover for the harm that ERISA ignores.

79, 282–83 (providing an in-depth discussion of ERISA’s preemption and savings clauses). ERISA, however, does not preempt claims that are exempted from preemption by a savings clause. See Charlotte Johnson, Comment, *Justice Ginsburg’s Fiduciary Loophole: A Viable Achilles’ Heel to HMOs’ Impenetrable ERISA Shield*, 2006 BYU L. REV. 1589, 1590 (“ERISA itself contains a safe harbor called the Savings Clause, which allows state law claims to avoid ERISA preemption if the claims relate to the ‘business of insurance.’ However, the Supreme Court has narrowly interpreted the Savings Clause to only allow exemption from preemption if the state law claimed does not . . . conflict with what is covered by ERISA’s remedial scheme as contained in § 502.” (footnote omitted) (quoting 29 U.S.C. § 114(b)(2)(A)); see also McKenzie, *supra* note 8, at 278–79, 282–83 (providing an in-depth discussion of ERISA’s preemption and savings clauses).

59. See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (“[ERISA’s] pre-emptive force mirror[s] the pre-emptive force of LMRA . . . [T]he ERISA civil enforcement mechanism is one of those provisions with such ‘extraordinary pre-emptive power’ that it ‘converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.’” (quoting *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987))).

60. Johnson, *supra* note 58, at 1590. Courts disagree as to whether Congress foresaw that ERISA would preempt causes of action arising from the negligent implementation of cost-containment policies. Compare *Pappas v. Asbel (Pappas)*, 675 A.2d 711, 716 (Pa. Super. Ct. 1996) (reasoning that Congress did not intend to preempt recovery for negligent implementation of cost-containment policies because these policies were nonexistent at the time), with *Pappas v. Asbel (Pappas I)*, 724 A.2d 889, 894 n.6 (Pa. 1998) (pointing to the enactment of the Health Maintenance Organization Act of 1973 as evidence that Congress understood the extent and implications of cost-containment activities when it drafted ERISA). Whether Congress foresaw cost containment as an element of health care administration is a rather academic point; regardless of congressional intent, ERISA preemption has resulted in a completely inconsistent recovery system for the negligent administration of cost-containment policies, and thus creates an inadequate legal landscape for the governing of managed care activity.

The Supreme Court is not blind to ERISA's shortcomings in the context of health care administration. It has tried to account for the unique nature of the administration of health care benefits in its preemption reasoning. Specifically, the Court has distinguished between coverage decisions hinging on eligibility and those hinging on treatment,⁶¹ reasoning that only the former fall under ERISA.⁶² In other words, the Court has acknowledged that when plans make treatment decisions, they affect patient care rather than the administration of benefits, and thus implicate state medical malpractice law. The Court's reading of ERISA preemption, however, is so broad that it has refused to allow wronged beneficiaries to use state law to challenge a coverage decision that involved *both* medical judgment and plan administration, so long as the medical judgment was made by a utilization review physician who never saw the patient.⁶³ As a result, patients denied coverage of medically necessary care suffer real health consequences but are precluded from recovering anything more than the cost of benefits denied.

Pure eligibility decisions emulate traditional plan administration tasks, hinging on "[r]ules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services."⁶⁴ In other words, an eligibility decision

61. *Pegram v. Herdrich*, 530 U.S. 211, 228 (2000).

62. *See, e.g., id.* at 229–31 (refusing to allow a claim filed under ERISA to allege breach of fiduciary duty where the contested action involved an element of a treatment decision, rather than a pure eligibility decision).

63. *See, e.g., Danca v. Private Health Care Sys., Inc.*, 185 F.3d 1, 7 (1st Cir. 1999) (holding that the plaintiffs' state tort claims against the defendant insurance company for negligent supervision and training of personnel and negligent infliction of emotional distress were preempted by ERISA because they "create[d] a threat of conflicting and inconsistent state and local regulation of the administration of ERISA plans"); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 941–42 (6th Cir. 1995) (holding that the plaintiffs' state law claims against the defendant insurance company for wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith were preempted by ERISA because they related to the insurance plan); *Corcoran v. United HealthCare Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that, because the defendant insurance company had made "medical decisions *incident to* benefit determinations," the plaintiffs' state tort action for wrongful death of their child was preempted by ERISA (emphasis added)); *Elsesser v. Phila. Coll. of Osteopathic Med.*, 802 F. Supp. 1286, 1290–91 (E.D. Pa. 1992) (holding that the plaintiffs' state tort negligence claims, founded on the defendant insurance company's refusal "to pay for the [requested medical device]," were preempted by ERISA when the plaintiffs sought to hold the company "*directly* liable" for negligence, explaining that "such a claim . . . clearly has a [connection to] a benefit plan" (second alteration in original)).

64. *Pegram*, 530 U.S. at 223.

involves nothing more than a determination as to whether a given treatment is covered under the terms of a beneficiary's plan.⁶⁵ These decisions are squarely governed by ERISA.⁶⁶ Thus, ERISA would preempt a beneficiary from using state law to challenge denied coverage of a given drug treatment based on the terms of a plan because the claim would contest what was "promised under the terms of [an] ERISA-regulated employee benefit plan[]." ⁶⁷

Treatment decisions, on the other hand, involve medical judgments. Because managed care organizations perform utilization review, some benefits decisions go far beyond the scope of traditional plan administration. For example, a blanket provision in a policy that required all newborns to be discharged within twenty-four hours of birth was not governed by ERISA (and could be challenged under state law) because it directly implicated medical care.⁶⁸ When eligibility for coverage hinges on a treatment being medically necessary, a plan administrator must make a "mixed" coverage decision—interpreting both the terms of a beneficiary's plan and the medical needs of the patient.⁶⁹ To the extent that a health plan covers medically necessary treatment, a coverage denial will hinge on an insurer's determination that physician-recommended care is not implicated, and will result in the insurer overriding the treating physician's course of treatment—substituting a lower-cost option or denying coverage completely. Inappropriate coverage denial can have the same practical effect as a physician's failure to exercise reasonable care, and can cause far greater harm than ordinary misappropriation of plan benefits.⁷⁰ Thus, in *Pegram v. Herdrich*,⁷¹ the Supreme Court

65. *Id.* at 228.

66. *See, e.g.,* *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (reasoning that a state or common law cause of action "based on alleged improper processing of a claim for benefits under an employee benefit plan, *undoubtedly* meet[s] the criteria for pre-emption" (emphasis added)).

67. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 211 (2004).

68. *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 162–64 (3d Cir. 1999). *But see Corcoran*, 965 F.2d at 1322–24, 1333 n.16 (concluding that ERISA preempted a medical malpractice claim against an insurer for refusal to cover hospitalization for fetal monitoring—resulting in stillbirth—because the decision was related to a "cost-containment feature of the plan" and thus "implicated the management of plan assets").

69. *See Pegram*, 530 U.S. at 228 (reasoning that pure "eligibility decisions" turn on a plan's coverage of particular conditions or medical procedures, whereas "[t]reatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response").

70. *See Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993) (discussing how the defendant insurance company refused to cover the plaintiff's heart surgery until it was

concluded that ERISA does not govern treatment decisions that ultimately affect quality of care (rather than mere quantity of benefits).⁷² In *Pegram*, a patient suffered a ruptured appendix after her physician ordered her to wait eight days for an ultrasound at a clinic affiliated with the insurer, rather than get immediate care at a local hospital. The treating physician happened to own the HMO governing the patient's benefits.⁷³ The Court concluded that ERISA could not bar the beneficiary from bringing state law malpractice and fraud actions against the insurer-physician because the provision of medical care is not within ERISA's scope.⁷⁴

Since concluding that treatment decisions are beyond ERISA's scope,⁷⁵ however, the Court has construed the class of coverage determinations that implicate these decisions extremely narrowly.⁷⁶ In other words, the universe of mixed decisions that survive preemption is quite small⁷⁷—ERISA governs any utilization review decision *unless* the patient's treating physician is directly involved.⁷⁸ Courts reason that a claim dispute implicating a treating physician is beyond the

too late for him to undergo surgery); Petition for Writ of Certiorari at 19, *Kuhl*, 999 F.2d 298 (No. 93-755) (“Without threat of legal recourse, an HMO's most cost-effective decisionmaking process includes the provision of only suboptimal medical care to the patient/member It no longer makes economic sense for the HMO to base its medical decisionmaking on the best interests of patient/members. [The plaintiff] was a victim of that kind of . . . decisionmaking . . . and he died as a result.”).

71. *Pegram v. Herdrich*, 530 U.S. 211 (2000).

72. *Id.* at 232 (“[W]hen Congress took up the subject of fiduciary responsibility under ERISA, it concentrated on fiduciaries' financial decisions, focusing on pension plans, the difficulty many retirees faced in getting the payments they expected, and the financial mismanagement that had too often deprived employees of their benefits. . . . Its focus was far from the subject of [a medical necessity determination] claim.” (citation omitted)).

73. *Id.* at 215.

74. *See id.* at 214 (holding that treatment decisions made by HMOs' physician employees are not fiduciary acts under ERISA).

75. *Id.* at 228.

76. Health law scholar Professor Korobkin asserts that the Court's later narrowing of the category of medical decisions that subject insurers to state law was *not* based on ERISA language, and reflects a misreading of the law. *See* Korobkin, *supra* note 9, at 534–37 & n.372 (arguing that a proper interpretation of what falls within the scope of ERISA, and what does not, would reduce the perceived need for federal legislation either amending ERISA or creating a new federal cause of action against managed care entities).

77. *Mayeaux v. La. Health Serv. & Indem. Co.*, 376 F.3d 420, 431 (5th Cir. 2004) (noting that *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), significantly narrowed the class of mixed decisions that survive preemption).

78. *See Land v. CIGNA Healthcare of Fla.*, 381 F.3d 1274, 1276 (11th Cir. 2004) (per curiam) (holding that a claim challenging denial of coverage that entails a mixed eligibility and coverage decision is *not* preempted when that decision was made by either the treating physician or his employer).

scope of ERISA because it “does not involve a claim for benefits, a claim to enforce rights under the benefit plan or a claim challenging administration of the benefit plan,” and therefore does not relate to the plan.⁷⁹ In contrast, when a physician conducts utilization review on behalf of an insurer *without* seeing the patient, and disagrees with the treating physician’s recommendations, the reviewing physician’s decision has a “connection with or a reference to a benefit plan,” and is thus protected by complete preemption of any state law tort action.⁸⁰ Essentially, plans may be vicariously liable under state law for the actions of treating physicians they employ, but *not* for the actions of utilization review physicians who never see a patient.⁸¹

This narrow interpretation of the extent to which coverage determinations involve treatment decisions prevents patients from filing malpractice actions against insurers for negligent utilization review. For example, the Second Circuit concluded that an insurer’s fatal delay in approving coverage of a single stem cell transplant as medically necessary (in place of the double stem cell treatment that the insurer already had deemed experimental) could not be challenged under state law because the insurer was not “*actually*

79. *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 154–55 (10th Cir. 1995) (quoting *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 186 (E.D. Pa. 1994)); *see also id.* (“Just as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent.”); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 350 (3d Cir. 1995) (holding the insurer subject to a state malpractice action under a vicarious liability theory because the claim was unrelated to the collection of benefits or the terms of the plan); *Kohn v. Del. Valley HMO, Inc.*, No. 91-2745, 1991 WL 275609, at *2–3 (E.D. Pa. Dec. 20, 1991) (“Although an HMO is not usually liable for the negligence of the independent contractor physicians and health care providers that service the HMO members, an HMO may nevertheless be held liable if the health care provider is the ‘ostensible’ agent of the HMO. . . . [which requires that the plaintiff establish that] the HMO ‘act[ed] or omit[ed] (sic) to act in some way which leads the patient to a reasonable belief that he is being treated by the [HMO] or one of its employees.’” (alterations in original) (citations omitted) (quoting *Jones v. Philpott*, 702 F. Supp. 1210, 1210 (W.D. Pa. 1988); *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1229 (Pa. Super. Ct. 1988))).

80. *Elsesser v. Phila. Coll. of Osteopathic Med.*, 802 F. Supp. 1286, 1290–91 (E.D. Pa. 1992) (quoting *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1329 (5th Cir. 1992)); *see also id.* (allowing a state law malpractice action against an HMO for its employment of a primary care physician who failed to read the results of a heart monitor *after* the HMO denied coverage of the monitor and ordered the physician to discontinue the patient’s use, but not for the insurer’s decision to deny coverage of the monitor).

81. *See Kohn*, 1991 WL 275609, at *2–5 (holding that a malpractice action against an HMO for vicarious liability for its treating physicians was not preempted, but that the claims against the HMO for direct negligence were preempted).

providing medical care” to the patient.⁸² Similarly, the Eighth Circuit reasoned that ERISA preempted a malpractice action against an insurer that wrongfully denied coverage of a recommended heart surgery (only to grant coverage once the patient’s heart had deteriorated to a fatal degree) because the utilization review of the cardiologist’s recommendations could not be separated from the administration of the beneficiary’s benefits.⁸³

This rule—that preemption arguments fail when the treating physician contributes to the decision to deny coverage, but not when a utilization review physician denies coverage based on medical criteria—has proved impracticable in the lower courts. Courts struggle to accept that a medical decision made by a utilization review physician is not subject to tort simply because “the only relationship” between this physician and the patient is the administration of the beneficiary’s plan.⁸⁴ This confusion has resulted in an unpredictable pattern of preemption.⁸⁵ Liability under state law may turn on “the structure of the managed care organization . . . which state the plan is in . . . [and] the prevailing judicial attitudes toward ERISA preemption,”⁸⁶ among other things.⁸⁷ Plaintiff lawyers are therefore

82. *Cicio v. Does*, 385 F.3d 156, 158 (2d Cir. 2004) (per curiam) (emphasis added); *see also Land*, 381 F.3d at 1276 (reasoning that mixed decisions involving treatment and eligibility determinations are preempted so long as the named defendants are neither the actual treating physicians nor the physicians’ employers).

83. *Kuhl v. Lincoln Nat’l Health Plan, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993).

84. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 200, 211 (2004) (holding that the plaintiffs’ claims were preempted by ERISA, in part because “the only relationship [the defendant insurance company] had with [the plaintiff] was its partial administration of [the plaintiff’s] employer’s benefit plan”).

85. *See, e.g., Agrawal & Hall*, *supra* note 8, at 237–39 (discussing how “[various political and judicial events have] produced a complicated, evolving, and somewhat dichotomized liability landscape” (footnote omitted)); Peter J. Hammer, *supra* note 8, at 768 n.2 (“[A]ccountability for health care providers must be cobbled together in an ad hoc fashion. Within this patchwork system, it is nearly impossible to answer legal questions concerning managed care liability with any level of generality, other than ‘it depends.’”).

86. Hammer, *supra* note 8, at 768 n.2 (noting that judicial attitudes toward preemption “have themselves changed dramatically over just the past five years”).

87. The perceptions of attorneys working for managed care organizations reflect this uncertainty. In a series of interviews with health plan managers and attorneys representing the plans, Professors Agrawal and Hall found wide variability in the perceived risk of liability. *See Agrawal & Hall*, *supra* note 8, at 238–39 (noting that many attorneys working for local managed care organizations—in states with *and* without right-to-sue statutes—described the risk of liability as only a “theoretical concern,” whereas attorneys working for national or interstate managed care organizations described the risk of liability as substantial and predicted that the real impact of liability will be felt within a few years).

hesitant even to name a managed care organization as a defendant.⁸⁸ Thus, ERISA has sufficiently confused the legal backdrop behind managed care, creating a blanket of protection for insurers administering employee benefit plans.⁸⁹

B. *A Day Late and a Dollar Short*

ERISA preemption precludes beneficiaries from recovering compensatory or punitive damages for denial of treatment coverage decisions that negatively affect care.⁹⁰ Furthermore, the Supreme Court's interpretation of ERISA preemption has resulted in inconsistent theories of liability that discourage wronged beneficiaries from filing claims against their insurers.

ERISA generally preempts state right-to-sue laws and denies injured plaintiffs recovery of anything more than the cost of benefits denied.⁹¹ State laws creating liability for the negligent denial of

88. See Mark A. Hall & Gail Agrawal, *MarketWatch: The Impact of State Managed Care Liability Statutes*, 22 HEALTH AFF. 138, 143 (2003) (“[A]lmost all of the plaintiffs’ lawyers we interviewed said that they are very reluctant to sue health plans unless the right set of facts presents itself.”).

89. See, e.g., Agrawal & Hall, *supra* note 8, at 250 (“[M]anaged care organizations have enjoyed a shield from liability for challenges to cost containment initiatives, at least as to claims by those 137 million Americans who are ERISA plan beneficiaries.” (footnote omitted)); Scott, *supra* note 48, at 290 n.138 (“ERISA has evolved into a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits.” (quoting *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53 (D. Mass. 1997))).

90. There is a strong argument that the Court has mistakenly focused on preemption, ERISA’s secondary purpose, at the expense of benefit protection, its primary purpose. See McKenzie, *supra* note 8, at 276 (“The Court’s emphasis on ERISA’s secondary purpose [preemption] has come at the expense of the Act’s stated primary purpose. Although drafted primarily to protect the interests of employees in their pension and benefit plans, ERISA often erects insurmountable barriers to employees’ claims against these plans. The result is that a beneficiary sustaining damages as a result of this health plan’s denial of a covered benefit often has no adequate remedy under state or federal law.” (footnotes omitted)); see also Johnson, *supra* note 58, at 1589–90 (“[T]he U.S. Supreme Court has inadvertently painted itself into a corner by restrictively interpreting ERISA to preclude compensatory relief to victims of HMO patient treatment decisions[] . . .”).

91. See, e.g., *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1326 (5th Cir. 1992) (noting that recovery under ERISA is limited to the cost of medical benefits denied); *Summers v. Touchpoint Health Plan, Inc.*, 749 N.W.2d 182, 195 (Wis. 2008) (holding that “the appropriate remedy is for the beneficiary to be provided with a benefits application process that is not arbitrary and capricious, which may or may not result in coverage for the treatments”). The Court has consistently rejected arguments that ERISA’s grant of “equitable relief” under section 1132 allows for a remedy that would make the plaintiff whole—a remedy that, following the denial of health care coverage, would require recovery of much more than the monetary value of benefits denied. See, e.g., *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S.

coverage for medically necessary care⁹² expressly allow plaintiffs to sue managed care organizations,⁹³ but very rarely survive preemption challenges.⁹⁴ As a result, wronged beneficiaries seeking recovery from an employer-based insurer are left with the sparse civil remedies offered by ERISA.⁹⁵ The following three cases are illustrative of this problem, and set the scene for understanding why patients often sue their physicians for the harm their insurers have created.

First, in the most famous wrongful denial of coverage dispute, the Supreme Court considered two consolidated challenges to two different health plans.⁹⁶ Uncontested in both challenges was that the plan beneficiaries had suffered irreversible harm as a result of wrongful denials of care coverage. One suffered internal bleeding after his plan substituted a lower cost pain killer for his physician-prescribed medication.⁹⁷ He was subsequently hospitalized and

204, 209–10 (2002) (noting that equitable relief does not constitute all relief); *Mertens v. Hewitt Ass.*, 508 U.S. 248, 258 (1993) (“‘Equitable’ relief must mean *something* less than *all* relief.”); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (“Congress did not provide, and did not intend the judiciary to imply, a cause of action for extracontractual damages caused by improper or untimely processing of benefit claims.”); see also John H. Langbein, *What ERISA Means by “Equitable”*: *The Supreme Court’s Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1319 (2003) (arguing both that the Court has erred in applying an antiquated meaning of “equitable relief” to ERISA litigation, and that this error may be corrected in time, as suggested by the strong dissents in all three cases).

92. See, e.g., Agrawal & Hall, *supra* note 8, at 271–74 (describing state laws creating managed care liability whenever possible without running into ERISA preemption).

93. See, e.g., Scott, *supra* note 48, at 290 n.138 (discussing various theories of liability under which challenges to denials of medically necessary care have been successful); see also Agrawal & Hall, *supra* note 8, at 240 n.16 (noting the large awards against managed care organizations for denial of coverage); James Bartimus & Christopher A. Wright, *HMO Liability: From Corporate Negligence Claims for Negligent Credentialing and Utilization Review to Bad Faith*, 66 UMKC L. REV. 763, 772 (1998) (noting the first successful bad faith tort claim for denial of coverage of care).

94. Cf. Agrawal & Hall, *supra* note 8, at 253–54 (discussing lower court cases that seem to chip away at ERISA preemption of state laws that create managed care liability, but noting that a few Supreme Court opinions only hint at doing so in dicta); McKenzie, *supra* note 8, at 272 (discussing a punitive damages award against an employer-sponsored health care plan, which seems to contradict ERISA preemption precedent); Noble & Brennan, *supra* note 37, at 291 (suggesting that ERISA preemption is weakening).

95. Justice Ginsburg has described ERISA as creating a “regulatory vacuum” in which “virtually all state law remedies are preempted but very few federal substitutes are provided.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring) (quoting *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 456 (3d Cir. 2003) (Becker, J., concurring)).

96. *Id.* at 204 (majority opinion).

97. *Roark v. Humana, Inc.*, 307 F.3d 298, 303 (5th Cir. 2002), *rev’d sub nom. Aetna Health*, 542 U.S. 200.

underwent substantial treatment.⁹⁸ The other experienced post-surgical complications and was rehospitalized after her insurer denied coverage of the extended hospital stay recommended by her physician.⁹⁹ The issue was whether the wronged beneficiaries could recover pain and suffering damages under a state law that required health plans to exercise ordinary care in making health care treatment decisions.¹⁰⁰ The Court concluded that the state law cause of action could not survive ERISA's "extraordinary pre-emptive power," even though it did not facially implicate the federal law.¹⁰¹ In other words, because the "only connection" between the beneficiaries and their respective health plans was the administration of the plan, the plaintiffs were doing nothing more than contesting that administration, even though it involved medical decisionmaking.¹⁰² Therefore, the plaintiffs were unable to recover under state tort law and were limited to filing a federal action for breach of contract, seeking nothing more than "recovery of benefits denied."¹⁰³

The Fifth Circuit also concluded that ERISA preempted a beneficiary's claim for wrongful denial of coverage, which had been filed under state insurance regulations.¹⁰⁴ The plaintiff, a cancer patient, sued the third-party administrator of her insurer's utilization review policy, alleging that it had issued secret coverage guidelines instructing its employees to differentiate between medically necessary and experimental treatments in a different manner than that set forth in the plan's policy.¹⁰⁵ Reasoning that ERISA does not provide a remedy for generating and adhering to secret coverage guidelines—even those that materially affect decisions to deny coverage—the Fifth Circuit affirmed the district court's grant of summary judgment for the defendant insurer, leaving the plaintiff with nothing.¹⁰⁶

98. *Id.*

99. *Aetna Health*, 542 U.S. at 205.

100. *Id.* at 204; Texas Health Care Liability Act (THCLA), TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001–.003 (West 2004 Supp. Pamphlet).

101. *Aetna Health*, 542 U.S. at 207–09 (“[W]hen the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law. ERISA is one of these statutes.” (citations omitted)).

102. *Id.* at 214.

103. *Id.* at 211.

104. *Hubbard v. Blue Cross Blue Shield Ass’n*, 42 F.3d 942, 945 n.7 (5th Cir. 1995).

105. *Id.* at 944–45.

106. *Id.* at 946.

Finally, a court in the Northern District of Texas came to the same conclusion when presented with a preemption challenge to common law malpractice and negligence claims filed against an insurer.¹⁰⁷ The deceased beneficiary—a non-Hodgkin’s lymphoma patient—experienced a fatal delay in beginning chemotherapy after a Kaiser physician misdiagnosed her with Hepatitis C.¹⁰⁸ Her estate sued Kaiser, alleging that cost-containment policies had limited the physician’s use of diagnostic procedures and had tortiously interfered with the patient-physician relationship.¹⁰⁹ The court, concluding that “claims regarding plan guidelines and utilization review procedures” are always preempted, denied the plaintiff’s motion to remand to state court.¹¹⁰

These cases provide a glimpse of the extent to which ERISA’s preemptive force denies beneficiaries recourse against insurers. The result is that beneficiaries—wrongly denied coverage of medically necessary care—suffer the ensuing harm of forgoing treatment, and are left with no recourse other than the recovery of benefits originally denied. Several courts have recognized this inherent gap in the law¹¹¹ and have called out to Congress to address the issue.¹¹² Others insist that the recovery of benefits is equitable and fair,¹¹³ turning a blind

107. *Silva v. Kaiser Permanente*, 59 F. Supp. 2d 597, 600 (N.D. Tex. 1999).

108. *Id.* at 598.

109. *Id.* at 599.

110. *Id.* at 599–600.

111. *See Yodzis v. Tilak*, 2009 WL 465448, at *13–14 (N.J. Super. A.D. 2009) (noting that preemption of a malpractice claim against an insurer for wrongful denial of coverage unfairly leaves the plaintiff without recovery, but that the court is helpless to rule otherwise until Congress amends the law).

112. Justice Ginsburg, feeling compelled by ERISA’s plain language to concur in the Court’s *Aetna Health* decision, announced that she did so only while joining “the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring); *see also Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003) (Calabresi, J., dissenting in part) (describing ERISA’s remedial scheme as a “gaping wound” that “will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end”).

113. *See, e.g., Aetna Health*, 542 U.S. at 211 (“Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a § 502(a)(1)(B) action, or sought a preliminary injunction.”); *Cicio v. John Does*, 385 F.3d 156, 157 (2d Cir. 2004) (per curiam) (noting that the decedent “could have paid for the treatment . . . and then sought reimbursement . . . or sought a preliminary injunction” (internal quotation marks omitted)); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273–74 (3d Cir. 2001) (suggesting that patients who are wrongfully denied care should seek an injunction enforcing the administration of employee benefits under ERISA’s section 502(a)).

eye to the immeasurable harm that the denial of coverage can cause patients who cannot otherwise afford necessary treatment.¹¹⁴

III. THE GAP BETWEEN CONTRACT AND TORT LIABILITY: APPLYING DIFFERENT STANDARDS OF CARE TO UTILIZATION REVIEW AND DIRECT PATIENT CARE

Extensive federal preemption shields most managed care plans from state and common law liability even when they make coverage decisions regarding the medical necessity of care. Thus, the liability attaching to negligent treatment decisions made during utilization review is substantially less than the liability that attaches to treatment decisions made by the practicing physician. Ironically, the former's treatment decisions trump and sometimes even shape those of the latter. This discrepancy in liability and authority results in two paradoxical consequences. First, insurers exert tremendous control over physician decisionmaking and can prospectively deny coverage for a physician's recommended course of treatment. Second, despite subjection to this power, treating physicians retain ultimate responsibility for the patient's treatment as well as any adverse outcomes. Moreover, because patients often cannot file state law claims against managed care organizations, this physician is frequently the only available defendant.

A. *Managed and Well Controlled*

The essence of managed care organizations is control over physician decisionmaking. Indeed, this control is imperative to the ultimate success of any cost-containment policy seeking to curtail unnecessary care. The Congressional Budget Office attributes the

114. The harm caused by the denial of treatment is often fatal. *See, e.g.,* Payton v. Aetna/US Healthcare, No. 100440/99, 2000 N.Y. Misc. LEXIS 91, at *2 (Sup. Ct. Mar. 22, 2000) (noting that the patient, who had repeatedly appealed the denial of coverage for inpatient chemical dependency rehabilitation, died of a drug overdose eight days before his insurer accepted the State Insurance Department's finding that the patient's contract "'plainly' covers inpatient substance abuse rehabilitation" and reversed its denial of coverage); Mariner, *supra* note 9, at 265 ("[I]t is unlikely that [seeking an injunction to enforce administration of benefits] could speed up or improve the decisionmaking process in the majority of cases It is unrealistic to expect patients who are sick and in need of rapid treatment to go to federal court to make sure that their health plans make timely, accurate decisions."); *see also* Hughes v. Blue Cross of N. Cal., 263 Cal. Rptr. 850, 856-57 (Ct. App. 1989) (finding ample evidence that the insurer acted unreasonably in denying benefits); Pappas v. Asbel (*Pappas I*), 724 A.2d 889, 894 n.6 (Pa. 1998) (arguing that Congress was not ignorant of cost-containment procedures utilized by HMOs when it crafted ERISA).

success of insurers' cost-containment efforts to four factors, all of which require a level of control: (1) contracting with cost-conscious providers; (2) establishing an effective network of information about and control over these providers; (3) placing financial risk on providers; and (4) generating a large portion of each provider's patient load.¹¹⁵

Managed care organizations exert this control in various ways, many of which stem from their contractual agreements with providers.¹¹⁶ By limiting coverage to a given set of physicians, managed care organizations ensure that doctors cannot treat their enrollees without being bound to their policies.¹¹⁷ Thus, managed care organizations effectively force physicians to comply with cost-containment practices.¹¹⁸ Capitation payments, salaries and bonuses, fee withholding, without-cause termination, and utilization review are all examples of either direct or indirect control over physicians.¹¹⁹ Short of exclusion from a policy, these forms of control, coupled with physicians' liability risks,¹²⁰ negatively affect morale, relationships with patients, and the ability to provide quality health care.¹²¹

115. Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678, 1682-83 (1995).

116. Legislation passed in the 1980s provided managed care organizations with the right to selectively contract with physicians. Harold S. Luft, *Why Are Physicians So Upset About Managed Care?*, 24 J. HEALTH POL. POL'Y & L. 957, 958-59 (1999).

117. Restriction over patients' choice of physicians varies by type of managed care organization; Health Maintenance Organizations (HMOs) restrict patients to visiting providers contracting with the HMO, whereas Preferred Provider Organizations (PPOs) and Point of Service HMO plans offer higher benefits or lower co-pays to patients who see providers contracting with these plans. Kristin L. Jensen, *Releasing Managed Care's Chokehold on Healthcare Providers*, 16 ANN. HEALTH L. 141, 147 (2007). *But see* Luft, *supra* note 116, at 960-62 (defining a managed care organization as one that controls the number and type of patient services offered, and arguing that PPOs are not part of managed care but are rather a discounted version of a fee-for-service model).

118. *See* Luft, *supra* note 116, at 959 (noting that managed care organizations use their large member enrollment to coerce physicians into signing contracts with cost-containment policies).

119. Talesh, *supra* note 9, at 62; *see also* Richard C.W. Hall, *Legal Precedents Affecting Managed Care: The Physician's Responsibilities to Patients*, 35 PSYCHOSOMATICS 105, 105 (1994) ("[M]anaged health care inserts a layer of control between patient and physician. The physician's motives and duties may become confused and suspect in this new context and relationship.").

120. *See supra* Part II.C.

121. A survey by the New York Medical Society found that 90 percent of physicians change their treatment patterns because of managed care restrictions and 92 percent believe that these restrictions are not in patients' best interests. HEALTH CARE FOR AM. NOW, HEALTH INSURANCE COMPANY ABUSES: HOW THE RELENTLESS DRIVE FOR PROFIT ENDANGERS AMERICANS 7 (2009), available at [http://healthcareforamericanow.org/page/-/documents%](http://healthcareforamericanow.org/page/-/documents%20)

Some managed care contractual provisions control physician behavior directly. For example, without-cause termination clauses allow insurers to exclude physicians from their coverage policies for failure to adhere to a given cost-containment policy. Failure to adhere to a cost-containment policy may be as simple as recommending a treatment to a patient that is not covered by the patient's benefits package.¹²² The American Medical Association ("AMA") has opined, "Physicians can feel a real threat that their patient advocacy will be punished by termination from the plan."¹²³

Other contractual forms of control are less overt but still affect patient care. For example, a physician cannot provide care if an insurer denies coverage for the treatment the physician recommends.¹²⁴ Moreover, the utilization review physicians that managed care organizations employ often have the authority to deny or approve a treating physician's recommendation with little or no role for the treating physician's input.¹²⁵ These physicians have the authority to deny or approve a treating physician's recommendation without ever seeing the patient in question.¹²⁶ Thus, physicians contracting with managed care organizations often feel a loss of control over patient care.¹²⁷

20for%20download/HCAN%20-%20Health%20Insurance%20Company%20Abuses%20-%20Final.pdf.

122. Jensen, *supra* note 117, at 153 (noting that managed care organizations use termination-without-cause clauses to restrict the flow of information between physicians and patients).

123. DIV. PHYSICIAN & PATIENT ADVOCACY, AMA ADVOCACY RES. CTR., PHYSICIAN PRACTICE STRATEGIES: PROTESTING UTILIZATION/MEDICAL NECESSITY DECISIONS 5 (undated), <http://getwell.org/Wihwod/Doc/physstrat.pdf>.

124. See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 204–05 (2004) (noting a managed care organization's drug formulary constrains a physician unless a patient can afford to pay a drug's market price outside of a plan); *Pappas v. Asbel (Pappas I)*, 724 A.2d 889, 890 (Pa. 1998) (noting that the physician was forced to choose between delaying an emergency hospital transfer until the HMO approved his hospital referral, or transferring the patient without approval at his own expense); see also Luft, *supra* note 116, at 963 (noting that managed care organization formularies constrict physicians in the drugs they prescribe).

125. AMA, MODEL MANAGED CARE CONTRACT 42 (4th ed. 2005).

126. See Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, 16 HEALTH AFF. 34, 43 (1997) (noting that "utilization review organizations with high levels of physician control were particularly willing to interfere with practicing physicians' autonomy" (footnote omitted)).

127. Luft, *supra* note 116, at 964 (attributing physicians' negative reaction to managed care to perceptions of loss of control); see also David S. Brody & Pamela Brody, *Managed Care and Physician Burnout*, 5 AM. MED. ASS'N J. ETHICS, Sept. 2003, <http://virtualmentor.ama-assn.org/2003/09/ccas3-0309.html> (noting that managed care organizations often dictate how

Externally imposed control over treating physicians is demeaning¹²⁸ and can lead to “burnout,”¹²⁹ which negatively affects care in pervasive ways. Doctors Brody and Brody define burnout as frustration from managed care policies that results in “emotional and physical exhaustion, a sense of alienation, cynicism, negativism, and detachment to the point that the physician begins to resent work and the people who are associated with it.”¹³⁰ They estimate that up to 40 percent of physicians experience burnout and exhibit a wide range of symptoms, including anger and irritability; excessive complaining; blaming annoyances on external factors; becoming introverted, isolated, and withdrawn; overeating; abusing alcohol or drugs; or experiencing chronic physical symptoms.¹³¹ These symptoms and the underlying frustration that causes them negatively affect patients as well as doctors. Patients of physicians experiencing burnout are less likely to adhere to medications and follow-up appointments.¹³² Finally, physician burnout may actually counteract the purpose of cost-containment policies; physicians exhibiting these symptoms tend to make more referrals and use more outpatient procedures than physicians satisfied with their work arrangements.¹³³

Moreover, physicians themselves report that managed care decreases the quality of care they are able to administer and negatively affects their relationships with patients.¹³⁴ Bottom-line-oriented cost-containment policies have considerable impact on providers in their practice of medicine, and “conflict with the physician’s duty of loyalty to the patient.”¹³⁵ Furthermore, managed care’s effect on physician decisionmaking is so pervasive that it also affects treatment decisions for patients covered by traditional fee-for-service policies.¹³⁶ For example, one study comparing the care

many patients physicians must see per hour, thus controlling even the style of interaction between the physician and patient).

128. See Luft, *supra* note 116, at 962–63 (arguing that a physician’s professional opinion is diminished when managed care organizations require that a nurse or clerk provide preapproval for medical decisions about treatment).

129. Brody & Brody, *supra* note 127.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. Jensen, *supra* note 117, at 148.

136. Under a fee-for-service policy, an insurer reimburses a provider without reviewing the appropriateness of the treatment prescribed.

resulting from managed care as opposed to fee-for-service Medicare beneficiaries found that increases in managed care's overall market share was associated with decreased health care costs for *all* patients, regardless of insurer.¹³⁷ In other words, by subjecting physicians to utilization review oversight, managed care organizations change the way physicians treat patients.¹³⁸ Thus, although cost-containment policies are necessary to curb the unsustainable growth in health care spending, they must be carefully circumscribed to avoid negating the benefit that well-trained physicians bring to health care.

B. Bearing Responsibility for All

Although managed care organizations exert authority over the physician's utilization patterns and exercise discretion in determining which prescribed treatments to cover, the physician ultimately retains all responsibility for the patient's well being. When a patient suffering from the consequences of denied coverage seeks a legal remedy, the physician will inevitably be named as a defendant—with or without the insurer. This disconnect between legal responsibility and actual control illustrates the inherent problem with the different standards of care governing treatment decisions made by practicing physicians and insurers.

The unpredictable and unlikely chance that a beneficiary will recover from an insurer for a wrongful denial of coverage creates tremendous liability risk for the physician who prescribed the treatment. Because ERISA limits beneficiaries' recovery to the cost of benefits denied, harmed patients often sue their treating physicians in tort, even if the harm stemmed from the denial of the very care that the physician had recommended. Furthermore, the Supreme Court's narrow definition of treatment decisions contributes to the frequency with which treating physicians are named as defendants in denial of coverage actions. As discussed, only mixed decisions survive preemption, and avoiding preemption often depends on a finding that the treating physician played a role in the utilization review decision.¹³⁹ A plaintiff is therefore more likely to succeed with a state law claim against an insurer when the claim directly implicates the

137. Laurence C. Baker, *Association of Managed Care Market Share and Health Expenditures for Fee-for-Service Medicare Patients*, 281 JAMA 432, 435 (1999).

138. *See id.* at 436 (hypothesizing that physicians "adopt managed care practice patterns for all their patients").

139. *See supra* Part II.A.

treating physician's actions.¹⁴⁰ In other words, patients may state a negligence claim against their treating physicians, alleging that the failure either to insist on or order a different diagnostic test or specialty referral is the cause of the adverse outcome, rather than the insurer's coverage decision.¹⁴¹

Thus, the ERISA scheme incentivizes wronged beneficiaries to reshape their claim into one relating to the quality of care delivered by the treating physician, rather than the quantity of benefits denied.¹⁴² Case law is replete with examples. In one instance, a patient had knee replacement surgery and then was denied coverage of the post-surgical physical rehabilitation recommended by her orthopedic surgeon.¹⁴³ When her knee failed to recover, she filed a state law claim against the insurer and its utilization review nurse for wrongful denial of benefits.¹⁴⁴ Although she had not sought action against her treating physician, she amended her complaint to preserve her state law claim, naming the physician as an additional defendant when the insurer removed her case to federal court.¹⁴⁵ Suing her treating physician proved to be the only way to do this: the district court dismissed all of the claims against the insurer and remanded the claims against the surgeon to state court for litigation.¹⁴⁶

Furthermore, because of the tremendous expense involved in litigating a preemption dispute, treating physicians are often the *sole* defendant in an action stemming from harm resulting from the denial of coverage.¹⁴⁷ Thus, when an insurer denies coverage of care, the

140. See Agrawal & Hall, *supra* note 8, at 252 ("ERISA is not a bar to suing as long as you can avoid 'pleading into the teeth of ERISA' by taking the 'square peg of a benefits denial case and fitting it into the round hold of a direct liability theory.'" (quoting from the authors' interviews with plaintiffs' lawyers)).

141. David J. Lowe, *Avoiding Liability for HMO Denials*, PHYSICIANS NEWS DIG., Sept. 1997, available at <http://www.physiciansnews.com/law/997lowe.html>.

142. "[S]mart plaintiffs lawyers' are learning how to plead their cases to 'get around ERISA,' by framing almost any scenario as a quality-of-care issue rather than a covered-benefits issue." Agrawal & Hall, *supra* note 8, at 252. Alleging that an insurer negligently denied coverage without acting through a treating physician is considered a claim contesting the *quantity* of benefits provided, and is thus subject to ERISA preemption. See *supra* Part II.A.

143. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1485 (7th Cir. 1996).

144. *Id.*

145. *Id.* at 1485–86.

146. *Id.* at 1484 n.1, 1495 (noting that the district court's remand of the claims against the physician were not appealed, and affirming the district court's dismissal of the claims against the insurer).

147. See, e.g., Agrawal & Hall, *supra* note 8, at 251 (noting that plaintiffs' lawyers report that it is far easier to name a physician than an insurer in a wrongful denial of coverage action).

treating physician could potentially bear all liability. In a landmark managed care preemption case, a patient sued the treating hospital and physician after his insurer denied coverage of appropriate care.¹⁴⁸ The patient arrived at a community hospital emergency room with an epidural abscess.¹⁴⁹ Recognizing the severity of the patient's condition, the physician recommended immediate transfer to a larger hospital with more specialized staff.¹⁵⁰ The patient's insurer, however, denied approval for the transfer, and the consequent delay left the patient paraplegic.¹⁵¹ Although the physician and admitting hospital brought the insurer into the suit, both were forced into settlement after the trial court granted summary judgment against them in their third-party action.¹⁵²

Arguably, allowing treating physicians to be named in tort for failing to successfully contest an insurer's denial of coverage of care appropriately incentivizes a physician to advocate for the patient. The duty that attaches to the physician when the insurer denies coverage, however, is not clearly defined. Consequently, patient care is negatively affected by inefficient attempts to avoid unpredictable liability risks. Without a shift in liability from the provider to the managed care organization for the refusal to cover physician-recommended care, physicians are burdened with a risk that is both uninvited and unavoidable.¹⁵³

148. *Pappas v. Asbel (Pappas II)*, 768 A.2d 1089, 1091 (Pa. 2001).

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.* at 1092 n.2.

153. *Compare Summers v. Touchpoint Health Plan, Inc.*, 749 N.W.2d 182, 186, 197 (Wis. 2008) (finding that denial of coverage of the experimental treatment was arbitrary and actionable when the physician providing the second opinion recommended radiation and chemotherapy because the patient's health plan excluded coverage of clinical trials), *with Emerson v. Med. Mutual of Ohio*, 2004 Ohio App. LEXIS 3512, 2004-Ohio-3892, ¶¶ 20–36 (Ct. App. July 23, 2004) (dismissing all claims against an insurer because the patient's coverage excluded experimental treatments). These cases both involve allegations of wrongful denial of coverage for experimental cancer treatment. The fact that the courts came out differently on whether treatment was covered by the plans' terms indicates that physicians cannot predict when a coverage decision will result in liability, on the part of either the managed care organization or the physician. Although neither patient accepted treatment from the physicians recommending the covered treatment, it cannot be said that had they done so, the treatment would not have been actionable. In *Summers v. Touchpoint Health Plan, Inc.*, 749 N.W.2d 182 (Wis. 2008), the court noted several times that the external review board had concluded that the experimental cancer treatment was, in fact, the standard of care applied to a child. *E.g., id.* at 185. Thus, had Summers accepted treatment from Dr. Maloney and filed suit when radiation

Physicians are not only powerless to reverse denials of coverage but also must take affirmative steps to minimize their own risk. They must invest in both offensive measures to minimize the risk of being sued and defensive measures if they nevertheless end up in court. At a minimum, physicians must formally protest a plan's denial of coverage for medically necessary care, and should formally indicate to their patients how they have done so. The AMA provides physicians with form letters to indicate to a plan and to a patient the physician's disagreement with a plan's denial of coverage or premature hospital discharge.¹⁵⁴ Precautionary measures range from maintaining documentation of every communication made between each patient and each patient's insurer, including a form signed by the patient detailing his understanding of the denial of coverage, to investigating managed care organizations before entering into a contractual relationship as a covered provider.¹⁵⁵ Attorneys instruct physicians to familiarize themselves with circumstances under which a particular insurer is likely to deny coverage. In addition, they counsel doctors to understand the appeal process in advance, to join an insurer's review board, to develop relationships with managed care decisionmakers to reduce the likelihood that coverage for their patients will be denied,¹⁵⁶ to file multiple appeals until reaching a different and more sympathetic claims reviewer, and to submit a colleague's report supporting the recommendation for coverage.¹⁵⁷ Moreover, some attorneys even recommend that physicians refuse to further treat patients who cannot pay out of pocket and are denied coverage for the treatment the physician first recommends.¹⁵⁸

Physicians' inability to minimize the tremendous liability risk they bear for insurers' cost-containment activities directly detracts from patient care. When an insurer refuses to cover medically necessary care, a physician bears an ethical¹⁵⁹ and legal duty¹⁶⁰ to

failed, the physician would have faced liability despite her belief that the patient's coverage excluded treatment involving clinical trials.

154. See DIV. PHYSICIAN & PATIENT ADVOCACY, *supra* note 123, at 3-4 (providing physicians with form letters A-C for these purposes).

155. Lowe, *supra* note 141.

156. *Id.*

157. Hall, *supra* note 119, at 116.

158. *Id.*

159. The AMA imposes an ethical duty on physicians to "advocate for any care . . . [that] will materially benefit their patients." AMA, Code of Ethics Op. E 8.13 (1996).

160. This duty first amounted to a legal duty in *Wickline v. State*, 239 Cal. Rptr. 810, 819 (Ct. App. 1986).

appeal the insurer's decision. Physicians are often liable for their failure to make such an appeal even when a claim against the managed care organization is not preempted.¹⁶¹ Although the physician's ethical duty to appeal a denial of coverage is unavoidable (physicians are ultimately responsible for the patient's care), the legal duty is problematic for three reasons. First, physicians have neither the time nor the legal expertise to interpret the terms of a patient's coverage to determine whether an appeal of a coverage decision is either justified or worthwhile. A physician who does not understand the terms of a plan could waste a great deal of time appealing coverage decisions that are contractually justified. Second, physicians may apply a different standard of care than a plan exercises in making a medical necessity determination (because not all plans apply community standard of care measures when making coverage determinations),¹⁶² and thus cannot necessarily determine when a plan has wrongly denied coverage. Third, physicians burdened by the appeal process reallocate time from providing patient care to filing appeals. When potential liability shifts from physicians to the managed care organization, however, insurers are much more likely to apply medical criteria in making coverage determinations, even if not legally bound to do so.¹⁶³

Physicians face tremendous liability risk for the cost-containment activities of managed care organizations—and yet they are effectively powerless to minimize these activities. By holding managed care organizations to a uniform standard of care in making coverage decisions, physicians could prescribe necessary treatment, file quick and timely appeals of any denial of coverage (if necessary), and move on to treat the next patient, without being preoccupied by the risk of

161. See *James River Corp. v. Bolton*, 14 So.3d 868, 875 (Ala. Civ. App. 2008) (“[I]t would be incumbent upon the doctors treating [the plaintiff], as providers, to appeal the denial of medical treatment.”).

162. Compare *Summers v. Touchpoint Health Plan, Inc.*, 749 N.W.2d 182, 200 n.20 (Wis. 2008) (Roggensack, J., dissenting) (arguing that the standard of care to which the physician is bound is irrelevant to the determination that a policy does or does not cover treatment, and that the majority violated the “primary rule of ERISA-governed plans” in reasoning otherwise), with *Hughes v. Blue Cross of N. Cal.*, 263 Cal. Rptr. 850, 857 (Ct. App. 1989) (“[A] standard of medical necessity significantly at variance with the medical standards of the community . . . frustrat[es] the justified expectations of the insured, [and] is inconsistent with the liberal construction of policy language required by the duty of good faith.”).

163. See *Agrawal & Hall*, *supra* note 8, at 265 (“[T]he need to defend coverage decisions in court has caused health plans to rely more on objective medical criteria that can be documented in the medical literature, rather than on the subjective opinion of medical directors.”).

liability and without fear that the patient is forgoing necessary care. Furthermore, upon a denial of coverage, a physician could recommend and provide an alternate treatment rather than turn the patient away in fear of liability.

Several courts have explicitly pointed to the discrepancy between a physician's actual authority and legal responsibility. For example, the Southern District of New York noted that a plan administrator—after prospectively denying coverage of the prescribed treatment—instructed the beneficiary's physician that, "Regardless of our decision you and the patient have the responsibility for determining the appropriateness of treatment."¹⁶⁴ The Fifth Circuit referred to similar language appearing in a plan's written policy.¹⁶⁵ Requiring precertification for certain procedures, the policy provided that "When reading this booklet, remember that all decisions regarding your medical care are up to you and your doctor."¹⁶⁶ Immediately below this clause, the policy sets forth the monetary penalties that attach for failure to follow the plan's precertification decision.¹⁶⁷

Thus, because managed care organizations exert tremendous authority over the care provided by physicians but escape tort liability in doing so, they assume the ability to control treatment without any of the corresponding responsibility.

IV. STRUCTURING A STANDARD OF CARE TO INCENTIVIZE REASONABLE CARE WITHOUT DETERRING COST-CONTAINMENT ACTIVITIES

The conflicting standards of care that govern the treatment decisions of practicing physicians and insurers are antithetical both to a sense of justice and to the goal of managed care—providing low-cost and high-quality health care. Several commentators and professional organizations have proposed remedial schemes to address ERISA preemption. But none have resulted in change, nor have they addressed the problem as one of irreconcilable liability regimes. This Part does not purport to offer a comprehensive solution, but rather suggests that a first step in reforming managed

164. *Rubin-Schneiderman v. Merit Behavioral Care Corp.*, No. 00 Civ.8101 JSM, 2003 WL 22019833, at *2 (S.D.N.Y. Aug. 27, 2003) (quoting a letter from the doctor who had performed the utilization review).

165. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321, 1323 (5th Cir. 1992).

166. *Id.* (emphasis omitted).

167. *Id.*

care liability is to align the legal standards that govern treatment decisions in *all* phases of care. Section A provides a review of the problems that emerge from the application of two different standards of care to decisions that lead to the same result—the provision or denial of medical care. Section B then reviews three attempts to address these problems, none of which has proven successful. Finally, Section C argues that only by aligning these legal standards can effective reform be initiated.

A. To Treat or Not to Treat: One Decision, Two Standards of Care

The different standards that govern insurers' coverage decisions and practicing physicians' treatments are antithetical both to a basic theory of the law and to the goal of delivering high-quality care at a sustainable cost.

1. *Confusing Causation and Eliminating Deterrence.* Allowing insurers to escape tort liability for wrongful denial of coverage defeats two basic principles of civil liability—that a plaintiff may seek recovery from the party that caused the harm, and that the remedy may deter future wrongs.

First, the gap between the tort and contract theories of liability that are applied to physicians and insurers creates an inconsistency in the legal theories plaintiffs can plead in court. Because harmed patients can seek greater remedies in tort than in contract,¹⁶⁸ they are more likely to sue their physicians for wrongful denials of coverage.¹⁶⁹ The very fact that the law allows a wronged beneficiary to name a treating physician as a defendant is inconsistent with the basic causation principles in tort—the treating physician simply did not cause the patient's harm.¹⁷⁰

Second, and more importantly, applying contract law to utilization review decisions fails to deter negligent coverage denials. Unbound by the professional ethics governing physicians,¹⁷¹ insurers

168. *Payton v. Aetna/US Healthcare*, No. 100440/99, 2000 N.Y. Misc. LEXIS 91, at *7 (Sup. Ct. Mar. 22, 2000) (“[A] recovery in tort may well be greater than a recovery based merely on the contract claim, which may be limited to recovery of the premiums paid . . .”).

169. *See supra* Part II.C.

170. *Wickline v. State*, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (finding that a cost-containment policy is the *proximate cause* of the injury if it *affects physician judgment*).

171. *See Gray, supra* note 126, at 40 (“[E]thical standards are not well established in the managed care industry and devote little or no attention to the problems addressed by the

administering utilization review procedures need explicit incentive to act in the best interest of the patient. Inappropriate denials of coverage are extremely common. In 2007, for example, Blue Cross Blue Shield Association (“BCBS”) and twenty-three of its affiliates agreed to settle allegations of conspiracy to reject or delay claims for medically necessary covered services, among other things.¹⁷² BCBS will pay out over 131 million dollars¹⁷³ and will adopt new contract provisions, including the AMA’s recommended definition of “medical necessity.”¹⁷⁴

In contrast, tort liability would deter managed care organizations from negligently denying coverage of care.¹⁷⁵ Threatened with liability for compensatory and punitive damages, rather than merely the cost of benefits denied, insurers tempted to increase profits through aggressive utilization review would first consider the steep cost of a judgment in tort.¹⁷⁶

2. *Undermining Cost-Containment.* The law’s disparate treatment of insurers and treating physicians is not only antithetical to a basic sense of justice but also to the practical and highly relevant goals of delivering quality care at a reasonable cost.

Managed care organizations contain costs by reducing utilization of health care services.¹⁷⁷ They successfully reduce utilization by

fiduciary ethic, particularly the conflict-of-interest problem and its resolution in favor of the patient.”).

172. See Plaintiffs’ Class Action Complaint at 65–68, *Thomas v. Blue Cross & Blue Shield Ass’n*, No. 03-21296 (S.D. Fla. May 22, 2003) (alleging conspiracy, among other things); Order Approving Settlement Among Certain Blue Parties and Physicians, Physician Groups, and Physician Organizations, Certifying Class, and Directing Entry of Final Judgment, *Love v. Blue Cross & Blue Shield Ass’n*, No. 03-21296 (S.D. Fla. Apr. 19, 2008) (approving settlement of class action complaints).

173. Order Approving Settlement Among Certain Blue Parties and Physicians, Physician Groups, and Physician Organizations, Certifying Class, and Directing Entry of Final Judgment, *supra* note 172, at 5.

174. PRACTICE MGMT. CTR., AMA, HOW THE BLUE CROSS BLUE SHIELD SETTLEMENT AGREEMENT HELPS THE PHYSICIAN PRACTICE (2008), <http://www.ama-assn.org/ama1/pub/upload/mm/368/bcbsflyer.pdf>. Health Care for America NOW provides multiple examples of egregious denials of coverage. See HEALTH CARE FOR AM. NOW, *supra* note 121, at 7 (pointing to eight instances of penalties imposed by state departments of insurance and four examples of state attorney general investigations, all for wrongful denials of coverage).

175. See Agrawal & Hall, *supra* note 8, at 266 (“Liability . . . affects how health plans exercise the discretionary authority they may have to deviate from contractual coverage limitations.”).

176. Noble & Brennan, *supra* note 37, at 300.

177. Baker, *supra* note 137, at 435.

carefully drafting contractual provisions that theoretically eliminate repetitive, unnecessary, or ineffective care.¹⁷⁸ The ERISA preemption scheme, however, incentivizes states to require insurers to provide *more* than a plan's terms, which ultimately defeats the cost-containment purpose of managing health care. For example, in *Aetna Health Inc. v. Davila*,¹⁷⁹ the Supreme Court explicitly stated that ERISA preempts recovery under a Texas law requiring health plans to exercise ordinary care in the administration of benefits *because* “[t]he duties imposed by the [state law] . . . do not arise independently of ERISA or the plan terms.”¹⁸⁰ In other words, the state law could survive preemption only by imposing liability for failure to provide coverage for treatment that was *not* covered by the terms of the plan.¹⁸¹ Thus, for a state law to govern coverage decisions made by employer-sponsored health plans, liability must attach for denial of *extracontractual* benefits. Such legislation, however, would be antithetical to the cost-containment efforts of the managed care movement.

Protecting insurers from tort actions for their wrongful denials of coverage is also deleterious to the quality of managed care. Imposing liability for negligent coverage determinations incentivizes reasonable care in making these determinations¹⁸² and would help reduce tension between the physicians providing care and the insurers challenging their treatment decisions.¹⁸³ Physicians may always share a “collective nostalgia for a simple world of doctors know best,”¹⁸⁴ but they will be far more amenable to industry reform that strongly discourages cost containment that is detrimental to patient care. Imposing a standard of care on insurers would “lead to system-wide improvements”¹⁸⁵ in

178. See, e.g., Danzon & Pauly, *supra* note 20, at 593 (describing the ability of the managed care contract to reduce both moral hazard as well as physician initiated unnecessary care).

179. *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

180. *Id.* at 212–13.

181. *Id.*

182. For a discussion of the deterrent value of managed-care liability for negligent coverage denials, see Arlen & MacLeod, *supra* note 34, at 1968–77.

183. This suggestion assumes that physicians' strong resistance to managed care's assumption of the utilization review function is attributable to the lack of liability attaching to an insurer's denial of coverage that is harmful to patient health. This tension could ease as liability is reallocated. Not all commentators accept this explanation for physician hostility toward managed care. For an excellent argument that physicians reject third-party payer cost-containment efforts for professional reasons, see Richman, *supra* note 24, at 1736–37.

184. *Id.* at 1736 (internal quotation marks omitted).

185. Agrawal & Hall, *supra* note 8, at 270.

overall cost-containment efforts, incentivizing managed care organizations to utilize clinically based standards in making coverage determinations.¹⁸⁶ This would result in better patient care at a lower cost—reflecting the systems-approach to quality improvement promulgated by the Institute of Medicine almost a decade ago.¹⁸⁷

B. Patchwork Proposals

The problems created by ERISA preemption of challenges to denied health care benefits are extensive and entrenched in the legal landscape governing insurers. Both academics and professional associations have proposed potential remedies to the problem, which this Section groups into three categories. These proposals have fallen on deaf ears in Congress. The strengths—and weaknesses—of these proposals are instructive to the effort to align the standards of care governing treatment decisions of insurers and practicing physicians.

1. *Imposing Ethical Standards on Managed Care Organizations.* First, several attempts have been made to impose ethical standards on managed care organizations. This is directly related to aligning the standards of care governing treating physicians and the utilization review boards that scrutinize their recommendations. For example, the American Association of Health Plans promulgated a “Philosophy of Care” mission statement, providing that “patients should have the right care, at the right time, in the right setting.”¹⁸⁸ Ethical standards are also imposed on insurers: the National Committee for Quality Assurance (“NCQA”) created the “Accreditation Standards for Managed Care,” requiring insurers seeking accreditation to adopt a statement of beneficiaries’ rights and responsibilities that includes access to information, available grievance procedures, and confidentiality standards.¹⁸⁹ The NCQA could go even further, requiring insurers—like hospitals—to construct

186. *Id.* (“Managed care organizations might be encouraged to select skilled and careful clinical decisionmakers, supply them with proper information and tools, assign them to areas within their expertise, and monitor their performance.”).

187. Using liability to incentivize managed care organizations to implement systems designed to reduce error would lead to far greater quality improvement in patient care than can be attained through individual physician malpractice liability. *See Noble & Brennan, supra* note 37, at 297 (“[B]y holding the ‘enterprise’ accountable through liability, courts may create an impetus for MCOs to implement systems with patient safety in mind.”).

188. Gray, *supra* note 126, at 40.

189. *Id.* at 39–40 (suggesting that the NCQA make accreditation contingent on the adoption of additional fiduciary language).

financial incentives in such a way that “protects the integrity of clinical decisionmaking.”¹⁹⁰ The Centers for Medicare and Medicaid Services (“CMS”) already imposes a similar standard on the health plans with which it contracts, prohibiting any physician contract from attaching a financial incentive to the reduction or limitation of medically necessary care.¹⁹¹

Although these pledges encourage health plans to at least superficially operate on ethical grounds, they do not impose any real requirements on insurers—and importantly, they do not require the insurer to adhere to the “best interest of the patient,” as treating physicians are required to do.¹⁹² Notably, the law that does impose a legally binding fiduciary duty on insurers—ERISA—does not allow a meaningful remedy to attach when this duty is breached, and has proved to be minimally effective in incentivizing ethical administration of benefits.¹⁹³

2. *Uniform Standards of Care.* A second proposal to remedy the legal vacuum that governs coverage decisions is to impose a uniform standard of care on the processes that managed care organizations follow in making coverage determinations.¹⁹⁴ This approach purposely circumvents plaintiffs’ attempts to apply state tort law to managed care organizations, and instead creates a unique standard to account for insurers’ function in containing costs and allocating resources.

190. The Joint Commission on the Accreditation of Healthcare Organizations imposes this accreditation requirement on hospitals. Scott, *supra* note 48, at 288.

191. *See id.* at 288 n.135 (noting that the Civil Monetary Penalties Law requires that insurers providing benefits to Medicaid or Medicare beneficiaries may only operate physician incentive plans relating to those patients if “[n]o specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services” (alteration in original) (quoting 42 C.F.R. § 417.479 (1998))). Notably, ERISA does *not* preclude insurers from attaching financial incentives to physician utilization of care, but rather requires full disclosure of any such arrangement. *See* *Shea v. Esenstein*, 107 F.3d 625, 629 (8th Cir. 1997) (“When an HMO’s financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA’s fiduciary duties.”).

192. Gray, *supra* note 126, at 39–40.

193. *Pegram v. Herdrich*, 530 U.S. 211, 232 (2000).

194. *See, e.g., Agrawal & Hall, supra* note 8, at 288–89 (suggesting that “the development of a procedural standard of care as a means to assess the conduct of a managed care organization implementing a cost-quality tradeoff through a clinically based coverage determination”).

Dean Agrawal and Professor Hall have set forth a “reasonable” process standard that would exclusively and directly govern utilization review procedures.¹⁹⁵ Under this standard:

A managed care organization would be liable for its share of a patient’s injury caused by an incorrect coverage denial only if the plaintiff proved that the applicable cost containment procedure was (a) not designed to acquire and consider relevant clinical factors or to base coverage determinations on one or more sources of externally developed, scientifically valid, current medical information, or (b) the cost containment procedure otherwise meeting (a) was not implemented substantially according to its own terms, and (c) the coverage determination was the proximate cause of plaintiff’s harm.¹⁹⁶

Others have proposed additional process standards that might directly apply to the utilization review process. For example, the AMA has asserted that the law should require a licensed physician, specialized in the relevant area of medicine, to make a final denial of coverage.¹⁹⁷

A process approach is advantageous because it avoids the pitfalls of tort law. Dean Agrawal and Professor Hall caution against applying the professional medical standard to utilization review processes for several reasons.¹⁹⁸ First, traditional medical malpractice standards of care are generally simplistic and ambiguous—requiring, for example, that a physician apply “ordinary care.”¹⁹⁹ A process-based standard designed explicitly for utilization review, on the other hand, could provide explicit guidelines for avoiding liability.²⁰⁰ Second, a medical standard of care would subject a managed care organization to “[e]xcessive second-guessing of the substance of coverage decisions [which] could over-deter insurers’ socially

195. *Id.* at 292.

196. *Id.* (footnote omitted).

197. *See* DIV. PHYSICIAN & PATIENT ADVOCACY, *supra* note 123, at 5 (“[S]tate law may also require that final adverse determinations be issued by a licensed physician that specializes in the area relevant to the requested service or treatment.”).

198. Agrawal & Hall, *supra* note 8, at 285.

199. *Id.* at 297–98.

200. *See id.* at 298 (“A process standard would hold managed care organizations liable for consequential personal injury if, in determining health insurance coverage based on medical criteria, they use a procedure that is not designed to acquire and consider relevant clinical factors, or if they depart materially from normal procedures without adequate justification.”).

beneficial efforts to contain costs.”²⁰¹ Thus, a process-based standard imposes liability for wrongful or negligent coverage denials, but affords managed care organizations “reasonable leeway to respond in good faith to unusual situations by deviating from normal procedures when . . . appropriate,” so long as the elements of the standard are met.²⁰²

3. *Enhancing Patient Rights.* Finally, a third type of remedy to minimize the wrongful denial of coverage empowers patients to advocate for themselves. First, insurers can be required to implement and adhere to better appeal processes so that patients may effectively contest coverage decisions. Second, insurers can be required to use unambiguous language in enrollment applications so that potential beneficiaries can select the plan that best approximates their anticipated health care needs.

Insurers managing ERISA health plans are already subject to relatively stringent appeal processes requirements, which helps ensure that negligent coverage denials are at least reviewed in a timely manner, if not reversed.²⁰³ Furthermore, most states require that health plans allow beneficiaries to challenge a coverage denial in an external review process.²⁰⁴ Because the Supreme Court has ruled that ERISA does not preempt state laws governing review processes, all health plans operating in these states are subject to external review requirements.²⁰⁵ The AMA’s Model Managed Care Contract advocates that health plans themselves should provide that coverage denials will be eligible for due process review by independent peers.²⁰⁶

Requiring insurers to use plain language terms in their policies would allow applicants to enroll in the plan that is most likely to

201. *Id.* at 298; *see also id.* at 287, 295 (noting that a managed care organization should not be held liable for honest differences of opinion when it chooses the less protective of two or more professionally justifiable courses of action, because in this situation the managed care organization is making a *resource* decision rather than a *treatment* decision).

202. *Id.* at 293–94.

203. The Department of Labor’s Employee Benefits Security Administration promulgated these rules. For a description of the requirements placed upon insurers to ensure a timely appeal process, *see* AMA, *supra* note 125, at 43–44.

204. *Id.* at 44.

205. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 355 (2002).

206. *See* AMA, *supra* note 125, at 44 (“Section 5.2 of the AMA Model Managed Care Contract requires that adverse decisions relating to medical necessity or coverage are subject to a due process review that is ultimately decided by independent peers, rather than by the MCO in its sole discretion.”).

cover potential health care costs.²⁰⁷ More importantly—because it is impossible for beneficiaries to predict future treatment needs—clear contractual language would deter plans from arbitrarily denying coverage.

C. Starting with the Basics: Aligning Liability

Health care reform that focuses on expanding coverage and reducing costs will have deleterious effects on quality of care unless it is coupled with managed care liability reform. Recovery in tort is more meaningful to wronged beneficiaries than is recovery in contract,²⁰⁸ and—absent preemption—insurers can be subject to tort despite their contractual relationship with beneficiaries.²⁰⁹ The problem, then, is that ERISA's extensive preemption regime obstructs the majority of these legal actions. The above proposals provide piecemeal approaches to imposing responsibility for coverage decisions, but they have not resulted in any legal change. The ultimate solution will require Congress to address a fundamental discrepancy in health law: physicians and insurers both face legal risk that is inversely related to the control they yield over the ultimate course of treatment administered to each patient.

This Section argues that aligning the standards of care such that the same standards apply to *all* treatment decisions—those made by practicing *and* reviewing physicians—should be the foundation for much-needed legal reform. This Section must begin with an important caveat: aligning the standards of care governing those who make treatment decisions does *not* require expanding tort liability. Indeed, medical malpractice actions have unnecessarily complicated the

207. Several bills currently under consideration promulgate such an approach. For example, both the Senate HELP Committee Affordable Health Choices Act and the Senate Finance Committee America's Healthy Future Act of 2009 would create a minimum "essential health care benefits package" and require all health plans to offer the package. HENRY J. KAISER FAMILY FOUND., *supra* note 12, at 19 (comparing the various congressional health reform measures on a continually updated basis).

208. *Payton v. Aetna/US Healthcare*, No. 100440/99, 2000 N.Y. Misc. LEXIS 91, at *7 (Sup. Ct. Mar. 22, 2000) ("[A] recovery in tort may well be greater than a recovery based merely on the contract claim, which may be limited to recovery of the premiums paid . . .").

209. *Id.* ("A legal duty independent of contractual obligations may be imposed by law as an incident to the parties' relationship. Certain professionals . . . may be found subject to tort liability for failure to exercise reasonable care, irrespective of their contractual duties. . . . In these instances, it is policy, not the parties' contract, that gives rise to a duty of [] care." (alterations in original) (quoting *Sommer v. Fed. Signal Corp.*, 593 N.E.2d 1365, 1369 (N.Y. 1992))).

practice of medicine, and medical experts have heralded tort reform for over three decades.²¹⁰ Given the failure of the tort reform movement to accomplish substantive change, however, and the stagnancy of the movement toward enterprise liability,²¹¹ this Section assumes that Congress is more likely to subject insurers to tort than physicians to contract. Holding physicians liable in tort does not improve quality of care,²¹² but a call for tort reform is far beyond the scope of this Note. This Note's discussion of tort liability is limited to the discrepancy in liability risk that treating and utilization review physicians face. This inconsistency has created problems that are too substantial to set aside in the hopes that tort reform will transpire. Thus, this Section asserts that utilization review physicians must be subject to the same standards of care as treating physicians, but does *not* purport to tout tort as a model—or even adequate—remedy for adverse medical outcomes.

Despite the problems that tort liability presents, many of its standards can be easily applied to insurers to incentivize reasonable utilization review processes without deterring cost containment. The AMA's Model Managed Care Contract promulgates a definition of medical necessity for utilization review that would align with the definition to which physicians are held in making treatment recommendations.²¹³ Attaching actual liability to this standard could

210. See, e.g., Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 504 (2004) (“Tort reform [began in the late 1970s and] continued in the 1980’s and the 1990’s . . .”); Bill Bradley, Editorial, *Tax Reform’s Lesson for Health Care Reform*, N.Y. TIMES, Aug. 30, 2009, § 4 (Week in Review), at 9 (noting that medical malpractice reform has been a constant in congressional debates since the early 1980s).

211. See Arlen & MacLeod, *supra* note 34, at 1933 (“[Enterprise] liability is essential to the provision of optimal medical care . . .”).

212. See, e.g., COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 109–11 (Linda T. Krohn, et al. eds., 2000) (arguing that the medical malpractice liability regime discourages reporting of error and thus inhibits quality control efforts); James Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*, 11 ANN. HEALTH L. 125 (2002) (noting that improving quality of care requires a systems approach to medicine which is incompatible with the tort-based malpractice system).

213. Under the AMA's model contract, an insurer would have to approve coverage for: “Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of

incentivize the exercise of reasonable caution in denying coverage,²¹⁴ as well as the administration of an expedient and responsive internal appeal process to address denials of coverage.²¹⁵ These benefits are realized even when actual litigation remains minimal, suggesting that the threat of liability need not significantly increase costs for insurers.²¹⁶

Tort liability may deter negligent coverage denials, but it must be strictly limited. Imposing unlimited liability, or creating liability risk even when coverage is properly denied, could deter managed care entities from implementing any cost-containment policies at all.²¹⁷ Thus, the application of tort to managed care entities must be limited in three critical ways. First, liability cannot attach when coverage is unambiguously excluded under the terms of the policy. Second, cost-effectiveness research must be admissible as evidence that a contested coverage decision was reasonable under a cost-containment policy. Third, damages for the wrongful denial of coverage must be capped.

First, liability cannot attach when a policy's terms unambiguously exclude coverage. Dean Agrawal and Professor Hall have argued extensively for managed care liability reform, but caution that "failure to grant [contractual] exceptions should not be the basis for personal injury liability. Tort suits should not become vehicles for rewriting coverage documents that are clear and precise."²¹⁸ The concern that a minimum standard of liability would lead to coverage

the patient, treating physician, or other health care provider." AMA, *supra* note 125, at 42. The AMA has repeatedly filed amicus briefs in ERISA preemption litigation arguing that questions of coverage for medically necessary care must be left to regulation by state malpractice law. *E.g.*, *Aetna Health Inc. v. Davila*, 542 U.S. 200, 203 (2004); *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 331 (2003); *Cicio v. Does*, 385 F.3d 156, 157 (2d Cir. 2004) (*per curiam*).

214. Interviews with health plan managers and attorneys suggest that the threat of tort liability effectively deters negligent denials of coverage. *See* Agrawal & Hall, *supra* note 8, at 264–65 (noting that plan managers and attorneys report that although the current threat of liability is not a major "driver of behavior or change," it is "'on the back of their minds' when making coverage decisions" and can cause them "to exercise 'a lot more caution' in denying coverage," including consulting "outside expert[s] to back up" coverage determinations).

215. Patient advocates note that plans have become "more attentive to coverage disputes" since states began passing right-to-sue laws, even though ERISA preempts the application of these laws to employer-sponsored plans. *Id.* at 264–65.

216. For example, plan managers and attorneys note that state right-to-sue laws have affected their practices but have not actually significantly increased litigation. *Id.* at 266.

217. For an argument that *any* application of tort to insurers would deter cost-containment, see generally Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUDIES 491 (1997). This Section proposes that appropriate limitations on liability would address the concerns that Danzon raises.

218. Agrawal & Hall, *supra* note 8, at 279.

approval of extracontractual treatment—out of fear of liability²¹⁹—is unfounded. When a treatment is unambiguously excluded from coverage, a health plan will not face liability for denying coverage,²²⁰ nor would a managed care organization face liability for terminating coverage upon expiration of a contract.²²¹ Even when contractual protections do not apply—that is, when a coverage denial is based on a finding that care is not medically necessary²²²—the threat of liability will not pressure managed care organizations to approve all requests. The sheer size of managed care organizations allows for prediction and spreading of risk that allows for fewer defensive mechanisms than physicians utilize.²²³

A second critical limitation on managed-care liability is that cost-effectiveness research must be admissible in court to defend cost-containment policies when challenged. Cost-effectiveness research allows insurers (or any entity trying to achieve cost containment) to measure the degree to which a new treatment provides either added benefit or lower cost.²²⁴ For example, in France, no treatment or drug is covered unless it serves one of these purposes.²²⁵ Managed care

219. *See id.* at 266 (“[D]ue to liability concerns, health plans are more willing to settle coverage disputes ‘extra-contractually,’ that is, agree to pay for something they believe is not covered by the insurance policy, especially where the patient has already incurred the cost at his physician’s recommendation.”).

220. *See* *Emerson v. Med. Mut. of Ohio*, 2004 Ohio App. LEXIS 3512, 2004-Ohio-3892, at ¶ 23 (Ct. App. July 23, 2004) (“[The] treatment was experimental/investigative as defined in the clear and unambiguous terms of the HMO Health Ohio policy, and, therefore, it was not covered.”).

221. Agrawal & Hall, *supra* note 8, at 283 (noting that when a contract expires, the physician or hospital may be liable for failing to continue to provide care according to the applicable standard to which they are bound, whereas the managed care organization would not face liability); *see also* *Muse v. Charter Hosp. of Winston-Salem, Inc.*, 452 S.E.2d 589, 595 (N.C. Ct. App. 1995) (holding a hospital liable for discharging a suicidal patient upon expiration of his insurance when it was contrary to his physician’s opinion).

222. Agrawal & Hall, *supra* note 8, at 279 (noting that liability may attach for coverage determinations that hinge on judgments of whether a treatment is “medically necessary, non-experimental, non-custodial [or] non-cosmetic”).

223. *Id.* at 270–71 (arguing that because of this ability to predict and spread risk, managed-care liability would likely not result in the defensive approval of claims in the way that physician liability results in the defensive practice of medicine).

224. LISA ROCHAIX & BERTRAND XERRI, COMMONWEALTH FUND, NATIONAL AUTHORITY FOR HEALTH: FRANCE 4–5 (2009), <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Jul/National-Authority-for-Health-France.aspx>.

225. *Id.* at 1. The same is true in many high-income nations. *See, e.g.*, David A. Henry, Suzanne R. Hill & Anthony Harris, *Drug Prices and Value for Money: The Australian Pharmaceutical Benefits Scheme*, 294 JAMA 2630, 2630–32 (2005) (describing the efficacy and comparative cost-effectiveness analyses applied in the United Kingdom and Australia).

organizations could use cost-effectiveness research to design and implement far more effective cost-containment policies without jeopardizing the health of beneficiaries. Managed care organizations rarely use this type of research, however, possibly because its validity in courts is widely unknown.²²⁶ Because courts have not traditionally dealt with cost-effectiveness research,²²⁷ legislation creating a uniform standard of care would have to expressly provide for the admissibility of this evidence.

Finally, managed-care liability for actions against coverage determinations must be subject to federally imposed damage caps.²²⁸ Absence of caps in states with right-to-sue laws has resulted in very large (albeit few) punitive awards against managed care organizations.²²⁹ Although managed care organizations are extremely profitable businesses, verdicts that would sink profits would deter health plan administrators from exercising any cost-containment policies whatsoever.²³⁰

With these limitations in place, subjecting managed care organizations to the same tort liability as physicians would not deter beneficial cost-containment activity. Imposing liability for the negligent denial of coverage imposes a financial burden on managed care organizations *only* when care is wrongfully withheld. Thus, managed care organizations that effectively administer cost-containment policies will experience minimal threat of liability; the only plans that would experience financial threat are those that wrongfully withhold coverage. In other words, this liability scheme would only hurt those plans that do not benefit the health care market. Therefore, contrary to the allegation that managed care

226. Clark C. Havighurst et al., *Evidence: Its Meanings in Health Care and in Law*, 26 J. HEALTH POL. POL'Y & L. 195, 206 (2001).

227. *See id.* at 198 (discussing the “little health care litigation that explicitly involve[s] the application of [cost-effectiveness analysis]”).

228. Damage caps may be particularly necessary in the managed care arena because of society’s negative view of managed care organizations, which is apparent even in judicial opinions. *See, e.g.*, Agrawal & Hall, *supra* note 8, at 238 n.12 (“Not even the judiciary is immune from negative views of managed care organizations. . . . [Defendant insurer] behaved like the stereotypical HMO, with a beady eye on the bottom line and stony indifference to patient welfare.” (quoting *Wagner v. Magellan Health Servs., Inc.*, 125 F. Supp. 2d 302, 304 (N.D. Ill. 2000))).

229. *See id.* at 240 n.16 (noting that verdicts against managed care organizations ranged from 51 to 120 million dollars).

230. *See id.* at 271 (“The managed care industry . . . cannot serve the resource allocation mission assigned to it by society . . . if ERISA preemption were lifted entirely and massive punitive awards became commonplace.”).

liability would increase consumer costs,²³¹ liability would drive up premiums only for those plans facing greater risk because of negligent administration of cost-containment policies.²³² A minimal standard of care would thus improve competition in the coverage market without increasing consumer costs.²³³

Moreover, there is no evidence to suggest that a minimum standard of care for coverage decisions would expose managed care organizations to tremendous amounts of litigation. In fact, states with right-to-sue laws have *not* experienced marked increases in the number of suits filed against managed care organizations.²³⁴ This may be due in part to plaintiffs' fear of facing an ERISA preemption challenge,²³⁵ but the absence of an abundance of suits against nonemployer-sponsored plans suggests that this fear is not the only factor keeping plaintiffs out of the courts. Furthermore, it is not litigation itself, but rather the threat of liability, that serves as a deterrent to negligent denials of coverage.²³⁶

CONCLUSION

As health care costs become prohibitive, managed care organizations must increasingly perform the utilization review role traditionally reserved for treating physicians. Shifting this task from physician to insurer allows for effective cost containment, but subjects

231. See Noble & Brennan, *supra* note 37, at 298 (“Likely adaptations [to increased liability] include an increase in premiums or a curtailment in benefits to cover the projected costs of litigation.”).

232. Furthermore, courts have *explicitly* rejected the argument that the danger of increasing consumer costs is a defense to liability. See *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756, 764 (Ill. 1999) (“We disagree with [the defendant-HMO] that the cost-containment role of HMOs entitles them to special consideration. The principle that organizations are accountable for their tortious actions . . . is fundamental to our justice system. There is no exception to this principle for HMOs.”).

233. See Noble & Brennan, *supra* note 37, at 300 (noting that most managed care organizations, if acting as “rational economic players,” would avoid significant increases in premiums, “either by modifying their managed care techniques to promote quality or by eliminating them”).

234. See Agrawal & Hall, *supra* note 8, at 275 (“To date, however, there is no evidence of the much ballyhooed ‘flood of litigation’ that was predicted . . .”).

235. See *id.* at 277 (“Uncertainty about ERISA is [one] reason for the absence of state litigation under the right-to-sue laws.”).

236. See, e.g., *id.* at 266 (noting that a health care plan “reviewed and improved its processes when a managed care liability statute was first enacted in the state because it originally thought the statute would produce a lot of litigation. The changes *remain in place, even though little litigation has ensued.*” (emphasis added)).

the delivery of care to a second layer of decisionmaking that impacts patient outcomes in the same manner as conventional medicine. The discrepancy in liability that attaches to treating and utilization review physicians has created two incompatible legal standards for the delivery of care.

Extensive federal preemption has created a shield of legal protection for employer-sponsored health plans. Potentially liable only for the cost of benefits denied, insurers avoid tremendous legal risk that would attach under state law—and that does attach to affiliated treating physicians. Moreover, these insurers—in efforts to achieve cost containment—exert considerable control over physicians. Thus, the incongruity between provider and managed-care liability has created a system of health care delivery in which only the treating physician is subject to externally imposed restraint and legal risk.

Managed-care liability reform is critical not only to providing wronged beneficiaries with adequate remedies and to incentivizing reasonable care in coverage denials, but also to alleviating physicians of the legal responsibility arising from insurer conduct. Legislators could spur this reform simply by aligning the standards governing the two parties that bear tremendous control over the delivery of care.