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Abstract

Managed care organizations (MCOs), as insurance entities, should be liable under contract for inappropriate denial of coverage, whereas treatment errors should be conventional malpractice claims against physicians. Most MCOs are loose networks of independent practices that lack the requisite information or technology to improve care. Holding such MCOs vicariously liable for their physicians' negligence would lead to increased “false positive” claims and distort deterrence. Integrated MCOs already contractually assume responsibility for the negligence of their salaried physicians, which appears to be efficient. Maintaining the distinction between medical error and coverage denial requires that treatment decisions be evaluated relative to a standard of care that recognizes common MCO control strategies. Class actions against MCOs are based on the false premise that MCO cost control strategies harm patients. Charges that enrollees were led to expect more coverage than they actually received imply, if true, that HMOs should have realized supernormal profits, for which there is no evidence.

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COMMENTS ON "THE ASSAULT ON MANAGED CARE: VICARIOUS LIABILITY, ERISA PREEMPTION, AND CLASS ACTIONS"

PATRICIA DANZON and FRANK SLOAN*

ABSTRACT

Managed care organizations (MCOs), as insurance entities, should be liable under contract for inappropriate denial of coverage, whereas treatment errors should be conventional malpractice claims against physicians. Most MCOs are loose networks of independent practices that lack the requisite information or technology to improve care. Holding such MCOs vicariously liable for their physicians' negligence would lead to increased "false positive" claims and distort deterrence. Integrated MCOs already contractually assume responsibility for the negligence of their salaried physicians, which appears to be efficient. Maintaining the distinction between medical error and coverage denial requires that treatment decisions be evaluated relative to a standard of care that recognizes common MCO control strategies. Class actions against MCOs are based on the false premise that MCO cost control strategies harm patients. Charges that enrollees were led to expect more coverage than they actually received imply, if true, that HMOs should have realized supernormal profits, for which there is no evidence.

RICHARD EPSTEIN and Alan Sykes provide a very useful summary of the current state of the law and legal issues related to managed care organization (MCO) liability in tort and contract, the Employee Retirement and Income Security Act (ERISA) preemption, recent class action suits, and patients' bill of rights legislation.¹ After describing these developments, most of the paper is devoted to a careful analysis of recent and proposed legislative changes and judicial interpretations. They focus on (1) imposing vicarious liability on MCOs for the malpractice of affiliated physicians, (2) introducing a new remedy for wrongful denial of coverage in addition to or in lieu of the existing civil enforcement action under ERISA, and (3) restrictions on contracting between MCOs and their physicians or subscribers, including prohibitions

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¹ Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, in this issue, at 625.

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of indemnification and retaliation or waiver of statutory duties. They conclude with a detailed analysis of class action suits, both costs and benefits of such litigation in general and as applied to MCOs.

With some relatively minor quibbles, detailed below, we concur with the authors' basic conclusions. Some of our comments are already reflected in the published version of their paper. Our comments here focus on the positive analysis of implementing these proposals in practice and on the likely effects of alternative legal rules on health care systems.

VICARIOUS LIABILITY

On the issue of vicarious liability, Epstein and Sykes conclude that MCOs should be liable under contract for denial of coverage but, in general, MCOs should not be subject to vicarious liability for negligent care by contracted providers. As managed care organizations, MCOs ideally would possess excellent information systems for tracking practice patterns of individual physicians and medical errors, and practice patterns would be guided by evidence from randomized controlled trials. Their decision-making systems would be sufficiently sensitive to patient heterogeneity in clinical condition and in preferences.

In practice, however, managed care to date has amounted to much less than this. If imposing vicarious liability on such organizations would encourage MCOs to implement such systems, it might be worthwhile, but invention precedes innovation, and many of the requisite inventions to really improve efficient provision of care in multipractice or network settings do not exist.

An MCO is a risk-bearing insurance entity that designs coverage, sets premiums, and negotiates with providers, who agree to accept discounted fees or capitation in return for being in the preferred network. The predominant, network-type MCO lacks the information and the authority that would be necessary to monitor and guide providers' care patterns on a day-to-day basis. Most MCOs—*independent practice association (IPA)* and *point-of-service (POS)* model HMOs and preferred provider organizations (PPOs)—are set up as networks of providers who practice individually or in groups across a broad geographic area that spans the MCO's coverage area. Even with the growth of MCOs, most individual physicians still practice on a fee-for-service, albeit discounted fee-for-service, basis. The typical physician or physician group contracts with several networks, making it highly impractical for a single MCO to dictate an individual's practice style. Market shares of truly vertically integrated MCOs—those that employ exclusive, salaried physicians who practice in designated clinics—have been declining as the less vertically integrated variants have expanded, perhaps in part because such integration has not delivered on its promises and/or consumers want complete choice of provider.

In fact, the integrated variants have already contractually assumed responsibility for the negligence of their salaried physicians, which seems appropriate. By contrast, in the case of network models, concern to create incentives for deterrence while minimizing transactions costs argues for generally placing liability for negligence on physicians, who are best placed to make appropriate care decisions. Placing vicarious liability on the MCO might lead MCOs to try to assert more control over physicians without having the requisite information or technology for truly improving care. Thus, given the imperfect "real" world in which medicine is practiced, the market appears to be already providing for efficient assignment of liability, depending on other elements of the contractual relation between physicians and the institutions that they relate to—either HMOs or hospitals (for example, peer review). There is no obvious efficiency reason for courts or legislatures to interfere with this contractual assignment, by forcing vicarious liability on MCOs of all stripes. This might be done for political reasons, however, as public sentiment for "MCO bashing" aligns with provider self-interest.

Another potential shortcoming for making MCOs vicariously liable is that this might lead to blame shifting. If MCOs can be named as codefendants, with joint and several liability, the physician defendant's optimal strategy might be to support the plaintiff's case, implicitly or explicitly, arguing that the patient could or should have had better care but that this was precluded by the various constraints imposed by the MCO. Physicians would often be in a position to shift liability to the MCO because, at the end of the day, physicians are viewed as the experts when it comes to defining appropriate care. Another view, one that we share, is that physicians bear some responsibility in contracting with "rogue" organizations. If the organization is not one with which he or she feels comfortable, a physician is under no obligation to contract with it. This consideration is particularly relevant in major metropolitan areas where there are many MCOs among which physicians and patients can choose. The first-line safeguard of quality is physicians' and patients' free ability to select among competitor health plans.

Organized medicine has been on both sides of the fence on the vicarious liability issue. On the one hand, there is the deep-pocket issue. People may not want to sue their physicians, with whom they have a personal relationship. However, suing a "big HMO" is another matter. Thus, frequency of suits may rise. On the other hand, it seems to view anything bad for MCOs as a good thing.

This turns out to be a complicated issue. Even in the case of multiple physician or hospital defendants, adding additional defendants tends to increase the size of the award, plausibly because these multiple defendants serve the patient's case in trying to shift liability between themselves.² This

² Patricia M. Danzon & Lee A. Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. Legal Stud. 345 (1983). Randall R. Bovbjerg *et al.*, *Juries and Justice:*

effect would surely extend to an increased probability of winning in cases where the codefendant is an MCO, because the physician could point to reimbursement rules and protocols as limiting what could be done. This is surely an easier argument to develop and a more persuasive one to juries than trying to find some clinical error of judgment of a codefendant, as in the standard multiple-defendant case. Whether securing a new deep pocket is socially optimal or not depends in part on whether or not there is under- or overclaiming prior to the change and on whether the resulting decisions reflect an appropriate standard of care and coverage. If anything, as discussed further below, there is evidence of underclaiming (false negatives) rather than overclaiming (false positives) for injuries caused by physician negligence.³ However, it is far from certain that adding the potential to sue HMOs will, on balance, reduce the false negatives more than it increases the false positives. And if medical error claims are generally converted into coverage claims, it is far from certain that the resulting norms will be sound.

LIABILITY FOR WRONGFUL DENIAL OF COVERAGE

As discussed by Epstein and Sykes, because of the ERISA preemption, which applies to the vast majority of privately insured individuals, MCO enrollees are largely limited to a civil enforcement action under ERISA when they seek redress of denial of benefits by the MCOs. This means that plaintiffs are not entitled to recovery for their economic and noneconomic losses as under tort. Rather, such disputes are limited to reinstatement of the denied benefit.

Although lack of ability to recover damages would seem to encourage plans to deny benefits, Epstein and Sykes make some good points that, because of other constraints, the plans are unlikely to do this. For example, disgruntled employees, facing denials, will complain about this to their employers, encouraging the firm to drop the plan from its options. Or the employee can exercise his or her option to exit at the next open-enrollment period. The bedrock safeguard of patients' rights in the end is the market, not the legal system. Also, employee groups should have the option of contracting away certain benefits with the proviso that they reap the savings in some form, such as higher wages and/or more fringe benefits.

With recoveries being potentially much larger for conventional tort claims for medical errors than for denial of coverage, it seems likely that plaintiffs will want to convert the latter case types into the former. The distinction between errors in treatment, which should be handled as conventional claims of malpractice against physicians, and denial of coverage, which should be

Are Malpractice and Other Personal Injuries Created Equal? 54 Law & Contemp. Probs. 5 (1991).

³ See note 12 *infra*.

contract cases against MCOs, is fundamental to the arguments in Epstein and Sykes's paper and this comment.⁴

However, whether this distinction can be made in practice is a key issue, in order to respond to those who argue that in fact physicians' treatment decisions are so influenced by the financial and other constraints imposed by MCOs that MCOs must be viewed as participants in the treatment decision. If most allegations of improper treatment can be reasonably transposed into claims of improper denial of coverage—that a physician would have treated the patient differently were it not for the MCO's constraints—then the case against vicarious liability is weak, conceptually and in practice.

This conceptual distinction between medical error and coverage denial should be clear in egregious cases of errors of commission, such as amputating the wrong leg. But these cases are surely very rare. Much more common are errors of judgment or errors of diagnosis, sometimes due to not spending enough time with the patient, not having backup personnel, and so forth. In such cases, there may be no explicit coverage decision by the MCO, but the physician/providers may be responding to the financial incentives created by capitation, risk pools for referrals, and so forth. (although most physicians, especially specialists, are not currently subject to these incentives),⁵ and/or hassles of dealing with utilization reviewers.

Does this mean that the coverage/treatment dichotomy breaks down and the case against vicarious liability dissolves? We think not, provided that treatment decisions are evaluated relative to a new standard of care, which recognizes the legitimacy of standard MCO control strategies such as provider risk sharing, in the situations in which such incentives apply, not relative to the old indemnity standard. Of course, defining this new standard is not easy, particularly during a time of flux. Emerging new standards of care reflect not only new forms of insurance coverage but also new information on effectiveness/cost-effectiveness of treatments. The evolution of these new norms will be determined in part by legal constraints. Already, in response to the legal and public opinion backlash, some major MCOs are reducing or eliminating their use of direct controls and protocols, which makes coverage decisions explicit, resorting instead to placing incentives on physicians.⁶ This blurs the coverage/treatment decision. It may also be one reason why physicians are now supporting MCO liability.

⁴ See also Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?* 26 *J. Legal Stud.* 491 (1997).

⁵ Marsha Gold, *Financial Incentives: Current Realities and Challenges for Physicians*, 14 *J. Gen. Internal Med.* S6 (1999).

⁶ Center for Studying Health System Change, *Providing Insights That Contribute to Better Health Policy* (1999) (annual report).

LIMITATIONS ON CONTRACTS WITH MANAGED CARE ORGANIZATIONS

In recent years, under the guise of patient protection, state legislatures have enacted various legal rules with the ostensible purpose of helping the public. These include anti-indemnification rules, antiretaliation rules, and antiwaiver rules. Anti-indemnification rules prohibit an MCO from collecting indemnity from physicians after the MCO has been found liable. The rationale for such prohibitions is asymmetric bargaining power between MCOs and physicians.

Here we are in total agreement with Epstein and Sykes. An indemnification clause is only one of many elements of the contract between a plan and a physician. To the extent that doctors dislike such clauses, they can choose not to contract with the MCO or demand higher compensation. This assumes, of course, that MCOs in a market do not collude in setting terms of contracts with doctors. The appropriate remedy for exercise of market power is the use of antitrust laws, not implementation of multiple rules, which are Band-Aids.

For antiretaliation rules, as Epstein and Sykes note, the basic question is adequacy of remedies for wrongful denial of coverage rather than whether an antiretaliation rule is implemented. We might add that an MCO that gets a reputation for retaliating against its physicians for providing professional advice about the benefits versus costs of procedures will ultimately have to pay its doctors more. Thus, it is likely to be in the MCO's business interest to limit the number of retaliatory measures in which physician judgment was clearly poor. We totally agree with Epstein and Sykes that broad statutes limiting MCOs' ability to retaliate may unduly constrain the MCOs in dealing with "bad apple" physicians.

We also are not very sympathetic to antiwaiver rules. An employee or employer group may be willing to relinquish its tort rights in return for a lower premium, and the law should not ban such transactions outright. On the other hand, there should be a quid pro quo, not just a giveaway to an MCO. Also, waivers signed by patients at the point of service are questionable, especially if nothing is given in return.

CLASS ACTIONS

Class actions are a more recent mode of legal attack on MCOs but are based on the same false premise, that cost control strategies harm patients. This is a blatant case of "Look Mom, no empirical evidence" (but plenty of anecdotes). The empirical evidence overall does not indicate that quality of care is worse in MCOs than that delivered by indemnity plans.⁷ Similar

⁷ Robert H. Miller & Harold S. Luft, Does Managed Care Lead to Better or Worse Quality of Care? 16 Health Aff. 7 (1997).

objections apply to the class action allegations as to the vicarious liability tack. Epstein and Sykes make a strong legal case against class certification. In addition, the charges are surely absurd on economic grounds. The plaintiffs' argument, explicit or implicit, reduces to the charge that MCO enrollees were charged too much, presumably because they were misled into expecting a higher quality of coverage than the plans actually delivered. This was allegedly possible because enrollees were expecting standard norms of care, whereas in fact MCOs use various supply-side strategies to control costs, including utilization review by administrative personnel, as described by Epstein and Sykes. If it is true that enrollees were led to expect systematically more coverage than they actually received, then either the offending HMOs would have realized supernormal profits during the period of the alleged overcharging or rapid entry would have occurred to bid away the excess expected profit or both. More technically, a profit margin, or the types of other margins that are typically used to give support to the notion of excess profitability, is an inadequate indicator of profitability. Furthermore, profit (underwriting) cycles in the insurance industry are a well-known characteristic of this sector.⁸ If profits are artificially limited at the high end of a profit cycle, such insurers will not earn a competitive, risk-adjusted rate of return and will exit (which might suit many observers, including physicians whose incomes have been reduced by managed care, just fine).

QUIBBLES

Although we are in general agreement with Epstein and Sykes, we end with some differences of opinion. First, the case for allocating liability for coverage decisions to MCOs and liability for negligent practice to providers rests on the assumption that it is possible to distinguish between the insurance function, which finances care, and the provision or delivery of the care itself. Given this, it is confusing to refer to MCOs as providers, as in "third-party providers," or to say that MCOs "contract with employers and occasionally with individuals to provide a bundle of health care services for a predetermined fee."⁹ More precisely, MCOs contract to provide insurance coverage for covered services, conditional on the enrollee getting those services from specified providers of care and subject to certain reviews of appropriateness. Thus, the conventional usage, which refers to MCOs and other insuring entities as insurers or "payers," is worth retaining here, whereas "providers" refers to hospitals, physicians, and others who deliver medical care.

This may be hairsplitting, but it may help maintain the conceptual distinction between the insurance function and the care delivery function, which

⁸ Ralph A. Winter, *The Liability Crisis and the Dynamics of Competitive Insurance Markets*, 5 Yale J. on Reg. 455 (1988).

⁹ Epstein & Sykes, *supra* note 1, at 627.

is fundamental to the case for splitting liability. Similarly, Epstein and Sykes refer to MCOs as “denying treatment to subscribers,”¹⁰ which again may undermine the case they are trying to establish. The function of MCOs is risk bearing, contracting for and paying for care. As part of this insurance function, MCOs, like all other insurers, must define limits on what they will pay for. Thus MCOs, like indemnity and government insurers, may deny payment for treatment. But denying payment is less than denying treatment: the patient can still obtain treatment by paying out-of-pocket or seeking charity care or other financing sources. The denial of coverage has financial consequences, but it does not directly lead to medical consequences.

Second, the authors state that “[i]n the malpractice area, scholarly studies suggest that the courts are rather poor at identifying malpractice—many bona fide cases of malpractice are overlooked, while lawsuits often focus on cases where the physician did nothing wrong.”¹¹ They cite two sources.

If this statement were more important to the paper, it would be worthy of more discussion. However, we make the following points. The view that there is considerable underclaiming, that is, that the number of medical errors exceeds the number of medical malpractice claims, appears to be valid.¹² These measures of medical error were based on medical definitions, not the concept of cost-justified care that underlies the economic definition of negligence, but this is an issue beyond the scope of this comment.

However, the second part of the statement is far more controversial. Courts and, much more commonly, the settlement process are not perfect in meting out compensation for wrongdoing, but the system’s results are far from random.¹³ Some of the evidence on the system’s inadequacies comes from medical chart reviews that compare the status of the suit with the “medical truth” as determined by a couple of raters.

Two assumptions underlie this rating process. First, given available information, the raters know more than the parties to a suit. Second, the raters have as much information at their disposal as the parties to the suit. Typically, the raters have one medical record. By contrast, the parties have depositions, material obtained through the discovery process, including medical records, expert testimony, and, in those cases that go to trial, information introduced at trial. Juries, but not medical chart raters, can see the sweat on the defendant’s brow. Attacks on the legal system serve many purposes, mainly political ones, but we in the academic community should demand a higher standard of evidence.

¹⁰ *Id.* at 647.

¹¹ *Id.* at 642.

¹² Institute of Medicine, *To Err Is Human: Building a Safer Health System* (2000).

¹³ Frank A. Sloan *et al.*, *Suing for Medical Malpractice* (1993).