

# TORT LIABILITY: A MINEFIELD FOR MANAGED CARE?

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## ABSTRACT

The restructuring of health insurance contracts and health care delivery systems under managed care is the result of competitive attempts to reduce the inefficiencies that developed in medical markets under traditional indemnity insurance. Liability rules that continue to apply norms of customary care threaten to undermine these potential efficiency gains. Liability rules under managed care should treat claims for denial of coverage as contractual disputes, to be brought against health plans as residual claimants. Where contracts are ambiguous, appropriate coverage should be determined using a cost-benefit criterion based on beneficiaries' willingness-to-pay. Liability claims for negligent care should be permitted only against providers, not against health plans, except where the plan voluntarily assumes liability by contract. Extending liability for negligent care to health plans is likely to distort liability decisions and constrain the competitive evolution of delivery systems. These principles should apply equally to all plans, regardless of their status under the Employer Retirement Income Security Act.

## I. INTRODUCTION

THE purpose of this article is to examine the implications for liability of the growth of managed care. Since the 1980s, the development of managed care has led to fundamental change in the nature of health insurance contracts and in the structure of medical care delivery systems. For patients, managed care entails accepting restrictions on choice of providers and controls on covered services, in return for lower premiums and copayments. For providers, managed care establishes risk-sharing forms of reimbursement in place of the unrestricted fee-for-service or cost-based reimbursement contracts used by traditional indemnity insurance.

This transformation of health insurance contracts parallels fundamental restructuring and consolidation of health care delivery systems. By one

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count, 1,318 health care acquisitions and an additional 2,152 joint ventures took place between 1989 and 1993. These include horizontal, vertical, and conglomerate mergers and alliances: hospitals with other hospitals, both contiguous and in distant geographic markets; hospitals and physician group practices; hospitals and ambulatory surgery centers; health maintenance organizations (HMOs) with other HMOs; and HMOs with traditional insurance companies.

The growth of managed care and the associated restructuring of insurance contracts and medical delivery systems can be viewed as a competitive response of insurance markets to the demand for forms of medical insurance that provide better value for the money than traditional indemnity insurance contracts. Traditional indemnity insurance gave patients unrestricted choice of providers and reimbursed providers on a fee-for-service basis. Thus the only constraint on "moral hazard" (insurance-induced overuse of services) was patient copayment. The essential features of managed care are the use by third party payers of new techniques for moral hazard control, often involving provider-targeted incentives and discretionary restrictions on reimbursable services through utilization review. Managed care thus offers new forms of contract for insured medical care that are preferred by at least some consumers. Managed care plans differ in the details of their restrictions on choice, copayments, access to new technologies, and cost. The growing market share of various types of managed care plans is compelling evidence that a significant fraction of consumers are willing to forgo some choice in return for the lower premium and lower out-of-pocket payments that managed care can offer.

These managed care constraints are generating new types of liability claims arising out of the apparent integration of insurance and provider functions, as plans become more actively involved in decisions about reimbursable care and providers become more involved in risk sharing. Claims against managed care organizations (MCOs) raise two broad questions. First, under what circumstances, if any, should there be liability for withholding care? If there is liability, on whom should it be placed—the plan, the provider, or the utilization review entity? Second, under what circumstances, if any, should the plan—in addition to the individual provider—be liable for negligent care by providers that participate in the plan?

The liability of health plans appears to be growing. Between 1990 and 1994 there were at least 33 punitive damage awards against health insurers and MCOs, and almost half were for \$1 million or more.<sup>1</sup> However, the

<sup>1</sup> Brent J. Graber, *Legal Crisis Threatens Managed Care*, Best's Review Life/Health 37 (October 1995).

divergent rulings often suggest a lack of appreciation of the nature of this form of insurance and the incidence of costs. There is a legitimate concern that liability may undermine the potential for managed care to improve efficiency in the provision of insured health care.

A major thesis of this article is that the growth of managed care liability exposes the fundamental flaws in traditional rules of liability for medical malpractice. The traditional, custom-based standard of care has no basis in efficiency. On the contrary, it gives legitimacy to the standard of care that developed under traditional indemnity insurance. Customary care under traditional insurance reflects severe moral hazard and hence overuse of costly services. The controls and financial incentives of managed care provide a potentially efficiency-improving (albeit still imperfect) solution to these problems of moral hazard and the underlying asymmetric information that undermine efficiency in health insurance markets.

Rules of liability applied to managed care will be fatally flawed unless courts understand these and other basic features of insurance and health care markets. Courts must recognize that insurance creates an intrinsic conflict between the insured patient's preferences *ex ante*, when he or she selects a health plan and pays the premium, and those preferences *ex post*, when illness strikes and care appears to be virtually free, because of insurance coverage. An alternative view of this *ex ante* versus *ex post* tension is the conflict between the individual interest of the patient who wants care and the interest of insured consumers as a group, all of whom face some probability of falling ill and who collectively bear the cost of the care through higher premium payments. Because traditional indemnity insurance encouraged severe moral hazard, the standards of care that developed more closely reflected the *ex post* preferences of individual patients. However, efficient standards of care should reflect *ex ante* preferences or, equivalently, the average preferences of insureds as a group.

A second misperception that undermines the adoption of sound liability rules for medical malpractice is the fiction that employers pay for employer-sponsored insurance. On the contrary, economic theory and evidence indicate that, at least as a first approximation, employees ultimately bear the costs of employer-sponsored plans—including the costs of liability—through lower wages or higher premium contributions. In making hiring decisions, employers are concerned with the total labor compensation cost; the division between wages, health care, and other fringe benefits is designed to meet the preferences of employees. Most employees are willing to trade some cash wages for health benefits because of the tax and other advantages of obtaining insurance through employment rather than purchasing it individually. The implication is that the level and structure of health

benefits reflect employee preferences. Employers are largely intermediaries.<sup>2</sup>

The fiction that employers pay for health insurance fosters the further misperception that managed care controls reflect the cost-cutting incentives of employers against the interests of their employees. These mistaken beliefs obscure the interests of employees/consumers in the enforcement of managed care restrictions. The growing market share of managed care plans, at the expense of traditional indemnity insurance, implies that employees are willing to accept some restrictions on choice in return for the lower premium, the lower copayment, or more comprehensive coverage offered by managed care plans.

Once coverage restrictions of managed care are understood as contractual terms that employees choose in return for lower premiums, the implication is that coverage disputes should be handled as contractual disputes. Where contracts are ambiguous, appropriate coverage should be determined using a cost-benefit criterion based on beneficiaries' willingness-to-pay. Specifically, the court should attempt to determine what coverage and implied cost these insured consumers would want *ex ante*, when faced with the choice and the bill. For publicly funded plans, the analogous question should take into account willingness-to-pay of taxpayers as well as beneficiaries.

In this article, Section II reviews the implications of asymmetric information and insurance in health care markets. Section III describes the structural change in health care insurance and delivery systems as a potentially efficient response to these problems of asymmetric information and moral hazard. Section IV examines the implications of these structural changes for appropriate liability rules, including proposals for enterprise liability and termination of the Employer Retirement Income Security Act (ERISA) preemption. Section V concludes.

## II. CHARACTERISTICS OF HEALTH CARE MARKETS

The design of appropriate liability rules for medical care, including managed care organizations, must recognize the fundamental role of asymmetric information and insurance in health care markets.

### A. *Asymmetric Information*

Asymmetric information between buyers and sellers is the basis for professional liability in general and medical malpractice in particular. In general, the physician knows more than the patient about the best treatment

<sup>2</sup> Employers may bear health costs to the extent that actual costs exceed the level expected in employment contracts.

for the patient's condition and the quality of care actually delivered. This information asymmetry implies that providers appropriately play a key role as agents to guide patients in their use of medical services. However, these same agents/advisors often themselves implement, and therefore have a financial stake in, the recommended course of treatment. If consumers lack good information to evaluate quality, competitive markets may fail to provide the optimal level and mix of qualities.<sup>3</sup> However, market participants may themselves have incentives to provide information, such as quality rating systems, and to develop contractual forms and other mechanisms for reducing the potential inefficiencies that result from imperfect information. The managed care revolution may be viewed as one stage in the evolution of health care markets toward more efficient forms of insurance contract, provider reimbursement, and organizational structure, in order to make providers better agents.

In markets that are subject to imperfect information, a negligence rule of liability is one potential corrective device, assuming that courts know and can costlessly enforce the efficient standard of care. However, if courts lack perfect information, then the effect of a systematically biased rule or even a rule that is unbiased on average but unpredictable can be perverse.<sup>4</sup>

### B. Insurance and Moral Hazard

The second distinguishing feature of health care markets is the pervasive role of insurance. The percentage of total health expenditures that was paid out-of-pocket fell from 56 percent in 1960 to 23 percent in 1990, reflecting the growth in employer-provided health insurance benefits and the expansion of Medicare and Medicaid programs. The percent paid out-of-pocket ranges from under 10 percent for inpatient hospital care to 50 percent or more for services such as outpatient drugs and vision care.<sup>5</sup>

The obvious advantage of insurance is that it protects consumers from the financial risk of medical expense and makes care affordable that would otherwise not be. The disadvantage is that this financial protection makes consumers indifferent to the cost of the care, leading to the use of a greater

<sup>3</sup> See, for example, Michael Spence, *Consumer Misperceptions, Product Failure, and Product Liability*, 64 Rev Econ Stud 561 (1977); Steven Shavell, *Strict Liability vs. Negligence*, 9 J Legal Stud 1 (1980).

<sup>4</sup> John Calfee and Richard Craswell, *Some Effects of Uncertainty on Compliance with Legal Standards*, 70 Va L Rev 965 (1986); Patricia M. Danzon, *Liability and Liability Insurance for Medical Malpractice*, 4 J Health Econ 309 (1985).

<sup>5</sup> Since employer contributions to employee health insurance are not taxable income to employees, employer contributions are implicitly subsidized at the employee's marginal tax rate, including federal and state taxes on income and payroll. This subsidy has led to more comprehensive coverage and less copayment than would occur without this tax distortion.

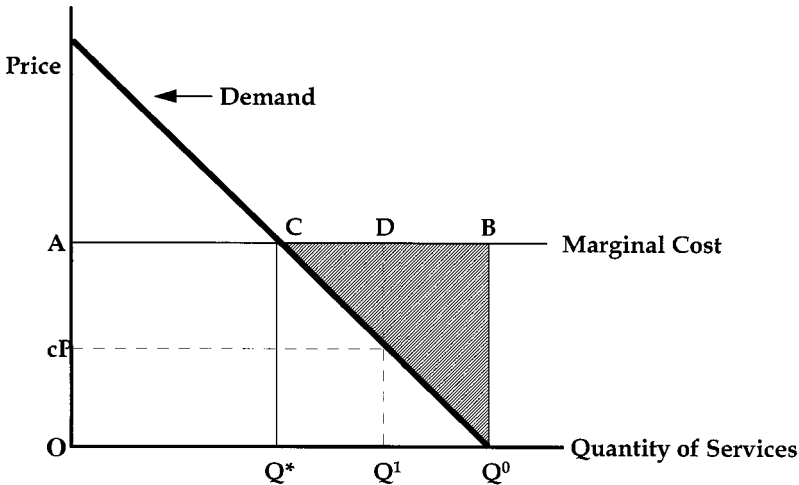


FIGURE 1.—Effect of insurance on utilization of health services

volume of services and/or higher cost services than consumers would choose if they faced the full cost. This is illustrated in Figure 1, in which the demand for medical services  $D$  assumes that consumers have unbiased expectations of benefits of care. Services are assumed to be competitively supplied at a price equal to the constant marginal cost.<sup>6</sup> The socially optimal quantity is  $Q^*$ , which is also the private optimum chosen by the consumer if faced with the full price. With full insurance (zero copayment), the patient prefers  $Q^0$ . If physicians are paid fee-for-service, they have every incentive—as good agents for their patients and in their own financial interests—to recommend and provide all services that offer an expected benefit to the patient at least equal to the patient’s copayment, in this case  $Q^0$ .

The difference between the insurance-induced increase in cost  $Q^*CBQ^0$  and the value of the additional care received  $Q^*CQ^0$  is an insurance-induced excess burden or deadweight loss. This excess burden reduces the value of insurance to consumers who ultimately pay the full premium  $OABQ^0$  either directly or as a wage offset for employer-provided insurance. If premiums are actuarially fair—just adequate to cover the full cost of insured services to the insurer—consumers correctly perceive that premiums

<sup>6</sup> Changing these assumptions to include imperfect information and imperfectly competitive supply would complicate the measurement of deadweight loss but not change the main point. See Mark Pauly, Comment, *The Economics of Moral Hazard*, 58(3) *Am Econ Rev* 531 (1968). See also Martin Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 *J Pol Econ* 251 (March 1973).

are excessive relative to the value that they place on covered services. But each consumer faces a prisoner's dilemma: the dominant strategy for the individual is excessive consumption, correctly reasoning that costs are borne largely by other insureds and that they will do the same.<sup>7</sup> A similar incentive to ignore costs applies to the choice of quality of service. Hereafter "moral hazard" refers to insurance-induced overuse of quantity or quality of services.

Because moral hazard undermines the value of insurance to consumers, insurers in competitive markets attempt to compete by devising new strategies for controlling moral hazard in ways that are least objectionable to consumers. Traditional indemnity insurance relied almost exclusively on various forms of copayment. But because copayment reduces financial protection, insurance contracts optimally include a limit or stop-loss on the consumer's exposure to copayments. In the case of health insurance, most patients who have a significant episode of care, such as a hospitalization, incur sufficiently high expense to exceed their stop-loss. Thus the evidence from actual contracts indicates that optimal limits on copayment are such that most patients face a zero marginal price for most inpatient care and other high cost procedures. Optimal copayment levels for low income persons are also generally too low to be effective in controlling overuse.<sup>8</sup>

### III. THE MANAGED CARE REVOLUTION

The rising cost of health insurance premiums has led consumers<sup>9</sup> to demand—and insurers to offer—alternative strategies to control overuse. Traditional indemnity insurance, with fee-for-service reimbursement of providers, relied solely on patient copayment to constrain moral hazard. Managed

<sup>7</sup> In theory, moral hazard can be deterred through experience rating. Accurate experience rating requires a long-term contract in which the insurer can accurately distinguish between the care that is optimal, given exogenous shocks to health, and overuse due to moral hazard. In health insurance, experience rating is usually at the level of the group, not the individual, plausibly because insurers lack the necessary information to apply individual experience rating without exposing individuals to the risk of being unfairly rated.

<sup>8</sup> Although actual copayment levels may be less than would be optimal in the absence of tax subsidies, similar conclusions emerge from the Rand Health Insurance Experiment. That experiment imposed a cap on cost sharing at 5, 10, or 15 percent of family income. In practice, virtually everyone who was hospitalized exceeded the cap, such that for marginal choices all care was free. Willard G. Manning et al, *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 Am Econ Rev 251 (1986).

<sup>9</sup> "Consumers" refers here to individual consumers who ultimately pay and to employers and public entities that act as intermediaries to arrange insurance on behalf of final consumers.

care plans have developed a range of direct controls and provider incentives to control overuse while offering consumers lower copayments.

### A. *Managed Care Strategies*

#### 1. Direct Controls and Information-Based Rules

The most common restriction is utilization review (UR), which requires prior authorization of expensive services by the insurer before a service is reimbursed. More recent developments include treatment protocols and practice guidelines that outline approved treatment plans for particular medical conditions. Failure to adhere to these guidelines may result in the denial of reimbursement for the patient and/or some requirement on the provider to justify deviation. Importantly, UR limits only the reimbursement by the plan, not the actual use of services by the patient. In practice, however, insurance coverage may be necessary for the patient to afford high cost care.

#### 2. Selected Provider Networks

Managed care plans typically restrict coverage to a network of “preferred providers,” who agree to accept lower fees and/or assume financial risk in return for the higher volume that results from participation in the network. In traditional HMOs and preferred provider organizations (PPOs), patients must pay in full for out-of-network use. More recently, point-of-service plans provide partial coverage but require higher copayment for use of out-of-network providers.

#### 3. Provider Risk Sharing

A third basic managed care strategy is to shift from passive payment of providers, based on fee-for-service or costs incurred, to various forms of fixed fee payment for a comprehensive episode or period of care, regardless of the volume or cost of services actually delivered. Primary care physicians in HMOs commonly receive a capitation payment per enrolled patient per month, to cover all primary care services. Primary care physicians also frequently act as gatekeepers, whose referral is required before a patient can be reimbursed for specialty care. Some plans use separate capitation payments for referrals to specialists, ancillary services, or pharmaceuticals. For hospital care, HMOs generally pay negotiated rates per diem or per case, which puts the hospital at risk for services per day or per admission, combined with penalties for high volume.

Capitation forms of reimbursement reverse provider incentives, compared to fee-for-service. When the provider is paid a fixed amount per pa-

tient or episode, ordering extra services or tests entails additional costs but generates no additional revenue.<sup>10</sup> Both theory and evidence indicate that managed care strategies reduce utilization and expenditures, particularly for inpatient care, relative to unconstrained fee-for-service.<sup>11</sup>

Under certain conditions, capitation could lead to provision of the optimal level of care ( $Q^*$  in Figure 1). A sufficient condition is that patients are reasonably well informed about the expected health outcomes delivered by different providers before they select their plan and provider. With good information about outcomes, providers would have incentives to make optimal choices for care, in which case liability would be unnecessary.

However, with imperfect monitoring of outcomes, the capitated provider may have incentives to provide too little care. In that case, liability may be a potentially useful corrective device, *ceteris paribus*.<sup>12</sup>

### B. Efficiency Gains of Integrated Networks

Expanding the scope of services for which providers can efficiently assume capitation is a major motivation for the current consolidation and formation of networks. Integrated delivery systems (IDSs) offer potential efficiency gains in the bearing of risk, more cost-effective substitution among services, economies of scale and scope, and monitoring of quality. The net effect is likely to be a reduction in the need for liability.

<sup>10</sup> With discounted fee-for-service, as in PPOs, the physician still has incentives to increase revenue by performing additional services. However, PPOs usually combine fee-for-service payment with monitoring and strict criteria for excluding high cost providers from the network.

<sup>11</sup> For evidence on UR, see Paul Feldstein et al, *The Effects of UR Programs on Health Care Use and Expenditure*, 318 *New Eng J Medicine* 1310 (1987). For evidence on effects of HMOs, see Manning et al (cited in note 8). In 1994, inpatient days per thousand insured lives ranged across communities nationwide from 279 to 380, or over 25 percent, with almost a 50 percent spread in premiums per member per month, from \$125 to \$297. By contrast the spread across the seven largest plans in Los Angeles was from 175 to 286 inpatient days, with monthly premiums ranging from \$100 to \$119. Jacques J. Sokolov, MD, *Accountable Health Plans, Advanced Integrated Delivery Systems and Optimal Physician Organizations: Understanding What to Do and Why* (paper presented at the annual meeting of the American Bar Foundation, New Orleans, August 1994).

<sup>12</sup> The effect of alternative liability rules on levels of care and hence on patient utility, under capitation or fee-for-service reimbursement, is analyzed in Patricia M. Danzon, *Alternative Liability Regimes for Medical Injuries: Evidence from Simulation Analysis*, 61 *J Risk & Insurance* 219 (1994). Under reasonable assumptions, the gains in the patient's utility from provider liability are greater when providers are capitated than with fee-for-service, because of the incentives for underprovision with capitation. However, this model ignores the improvements in market monitoring that are actually occurring with capitation forms of reimbursement.

### 1. Risk-Bearing Advantages of Networks

Larger, more diversified networks permit more efficient bearing of exogenous risk, that is, the risk related to the frequency and severity of exogenous shocks to health of the insured population, which are beyond human control, at least in the short run. Pooling this exogenous risk is the essential function of traditional insurance. But this exogenous risk is partially shifted to providers, as insurers adopt capitation forms of payment as a device to control the endogenous, moral hazard "risk." Under full capitation, a provider becomes *de facto* the insurer. The moral hazard "risk" is most efficiently borne by the individual physician, for whom it is not a risk but a controllable cost. But the individual physician has insufficient diversification to be an efficient bearer of the uncontrollable, exogenous risk. An individual or small group practice could purchase reinsurance or shift risk to some other risk-bearing entity, such as an HMO, but this dilutes the incentives for moral hazard control. By contrast, a capitated network that spans a large volume of patients and a comprehensive range of services is more diversified and hence able to bear the exogenous risk. Thus, given the potential efficiency gains from provider risk assumption for purposes of moral hazard control, the formation of larger provider groups becomes efficient in order to diversify the exogenous population health risks.

The capitated provider networks would ideally span a sufficiently broad range of services and providers to meet consumers' demand for choice and comprehensive care, while at the same time providing good diversification of exogenous risks. But the larger the provider network, the greater the incentive for each provider to "shirk" on controlling moral hazard, since each individual's utilization has a negligible effect on the performance of the group as a whole. Thus, the optimal size and structure of networks and the optimal risk-sharing and management strategies for effective control within large networks are complex, requiring trade-off on many dimensions. The current heterogeneous mix of network structure and risk-sharing arrangements reflects the trial and error that is a necessary stage in learning the most efficient management and risk-sharing arrangements.

### 2. Efficient Substitution among Services

Under traditional fee-for-service insurance, the separate reimbursement of individual hospitals and physicians creates incentives for duplication. Simple capitation of primary care physicians, as in traditional HMOs, creates incentives for excessive referrals to specialists and inefficient substitution of other services that are excluded from the primary care capitation. This incentive to overrefer can be countered by expanding the gatekeeper's capitation to include partial risk sharing for other services. However, this

in turn may entail unacceptable financial exposure and require that the primary care physician become a manager or purchaser of other services, which may not be to his or her comparative advantage.

The integrated provider network that assumes a comprehensive capitation payment to cover the full range of medical services has incentives to substitute efficiently between all medical resources—for example, primary or specialist care, home care or inpatient care, drug therapy or surgery. For the purchaser, this yields either lower cost for the desired quality of care or greater value for a given cost. Distortions such as excessive specialty referrals by primary care physicians are eliminated.

### 3. Network Advantages in Competing on Quality

The integrated network has a competitive advantage, for both statistical and economic reasons, in responding to consumers' demands for competition on quality and outcomes. The outcome for an individual patient or individual physician lacks statistical credibility; that is, the effect of the individual provider's actions cannot be distinguished from other random factors that affect outcomes in small samples. The low signal to noise ratio undermines accurate outcomes measurement for all but the largest hospitals. Moreover, since patient care optimally requires input from many individual providers and institutions, measuring outcomes for each provider individually raises problems of distinguishing marginal contributions.

By contrast, the average outcomes experience for a comprehensive network for a large patient population provides a more credible statistical measure of quality. With a network, the problem of monitoring individual providers becomes a problem for internal management, not the purchaser. The integrated network thus has a competitive advantage in competing on the basis of quality and cost, assuming that managers are better informed than purchasers.

### 4. Economies of Scale and Scope

Comprehensive networks can take advantage of economies of scale and scope in several areas. First, the information systems, expertise, and other human capital required for managing costs and quality can be shared. Second, since managed care has reduced the demand for inpatient and specialist care, efficient scale may require rationalization across hospitals—for example, unit costs can be reduced by concentrating cardiac care in one facility, while another does obstetrics. Quality is also enhanced, since facilities that perform higher volumes of complex procedures generally have better outcomes.

Third, networks that provide a comprehensive range of medical services

offer transactions cost savings to purchasers, including self-insured employers, HMOs, Medicaid agencies, and others. Multistate employers with employees in diverse geographic areas seek the transaction cost savings of contracting with a single insurer or provider network that can serve all employees, regardless of location. Traditional HMOs have had limited geographic coverage tied to their local network of contracted providers. The current merger wave has produced alliances between such provider networks in different geographic markets in order to offer economies in contracting costs for services that span broadly defined product and geographic markets.

### *C. Control and Residual Risk Bearing in Networks*

Organizational forms and allocation of risk and control within health care institutions are in flux. Any MCO includes an insurance component, multiple hospitals, and physicians organized individually or in groups. The sharing of control and risk between these components varies, reflecting complex explicit and implicit contracts. If the residual risk bearer is other than a traditional insurer or HMO, then it may have to meet licensure requirements as an insurer under state regulation, although the law on this point is in flux. The underlying trend is that providers, through more or less loosely integrated systems, are bearing an increasing share of the financial risk, taking capitation for an increasingly broad range of services. Some IDSs contract directly with self-insured employers, using a traditional insurance intermediary only for claims administration. Others contract with existing HMOs that in turn contract with employers and public payers. The role of the HMO may include some benefit design, claims handling and administration, and acting as the insurance entity for compliance with state regulatory requirements for solvency, rate filing, and so forth.

Health plans differ not only in organizational form but also in the services covered, premium and copayment structure, incentives and controls on providers, use of third party review organizations, and so forth. For patients, this implies variation in out-of-pocket exposure, time and hassle costs of dealing with UR and gatekeepers, restrictions on choice of providers, and limits on covered services. Market equilibrium in theory entails a matching of consumers to plans, based on consumer preferences for these different coverage dimensions.

Employers play a significant role as intermediaries in health insurance markets, since roughly 80 percent of private insurance is obtained through employment. The role of employers may be limited to contracting with insurers or HMOs for off-the-shelf plans that bear full risk. Increasingly,

however, medium- and large-size employers self-insure at least part of the financial risk, and some negotiate plans that are specifically tailored to their workforce. This role of employers has raised issues of liability, particularly related to the preemption of state laws for employer-sponsored plans under ERISA.

If managed care does offer significant efficiency gains, as argued here, an obvious question is, why have these changes not occurred sooner? Among the many contributing factors, two seem particularly important to current trends. First, advances in information technology have made feasible the operation of large networks at reasonable cost. The electronic patient record that can instantaneously coordinate and disseminate all available information about a patient's history, prior tests, treatments, and medications to all relevant providers and to the billing department is now close to a reality in some systems. Improved information flows should permit significant efficiency gains from eliminating duplication and more efficient coordination of care.

The second major stimulus to managed care is the continued increase in absolute cost of health care. Rising health costs are driven largely by technological advances. However, traditional insurance lacks both principles and mechanisms for technology assessment as a precondition of coverage. Standard contracts promise coverage of all "medically necessary" care, with the exclusion of "experimental procedures" and possibly certain broadly defined services such as chiropractic or physiotherapy.<sup>13</sup>

These criteria in fact defer coverage decisions to physicians. Under traditional insurance, physicians have financial and professional incentives to provide all services that offer any expected benefit to the patient. But the continual development of cost-increasing but quality-enhancing technologies is forcing private and public payers to confront the politically and technically difficult issues of deciding what services insurance should cover. Managed care is a step in that direction. Although managed care plans still typically retain the promise to cover all "medically necessary care," making that determination is no longer left to the treating physician. Information-based tools of technology assessment, including cost-effectiveness and cost-benefit analysis, are increasingly used.<sup>14</sup>

<sup>13</sup> For detailed discussion of the content of actual health insurance contracts and proposals for greater specificity, see Clark C. Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform* (1995).

<sup>14</sup> Anne Elixhauser, Bryan R. Luce, and Claudia A. Steiner, *Cost Effectiveness Analysis, Medical Technology Assessment, and Managed Care Organizations* (paper presented at the American Enterprise Institute Conference on Policy Issues in Cost-Effectiveness, Washington, DC, November 20, 1996).

#### IV. IMPLICATIONS FOR LIABILITY

These characteristics of health care and insurance markets—asymmetric information and moral hazard under traditional insurance and the resulting evolution of managed care—have important implications for liability rules.

##### A. *Liability under Traditional Insurance*

The traditional liability rule for medical malpractice is negligence, with due care defined as customary care. As argued above, where care requires the performance of additional reimbursable procedures, there is a strong presumption that customary care exceeds the socially optimal level, because of moral hazard–induced excess under traditional insurance. Thus the standard presumption that a negligence rule leads to a socially efficient level of care<sup>15</sup> does not apply. It might be argued that if health insurance markets are competitive, the level of insurance coverage and implied level of care are second best, subject to imperfect information. However, this presumption does not apply to private or public insurance in the United States. Private insurance is distorted by the tax subsidy. The excessive norms under private insurance are largely adopted by the public insurance programs, Medicare and Medicaid, which may be further distorted due to the political process. Thus traditional liability with negligence based on customary care tends to reinforce insurance-driven overuse of medical services; at best it may prevent suboptimal precautions per unit of service and significant deviations from expected care. If managed care is to succeed as a mechanism for reducing the deadweight loss from traditional overuse of medical services, then liability rules must recognize the excess embedded in customary care and must evaluate managed care by standards other than medical custom.

##### B. *Liability under Managed Care*

Claims against health plans fall into two categories—claims for wrongful denial of access to needed medical treatment, and claims based on quality of care or provider malpractice.<sup>16</sup>

##### 1. Claims for Denial of Coverage

In *Wickline v. State*, Mrs. Wickline sued MediCal (California's Medicaid program) for negligence in approving only a 4-day postoperative hospital-

<sup>15</sup> Richard Posner, *A Theory of Negligence*, 1 J Legal Stud 28 (1972); John P. Brown, *Towards a Theory of Liability*, 2 J Legal Stud 323 (1973); Patricia M. Danzon, *Liability for Medical Malpractice*, 3 J Econ Perspectives 51 (1991).

<sup>16</sup> See, for example, Robert J. Conrad, Jr., and Patrick D. Seiter, *Health Plan Liability in the Age of Managed Care*, 62 Defense Counsel J 191 (1995).

ization, rather than the 8-day period requested by her physician. Following discharge, Mrs. Wickline's condition deteriorated. When she was readmitted 9 days later her leg had to be amputated.

The lower court awarded damages but the California Court of Appeal reversed, finding that the MediCal restriction was not the cause of her discharge, which was the responsibility of her physician, who had not appealed the decision. The court also referred to the fact that the discharge was consistent with the usual standards of medical practice in the community, and as a result, MediCal was not culpable of breach of duty.

A very different conclusion was reached in *Fox v. HealthNet*. In this case, the HMO denied coverage of a bone marrow transplant for treatment of Mrs. Fox's breast cancer, on grounds that it was "investigational." She had previously undergone two radical mastectomies and chemotherapy. One cancer center had evaluated her as an eligible candidate for a bone marrow transplant, but another center considered her ineligible because the cancer had metastasized to her bone marrow. Mrs. Fox raised the necessary funds through a public appeal and had the transplant. She and her husband sued HealthNet alleging breach of contract, breach of covenant of good faith and fair dealing, and intentional infliction of emotional distress. Mrs. Fox died before trial. The jury awarded approximately \$89 million, including \$77 million in punitive damages, finding that the HMO had acted in bad faith, breached its contract for care, and intentionally inflicted emotional distress through reckless denial of coverage. The jury was allegedly irritated that the plan provided financial incentives to withhold care. The case was ultimately settled prior to appeal. However, thereafter, as David Maslen notes, "all insurers and HMOs universally make the procedure available for the treatment of breast cancer."<sup>17</sup> Note that, unlike *Wickline*, *Fox* did not allege negligence; rather, it relied on contract theories commonly used to challenge insurance coverage decisions.

These cases raise two questions. First, what—if any—should be the basis for liability for denial of coverage of medical treatment, and what is the appropriate measure of damages? Second, assuming that there is a finding of liability, who should be liable—the physician, the plan, or the UR company? Or should joint and several liability apply to any party who contributes to withholding care?

The question of who should be liable, assuming that liability is to be imposed, requires drawing a distinction between the insurance/coverage function and the care delivery function. The health plan defines the contract for insurance coverage with the patient and is the ultimate residual claimant for

<sup>17</sup> David P. Maslen, *Employer Managed Care Liability: Defining and Managing the Risk*, *J Compensation Benefits* 5 (July/August 1995).

profit or loss. The plan may share financial risk with providers and contract with UR agencies for implementation. Nevertheless, the plan as ultimate insuring entity and residual claimant should bear liability for coverage decisions. This principle applies to an insurer-sponsored MCO, a provider-sponsored HMO, or an IDS licensed to act as insurer. In the latter case, the liability of the provider IDS arises out of its role as insurer and ultimate risk bearer, not its role in delivering care.

Of course the Coase Theorem implies that where the courts place liability is largely irrelevant, if transacting is costless. For example, if liability is placed on physicians, physicians could contract with the plan for either indemnification of damages or reimbursement high enough to cover the expected costs of liability.<sup>18</sup> Similarly, if liability is placed on a UR company, it could contract with the plan for indemnification. However, placing liability on an agent of the plan, such as the physician or the UR agency, could lead to nonoptimal legal defense effort and added transactions costs of indemnification. Minimization of transactions costs therefore requires that liability be placed directly on the plan as residual claimant and the entity ultimately responsible for coverage decisions.

In *Wickline*, the court suggested that liability should be placed on the physician, because the advice of the treating physician is a significant factor in the plan's determination of whether to make an exception to a general coverage rule. Most plans have appeal procedures, in which the physician may act as the patient's agent. But if the treating physician is to be potentially liable for denial of care, how is a due care standard for physicians to be defined? What appeal procedures must they undertake? How much uncompensated time must the physician spend arguing the patient's case? If the claim is denied, does due care require that the physician provide free services? What about referrals for hospital care?

More formally, consider the definition of a due care standard for effort by the physician in appealing plan decisions. Efficient investment of physician time requires that the expected benefit is equal to its marginal cost:

$$p(B - C) = c, \quad (1)$$

where  $p$  is the probability that the plan agrees to provide coverage,  $B$  is the expected marginal benefit of the service to the patient,  $C$  is the marginal cost of the service, and  $c$  is the marginal opportunity cost of the physician's

<sup>18</sup> For a similar analysis in the context of enterprise liability in general, see Lewis Kornhauser, *An Economic Analysis of the Choice between Enterprise and Personal Liability for Accidents*, 70 Cal L Rev 1345 (1982).

time. The efficient decision rule is to perform the procedure if the expected net benefit exceeds the cost:

$$B - C \geq c. \quad (2)$$

Assume that the courts set the damage award  $A$  equal to  $B$ . If the physician is liable for damages, his private incentive is to appeal if  $pA = pB > c$ , regardless of treatment cost  $C$ , assuming that he bears no fraction of  $C$ . Thus, physician liability is likely to lead to excessive appeal whenever  $p$  is reasonably high. On the other hand, the plan's incentive is to deny coverage as long as  $C > 0$ , assuming that the plan bears none of the liability cost.

Thus the plan faces optimal incentives for coverage decisions *only* if the expected social net benefit from treatment  $B - C$  and the opportunity cost of reevaluating the decision  $c$  are internalized to the plan. This requires that physicians can costlessly contract for indemnification of damages and time spent in appeal. It is simpler to place liability directly on the plan, in which case the plan has incentives to encourage physicians to invest optimally in appeal and in providing information for making coverage decisions. In conclusion, any liability for coverage denial should be placed only on the health plan as residual claimant, not on providers or UR personnel.<sup>19</sup>

The more fundamental question is: what, if any, should be the basis for liability, and what damages are appropriate? The plaintiff in *Wickline* sued for negligent denial of coverage. Although the court ruled for the defense, it left open the possibility that third-party payers could be liable for "defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on the patient's behalf are arbitrarily ignored or unreasonably overridden." The court considered it "essential that cost limitation programs not be permitted to corrupt medical judgment."<sup>20</sup>

By suggesting that health plans could be liable for "defects in the design of a cost containment mechanism," the court implicitly assumed the existence of an objective standard for a nondefective cost containment mechanism. The additional allusion to "corruption of medical judgment" suggests that medical judgment should define appropriate medical care and, by implication, serve as the basis for defining an acceptable cost containment mechanism. Certainly, this language does not appear to permit the possibility that medical judgment might define an inappropriate standard of care.

However, the notion that medical science can or should define appro-

<sup>19</sup> The issue of employer liability for coverage restrictions in self-insured plans is discussed below.

<sup>20</sup> *Wickline v State*, 239 Cal Rptr 810 (Cal App 1986), review granted, 727 P2d 753 (Cal 1986), review dismissed, remanded, ordered published in part, 741 P2d 613 (Cal 1987).

appropriate care is a fiction. At best, medical science may be able to tell us the probability distribution of health outcomes and risks from a given treatment.<sup>21</sup> To decide whether a particular procedure is worth performing requires comparing the value of the expected health outcomes to costs. Valuation of medical services ultimately depends on consumer preferences for alternative outcomes, including tolerance for risk and discomfort, preferences for health care versus other goods, and so forth. Thus “medical judgment” alone cannot provide a basis for evaluating a particular cost containment mechanism or coverage decision.

A standard based on “medically necessary” care not only lacks sound theoretical grounding, in practice it is also likely to be biased in the United States toward excessive use of care because of the moral hazard incentives of traditional insurance. With fee-for-service insurance plans and low patient copayments, physicians had incentives to define all care with positive expected gross benefit ( $B > 0$ ) as “medically necessary.” However, the socially optimal standard would define care as appropriate only if the expected *net* benefit is positive:  $B - C \geq 0$ . This corresponds to  $Q^*$  in Figure 1 and is the level consumers would choose *ex ante*, before decisions are distorted by moral hazard.

The court in *Wickline* also referred to custom as a standard of defining appropriate care, without identifying the norm for customary care. But if the purpose of managed care is to change the norms of customary care that prevailed under indemnity insurance, then failure by the courts to recognize and respect this shift will obstruct the evolution of managed care and prevent the realization of its potential efficiency gains.

The only valid criterion for resolving coverage disputes under managed care is the contractual terms of the particular plan or, where these terms are not sufficiently specific, a cost-benefit analysis to determine what coverage consumers would have been willing to pay for.<sup>22</sup> Viewing a coverage dispute as a contract issue, the relevant question is: would consumers have been willing to pay for insurance coverage of this service, given their *ex ante* probability distributions of illness and expected outcomes from treatment, the cost of treatment, and iatrogenic risks? For private health plans, the relevant measure is the *ex ante* willingness-to-pay of plan enrollees. For

<sup>21</sup> Basing treatment decisions on objective measures of effectiveness or cost effectiveness is limited in practice because of lack of information about the effectiveness, hence the cost effectiveness, of most existing technologies and treatments.

<sup>22</sup> Broader proposals for treating all medical malpractice claims as claims in contract, not tort, are discussed in Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 76 *Am Bar Found Res J* 87 (1976); and Patricia M. Danzon, *Medical Malpractice: Theory, Evidence and Public Policy* (1985). See also Havighurst (cited in note 13).

tax-financed plans such as Medicare and Medicaid, the relevant willingness-to-pay is the summation of willingness-to-pay of beneficiaries and of taxpayers. This assumes that taxpayers derive some benefit, possibly including altruism, peace of mind, or protection against contagious diseases, from subsidizing health care for the poor and elderly.

Inevitably, an ex ante willingness-to-pay standard will appear to conflict with the interests of the individual insured patient once sick, who would then want to have coverage of all services that offer any expected positive benefit. However, to achieve an efficient standard of liability for coverage disputes, courts must ignore the ex post or patient-specific private optimum and focus on the ex ante or group optimum, which also approximates the social optimum.

In the managed care marketplace, if plans compete on price, choice, and quality, they have incentives to cover services that yield expected health benefits that are worth their cost to consumers. Patients who want comprehensive coverage can choose high premium plans. If patients who select low coverage plans are permitted to sue whenever the restrictions on coverage come into effect, in the long run lower cost, lower coverage plans will not break even, and consumers will be denied the option of selecting such plans.<sup>23</sup>

The risk that liability will deprive consumers of the option of choosing lower cost, lower quality products is familiar from the context of product liability and will not be repeated here.<sup>24</sup> However, it is worth noting that this risk and the resulting deadweight losses are likely to be particularly great in the context of health plans for several reasons. First, the political process seems to require adherence to the view that there should be a single level of health care for all, despite the strong evidence that individuals make different decisions for their own coverage and that taxpayers are not willing to pay the subsidies necessary to finance the same level of care for the poor as they want for themselves. Second, because employers and insurers act as financial intermediaries between patients and medical care providers, it is easy to exploit the fiction that restrictions are imposed by uncaring, profit-seeking third parties, rather than resulting from the voluntary choices of consumers who choose lower cost health plans in return for higher cash wages. Third, in the case of public programs, courts may attempt to require more comprehensive coverage than taxpayers are willing to finance for the poor and elderly. In that case cuts are likely to be made in other program

<sup>23</sup> The recognition by courts of a "significant minority" standard of care is a very inadequate means to address the fundamental fact that standards of care are heterogeneous.

<sup>24</sup> Walter Oi, *The Economics of Product Safety*, 4 Bell J Econ 3 (1973).

dimensions, through the political process, to bring expenditures more in line with the expenditure levels desired by taxpayers.<sup>25</sup>

If coverage disputes are to be resolved as cases of contract, the appropriate remedy is specific performance; that is, the plan is required to pay for the service. If the service is no longer appropriate, the plan should reimburse the patient for costs incurred due to breach, including economic and noneconomic loss.

A remaining question is whether awarding punitive damages, as in *Fox* and several other recent cases, is appropriate. In theory, punitive damages could serve a useful deterrent function if consumers systematically underreport valid claims, such that plans face suboptimal incentives to adhere to contract terms. In practice, there is no evidence that such underclaiming is common. Moreover, this theoretical result presupposes that liability is the only corrective mechanism, as in injuries to strangers. In the case of medical injuries, regulation and market forces also play a role. Private and public payers increasingly demand that plans report a range of measures of health outcomes and consumer satisfaction. Moreover, employee benefit managers act as surrogates in monitoring plans for consumers. Thus the ability of the market to penalize plans for renegeing on contract terms is growing. To the extent that market policing is effective, liability and a fortiori punitive damages are unnecessary.

Moreover, any potential deterrence benefits of punitive damages must offset the potential costs in terms of excessive levels of care. Even if legal standards and rules of damages are unbiased for efficient levels on average, uncertainty about the standards can lead providers to adopt excessive levels of care.<sup>26</sup> This incentive arises if excessive care reduces the probability of being found liable. The tendency for excessive care is exacerbated if the size of awards, including punitive damages, is excessive and if providers are risk averse. Risk aversion seems a reasonable assumption, given the negative reputation effects of a widely publicized adverse ruling against a health plan.

If punitive damages are to be permitted for denial of coverage, then the contractual arrangements between the health plan, the physicians, and UR personnel should not be admissible evidence. In *Fox* the jury was allegedly influenced by the fact that the claims reviewer's financial compensation was linked to the denial of claims.<sup>27</sup> Extending this argument to its logical con-

<sup>25</sup> Lower reimbursement for providers is the most common means of cutting costs. Although providers typically adjust by reducing some dimension of quality of service, such as time spent per patient, the resulting hidden costs are apparently more politically acceptable than explicit cuts in coverage.

<sup>26</sup> Calfee and Craswell (cited in note 4).

<sup>27</sup> Graber (cited in note 1).

clusion, all forms of capitation could be viewed as rewarding providers for withholding care. This implies that any plan that uses capitation or other risk-sharing reimbursement, to constrain moral hazard below the level that prevails in indemnity plans, could be held liable with punitive damages. But both theory and market evidence suggest that such incentive-based contracts may be efficient contracts to constrain moral hazard. The fact that consumers increasingly select plans that employ capitation and UR controls indicates that consumers are willing to accept such techniques for controlling overuse of insured services, in preference to either higher premiums or higher copayments.

If the incentive-based contracts used by managed care are admissible evidence in court, then courts have an obligation to explain to juries the market-based rationale for such contracts, including the problems of moral hazard and deadweight loss, the disadvantages of copayments to control moral hazard, the conflicting interests of the individual patient when sick and their preferences *ex ante* when contracting for the coverage, and the incidence of insurance costs on consumers, not employers. If courts and juries fail to understand these essential realities of insurance markets, liability will obstruct the potential efficiency gains from managed care and, in the long run, significantly add to the costs of medical care. The risk that liability obstructs the efficient evolution of managed care is greater, if punitive damages are permitted and if evidence on incentive based contracts are admissible evidence in coverage denial cases.

This principle that coverage disputes should be decided as contractual disputes, with the default rule being willingness-to-pay, applies equally to HMOs, managed indemnity plans that operate UR programs, and unmanaged indemnity plans. The same principles apply, because all plans must define limits on covered services. However, the conclusions reached may differ because plans offer different benefits, charge different premiums, and appeal to different types of consumer. Consumers self-select to different types of health plan, based on their preferences for cost, coverage, copayment, prompt access to new technologies, restrictions on choice, and so forth. Thus consumers' choices among health plans reflect their preferences and willingness-to-pay, and they should be held to those choices. Similarly, each type of plan should be held to the coverage as implicitly or explicitly defined in its contract.

## 2. Claims Based on Quality of Care

Health plans may be liable for claims related to the quality of care, under theories of direct corporate negligence, vicarious liability, and ostensible agency. All such claims also require negligence on the part of a physician.

*Liability for Negligent Credentialing.* Theories of direct corporate liability for negligent credentialing extend to health plans the theories that have been applied to hold hospitals responsible for credentialing staff physicians, including physicians who are independent contractors with admitting privileges at the hospital.

Some useful deterrent value may be served by requiring that managed care plans that restrict coverage to a selected provider network should adhere to a standard of care in credentialing their providers. As argued earlier, cost and quality of care may be more effectively measured at the system level than at the level of the individual provider. When consumers choose a managed care plan, they rely to some extent on the plan for basic certification of the providers who participate in the plan's network. If consumers could perfectly evaluate quality at the plan level, then plans would face appropriate incentives for provider selection and liability for credentialing would not be necessary. As long as quality measurement is imperfect, liability for negligent credentialing may serve some useful deterrent function, assuming that a reasonable standard of care can be defined.<sup>28</sup>

In practice, standards of care for credentialing are largely process-based—for example, a hospital or plan must check a physician's previous malpractice history before granting privileges. Such measures are imperfect, to the extent that the malpractice system commits both type I and type II errors.<sup>29</sup> Nevertheless, provided that process measures are interpreted in light of the individual physician's actual exposure, including volume and type of patients treated, location, and medical specialty, process measures are probably the best available.

In the case of an IDS that contracts with an MCO, the question arises whether liability for negligent credentialing should be placed on the IDS or the MCO. As argued earlier, one motive for providers to form an IDS is to take fully capitated contracts, competing on cost and quality. If an MCO that contracts with an IDS has imperfect information about the quality of the system's individual providers, then holding the IDS to a standard of care in selecting participating providers may serve a useful deterrent function. The IDS is likely to have lower costs in credentialing individual providers than the MCO. Thus placing liability on the MCO would likely result in reassignment through indemnification contracts, adding transactions costs.

<sup>28</sup> Market failure is most likely to occur when a plan has financial difficulties, such that go-for-broke behavior becomes an optimal strategy. In such circumstances, the plan is likely to be judgment proof, in which case liability is also likely to be ineffectual.

<sup>29</sup> See, for example, Danzon (cited in note 22 and 15); Frank Sloan et al, *Medical Malpractice Experience of Physicians: Predictable or Haphazard?* 262, No 23 JAMA 3291 (1989); Paul C. Weiler et al, *A Measure of Malpractice Medical Injury, Malpractice Litigation and Patient Compensation* (1993).

In particular, if liability is placed on the MCO, which in turn has a full indemnification agreement with the IDS, the MCO has less incentive to monitor legal defense expense and payout of damages than if all these costs are internalized. The indemnification agreement would likely permit the IDS to assume responsibility for defense of the claim, but in that case liability should be placed directly on the IDS. Since credentialing ultimately only makes sense at the level of the individual provider, efficient deterrence, claim defense, and transactions costs argue for placing liability directly on the IDS, rather than on the MCO.

No additional value would arise from holding the MCO to a duty of care in credentialing the IDS as a whole. Any reasonable standard of care for a system depends on its provider mix, so the standard for the system would reduce to standards for its member providers. For example, a relatively high frequency of claims against a system that includes a high proportion of surgeons and tertiary care hospitals could indicate high quality care and specialization as a referral center for difficult cases, rather than low quality care.

*Vicarious Liability and Ostensible Agency.* A separate issue is whether an MCO should be liable, under theories of vicarious liability or ostensible agency, for the negligence of its independent contractor physicians, assuming that the MCO has exercised due care in credentialing.

In *Boyd v. Albert Einstein Medical Center*, the Pennsylvania Superior Court reversed a lower court's summary judgment against the plaintiff, arguing that the HMO could be held liable under a theory of ostensible agency, if (1) the plaintiff looked to the HMO, not just to the physician, for care and (2) the HMO "holds out" the physician as its employee. The HMO's promotional materials were the major source for making this finding of fact. The promotional brochure described the HMO as a "total care program" that "provides medical care" as an "entire health system."

Such phrases reflect the attempt by an HMO to distinguish its coverage from traditional indemnity plans and, specifically, to convey the notions that coverage is restricted to selected providers, that there may be greater coordination of care between these providers, and (usually) that financial coverage is more comprehensive. While these functions make it appropriate that HMOs be held liable for negligent credentialing, the case for direct liability for negligence of affiliated providers is much weaker.

In the case of a staff model HMO, in which physicians are salaried employees who work exclusively for the HMO and are subject to direct and indirect controls by the HMO, liability may be appropriately placed on the HMO. In fact, some staff model HMOs and hospitals that employ salaried physicians already contract to assume the liability of their employees. Such contractual shifting of liability appears to occur only where the physicians

exclusively treat patients covered by the plan (or being treated at a single hospital) and where the close physical proximity enables the institution to monitor and control the physicians.

However, in the case of independent practice associations (IPAs), PPOs, point-of-service plans, and IDSs, the contractual relationships between the plan and the physicians fall far short of control over delivery of care. The relationship is primarily a financial one, in which the plan acts as an insurance/reimbursement intermediary for the physicians, including financial incentives for control of volume of services but not care per unit. The physician is better placed to evaluate and provide appropriate care per unit of service, conditional on the coverage decisions for which the plan should be contractually liable, as discussed above.

Making the plan potentially liable for the negligence of the physician is unlikely to improve efficient deterrence and may actually reduce efficiency. Adding another, deeper pocket defendant increases the plaintiff's incentives to invest excessively in litigation and raises costs of coordinating the defense, which in turn is likely to lead to higher litigation costs, more frequent false positive findings of liability, and excessive damage awards. Thus, adding plans as potential defendants may in fact change outcomes, in which case the allocation of liability is not an irrelevant detail that can be rectified through contract. If imposing liability on plans in fact increases defense costs and/or false positive findings of liability, then plans will seek greater control over providers, in order to reduce their liability costs. Such control will reduce the range of options available to consumers and is likely to reduce efficiency in the delivery of health services.

The only possible rationale for holding the plan, as well as the physician, liable for physician negligence is to provide compensation in cases where the award exceeds the physician's liability insurance and attachable assets. But if inadequate compensation is a concern, then the focus should be on other areas of personal injury litigation, particularly automobile injuries, because physicians typically carry higher limits of liability insurance and have greater personal wealth than most other individual defendants. There is no obvious equity rationale for singling out victims of medical injuries for special compensation. However, if this is a social goal, it can be achieved at lower cost through social insurance systems rather than through distortions of the liability system.

### *C. Enterprise Liability*

Proposals for enterprise liability call for shifting liability entirely from individual physicians to larger enterprises, either health plans or hospitals, rather than simply adding these institutions as potential additional defen-

dants under theories of vicarious and agency liability. Paul C. Weiler<sup>30</sup> and Kenneth S. Abraham and Weiler<sup>31</sup> argue for holding the hospital liable for all injuries arising out of care of the physicians on their staff, including injuries that occur outside the hospital. They argue that this would improve efficiency of deterrence, because hospitals are best placed to coordinate the allocation of resources to reduce injuries; provide more accurate internalization of costs, because experience rating of liability insurance is more accurate if applied to hospitals than to individual physicians; and reduce the costs of legal defense.

However, the evidence suggests that liability is already being shifted through voluntary contract in circumstances where such shifting offers potential efficiency gains, notably staff HMOs and hospitals that employ salaried physicians. The fact that liability is not shifted by voluntary contract in the majority of managed care plans, physician/hospital arrangements, and IDSs strongly suggests that to mandate such shifting would reduce efficiency. This is plausible, because in these circumstances the relationship is often not exclusive, does not entail close physical proximity, and the plan or hospital lacks the information necessary to control the care provided by the physician.

The hospital is particularly inappropriate as a bearer of liability given the current trend toward shifting care out of the traditional hospital into other settings. Surgical procedures are increasingly performed in outpatient facilities, recuperative care is shifting to skilled nursing facilities, and so forth. In an IDS that links primary care group practices, several secondary care hospitals, and one or more tertiary care hospitals, there is no efficiency rationale for singling out one of the hospitals as the sole locus of liability since none is necessarily well placed to control the quality of care in the others. Moreover, since care often optimally involves multiple ambulatory and institutional care providers, outcomes and quality are most efficiently measured at the level of the plan, not the individual hospital.

If liability is shifted from individual providers to the health plans with which they participate, this is likely to lead to tighter integration, more strict control by plans over their providers, and exclusive plan-provider arrangements. Exclusive arrangements, whereby each provider participates in only one plan, would greatly restrict the choice of providers available to patients who sign up with a particular plan and would increase travel time for consumers. Choice and proximity to providers is a major concern of consumers in selecting among managed care plans. The current rapid growth in market

<sup>30</sup> Weiler et al (cited in note 29).

<sup>31</sup> Kenneth S. Abraham and Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health System*, 108 Harv L Rev 381 (1994).

share of point-of-service plans indicates that patients are willing to pay for more flexibility in their choice of providers than is offered even by the traditional IPA type of plan, which does not require an exclusive arrangement between plan and providers. Independent practice associations and, a fortiori, point-of-service plans do not fit the enterprise liability model. Thus a requirement for enterprise liability would likely obstruct the flexibility of MCOs in developing wider choice options within a managed care environment.

The argument that enterprise liability would reduce defense costs while at the same time improving efficiency of deterrence is not convincing. Standards of care can only meaningfully be defined for providers who ultimately make decisions about the delivery of care. Health plans, by contrast, as financial intermediaries and residual claimants that define and enforce coverage decisions, can only meaningfully be held liable in contract for performance of their contractual obligations, as described above.

If plans are held liable for negligence on the part of their participating providers, a reasonable standard of care must still be applied at the level of the provider. In that case, the provider will be called to defend the claim, which undermines potential savings in defense costs. If individual providers are not called as defendants, then it is likely that the standard for plans will evolve into a standard of strict liability for any adverse outcome. Although a strict liability standard can in theory yield efficient incentives for care, the necessary conditions to achieve this result are unlikely to hold in the case of medical care because of the difficulty of distinguishing an adverse outcome of the patient's underlying illness from an injury caused by medical care. Thus, the likely evolution of a strict liability scheme for medical injuries is toward a very broad social insurance scheme for all imperfect health outcomes. The experience of Sweden and New Zealand, which have operated quasi-no-fault systems for medical injuries, shows that the apparent savings in litigation cost are achieved by forgoing all attempts at deterrence.<sup>32</sup> It is unclear what efficiency or equity goals are served by these schemes.

#### D. *The ERISA Preemption*

The ERISA preempts state laws to the extent that they "relate to" an employee benefit plan subject to ERISA. This preemption generally extends to HMOs to the extent that HMO coverage is purchased through a health

<sup>32</sup> Patricia M. Danzon, *The Swedish Patient Compensation System: Myths and Realities*, 14 *Intl Rev L & Econ* 453 (1994); Patricia M. Danzon, *Tort Reform: The Case of Medical Malpractice*, 10 *Oxford Rev Econ Papers* 84 (1994).

benefit program sponsored by a private employer.<sup>33</sup> However, the exact reach of the ERISA preemption is uncertain and in flux. So far, most courts have denied plaintiff claims for money damages related to denial of coverage. For example, in *Kuhl v. Lincoln National Life Plan*, the plaintiff alleged claims of medical malpractice, intentional infliction of emotional distress, tortious interference with contract, and breach of contract against Lincoln National as administrator of plan benefits. The Eighth Circuit Court held that the plaintiff's state law claims were preempted by ERISA and that ERISA does not authorize recovery of money damages for an administrator's alleged misconduct. The facts and the allegations in this case are similar to those in *Fox*, but the outcomes are dramatically different because the employer sponsor in *Fox* was a California school district and, as a public entity, was not protected by ERISA.

The ERISA preemption is consistent with the contractual nature of employee benefit plans, with both benefits and costs ultimately borne by employees. As noted earlier, assuming that employees select jobs on the basis of the total compensation package offered, the employer has incentives to offer health plans that maximize the utility of covered employees, since this minimizes the money wage or other benefits that must be offered to attract a given workforce.<sup>34</sup> This makes clear the absurdity of permitting claims for denial of coverage, except where violation of contractual commitments can be shown.

Efficiency and equity argue for eliminating the inconsistencies between liability exposure of ERISA-protected plans and non-ERISA plans. Under the status quo, employers have incentives to assume more risk in self-funding, in order to qualify for the ERISA preemption and hence limit their expected liability costs,<sup>35</sup> even if this results in nonoptimal diversification of stochastic risk. The ERISA preemption reaches approximately the right conclusions, but often for the wrong reasons. Unfortunately, current legislative proposals appear more likely to achieve alignment of liability of ERISA and non-ERISA plans by extending liability for quality of care to all HMOs.<sup>36</sup> For reasons outlined earlier, the preferred approach would be to hold all health plans liable under contract for denial of coverage consis-

<sup>33</sup> Conrad and Seiter (cited in note 16).

<sup>34</sup> This incentive of employers to act as good agents for employees may be weaker in the case of coverage for retirees. However, appropriate incentives are preserved to the extent that current workers are aware of the coverage for retirees and factor this into their estimates of the value of the compensation package.

<sup>35</sup> The expected liability costs of a non-ERISA plan will be internalized to the employer through a higher premium.

<sup>36</sup> Robert Pear, *HMOs Asserting Immunity in Suits over Malpractice*, NY Times (November 17, 1996).

tent with the contract. However, claims for negligent delivery of care should be permitted only against individual providers, except in the case of hospitals or staff model HMOs that contractually assume all liability claims against their employees.

## V. CONCLUDING COMMENTS

The trend toward managed care reflects a competitive response to the demand for alternative forms of insurance contract that provide better control of moral hazard than traditional indemnity insurance. Change in insurance products, together with technological advance in both medical care and information systems, is leading to radical change in the scale and structure of health care enterprises. The volume and variety of consolidations occurring across all segments of the health care sector reflect ongoing experimentation to develop contractual forms that offer better control over cost and quality. These trends reflect attempts to find more efficient solutions to the problems of asymmetric information, risk, insurance, and control of moral hazard that have traditionally undermined efficiency in health care markets. Ideally, managed care strategies eliminate care that is not cost justified (expected marginal benefit less than marginal cost) and hence reduce deadweight loss. If managed care plans are held to the traditional standard of customary and "medically necessary" care, the potential efficiency gains from managed care will not be realized.

Although managed care is associated with increasing assumption of financial risk by providers, the conceptual distinction between the insurance function and the provision of care must be maintained as the basis for sound liability rules.

The health plan, as the insuring entity (whether or not owned by providers) should be liable for coverage decisions. Coverage disputes should be handled as contractual issues, with liability only for breach of contract. Where the contract lacks explicit guidance, the default rule should be a cost-benefit standard with benefits defined in terms of willingness-to-pay of participants in that type of plan.

Health plans should be liable in tort for negligence only in cases of negligent credentialing. Liability for negligent performance should be placed solely on the individual provider, who is usually best placed to make and monitor precautions in the delivery of medical care. Adding liability of plans, under theories of vicarious, agency, or enterprise liability, serves only to add an additional deep pocket defendant. To the extent that this increases the frequency of erroneous findings of liability, the ability of managed care to control insurance-induced overuse and improve efficiency in health care delivery will be obstructed.

However, contractual shifting of liability between provider and plans, as in the assumption by staff model HMOs of the liability of their physicians, should be permitted. Given the heterogeneity of plan types and organizational forms, permitting plans and providers to contractually shift liability offers potential efficiency gains. By contrast, a uniform system of placing enterprise liability on plans, either instead of or in addition to liability on individual providers, is likely to obstruct the ongoing evolution toward more efficient forms of health insurance and delivery systems.

