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A World That Won't Stand Still: Enterprise Liability by Private Contract

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"Well . . .
Of course the world *didn't* stand still. The world grew.
In a couple of years, the new highway came through
And they built it right over those two stubborn Zax
And left them there, standing un-budged in their tracks."[1]

INTRODUCTION

Over the last decade, political debate over the reform of the United States health care system has been left behind to a considerable extent by changes generated from within the health care system itself.[2] Nowhere is this more evident than in the area of medical malpractice. Like neighbors quarreling over who owns a path through the woods, the traditional parties to the malpractice debate have been arguing in such loud voices for so long that they have failed to notice that the forest is being cut down, and a new town is

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1. Dr. Seuss, *The Zax, in* THE SNEETCHES AND OTHER STORIES 26, 35 (1961).

2. Rather than proposing radically different ways of delivering health care, most national health care reform legislation currently before Congress builds upon industry trends (such as capitated payment systems and managed care) and attempts to lend them uniformity and fairness. *E.g.*, The Health Security Act, H.R. 3600, 103d Cong., 1st Sess. (1993); Managed Competition Act of 1993, H.R. 3222, 103d Cong., 1st Sess. (1993); The Affordable Health Care Now Act of 1993, 3080, 103d Cong., 1st Sess. (1993); Health Equity and Access Reform Today Act of 1993, S. 1770, 103d Cong., 1st Sess. (1993). The only exceptions to this pattern are the McDermott-Wellstone single-payor proposal contained in the American Health Security Act of 1993, H.R. 1200, 103d Cong., 1st Sess. (1993), which attempts to recreate the Canadian health care system in the United States, and the Stark proposal detailed in the Mediplan Health Care Act of 1993, H.R. 2610, 103d Cong., 1st Sess. (1993), which is based on a Medicare model.

being built.[3]

"Enterprise liability,"[4] combined with alternative dispute resolution and limits on noneconomic damages, was suggested by the malpractice working group of the President's Task Force on Health Care Reform as a way to align medical malpractice law with other forces in a health care system that must deliver high-quality, cost-effective care.[5] However, entrenched interests on both sides of the malpractice debate reacted with suspicion and alarm, and enterprise liability never became the focus of the Clinton Administration's malpractice proposal.[6]

So be it. As many experts and the health care organizations that currently assume liability explain, enterprise liability is coming any-

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3. The title of a comprehensive study by the General Accounting Office says it all: U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS (1986).

4. "Enterprise liability" is the name given to a system in which provider organizations rather than individual physicians bear responsibility for medical malpractice. These organizations might include group medical practices, hospitals and hospital systems, health maintenance organizations, and other managed care entities that are charged with both financing and delivering health care services to a defined patient population. *See* William M. Sage et al., *Enterprise Liability For Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1 (1994) (discussing enterprise liability comprehensively, especially its potential effect on the quality of health care).

5. Enterprise liability for medical malpractice was first proposed as part of the American Law Institute's Tort Reform Project using a scheme that held hospitals accountable for the actions of physicians. *See* 2 AMERICAN LAW INSTITUTE, REPORTERS' STUDY: ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 111-27 (Paul C. Weiler ed., 1991) (proposing a system believed to be equitable for those injured and predictable for insurers); Kenneth S. Abraham et al., *Enterprise Responsibility for Personal Injury: Further Reflections*, 30 SAN DIEGO L. REV. 333, 355-58 (1993) (proposing that hospitals or other health care providers should bear exclusive liability for all injuries other than those intentionally inflicted on a victim); *see also* Kenneth S. Abraham & Paul C. Weiler, *Organizational Liability for Medical Malpractice: An Alternative to Individual Health Care Provider Liability for Hospital-Related Malpractice* (June 29, 1992) (unpublished manuscript, on file with the *DePaul Law Review*) (proposing a system of organizational liability for medical malpractice). Other scholars have made similar suggestions. *See, e.g.*, Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985, 1030-32 (1986) (arguing that institutional liability could increase physician monitoring and hospital record-keeping); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1746-50 (1987) (suggesting that liability be shifted either to hospitals or third-party payors).

6. *See* David Rogers, *Initial Clinton Medical Malpractice Reform Plan Pulled After Resistance by Entrenched Interests*, WALL ST. J., June 15, 1993, at A20 (reporting on the Clinton Administration's retreat from enterprise liability in the face of competing lobbies of medical providers and trial lawyers). Although enterprise liability is not mandated by the Administration's Health Security Act, the bill includes a state demonstration project to test the effect of enterprise liability on quality of care and availability of compensation for negligent injury. H.R. 3600 § 5311. The Physician Payment Review Commission has supported federal demonstration projects and evaluations of existing examples of enterprise liability. PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS 199 (1994).

way and, if properly implemented, will make things easier for patients, physicians, and managers.[7] On the other hand, ill-conceived attempts to preserve historical distinctions between liability for insurance behavior and for clinical care could have disastrous consequences. Late last year, for example, a California jury held a prominent health maintenance organization ("HMO") liable for denying coverage for the cost of a breast cancer patient's bone marrow transplant which the HMO argued was "experimental" treatment.[8]

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7. *See, e.g., id.* at 199; Penni Crabtree, *HMOs Held More Accountable For Care*, SAN DIEGO BUS. J., Nov. 8, 1993, at 1 (indicating that holding health maintenance organizations ("HMOs") liable for physician mistakes is gaining slow but steady support); Armand Leone, Jr., *ADR and Enterprise Liability*, N.J. L.J., Nov. 8, 1993, at S8 (arguing that the benefits of enterprise liability will increase with the development of alternative dispute resolution); *see also* Edward Felsenthal, *Medical Plans Take On Greater Liability*, WALL ST. J., Oct. 18, 1993, at B8 (reporting that private HMO agreements and state court decisions have created enterprise liability without legislation).

There are four general theories of enterprise liability for medical malpractice. In the first model, hospitals and staff-model HMOs, like other employers, are generally liable for the medical negligence of physicians whom they employ under the traditional tort doctrine of respondeat superior. *See, e.g.*, Schleier v. Kaiser Found. Health Plan, 876 F.2d 174, 177-78 (D.C. Cir. 1989) (extending HMO liability to acts of nonemployed "consulting physicians" selected by the HMO staff); Stewart R. Reuter, *Toward a More Realistic and Consistent Use of Respondeat Superior in the Hospital*, 29 ST. LOUIS U. L.J. 601, 663-64 (1985) (advocating a modified version of respondeat superior in hospital setting based on traditional agency theory). Under the second model, hospitals and other health care institutions are legally responsible for reviewing the credentials of physicians seeking medical staff privileges and enforcing peer review of medical staff performance. *See, e.g.*, Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 258 (Ill. 1965) (upholding a negligence verdict, in part, because the hospital failed to review the attending physician's work or require patient consultation). Under the third model, hospitals and HMOs may be held liable on a theory of apparent agency where the organization has advertised the competence of its affiliated physicians or otherwise held itself out to the public as assuring quality. *See, e.g.*, Boyd v. Albert Einstein Medical Ctr., 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988) ("[T]wo factors relevant to a finding of ostensible agency are: 1) whether the patient looks to the institution . . . for care; and 2) whether the HMO 'holds out' the physician as its employee."); Kashishian v. Port, 481 N.W.2d 277, 281-87 (Wis. 1992) (expanding liability under apparent authority beyond the emergency room context where misleading conduct by the hospital, scienter, and reliance by the plaintiff can be shown). Finally, utilization review procedures and other financially-motivated behavior by insurers and other managed care entities have led to malpractice litigation. *See, e.g.*, Wilson v. Blue Cross of S. Cal., 271 Cal. Rptr. 876, 885 (Cal. Ct. App. 1990) (remanding the issue of patient liability based on a utilization review); Wickline v. State of California, 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986) ("Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms . . . .") (dictum); *see also* John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 226-28 (1989) (arguing that a clear understanding of the legal liabilities inherent in this area is essential to the use of utilization review and case management as cost containment vehicles). The development and use of clinical practice guidelines is likely to accelerate this trend.

8. Fox v. Health Net, No. 219692 (Cal. Sup. Ct. Dec. 28, 1993). *See* Christine Woolsey, *Jury Hits HMO for Coverage Denial*, BUS. INS., Jan. 3, 1994, at 1, 23 (stating that the "courts have split on whether [treatment] is warranted").

The jury awarded $89 million to the family of the deceased patient.[9]

Sound business planning for all sectors of the health care industry should therefore include the development of a consistent, coordinated approach to medical liability.[10] The purpose of this article is to help health care providers and insurers create such an approach by explaining the benefits and risks of voluntarily reassigning liability for medical injury along an enterprise liability model, and by outlining the legal and contractual elements that are required to do so successfully.

I. ACCOUNTABILITY FOR MEDICAL INJURY: AN ANACHRONISM

A. The Political Impasse

In the spring of 1993, President Clinton's Task Force on Health Care Reform mentioned enterprise liability, without elaboration, as a key component of its malpractice reform proposal.[11] Despite indications of support from large employers and some consumer groups,[12] enterprise liability was quickly and harshly condemned by both organized medicine and the managed care industry, while the trial lawyers were silently unsupportive (a fact that probably increased suspicion among health care providers).[13]

Some aspects of the health care industry's reaction to enterprise liability relate to the rapidly changing character of the health care delivery system. Fearful of any legislative proposals that appear to validate managed care, many medical organizations argue that enterprise liability would cause physicians to lose clinical autonomy.[14]

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9. Woolsey, *supra* note 8, at 1, 23. The case was subsequently settled for an undisclosed but lesser sum. Don Lee, *Health Net Settles Lawsuit Over Denial of Cancer Treatment*, L.A. TIMES, Apr. 7, 1994, at D1, D10.

10. Several legal scholars have advocated private, contractual approaches to improving the medical liability system. *See e.g.*, Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49 LAW & CONTEMP. PROBS., Spring 1986, at 143, 170-72 (concluding that privately negotiated reforms allow consumers greater flexibility and experimentation in addressing health care issues than political or legal reforms).

11. Robert Pear, *Clinton Advisers Outline Big Shift For Malpractice*, N.Y. TIMES, May 21, 1993, at A1.

12. *E.g., Reactions to the Clinton Health Care Proposal, 1993: Hearings on H.R. 3600 Before Subcomm. on Health of the House Ways and Means Comm.*, 103d Cong., 1st Sess. 1 (1993) (statement of Anne Marie O'Keefe, Washington Business Group on Health).

13. *See* David S. Starr, *Enterprise Liability a "Bottomless Well,"* AM. MED. NEWS, June 28, 1993, at 15 (arguing that plaintiffs' lawyers favor enterprise liability because, like corporate liability, it can lead to higher awards).

14. The American Medical Association's ("AMA") weekly newspaper straightforwardly stated: "For enterprise liability to work, every doctor would have to be part of an 'enterprise' (and, possi-

At the same time, some managed care groups, resistant to any legislation supporting the tendency of judges to hold them directly accountable to patients, criticize enterprise liability on the exact opposite grounds, claiming that insurers would be unable to enforce quality-related decisions.[15]

For the most part, however, interest groups view enterprise liability through the narrow lens of traditional "tort reform."[16] At the time that enterprise liability was first discussed, the Clinton Administration's position on such issues as damage caps, alternative dispute resolution, attorney's fees, statutes of limitations, and collateral source offset was unclear. Predictably, both sides assumed the worst: provider groups feared that enterprise liability in states without tort reform would lead to inflated verdicts against corporate defendants,[17] while the trial bar worried that malpractice claims under enterprise liability would reduce access to the courts because it would encourage the use of nonjudicial remedies.

Physicians and trial lawyers have been squabbling over tort reform for years. Organized medicine has long argued, with some justification, that unfettered liability for medical malpractice unfairly burdens physicians and adds unnecessary cost to health care.[18] Con-

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bly, only one). Organized medicine firmly opposes such constraints." *The Sinking of Enterprise Liability*, AM. MED. NEWS, July 5, 1993, at 17.

15. *See* Dana Priest, *Clinton Advisers Discuss Plan to Shift Liability From Physicians*, WASH. POST, May 21, 1993, at A10 ("The AMA . . . fears that enterprise liability would . . . erode physician autonomy by giving non-physicians more reasons to dictate how doctors do their work."). Physician-owned malpractice insurance companies who would stand to lose a captive market also oppose enterprise liability. Rogers, *supra* note 6, at A20.

16. Traditional tort reform proposals, most of which arose as the result of shortages or rapid increases in the price of malpractice insurance that have since eased, emphasize barriers to suit and restrictions on recovery. *See* AGENCY FOR HEALTH CARE POLICY AND RESEARCH, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, COMPENDIUM OF SELECTED STATE LAWS GOVERNING MEDICAL INJURY CLAIMS (1993) [hereinafter COMPENDIUM] (reviewing the current status of tort reform laws in the fifty states). The archetype of traditional tort reform is California's Medical Injury Compensation Reform Act of 1975. *See* 1975 Cal. Stat. 3949 (codified as amended at CAL. BUS. & PROF. CODE § 6146 (West 1990); CAL. CIV. CODE §§ 3333.1-.2 (West Supp. 1994); CAL. CIV. PROC. CODE §§ 340.5, 1295 (West 1982)) [hereinafter MICRA]. This act has served to lower malpractice insurance premiums principally through its fixed $250,000 cap on noneconomic damages. CAL. BUS. & PROF. CODE § 3333.2(b).

17. *See* Scott Shepard, *"Enterprise Liability": A Search For Deeper Pockets?*, MEMPHIS BUS. J., Aug. 2, 1992, at 14 (quoting Greg Duckett, Vice President of Baptist Memorial Health Care System, Inc., who stated that "shifting liability is not tort reform").

18. *See, e.g., Issues Relating to Medical Malpractice, 1993: Hearings on Health Care Reform Before the Subcomm. on Health of the House Ways and Means Comm.*, 103d Cong., 1st Sess. 50 (1993) (statement by Richard F. Corlin, American Medical Association). There are certainly many frivolous lawsuits. According to data from the Harvard Medical Practice Study, only one in six malpractice claims met reviewers' standards for "persuasive evidence" of negligent injury. Paul

sumer advocates and the trial bar have generally replied, also with some justification, that bad medicine is common and that malpractice suits help protect and compensate vulnerable patients.[19] The likelihood of national health care reform has added a note of urgency to both voices.

B. *The Reality of Change*

While this debate has raged, the landscape of the American health care system has changed dramatically. Medicine is increasingly complex, specialized, and dependent on technology and support services, so that serious health problems usually require the participation of a team of physicians working with other health professionals using the resources of highly advanced facilities. Many consumers are educated and demanding, and are therefore unlikely to place their full confidence in a single physician without an investigation, disclosure, and discussion of the available options. As a result, the traditional doctor-patient relationship has been strained to accommodate the need for coordination and communication among providers, and for more informed and active decision-making by patients and their proxies.

Business structures have also changed. In order to keep coverage affordable, most employers have shifted from pure third-party payment systems to various forms of managed care.[20] This integration

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C. Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355, 2355 (1992) (reviewing HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (1990)). There are also many excessive jury verdicts. *See* Randall R. Bovbjerg et al., *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, 54 LAW & CONTEMP. PROBS., Winter 1991, at 5, 6 & n.8 (recognizing empirical support for the notion that medical malpractice awards are much greater than other personal injury suits). However, the cost implications of malpractice law are often exaggerated. Estimates of defensive medicine are imprecise and impossible to separate from other causes of unnecessary services, while malpractice premiums and premium equivalents amount to only 1 percent of total health care costs. *See* ROBERT W. STURGIS, TORT COST TRENDS: AN INTERNATIONAL PERSPECTIVE 1 (1992).

19. *See generally* CALIFORNIANS FOR PATIENT RIGHTS, MICRA: IT'S TIME FOR A CHECK-UP! (1993) (arguing that the Medical Injury Compensation Reform Act shifts the burden of medical malpractice from doctors to patients). However, even if litigation helps, it doesn't help much. Although approximately 1 percent of all hospitalizations lead to negligent medical care, only one in eight such incidents gives rise to a malpractice claim, and only one in sixteen is compensated as a result. Weiler et al., *supra* note 18, 2355-56.

20. *See* Robert A. Berenson, *A Physician's View of Managed Care*, HEALTH AFF., Winter 1991, at 106 & n.1 (describing the mixed success of managed care); *see also* Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POLITICS, POLICY & L. 75 (1993) (reviewing past and current

of financing and delivery has had two principal effects. First, decisions that influence care delivery are now made by corporate enterprises as well as by front-line practitioners. Second, financial responsibility for overall costs is now borne by providers (through capitation arrangements,[21] risk pools, and other incentives) as well as by insurance companies. In California, approximately half of the population is enrolled in HMOs that fully merge insurance with medical services and offer comprehensive care to enrollees at a fixed annual price with minimal cost-sharing.[22] These organizations are likely to be the prototypes for the integrated delivery systems that would compete as "health plans" in the Clinton Administration's reform proposal.[23]

In conjunction with these general trends, several specific developments are occurring as health care providers and insurers join together to form organized systems of care:

- Single-specialty and multi-specialty group practices are replacing solo physician practices and small partnerships.[24]
- Group practices are affiliating with other group practices and/or with hospitals to form integrated provider networks to serve insurers and large employers.
- A greater percentage of physicians are employed by HMOs, physician groups, or — in many states — hospitals.[25]
- Patients are receiving care from HMOs and other closed-panel managed care organizations — some with a higher-cost, "out-of-network" option[26] — at an increasing rate.

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trends in the market for nontraditional health benefit plans).

21. *See* David F. Woods, *Health Care Reform and the Agent*, PROBE, March 21, 1994, at 1, 2 (explaining that in a fully capitated system, a provider network receives a flat fee in return for providing health care services to the payor).

22. According to the California Department of Corporations, 48.1 percent of California's population (between 57.1 percent and 59.4 percent of those with health insurance) are enrolled in a health care service plan. GARY MENDOZA & WARREN BARNES, CALIFORNIA SOC'Y FOR HEALTHCARE ATTORNEYS, THE HEALTH CARE WORLD IN THE EYES OF THE DEPARTMENT OF CORPORATIONS at iii (1993).

23. *See* H.R. 3600, § 1400 (defining "health plan").

24. Between 1969 and 1991, the percentage of nonfederal physicians practicing in groups increased from 17.6 percent to 32.6 percent. Penny L. Havlicek et al., *Medical Groups in the U.S.: A Survey of Practice Characteristics* 44 (1993). In 1991, 31 percent of those in group practice worked in multi-specialty groups with fifty or more physicians. *Id.* at 42.

25. According to an AMA survey, 32.6 percent of physicians were employed by or party to an independent contractor arrangement in 1992. CENTER FOR HEALTH POLICY RESEARCH, AMERICAN MEDICAL ASSOCIATION, PHYSICIAN MARKETPLACE STATISTICS 1992, at 128 (Martin L. Gonzalez ed., 1993).

26. "Out-of-network" means that patients may receive health care from practitioners who are

- Patients, especially those in HMOs, receive a comprehensive set of health benefits, including preventive services, with fewer benefit-specific restrictions on office visits or days of treatment.[27]
- Health care insurers and provider organizations are applying financial incentives, collecting practice data, and enforcing clinical protocols to reduce unnecessary utilization of services.
- Because many managed care plans emphasize "gatekeeping" for specialist referrals and hospital utilization, a greater percentage of care is being provided by primary care physicians and in outpatient settings.[28]

As a result of these changes, the medical malpractice system has become obsolete. For a substantial majority of Americans, comprehensive health care currently is or soon will be financed, planned, and provided by large enterprises using advanced clinical and management technologies. Equally sophisticated methods of quality management and dispute resolution are needed to identify substandard practice, promote quality improvement, and compensate injured patients. Nonetheless, allegations of poor quality care are still today settled in court by a single doctor and his or her patient with the help of two lawyers, a judge, and a jury.[29]

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not contractually affiliated with an established health plan. *See* Sage et al., *supra* note 4 (suggesting that medical malpractice liability should be shared between health plans and out-of-network practitioners under an enterprise liability system). According to the Group Health Association of America, HMO membership grew by 3.5 million in 1993, and may exceed fifty million during 1994. Mike Mitka, *Boom Year*, AM. MED. NEWS, Jan. 10, 1994, at 2.

27. Patients with indemnity coverage, on the other hand, often face higher deductibles and copayments, sweeping exclusions for preexisting conditions, and cutbacks in covered benefits. However, several states have enacted "small-group insurance reform" legislation which is reversing this trend. *See* John K. Iglehart, *Health Care Reform — The States*, 330 NEW ENG. J. MED. 75, 77 (1994) (outlining a variety of approaches including mandated coverage, guaranteed renewal, and restricted insurance rates).

28. The trend toward out-of-hospital care by primary care physicians is already being reflected in malpractice claims. The most recent data from the Physician Insurers Association of America ("PIAA") suggests that claims against office-based general practitioners are on the rise. Thomas E. Kirchmeier, Presentation to the American Society of Healthcare Risk Management (Oct. 25, 1993).

29. Donald M. Berwick, a leading authority on quality improvement in health care, has observed that "[t]he doctor no longer really controls health care, as in the days of solo practice, but, when it comes to quality, the doctor is still held accountable. . . . Control is shifting, structure is shifting, the pattern of care is shifting; but accountability is not." DONALD M. BERWICK ET AL., CURING HEALTH CARE: NEW STRATEGIES FOR QUALITY IMPROVEMENT 12 (1990).

II. THE FUTURE: A CONTRACTUAL MODEL FOR HEALTH CARE INJURIES

Successful integrated health care delivery systems will eventually replace the "tort model" of medical malpractice with a "contract model." Traditional torts, such as automobile accidents or toxic spills, generally involve strangers. By contrast, patients and health professionals base their actions on and derive their expectations from a close, preexisting relationship. For this reason, medical malpractice law, particularly the doctrine of informed consent, includes contractual elements.[30]

As managed care has become prevalent, so has the use of formal agreements to specify many aspects of the relationships among patients, providers, and payers. For example, agreements between patients and managed care insurers, such as HMOs, govern the selection of physicians and facilities as well as the scope of coverage. To further define the delivery as well as the cost of care, these organizations negotiate agreements with physicians, medical groups, hospitals, ambulatory care facilities, ancillary service providers, home health care agencies, and other parties.[31]

A contractual model is essential to any national health care reform that entitles every American to comprehensive, cost-effective care. One commentator has observed that "it is virtually inevitable that a rational and decent system of care will disappoint patients' and subscribers' expectations at critical and disputed points."[32] Therefore, it will be impossible to promote efficient medical decision-making unless patients and providers agree prospectively to rights and remedies with respect to clinical care.[33] Moreover, limited government oversight is needed to ensure that vulnerable par-

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30. The doctrine of informed consent requires a physician to inform the patient of the risks involved prior to providing treatment. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 187-88 (5th ed. 1984). *See* E. Haavi Morreim, *Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care*, 12 J. LEGAL MED. 275, 293-96 (1991) (arguing that doctors should have a contractual duty to supply patients with economic information in addition to medical information).

31. *See* Weiner & de Lissovoy, *supra* note 20, at 80-86 (describing the formal and informal contractual relationships that underlie all arrangements for medical care delivery and financing).

32. Paul T. Menzel, *Consumer Expectations and Access to Health Care: A Commentary*, 140 U. PA. L. REV. 1919, 1919 (1992).

33. The alternative to private agreement is likely to be a process of regulatory micromanagement and judicial second-guessing that would be as inefficient and counterproductive to the delivery of cost-effective care as the current vague standards of medical necessity coupled with retrospective utilization review are to health care reimbursement and financing.

ties are not treated unfairly.

The key to understanding the benefits of enterprise liability for medical malpractice is to recognize that existing managed care contracts can address quality monitoring, clinical performance, accountability for error, and dispute resolution procedures. Providers that choose to participate in integrated health care delivery systems therefore will be able to restructure and improve the efficiency of the malpractice system if they accept three propositions: (1) although quality management in health care is still in its infancy, one cannot manage the cost of care without also managing its quality; (2) in an integrated system, liability for poor quality care can be reassigned by contract to the party best able to improve quality and resolve disputes; and (3) courts will uphold fair contractual provisions among providers and between patients and providers, including more efficient methods of dispute resolution.

A. Backing Into Enterprise Liability

Several aspects of the developing health care marketplace have forced participants in integrated health care delivery systems to take on many of the responsibilities that an explicit assumption of enterprise liability would formalize. In particular, current and proposed legislative reforms hold health plans and large providers accountable for many determinants of both clinical care and dispute resolution.

1. Capitated Care and Future Medical Expenses

Many integrated health care organizations fear that bearing liability for medical malpractice would open a Pandora's box of financial risk. To the contrary, individual providers in the current system pass their liability costs along to insurers and patients. As a result, so long as proper safeguards exist against exceptionally high awards,[34] enterprise liability would not greatly increase malpractice exposure. In addition, the nature of capitated care[35] already makes health plans liable for a considerable amount of the financial risk created by malpractice. By agreeing to deliver necessary care for a preset amount, health plans and other providers compensated on a capitated basis bear the financial risk that an enrollee will require

34. *See infra* notes 96-108 and accompanying text (proposing legal limits on damages combined with binding arbitration as a safeguard to prevent grossly excessive awards).

35. *See* Woods, *supra* note 21, at 2 (describing a capitated care system).

medical services. This includes additional medical expenses caused by medical malpractice, which comprise about half of economic damages and approximately one-quarter of all damages.[36] Enterprise liability would not increase a health plan's exposure to these costs.[37]

2. *Demand for Quality-Related Information*

Until recently, the key to success for a health plan or capitated provider has been to accept predominantly healthy patients who are unlikely to require care. As managed care matures, however, these organizations are being forced to compete based on the price and quality of their health care services. This trend is being accelerated by state and federal legislative initiatives that require health plans to insure all applicants at a community rate and, in some cases, pay health plans a risk-adjusted annual premium.[38] Moreover, purchasers of care are demanding that health plans justify their cost-cutting measures by providing detailed information about enrollees' satisfaction, access to services and, increasingly, health outcomes.[39] The Clinton Administration's reform proposal requires health plans to disclose relevant facts to consumers choosing coverage, to meet clear standards for truth in advertising and marketing, and to provide additional data for verification by health care purchasers and government regulators.[40] As a result, health plans and organizations are

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36. The *Harvard Medical Practice Study* suggested that medical injuries in the group studied resulted in a total economic cost (insured and uninsured) of $3.8 billion, including $1.95 billion in lost wages and household production and $1.85 billion in medical care expenditures. Weiler et al., *supra* note 18, at 2356; *see* William G. Johnson et al., *The Economic Consequences of Medical Injuries: Implications for a No-Fault Insurance Plan*, 267 JAMA 2487, 2489, 2491 (1992) (suggesting that the undiscounted cost of medical injuries in the group surveyed was $21.4 billion, including $2.6 billion in lost wages, $3.4 billion in lost household production, and $15.4 billion in medical care expenditures).

37. Of course, some future medical expenses, notably long-term care, are not covered by most private insurance plans. The cost of such care would therefore be in addition to a health plan's existing obligations.

38. *See, e.g.*, H.R. 3600, §§ 1402-03, 1541-45 (1993) (stating that each health plan offered by a regional alliance or a corporate alliance must enroll every alliance-eligible individual who seeks enrollment using a community rate and that risk adjustment methodologies must be developed); CAL. HEALTH AND SAFETY CODE § 1357(i)-(k) (West Supp. 1994) (setting forth criteria, including geographic requirements, that health care services must follow in determining employee risk rates).

39. *See, e.g., Data Watch, A Profile of Outcomes Research*, BUS. & HEALTH, Jan. 1994, at 16 (providing survey results on health outcomes).

40. H.R. 3600, §§ 1404, 1410-13, 5000-13.

being held accountable for quality as never before.[41]

3. *The Convergence of Coverage and Care*

The present lack of meaningful liability on the part of managed care insurers stems in part from a historical distinction between coverage disputes and malpractice claims. As managed care organizations blend the financing of health insurance with the delivery of health care services, however, coverage decisions are increasingly likely to have direct clinical consequences.[42] At the same time, the benefits offered by health plans are more often comprehensive and based on case management principles rather than arbitrary limits on hospital days or physician visits.[43] Consequently, claims against health plans are likely to raise clinical as well as insurance issues.[44] The convergence of litigation over insurance coverage and medical malpractice is in part stating the obvious. In a health care system where all "medically appropriate" care is covered by health plans, coverage decisions are necessarily decisions about medical appropriateness and therefore implicate the standard of clinical care.

4. *Demonstrating Responsiveness to Consumers*

One obstacle to the efficient resolution of clinical disputes has been the health plans' and care managers' lack of control over the selection of providers and treatments by beneficiaries. However, the increasing popularity of HMOs and other closed-panel delivery sys-

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41. Enterprise liability would add to this requirement for quality-related information direct liability for a practitioner's failure to obtain the informed consent of his patients. *See* KEETON ET AL., *supra* note 30, § 32, at 189-92 (discussing the doctrine of informed consent).

42. Courts have begun to recognize this trend. *See, e.g.*, Wilson v. Blue Cross, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990) (holding that the trial court erred in granting summary judgment because genuine issues of fact existed as to whether the conduct of the decedent's insurance company was a substantial factor in causing the decedent's death); Wickline v. State, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986) (dictum) (holding that a third-party payor may be held liable for medically inappropriate decisions); *see also* Abraham et al., *supra* note 5, at 355 (proposing a new system of organizational liability in which individual hospitals and health maintenance organizations bear responsibility for medical malpractice).

43. This trend will increase if exclusions for preexisting conditions and other health-related limitations on benefits are prohibited by law. *See* H.R. 3600, §§ 1402-03, 1541-45 (stating that no plan may limit enrollees based on their health status or their anticipated need for health care).

44. The recent decision in Fox v. Health Net, No. 219692 (Cal. Sup. Ct. Dec. 28, 1993) demonstrates this tendency, although it was litigated as a coverage issue. *See infra* notes 131-33 and accompanying text (reviewing the decision in *Health Net* and concluding that in any system of comprehensive HMO-style health insurance, disputes over coverage are, by definition, disputes over the standard of care).

tems has made the health plan, rather than the individual physician, the first point of contact for many consumers. Competitive pressures are leading health plans to emphasize administrative accessibility, both to reduce unnecessary utilization of services and to handle questions or complaints. The government is similarly concerned. Under the Health Security Act, for example, consumers are assured access to health plan-based grievance procedures and to adjudication of disputes over coverage and benefits by state and federal administrative and judicial bodies.[45] The result of these forces is likely to be health plans that are better equipped to resolve disputes and plans that are held accountable for doing so fairly, whether or not they technically bear enterprise liability.

B. Benefits of Assuming Enterprise Liability

There are several advantages to an explicit, coordinated system of enterprise liability. The ultimate success of managed care depends in great part on the erosion of traditional barriers to collaboration among participants in the delivery of health care services. The traditional malpractice system retards this process. Breaking this logjam may therefore benefit all sectors: insurers, managed care companies, health facilities, provider groups, individual physicians, and nonphysician practitioners.

1. Physician Loyalty and Teamwork

Enterprise liability should help improve relations between clinical managers and front-line physicians. Existing managed care arrangements often place managed care companies and health professionals at cross-purposes. Insurers conducting utilization review bear little responsibility for injuries resulting from inadequate care, and are thus tempted to control costs by imposing arbitrary restrictions on services. On the other hand, physicians — who are often more anxious about malpractice litigation than about cost-effectiveness — may be led by their malpractice carriers to practice wasteful, defensive medicine. This adversarial process is better suited to courtrooms than to clinics.

If health plans or other institutions bear responsibility for individual instances of malpractice, relieving physicians of that burden, practitioners should have greater confidence that care management

45. H.R. 3600, §§ 1405, 5201-43.

decisions are being conducted with attention to quality. This should lead to better teamwork, especially as the health care industry consolidates and physicians become closely affiliated with a smaller number of organizations. Specifically, managers and administrators should ascribe increased importance to the contributions that clinicians can make to the organization's policies and protocols, and physicians should be less resentful of practice guidelines or other cost-oriented care management strategies.[46]

2. *Quality Improvement*

Once these impediments to cooperation are overcome, health plans and other institutional providers will have certain advantages over individual practitioners with respect to quality assessment and improvement. As noted above, quality-related information will constitute an important competitive advantage for product marketing and regulatory compliance.[47] For example, health care institutions serve populations large enough to collect statistically valid samples, and they possess the financial resources to develop medical information systems to analyze this data and communicate recommendations.[48] These activities form the basis of "total quality management" ("TQM") and "continuous quality improvement" ("CQI"), two management initiatives which are rapidly gaining favor in the health care industry.[49]

A managed care environment should also facilitate risk management, as care-related errors often have institutional causes and solutions. Clinical performance in the managed care setting may be influenced by staffing decisions, institutional capacity to deliver certain services, utilization policies, and clinical protocols.[50] For ex-

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46. *See* Jonathan Lomas et al., *Do Practice Guidelines Guide Practice?*, 321 NEW ENG. J. MED. 1306, 1310 (1989) (suggesting that the perceived threat of malpractice litigation prevents physicians from adopting clinically sound practice guidelines).

47. *See supra* notes 38-41 and accompanying text (discussing consumers' demand for quality-related information).

48. *See* David C. Kibbe & Richard P. Scoville, *Computer Software for Health Care CQI*, 1 QUALITY MGMT. HEALTH CARE 59 (1993); Stephen J. McPhee et al., *Promoting Cancer Prevention Activities by Primary Care Physicians*, 266 JAMA 538, 542 (1991).

49. *See* Glenn Laffel & Donald M. Berwick, *Quality in Health Care*, 268 JAMA 407, 408 (1992) (discussing TQM and the need to better integrate research results into routine care activities to improve the quality of health care); *The Quality March*, HOSPS. & HEALTH NETWORKS, Jan. 5, 1994, at 45 (reviewing the results of a national survey of hospital quality improvement activities).

50. For example, studies of surgical hospitalizations have strongly suggested that institutional and group characteristics ("hospital effect") predict performance to a greater degree than individ-

ample, the most common cause of serious medication errors with respect to antibiotics is a failure to note a patient's known allergy,[51] a mistake that can be addressed at the institutional level by devoting greater resources to eliciting information, developing more effective charting and communication among providers, and maintaining a work environment that promotes attentiveness.

Also, health care enterprises apply information technologies and quality improvement principles to their decisions to contract with physicians and to extend specific clinical privileges. Increasingly, health plans are assessing physicians' patterns of utilization and expense as they form provider networks. This practice, called "economic credentialing,"[52] provokes concern among physicians and the public because it appears to exclude considerations of quality. By contrast, health care organizations that elect to bear enterprise liability should necessarily focus on quality as well as on cost when they make affiliation decisions, and should therefore attract higher-quality physicians. Moreover, an organization's ability to terminate its affiliation with or withdraw privileges from a physician may serve as a powerful inducement for individual practitioners to improve the way they practice.

3. *Administrative Efficiency*

Another clear benefit of enterprise liability is that it will coordinate the grievance process and the defense of malpractice actions. About 25 percent of malpractice claims involve two or more defendants.[53] In these situations, avoidable claims may be filed because some participants in a patient's course of care have not been apprised of a bad outcome; for example, a large hospital bill may be sent to a patient who is considering bringing suit against an uncommunicative physician. In addition, meritorious claims may not be resolved promptly because parties are unaware of all the relevant facts until the suit is filed and discovery has commenced. Finally,

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ual characteristics ("surgeon effect"). ANN BARRY FLOOD & W. RICHARD SCOTT, HOSPITAL STRUCTURE AND PERFORMANCE 227-77 (1987).

51. *See* PHYSICIAN INSURERS ASSOCIATION OF AMERICA, MEDICATION ERROR STUDY 6-7 (1993).

52. *See* Michael J. Baxter, *Exclusive Contracting: The Original Economic Credentialing*, 26 J. HEALTH & HOSP. L. 97 (1993) (analyzing medical institutions' use of economic credentialing in evaluating the performance of physicians under exclusive contracts).

53. U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984, at 26 (1987).

groundless or questionable claims may receive undeserved compensation because plaintiffs' attorneys will exploit the tendency of multiple defendants with varying insurance coverage to implicate each other. Focusing responsibility for medical injury on a single party is a simple way to reduce these transaction costs.

A health plan or large institutional provider is also likely to be a more efficient purchaser of liability insurance.[54] As is the case with small-group health insurance, selling malpractice coverage to individual physicians requires a substantial investment in marketing and brokerage services as well as increased paperwork and other administrative costs. Large institutions are capable of self-insuring[55] low-level risk and can drive a hard bargain with carriers for excess coverage.

Reassigning liability to one organization in an integrated delivery system has the additional advantage of diversifying the malpractice risk associated with particular specialties across a broad range of clinical services. This should be attractive to managed care physicians in high-risk areas, such as obstetrics, who might otherwise be subject to substantial increases in premiums as the result of a single large claim in their region and specialty. It may also benefit primary care physicians in managed care networks who are performing an increasing number and range of clinical services in their offices. Traditional malpractice carriers are accustomed to selling insurance for these activities only to highly paid specialists, and may not be able to offer immediate coverage to primary care physicians at acceptable prices.

III. Setting Up An Enterprise Liability System

An effective contractual framework for malpractice liability should, at a minimum, include the following characteristics:

- Financial responsibility for damages from medical malpractice affecting a defined patient group should be borne primarily by a single enterprise in each integrated health care system.[56]

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54. For example, hospitals that operate channeling programs are able to offer below-market rates to participating physicians. *See infra* notes 114-20 and accompanying text (reviewing channeling programs offered by the Federation of Jewish Philanthropies and the Harvard Affiliated Medical Institutions which have reduced physicians' insurance premiums).

55. *See* Diana Slivinska, Comment, *Health Care Cost-Containment for Small Businesses: The Self-Insurance Option*, 12 J.L. & Com 333, 334 (1993) (describing the benefits of self-insurance for large companies).

56. For example, a health plan that chooses to bear enterprise liability on behalf of its network

- The enterprise that bears primary liability should conduct risk management and quality improvement activities, and should base privileging and/or compensation decisions for affiliated providers at least in part on quality-related performance.[57]
- Certain other enterprises contracting with the primary enterprise should bear liability and engage in risk management and quality improvement with respect to discrete episodes of care that are uniquely within the control of such enterprises.[58]

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physicians might include a provision resembling the following in its physician contracts (and might have analogous agreements with its contract hospitals):

> Health Plan agrees to indemnify and hold Physician harmless from any and all claims relating to the Physician's or Health Plan's provision of medical services to any Beneficiary of Health Plan, except that Physician shall indemnify Health Plan for any losses, damages, and expenses resulting from a claim or judgment based on allegations of the intentional, wilful, wanton, or grossly negligent actions of Physician in providing medical services to Beneficiaries of Health Plan. Health Plan agrees to maintain insurance for these claims. Physician agrees that Health Plan shall be substituted for Physician in any suit or arbitration filed against Physician relating to the provision of medical services to Beneficiaries of Health Plan. Physician shall make every effort to ensure that such substitution occurs and Physician shall cooperate in the defense of any lawsuit against Health Plan based on allegations of Physician's improper treatment of a Beneficiary.

57. Agreements between a health plan and its network physicians might include language with respect to privileging and risk management such as the following (the health plan's Physician Manual should make it clear that input from and participation by physicians in developing quality control systems is encouraged):

> Participating Physicians shall comply fully with, and participate in the implementation of, Health Plan's policies and programs, as described below and in Health Plan's Physician Manual, to promote high standards of medical care and to control the cost and utilization of medical services, including, without limitation, policies and programs regarding: (i) quality assurance; (ii) utilization management; (iii) claims payment review; (iv) Subscriber grievances; (v) Physician privileging and credentialing; and (vi) Physician sanctioning. Physicians shall abide by the determination of Health Plan on all such matters during the term of this Agreement.
>
> Health Plan shall establish and maintain a physician privileging and credentialing program, under which Health Plan shall establish privileging criteria and credentialing processes. Physicians shall abide by the terms of the privileging and credentialing program and shall meet the privileging criteria. During each term of this Agreement, Health Plan shall take reasonable steps to ensure that each Physician continues to abide by the terms of the privileging and credentialing program and continues to meet the privileging criteria.
>
> Health Plan shall establish and operate Utilization Management and Quality Assurance Programs ("UMQAP") with respect to services rendered to Subscribers by Physicians. Such programs shall include, without limitation, requiring Physicians to refer Subscribers to Participating Providers in accordance with guidelines established by Health Plan as part of the UMQAP. Physicians shall abide by the terms of the UMQAP, and Health Plan shall administer and take reasonable steps to ensure compliance by Physicians with the UMQAP.

58. For example, an academic health center that elects to assume liability with respect to patients it serves under contract to a health plan might include something along the following lines

• Enrollment agreements with subscribers and consent agreements for patient treatment should specify the enterprise liable for malpractice[59] and should set forth an efficient and consistent process for dispute resolution.[60]

A. Assumption of Liability

In the traditional world of fee-for-service health care, each licensed health care provider that is found negligent in the course of

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in its agreement with the health plan (at the same time, utilization review provisions should emphasize that the academic health center bears primary responsibility for quality control):

> University agrees to indemnify and hold Health Plan harmless from any and all claims relating to University's and Faculty's provision of medical services and hospital services pursuant to this Agreement. University agrees to maintain insurance for these claims. Health Plan shall cooperate in the defense of any lawsuit against University based on allegations relating to improper treatment of a Beneficiary of Health Plan.

59. A liability provision in a health plan's enrollment agreement with a subscriber might look something like this:

> By electing medical and hospital coverage pursuant to this Agreement, or accepting benefits hereunder, all Subscribers, and any beneficiaries of Subscribers, their representatives, agents, heirs and assigns, agree to waive any current or future right to sue or make a claim against any Provider for providing medical or hospital services pursuant to this Agreement, whether such right or claim is based in contract, common law, or statute. Health Plan agrees to accept responsibility for and be substituted for any such Provider for any such claim. Subscriber agrees to sue or make any such claim against Health Plan instead of such Provider and further agrees to substitute Health Plan in any action where such Provider is so named. Health Plan hereby notifies Subscriber that Health Plan has entered, and may in the future enter, into agreements with certain Providers pursuant to which such Providers are obligated to indemnify Health Plan and hold Health Plan harmless from certain claims involving such Providers; provided, however, that such agreements shall not affect the rights and duties of Subscriber under this paragraph.

60. The following is an example of how an arbitration provision in the agreement between a health plan and its subscribers might be drafted:

> By electing medical and hospital coverage pursuant to this Agreement, or accepting benefits hereunder, all Subscribers, and any beneficiaries of the Subscribers, their representatives, agents, heirs and assigns, agree that any and all controversies or claims which may arise out of or in connection with the medical services or hospital services provided or rendered by a Provider to a Subscriber under the terms of this Agreement shall be submitted to arbitration as provided for herein. Any dispute hereunder shall be submitted to arbitration by sending a written demand for arbitration to the other party and shall be settled in [location]. Each party to the arbitration shall select one arbitrator, and the two arbitrators shall choose a third arbitrator. The three arbitrators shall hear and decide the case in accordance with the Medical Arbitration Rules of the American Arbitration Association. The parties hereby agree to accept the decision and award of the arbitrators as their exclusive remedy and as final and binding between them, and agree that no suit at law or in equity based upon disputes, controversies or claims covered by this paragraph shall be instituted by Subscriber or Health Plan, except an action to compel arbitration pursuant to this paragraph or an action to enforce the award of the arbitrators. Subscriber specifically and expressly waives any right to a jury trial or trial by a judge in a court of law or equity.

care of an injured patient is jointly and severally liable for damages.[61] Although the law is changing, insurers and other managed care organizations who are not licensed providers have been held responsible for negligent care, as opposed to a denial of benefits, only under unusual circumstances.[62]

In an integrated delivery system, however, it makes sense that the party most directly responsible for the cost of coverage should also bear primary liability for improper care. This will usually be the health plan in which a subscriber enrolls.[63] Health plans have several advantages in performing this function. First, they are well capitalized and therefore reliable and efficient bearers of risk. Second, they are charged with coordinating the provision of care and are therefore best able to balance quality and cost considerations in their management decisions. Third, they are the entry point for subscribers joining the system, and can offer contractual provisions for dispute resolution at a time when individuals are free to choose among various health plans and are therefore better able to make uncoerced decisions than they might be as patients seeking treatment.

Tightly integrated staff- and group-model HMOs are in the best position to assume liability in the current market. The closed-panel character of their medical staffs, combined with the physical proximity among their practitioners' offices, give many of these organizations a corporate (or university) "feel." This environment is conducive to assessing quality of care using traditional "peer review"[64] processes and to influencing practice patterns through conferences, newsletters, and institutional guidelines and protocols.

However, Kaiser-style HMOs are unlikely to dominate most markets as the health care system evolves nationally. Excess capacity in

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61. *See* MICHAEL G. MACDONALD ET AL., HEALTH CARE LAW: A PRACTICAL GUIDE § 14.04[6] (1993) (stating that "all defendants in a negligence lawsuit are liable directly to the plaintiff in the entire award even though each may have been responsible for only a portion of the damages"). The doctrine of joint and several liability has been limited in several states. *Id.*

62. *See supra* note 5 and accompanying text (discussing proposals for enterprise liability).

63. The term "health plan" does not necessarily imply a system run by insurers. If the Administration's Health Security Act becomes law, or other reforms create incentives for care management rather than risk management, many of the most successful health plans are likely to be centered around physician groups or hospitals. *E.g.*, H.R. 3600, §§ 1400, 1402-03.

64. *See, e.g.*, LOWELL C. BROWN, CALIFORNIA SOC'Y FOR HEALTHCARE ATTORNEYS, MEDICAL STAFF AND MEDICAL PEER GROUP PEER REVIEW IN THE ERA OR PROVIDER INTEGRATION: CREDENTIALING, FAIR HEARINGS, AND CONFIDENTIALITY (1993) (discussing reasons for establishing a peer review committee for reviewing the quality of care provided by independent practice associations).

many markets, the high capital costs and limited useful lives associated with constructing health facilities, the improved cost-effectiveness of outpatient and community-based care, and the necessarily incremental growth of managed care as a percentage of a physician's practices all favor looser structures such as network-model HMOs. Nonetheless, these organizations will increasingly be capable of bearing malpractice liability and exerting effective quality control as medical information systems improve and performance data is collected for purposes of cost control, marketing, and regulatory compliance.

In less mature managed care markets, provider organizations that are not fully integrated health plans will negotiate discounted fee-for-service or capitated arrangements with insurers. Enterprises such as multi-specialty group practices, university hospitals, and physician-hospital ventures such as physician-hospital organizations ("PHOs")[65] that receive a combined rate for both professional and institutional services may find it advantageous to assume malpractice liability and develop their own quality management capacities. Specific issues that might arise in these situations are discussed below in the context of arrangements in which a health plan might transfer liability to such providers for certain services.[66]

Several examples of voluntary enterprise liability currently exist. Liability for the negligent acts of staff physicians is expressly assumed by managed care entities such as Kaiser-Permanente and Sharp Health Care,[67] and by government delivery systems such as the Public Health Service,[68] the Department of Defense,[69] the Vet-

65. Physician Hospital Organizations are joint ventures wherein hospitals and physicians join together to create a delivery system that can directly contract with managed care organizations, insurance companies, or employers. DAVID E. VOGEL, AMERICAN MEDICAL ASSOCIATION, THE PHYSICIAN AND MANAGED CARE 14 (1993).

66. *See infra* notes 74-83 and accompanying text (discussing the reallocation of liability risk).

67. *See* Crabtree, *supra* note 7 (stating that the Sharp Health Plan accepts medical malpractice liability for the physicians with whom it contracts).

68. Under the Federally Supported Health Centers Assistance Act of 1992, 42 U.S.C. § 201 (Supp. IV 1992), community and migrant health center grantees receive federal medical malpractice insurance coverage under the Federal Tort Claims Act, 28 U.S.C. §§ 2671-80 (1988 & Supp. IV 1992). *See generally* U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: ESTIMATED SAVINGS AND COSTS OF FEDERAL INSURANCE AT HEALTH CENTERS (1993) (examining medical malpractice insurance costs of federally-funded community health centers and migrant health centers).

69. *See* 32 C.F.R. § 61 (1993) (allowing malpractice claims against military and civilian personnel of the armed forces).

erans Administration,[70] the Indian Health Service,[71] and the Bureau of Prisons.[72] Other medical institutions, such as the Federation of Jewish Philanthropies in New York and the Harvard Affiliated Medical Institutions in Boston, do not directly assume liability but rather purchase malpractice insurance for their affiliated physicians.[73]

B. Distribution of Liability

It is axiomatic that one should never take responsibility for what one cannot control. Because the health care industry has only recently begun to consolidate into organized systems of care, many health plans may not be immediately capable of performing effective quality control. Therefore, enterprises may choose to bear primary liability only if they can, in many instances, transfer such liability to other enterprises within their integrated system that are better positioned to manage cost and quality with respect to certain discrete episodes of care. It should not be difficult to account for the financial consequences of reassigning liability as part of a managed care contract, although certain features of the current insurance market must be considered.[74]

Many organizations participating in health plan networks possess the size and diversification to be efficient risk-bearers and the utilization review and care management mechanisms to facilitate internal quality improvement. Put another way, the same consideration that leads some managed care organizations to compensate constituent providers by capitation or utilization-based withholding[75] — the

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70. *See* 38 C.F.R. § 14.514 (1993) (allowing the Department of Veterans Affairs to indemnify a department employee who is personally named as a defendant or settle or compromise a personal damage claim against an employee); 38 C.F.R. § 14.610 (1993) (permitting suits against Department of Veterans Affairs employees based upon medical care and treatment).

71. *See* Federal Tort Claims Act, 28 U.S.C. § 2672 (1988 & Supp. IV 1992) (providing that the head of each federal agency may compromise and settle any claim against the United States for damages caused by the negligent or wrongful act of an employee).

72. *See* 28 C.F.R. § 543.30 (1993) (providing that the Bureau of Prisons shall consider inmates' claims asserted under the Federal Tort Claims Act).

73. *See infra* notes 114-20 and accompanying text (reviewing the channeling programs of the Federation of Jewish Philanthropies and the Harvard Affiliated Medical Institutions).

74. *See infra* notes 121-24 and accompanying text (discussing the current insurance marketplace and the challenges it poses to new health care enterprises).

75. Current managed care contracts frequently involve the assumption of some degree of financial risk for overutilization. *See* Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 480-504 (1988) (outlining several plans involving the assumption of some degree of financial risk in overutilization); *cf.* Alex-

perception that such providers can control costs more effectively than the organization as a whole — will lead organizations to allocate malpractice risk along similar lines.

As a general rule, tightly-integrated systems will transfer liability in fewer situations than loosely-integrated systems. For example, a "staff-model"[76] HMO with salaried physicians may transfer liability only for organ transplantation or other highly specialized care for which the HMO contracts with outside parties, such as academic health centers.[77] In addition, a "single-service"[78] HMO would be likely to accept liability for the care it provides. These organizations will be attractive contract partners for many integrated systems because they can achieve efficiencies and economies of scale in areas, such as eye care, dental care or some orthopedic care, that are essentially severable from a beneficiary's other health care needs.[79]

By contrast, a loosely-integrated "network-model"[80] HMO may negotiate agreements that transfer liability to physician groups responsible for "gatekeeping," to hospitals providing specialized services, or to contracting and quality-control joint ventures. Under these contracts, physicians who are employed by an institution, such as interns and residents at a hospital or associates in a group practice, would be automatically covered by the terms of the contract between the institution and the plan. Other affiliated practitioners might reach agreement with the institution with respect to coverage.[81]

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ander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 725-28, 748-50 (1986) (describing the allocation of financial risk in HMOs and prepaid practice groups); *but see* 42 U.S.C. § 1320a-7a(b) (1988 & Supp. III 1991) (prohibiting payments made to induce a reduction of services to Medicare beneficiaries).

76. This term describes an organizational structure in which the physicians are salaried employees of the HMO. THE MANAGED HEALTH CARE HANDBOOK 16 (Peter R. Kongstvedt ed., 1989) [hereinafter HEALTH HANDBOOK].

77. Although some closed-panel HMOs currently have the size and quality review capacity to bear risk efficiently and to respond appropriately to incentives, those characteristics are most frequently found in hospitals and other large institutions. *See* Abraham et al., *supra* note 5, at 355-56 (proposing a new model of organizational liability wherein hospitals would bear exclusive liability for medical malpractice).

78. A single-service HMO offers only one component of a comprehensive benefits package and specializes in that service only. VOGEL, *supra* note 65, at 8.

79. *Id.*

80. A network-model HMO contracts with one or more physician group practices, which are responsible for providing all physician services to HMO members assigned to the group. HEALTH HANDBOOK, *supra* note 76, at 16.

81. It would prove inefficient to recreate the current malpractice system by transferring liability for the same clinical episode to more than one party or by leaving liability risk on individual

C. Cooperative Quality Management

Any future health care system will either reward providers based on measurable performance, such as health care outcomes, or allow providers to balance cost and quality within a fixed budget using capitation. Capitated arrangements are likely to predominate in the short term because true performance measures are still in their infancy.[82] Purchasers of capitated care, including HMOs or insurers that compensate their contract provider groups on a capitated basis, may favor compensation arrangements that include liability for malpractice, so that the capitated party must demonstrate attention to quality as well as cost consciousness.[83]

However, institutional quality control capacity may be underdeveloped in many managed care organizations, especially physician networks, management service organizations ("MSOs"),[84] PHOs,[85] and other contracting vehicles that lack a defined physical plant. As has been discussed, organizations that are centered around hospitals or other traditional health care facilities have the advantage of ongoing peer review,[86] credentialing, and quality control processes. In addition, a regulatory environment has developed that sets certain standards for the conduct of these activities.[87]

In contrast, nonhospital provider entities must develop quality

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physicians.

82. *See The Quality March*, *supra* note 49, at 46 (stating that "smaller hospitals have not yet initiated budgeting and performance appraisal systems that promote quality improvement efforts, while larger hospitals have difficulty implementing such changes due to their size").

83. This should not be interpreted as favoring liability for individual physicians, which would be contrary to the entire concept of enterprise liability. In general, very small business units, such as individual physicians, are neither efficient quality managers nor efficient risk-bearers. Therefore, both capitation risk and liability risk should gravitate toward provider-oriented enterprises that are somewhat larger.

84. A management (or mutual) service organization ("MSO") is an organization formed by a group of independent physicians that does not economically integrate them, but offers practice enhancement and management services such as billing and collection. DAVID C. MAIN, AMERICAN MEDICAL ASSOCIATION, FORMING PHYSICIAN NETWORKS 7 (1993).

85. *See* VOGEL, *supra* note 65, at 14 (defining PHOs).

86. Peer review is the process by which the diagnosis, care, and treatment of patients is reviewed and evaluated by those who have training and experience similar to the professional being evaluated. *See generally* Brown, *supra* note 64 (discussing some of the issues and problems presented by a peer review system).

87. At least ten states require hospitals to have risk management programs. MACDONALD ET AL., *supra* note 61, § 12.02[2]. In addition, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") requires hospital risk management programs to include ongoing assessments of patient care, and requires hospitals and their medical staffs to establish a variety of oversight committees. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, 1 ACCREDITATION MANUAL FOR HOSPITALS 42, 56 (1994).

control processes without the benefit of an established legal framework. For example, Independent Practice Association ("IPA")-model[88] HMOs should have a credentialing and peer review mechanism in place that affords adequate due process and confidentiality to both the examiners and the examinees.[89] These activities include gathering information from and sharing information with other provider organizations as well as reaching conclusions about specific clinical incidents; both activities necessarily raise antitrust and tort liability risks that are inadequately addressed by current law.[90] Therefore, enterprises that elect to bear malpractice liability should include in their agreements with individual practitioners the ability to receive and disclose relevant facts, and they should impose on practitioners a strict duty to verify and update their credentials and other performance-related information.

Quality control can be challenging even for established, integrated health plans that have effective systems in place if patients receive a certain proportion of their care from practitioners who are not contractually affiliated with the plan. This generally occurs in one of two circumstances. First, many health plans offer so-called "point-of-service" plans with out-of-network options.[91] In these arrangements, patients may obtain care from the practitioner of their choice, without seeking approval from the health plan, by incurring a higher co-payment and annual limit on out-of-pocket expenditures. Second, patients requiring emergency services often seek care at the closest facility, whether or not it is part of their health plan. Contracts accepting liability for malpractice affecting enrollees should plainly and expressly disclaim liability for actions of non-network physicians, including care sought in emergency situations. However, health plans should be aware that these disclaimers might not withstand legal scrutiny if the facts suggest that the plan did not make the needed services reasonably available.

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88. IPAs are usually corporations formed by independent practitioners who contract to provide services to various payors. MAIN, *supra* note 84, at 8.

89. *See* Brown, *supra* note 64, at 17-18 (explaining that the trend toward sharing peer group information by institutional healthcare providers conflicts with the need to maintain confidentiality).

90. For example, it is not clear whether the immunities conferred by the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-111, 11152 (1988 & Supp. III 1991), necessarily extend to new types of provider organizations.

91. The Health Security Act requires all health plans to offer a point-of-service option. *See* H.R. 3600, § 1402(d)(2) (stating that each health plan shall offer enrollees the opportunity to obtain coverage for out-of-network services).

D. Agreements With Patients

Health plans, hospitals, and any other entities that accept enterprise liability and enter into contractual relationships with health care consumers should inform those consumers of the transfer of liability and should specifically require consumers to waive their rights against the direct provider of care and to bring claims solely against the liable enterprise. The enrollment or patient care contract should also specify an efficient method of dispute resolution for those claims, such as binding arbitration.

Specifying in advance that only the liable enterprise will be subject to suit serves to influence consumers' expectations about the care they will receive and the proper mechanism for dispute resolution. Doing so may also reduce strategic behavior by entrepreneurial attorneys seeking several sources of compensation. However, courts can be expected to scrutinize contractual provisions to ensure that they are not "contracts of adhesion"[92] and that they do not deny patients their rights to due process.[93]

Although there are no reported judicial decisions with respect to such provisions in an enterprise liability context, it seems likely that courts will hold a transfer of liability enforceable if it does not materially reduce a plaintiff's right to fair compensation. Therefore, providers and health plans assuming enterprise liability must make sure that the responsible party is solvent, either through adequate capitalization and reserves or through insurance.[94] Courts may also look to the ease of bringing a claim against the substituted defendant. Therefore, health plans should ensure that their grievance procedures and dispute resolution mechanisms are accessible, and that consumers have been informed about their options through the use of marketing literature, enrollment material, and customer satisfaction surveys.

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92. An adhesion contract is a standardized contract offered for goods or services on essentially a "take-it-or-leave-it" basis. The distinctive feature of a contract of adhesion is that the weaker party has no realistic choice as to the terms of the contract. BLACK'S LAW DICTIONARY 40 (6th ed. 1990).

93. MACDONALD ET AL., *supra* note 61, § 14.07[2]. Contracts entered into by health plan subscribers during open enrollment periods are likely to be given greater deference than those signed by patients who are ill and anxiously awaiting treatment. *Id.* § 14.07[2][b].

94. A relevant analogy is to the "alter ego" theory of corporate liability. 18 C.J.S. *Corporations* § 12 (1990) (discussing the alter ego doctrine and its purpose of preventing entities from escaping responsibility for their acts or liabilities by hiding behind a corporate shield). One factor used to determine whether a corporation is simply the alter ego of its owners is whether the corporation is undercapitalized. *Id.*

Moreover, it is possible that contractual enterprise liability can function effectively without consumers agreeing to sue only the liable enterprise. For example, the enrollment agreements used by the Kaiser Foundation Health Plan ("KFHP") do not contractually require enrollees to bring suit solely against KFHP, although all claims arising from treatment remain subject to KFHP's arbitration requirement. If an individual physician in the Permanente Medical Group, is to be named in a malpractice suit (information about which is available as a result of the requirement that ninety-day advance notice of actions be given under California law),[95] KFHP notifies the plaintiff's attorney that KFHP will defend the suit. Most experienced plaintiff's attorneys subsequently amend their complaints to remove the physician as defendant, although some do not.

Enrollment and treatment agreements should also require patients to arbitrate their claims or use other forms of alternative dispute resolution ("ADR").[96] Although most states permit arbitration of medical claims,[97] the legality and contract requirements in each state must be reviewed carefully before drafting an arbitration provision. For example, voluntary binding arbitration is effective in most states and can apply to future as well as existing controversies in all but Alabama and West Virginia.[98] Some states limit enforceability to enumerated types of actions, such as construction claims,[99] while others expressly exclude certain actions such as torts and personal injury.[100] In addition, several states have specific statutory re-

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95. CAL. CIV. PROC. CODE §§ 364, 364.1 (West 1982 & Supp. 1994) The Permanente Medical Group is a professional partnership that maintains an exclusive contract with KFHP.

96. Some types of coordinated medical liability may not require ADR. For example, neither the Harvard Affiliated Medical Institutions nor the Federation of Jewish Philanthropies include arbitration provisions in their own risk management programs or in their "channeling" arrangements. *See infra* notes 114-20 and accompanying text (discussing the programs offered by the Harvard Affiliated Medical Institutions and the Federation of Jewish Philanthropies). However, an efficient administrative approach to dispute resolution will very likely be essential in a health care system comprised of integrated health plans. *Cf.* H.R. 3600, §§ 5201-43, 5302 (explaining the appropriate procedures for making benefit claims or requests for preauthorization of services).

97. *See generally* COMPENDIUM, *supra* note 16 (reveiwing various pieces of state legislation authorizing arbitration of medical malpractice claims).

98. *See* 1 MILES J. ZAREMSKI & LOUIS S. GOLDSTEIN, MEDICAL AND HOSPITAL NEGLIGENCE § 4.03 (1988) (discussing arbitration statutes as a means of alternative dispute resolution).

99. Although it no longer applies to present-day construction claims, Georgia law still excludes from arbitration any claims arising out of construction contracts made between July 1, 1978 and July 1, 1988. GA. CODE ANN. § 9-9-2 (Harrison 1990).

100. *See, e.g.*, ARK. CODE ANN. § 16-108-201 (Michie Supp. 1993) (providing that its uniform arbitration act does not apply to either tort or personal injury actions); KAN. STAT. ANN. § 5-401 (1992) (providing that the state's uniform arbitration act does not apply to tort actions).

quirements for agreements affecting malpractice claims in order to ensure that patients are aware of the proposed arbitration provisions when they accept treatment.[101] Such requirements can include allowing a rescissionary period, mandating that the agreement be in writing and in a separate document, prohibiting arbitration as a condition to receiving emergency care, and using clear language to waive the right to a jury trial.[102]

The fairness of arbitration provisions has been attacked mainly on two grounds. One theory is that the patient has no real choice but to accept arbitration in order to receive care (a "contract of adhesion").[103] The other theory is that the patient did not knowingly waive his right to a jury trial.[104] Generally, arbitration agreements that comply with specific statutory requirements have been upheld.[105] In California, binding arbitration of malpractice disputes was upheld even before the state's medical arbitration act was passed in 1975.[106] Judicial decisions in California suggest that arbitration provisions are especially likely to be sustained where group purchasers such as large employers have negotiated contracts with health plans.[107] This logic should also apply to health plans compet-

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101. *See, e.g.*, CAL. CIV. PROC. CODE § 1295 (West 1982) (requiring specific words to be printed in bold red type to notify the signer that he is giving up the right to a jury or court trial); MICH. COMP. LAWS § 500.3060 (1993) (providing that the commissioner shall approve forms of agreement for use by health care providers and hospitals which shall include a provision for arbitration); *Id.* §§ 600.5041-.5042 (1987) (describing agreements for health care providers, hospitals, and HMOs, including a patient's right to rescind the agreement printed in bold type); *see generally* Leone, *supra* note 7 (emphasizing that patients must receive notice that by accepting arbitration, they waive the right to have a judge or jury decide medical malpractice claims).

102. *E.g.*, CAL. CIV. PROC. CODE § 1295 (West 1982); MICH. COMP. LAWS §§ 500.3051-.3062 (1993 & Supp. 1994); *Id.* §§ 600.5033-.5065 (1987).

103. *See supra* note 92 (defining a contract of adhesion).

104. *See* Horn v. Cooke, 325 N.W.2d 558 (Mich. Ct. App. 1982) (holding that the safeguards included in the state's Medical Malpractice Arbitration Act ensure that the execution of all arbitration agreements results in the knowing and voluntary waiver of one's right to a jury trial); Moore v. Fragatos, 321 N.W.2d 781 (Mich. Ct. App. 1982) (holding that a party seeking to enforce an opposing party's waiver of his right of access to the court system must show that the party was aware of all material information concerning arbitration).

105. *See, e.g.*, Morris v. Metriyakool, 344 N.W.2d 736 (Mich. App. 1984) (holding that the Malpractice Arbitration Act of 1975, MICH. COMP. LAWS §§ 600.5040-.5065 (1987), did not deprive plaintiffs of the constitutional guarantee of due process by requiring them to submit their claim to arbitration).

106. *See, e.g.*, Madden v. Kaiser Found. Hosps., 552 P.2d 1178, 1179-84 (Cal. 1976) (addressing whether an agent acting on behalf of a group of employees can contract for medical services wherein he agrees to arbitration of the employees' malpractice claims under the contract); *but see* Kaiser Found. Hosps. v. Coburn, 23 Cal. Rptr. 2d 431, 433-34 (Cal. Ct. App. 1993) (vacating an arbitration award for failure to disclose possible bias of the arbitrator).

107. *See* Dinong v. Superior Court, 162 Cal. Rptr. 606, 610 (Cal. Ct. App. 1980) (upholding a

ing in a structured marketplace such as that envisioned by the Health Security Act or other reform plans based on managed competition. In fact, the Clinton proposal requires injured patients to utilize their health plan's ADR mechanisms before filing a malpractice suit.[108]

As the health care system matures, it is likely that more innovative methods of dispute resolution will be developed. Some of these methods, such as proposals to pay economic damages on a no-fault basis, may modify a patient's substantive as well as procedural rights.[109] Subject to applicable law, integrated delivery systems that elect to coordinate liability will probably experiment with these concepts in their contractual arrangements.

E. Other Legal Considerations

1. Indemnification and Insurance

A health care enterprise that elects to assume the defense of malpractice suits affecting its constituent providers must make several choices. First, it must decide whether to indemnify and defend its affiliated physicians or institutional providers against malpractice claims (which might be called "true enterprise liability"), or whether simply to add its network of providers as co-insureds on a single malpractice policy ("channeling"). Second, if it chooses to assume direct liability, it must decide whether to purchase commercial insurance to cover its risk or whether to self-insure[110] in whole or in part.

Kaiser-Permanente is the prototype for a managed care organiza-

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group medical contract negotiated by the Civil Service Commission for government employees against the plaintiff's claim that the arbitration clause was part of an adhesion contract); *Madden*, 552 P.2d 1178 (upholding the authority of the Board of Administration of the State Employees Retirement System to represent state employees in negotiating group medical plans).

108. H.R. 3600, § 5302 (providing that no medical malpractice liability actions may be brought until the final resolution of malpractice claims under the alternate dispute resolution system adopted by the plan pursuant to § 5302(B)).

109. *See* MEDICAL MALPRACTICE TASK FORCE, AMERICAN HOSPITAL ASSOCIATION AND THE AMERICAN ACADEMY OF HOSPITAL ATTORNEYS, NON-TRADITIONAL APPROACHES TO THE MEDICAL MALPRACTICE CRISIS 14-28 (1987) (addressing medical malpractice arbitration and compensation mechanisms); Geoffrey O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims By Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U. L. REV. 589 (1983) (offering new ways to adapt existing personal injury compensation systems to modern needs).

110. *See infra* note 124 and accompanying text (explaining the concept of self-insurance).

tion that assumes direct liability for medical malpractice.[111] In the Kaiser health system, Kaiser Foundation Health Plans, Inc. ("KFHP") maintains contracts with an affiliated hospital corporation called Kaiser Foundation Hospitals ("KFH") and with the Permanente Medical Group ("PMG"), a partnership of physicians who exclusively treat Kaiser patients. Pursuant to these contracts, KFHP — the indemnitor — has agreed to indemnify KFH and/or PMG — the indemnitees — for judgments arising from malpractice affecting KFHP enrollees, and KFHP has the right and obligation to defend any such suits.

From the indemnitee's point of view, indemnification agreements are reliable only to the extent that the indemnitor is willing and able to make good on its obligation. An important caution with respect to indemnification rights relates to business failure. As the health care industry integrates and consolidates to improve efficiency, many health provider and insurance organizations will no doubt fail and declare bankruptcy. Under federal bankruptcy law, contractual rights to indemnification in cases of joint liability are held invalid except to the extent that the indemnitee has already paid the injured party on the underlying claim.[112] Even payments made in satisfaction of a judgment will only be entitled to indemnification at the recovery rate allowed to general creditors.[113] Parties relying on indemnification for malpractice judgments should therefore obtain credit support, or at least security for their claims, at the time the indemnification agreement is signed.

Even without an explicit transfer of liability, the economies of scale and improved risk management capability associated with a unified malpractice defense have been apparent for several years. As a result, several health systems, including the Federation of Jewish Philanthropies in New York City ("FOJP") and the Harvard Affiliated Medical Institutions in Boston, operate malpractice insurance programs that offer private physicians the option of joining the insurance policy of the institution with which they are primarily associated.[114] For example, Harvard's channeling program is available

111. *See* Elaine Zablocki, *Tort Reform*, HMO MAG., May-June 1994, at 74, 77.

112. 11 U.S.C. §§ 502(e)(1)(B), 510(b) (1988).

113. Recovery may be minimal in the case of insurance companies. Under state insolvency laws, beneficiaries and claimants of failed insurers share in assets equally with or in preference to general creditors. *See* COUCH ON INSURANCE 2D §§ 22:84-87 (rev. ed. 1984) (discussing the insolvency of insurance companies and resulting claims, preferences, and distributions).

114. For example, the Harvard program includes approximately 6,400 physicians. HARVARD

to physicians and dentists with teaching appointments who: (1) conduct a majority of their practices from offices at participating institutions, or (2) devote at least 75 percent of their professional effort to such institutions.[115]

FOJP's program, known as Voluntary Attending Physicians ("VAP"),[116] is typical of a channeling arrangement. In VAP, nonemployed attending physicians at any of the five FOJP hospitals become additional insureds on the professional liability policy of the appropriate hospital. Physicians must apply for coverage and fulfill VAP's underwriting criteria. Liability is not shifted by contract to the hospital. VAP physicians remain directly liable for malpractice and are named as individual defendants whether or not the VAP hospital is a co-defendant, although defense and indemnification are provided as co-insureds under the hospital's policy. Payments made on behalf of VAP physicians are reported to the National Practitioner Data Bank.[117]

Although channeling programs have not been studied thoroughly, premiums charged to physicians in such programs have historically been lower than traditional malpractice coverage. In general, reports also suggest that these programs result in reductions in liability costs and improved cooperation between physicians and hospitals.[118]

AFFILIATED MEDICAL INSTITUTIONS, MALPRACTICE INSURANCE PROGRAM INFORMATION BOOKLET 1993-1994, at 1 (1993) [hereinafter MALPRACTICE BOOKLET]; *see also* NEW YORK STATE INSURANCE DEP'T., A BALANCED PRESCRIPTION FOR CHANGE: REPORT ON THE NEW YORK STATE INSURANCE DEPARTMENT ON MEDICAL MALPRACTICE 18 (1988) (reporting that the Department of Insurance gave permission to the FOJP Service Corporation and the Combined Coordinating Council, Inc., to manage channeling programs in New York); Myron F. Steves, Jr., *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*, 1975 DUKE L.J. 1305, 1324-32 (proposing a shift of medical malpractice liability exposure to institutional providers); Ann P. Wood, *Channeling: Medical Liability Insurance Concept Being Widely Discussed by Hospitals*, PEDIATRIC NEWS, Jan. 1987, at 10 (reviewing the channeling programs of the Harvard Affiliated Medical Institutions and the hospitals of the Federation of Jewish Philanthropies).

115. MALPRACTICE BOOKLET, *supra* note 114, at Question 9.

116. FOJP SERVICE CORPORATION, VOLUNTARY ATTENDING PHYSICIANS PROFESSIONAL LIABILITY INSURANCE PROGRAM 1 (1993) [hereinafter INSURANCE PROGRAM].

117. *See infra* notes 135-39 and accompanying text (discussing and explaining the National Practitioner Data Bank).

118. *See Channeling: What's in it for Doctors and Hospitals?*, MED. STAFF NEWS, March 1986, at 4 (arguing that channeling — whereby physicians and hospitals are covered under the same policy, share the same defense team, and enjoy premium rate savings — is the future of health care); James F. Holzer, *Channeling Programs Aid MD-Hospital Cooperation*, HOSPITALS, April 5, 1987, at 92 (discussing health care providers' exploration of channeling or nontraditional risk financing arrangements whereby hospitals and physicians are insured by the same policy while reducing potentially compensable events and patient injury); Robert Markowitz & Barbara Challan, *Confronting the Medical Malpractice Crisis: A View From the Bridge*, 2 HEALTHCARE

However, channeling programs have suffered from two accidents of history. Before the rapid growth of managed care contracting, it was difficult to enroll physicians in channeling programs and price their participation appropriately because there were no formal agreements between physicians and hospitals with respect to quality or cost.[119] In addition, channeling programs increase the potential policy exposure considerably and therefore require significant reinsurance,[120] which was not readily available in the insurance markets until recently.

2. *Networks and the Insurance Marketplace*

As enterprise liability arrangements become more common, it is likely that new forms of medical malpractice coverage and appropriate pricing structures will evolve. However, the way that malpractice insurance is currently offered presents several challenges to innovative health care enterprises.

Closed-panel institutions, whether they are hospitals that limit admitting privileges to an approved medical staff or HMOs that have exclusive contracts with a medical group or physician network, are easily adaptable to enterprise liability. For these enterprises, liability for affiliated physicians would be borne in the same way as for the health professionals they already employ, except that more care for which they are potentially responsible is likely to be delivered "off site."[121]

Enterprise liability may be harder to create in the nonexclusive provider networks that will dominate most geographic markets in the near future. For example, although hospitals often purchase experience-rated coverage, traditional physician insurance is priced ac-

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EXECUTIVE, Jan. - Feb. 1986, at 36 (discussing advantages of channeling including reduced cost of medical malpractice insurance and the benefits to physicians of a joint defense with hospitals in medical malpractice suits).

119. This is also the principal difficulty with Weiler and Abraham's proposal to "assign" physicians to hospitals for the purpose of liability. *See* Abraham et al., *supra* note 5, at 357 (noting the difficulty in legislatively mandating organizational liability).

120. Reinsurance means to insure again. It is the practice of one insurance company buying insurance from a second company to protect itself against part or all of the losses it might incur in honoring its claims. JOSEPH C. RHEA ET AL., THE FACTS ON FILE DICTIONARY OF HEALTH CARE MANAGEMENT 540 (1988) [hereinafter FACTS ON FILE].

121. A possible concern, however, is that the provision of malpractice insurance to affiliated physicians might be construed by the Internal Revenue Service as incompatible with their tax treatment as "independent contractors," especially if the institution is conducting quality assurance activities that influence clinical practice. *See* Internal Revenue Serv. Exempt Organization Guidelines Handbook § 337 (1992).

cording to specialty and location.[122] As a consequence, patient volume strongly drives institutional premiums, but is seldom directly related to physician premiums. Institutions that wish to provide enterprise liability to physicians for only those patients treated in association with the institution, such as a hospital-centered health plan that wants to limit its responsibility to malpractice affecting the plan's enrollees, may find themselves offering physicians nothing of value, because physicians would still pay full price for residual coverage.[123]

For this reason, health plans that want to attract physicians and build loyalty may often choose to cover the malpractice risk of a physician's entire practice in the hope that, eventually, the majority of patients seen by physicians who remain in the plan's network will become plan enrollees. However, two problems may arise. First, to the extent that nonplan patients participate in competitors' health plans rather than in traditional fee-for-service insurance such as Medicare, those competitors may "free ride" on the responsible plan's liability.

More importantly, providing coverage for nonnetwork patients may limit a health plan's ability to self-insure its malpractice risk. Many health care facilities, such as large hospitals, reduce cost and avoid state insurance regulation by self-insuring most or all of the malpractice risk incurred in the operation of their businesses either directly or through captive insurance companies.[124] By contrast, providing coverage for "outside" patients as a benefit to network physicians might be construed as selling insurance to those physicians and therefore be subject to state insurance laws. As a result, even a well-capitalized HMO or health insurer might be precluded from self-insuring its physician network unless it qualified as a property and casualty insurer in each applicable state. The health plan might therefore be forced to purchase commercial coverage at a higher price, although its size and bargaining power should allow it to ob-

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122. *See* PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 130 (1985) (explaining that institutional factors affect demand for insurance and may help explain the lack of demand for risk retention in medical malpractice insurance).

123. FOJP addresses this concern for part-time employed physicians who maintain unaffiliated private practices by offering them additional coverage for 50 percent of the full-time price. INSURANCE PROGRAM, *supra* note 116, at 3. Eventually, it is likely that a new market for residual malpractice coverage will emerge.

124. The Harvard Affiliated Medical Institutions, for example, insure through the Controlled Risk Insurance Company, Ltd., which is chartered in the Cayman Islands, British West Indies. MALPRACTICE BOOKLET, *supra* note 114, at Question 1.

tain a substantial discount.

3. *"Deep Pocket" Liability*

If malpractice liability is shifted from individual practitioners to health care institutions or managed care plans, enterprises in jurisdictions without legislative limits on damages may be plagued by grossly excessive awards. In the current system, having to sue one's personal physician is a barrier to both frivolous and meritorious claims. Therefore, wealthy or well-insured institutions that elect to bear enterprise liability most likely would attract a larger number of claims, many for inflated amounts.[125]

However, legal limits on damages, particularly combined with binding arbitration, can solve this "deep pocket" problem. As of April 1993, twenty-one states had placed limits on noneconomic, aggregate, or wrongful death damages in medical malpractice cases.[126] California's $250,000 cap on noneconomic damages has had the effect of reducing malpractice premiums.[127] In states with similar limits, health care institutions and health plans that elect to bear liability are likely to have more predictable losses and lower premiums.

Similarly, states that permit health plans to require patients to resolve disputes through arbitration will be more conducive to enterprise liability. More than forty states expressly authorize some form of alternative dispute resolution for medical malpractice claims.[128] According to published data from Kaiser Permanente, its assumption of liability subject to binding arbitration has decreased both the frequency of claims and the size of awards.[129] However, institutions relying on arbitration provisions to reduce "deep pocket" exposure

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125. *See* Bradford C. Kendall, Note, *The Ostensible Agency Doctrine: In Search of the Deep Pocket?*, 57 UMKC L. REV. 917 (1989) (discussing how courts have applied the ostensible ageny doctrine to expand hospital liability for physician medical malpractice).

126. COMPENDIUM, *supra* note 16, at 2.

127. *See generally* James Ludlam, *The Real World of Malpractice Tort Reform (Part II)*, 23 J. HEALTH & HOSP. L. 353 (1990) (discussing various tort reforms with a look toward developing an administrative process to settle medical malpractice disputes). Flat caps such as that employed in California have been criticized as selectively penalizing seriously injured patients. A sliding scale limit based on the severity and duration of injury would more fairly balance the needs of patients and providers. *See* Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908 (1989) (evaluating the merit of noneconomic damages under the current liability system and methods that can be used to assist judges and juries in computing damages for personal injury and death outside tort law's traditional methods).

128. *See generally* COMPENDIUM, *supra* note 16 (reviewing state legislation authorizing arbitration of medical malpractice claims).

129. *See* Leone, *supra* note 7, at 58.

should recognize that judicial decisions in this area are highly fact-specific.[130]

In the future, an even greater risk for health plans and other health care institutions that are managing cost and quality is that a medical malpractice case will be successfully recharacterized as a coverage dispute by a plaintiff's attorney. This risk will arise whether or not the institution has assumed enterprise liability by contract, and may be unameliorated by traditional tort reform statutes. Recently, in *Fox v. Health Net of California,*[131] a jury awarded the plaintiff $12 million in compensatory damages, almost all of it for emotional distress, plus $77 million in punitive damages.[132] Both sides elected to litigate the dispute around the definition of "investigational treatment" and the propriety of certain managed care incentives.[133] Presumably, plaintiff's counsel carefully avoided alleging medical malpractice, which would have placed a $250,000 cap on noneconomic damages.

From a policy perspective, in any system of comprehensive HMO-style health insurance, disputes over coverage are by definition disputes over the standard of care, resolvable according to established principles of malpractice law. However, the *Health Net* verdict demonstrates that our society is uncomfortable with a corporate cost-benefit decision to explicitly assume the risk of personal injury, and that this discomfort is not limited to Ford Pinto automobiles.[134] Therefore, health plans and provider organizations can expect plaintiffs' attorneys seeking large punitive damages to exploit other litigation postures in cases that might otherwise be considered malpractice disputes.

4. Reporting of Adverse Events

The National Practitioner Data Bank[135] ("Data Bank") was es-

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130. *See supra* notes 96-108 and accompanying text (discussing the enforceability and fairness of arbitration provisions).

131. Fox v. Health Net, No. 219692 (Cal. Sup. Ct. Dec. 28, 1993).

132. Woolsey, *supra* note 8, at 1, 23; *see also* Lee, *supra* note 9, at D1 (noting that the case was subsequently settled for a lesser sum).

133. Woolsey, *supra* note 8, at 23.

134. *See* Steven C. Bennett, *Developments in the Movement Against Corporate Crime*, 65 N.Y.U. L. REV. 871 (1990) (reviewing FRANCIS T. CULLEN ET. AL., CORPORATE CRIME UNDER ATTACK: THE FORD PINTO CASE AND BEYOND (1987)) (discussing the Ford Pinto case and the movement against corporate crime to reassert the fundamental value of equal justice).

135. 45 C.F.R. § 60 (1994).

tablished by the Health Care Quality Improvement Act of 1986[136] in order to prevent physicians who have been judged dishonest or incompetent from moving to another state and misrepresenting their credentials.[137] All malpractice judgments against physicians and all settlements made by or on behalf of a physician must be reported to the Data Bank.[138] Under current law, institutions accepting enterprise liability would therefore be responsible for reporting physicians to the Data Bank if a claim resulted in such payment.[139]

However, a health care system comprised of integrated health plans has needs different from those of a fee-for-service practice. Enterprise liability functions smoothly only if health plans and other institutions are able to resolve disputes nonadversarially without exposing physicians to the risk of arbitrary reporting.[140] The Data Bank and other malpractice reporting mechanisms must therefore be revised to recognize the increasing importance of institutional liability and quality management in the health care system. Eventually, methods other than reporting of malpractice actions will be required to identify low-quality medical practitioners.

5. *Fraud and Abuse*

The interdependency encouraged by enterprise liability might raise fraud and abuse concerns similar to those affecting many other managed care arrangements. Government control of Medicare[141] and Medicaid[142] was originally predicated on a fee-for-service model of health care delivery. As health care providers have joined together, often to achieve economies of scale and other efficiencies in a

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136. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784 (1986) (codified at 42 U.S.C. §§ 11101-152 (1988 & Supp. III 1991)).

137. 42 U.S.C. §§ 11101(a) (1988 & Supp. V 1993).

138. *Id.* § 11131 (Supp. V 1993).

139. *See id.* § 11131(a). Section 11131(a) of the Health Care Quality Improvement Act of 1986 reads in relevant part: "Each entity . . . which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof." *Id.*

140. There is a growing consensus that the Data Bank is struggling. Because of the randomness and error associated with individual reports, the AMA has changed its position on the Data Bank and now advocates the Data Bank's dissolution. AMA Board of Trustees, Resolution of June 15, 1993; *see* U.S. GENERAL ACCOUNTING OFFICE, HEALTH INFORMATION SYSTEMS: NATIONAL PRACTITIONER DATA BANK CONTINUES TO EXPERIENCE PROBLEMS (1993) (reporting inadequacies in the Department of Health and Human Services' management of the Data Bank).

141. 42 U.S.C. § 1395 (1988 & Supp. IV 1992).

142. *Id.* § 1396.

capitated or partially capitated environment, strict compliance with the broad kickback and self-referral prohibitions contained in existing law has become problematic. This is particularly threatening to nonprofit providers because violations of fraud and abuse laws that confer private benefits may jeopardize such providers' tax-exempt status.

For example, the provision of malpractice coverage for physicians in less-than-fully integrated systems might be construed as a payment made to induce referrals. Although the jurisdiction of the Office of the Inspector General is currently confined to Medicare and Medicaid abuses,[143] it is likely that national health reform will expand that authority to include all payers. As a result, enterprise liability might be difficult to implement unless clear safe harbor protection[144] is available.

6. *Reckless or Intentional Conduct*

Although parties bearing enterprise liability should not be held liable for grossly negligent or intentional acts of individual providers,[145] plaintiffs' attorneys may use such claims to gain strategic advantages. In the current tort system, these allegations may bully physicians who are fearful of incurring punitive damages into settling negligence claims. In the future, plaintiffs' attorneys can be expected to bring many such claims in the hopes of bringing defendants into conflict with each other, pressuring settlements, and avoiding arbitration or other forms of ADR. To avoid this scenario, parties bearing enterprise liability may elect to defend all claims, including those for intentional torts, but also maintain some level of deterrence by retaining rights to indemnification from individual providers for damages based on intentional or reckless conduct.

IV. CONCLUSION

Enterprise liability need not be perceived as a burden imposed on health care organizations and physicians from outside the health care system. Instead, it can be used voluntarily by such enterprises

143. 42 C.F.R. § 1001.1(a) (1993).

144. Safe harbor regulations are issued by the Office of the Inspector General ("OIG") to inform health care providers how to conduct their business affairs in compliance with the Medicare and Medicaid statutes. *Id.* § 1001.952 (1993).

145. *See* KEETON ET AL., *supra* note 30, § 8, at 33-39 (discussing the meaning of intent and the tendency to impose greater responsibility on one whose conduct is intended to cause harm).

to create a coordinated system of contract-based accountability that promotes collaboration, improves quality, and reduces overall liability costs.

Enterprise liability will prove to be of greatest benefit to those health systems that selectively employ or contract with practitioners, have close ties to hospitals and other facilities, apply strict standards for credentialing and privileging providers, and conduct meaningful peer review and quality assessment activities. For these entities, assuming liability is a sound business practice that simplifies the dispute resolution process and reduces burdens on physicians while also encouraging them to participate in the quality improvement efforts of the entire enterprise.

This Article explains the logic behind a systematic, contractual approach to malpractice liability, and identifies some of the legal and practical issues that are likely to arise. It is important to emphasize, however, that enterprise liability is not *the* solution to the problems that surround medical malpractice, but merely one way to move the liability system in the same direction as the rest of the health care industry.

Finally, no scholarly treatment of a health care issue can capture the complexity of actual practice. Right now, in the real world, enterprise liability is happening because it increases efficiency and reduces costs. Undoubtedly, health care lawyers and businesspeople will develop far more sophisticated approaches to malpractice accountability than have been presented in this article. The critical point to remember is that innovation is the only lasting cure for America's health care crisis, not only in clinical care but in the way that the health care system is organized and functions.