MAKING HEALTH PLANS ACCOUNTABLE FOR THE QUALITY OF CARE

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American health policy has come increasingly to rely upon competition among so-called “managed care” organizations (MCOs)—that is, health maintenance organizations (HMOs), preferred-provider organizations (PPOs), integrated delivery systems (IDSs), and the like—to ensure that consumers get the health care they want (and are prepared to pay for) at competitive prices. Gradually taking root over the last two decades, this market-oriented health policy is being superimposed on a system of liability and agency rules that developed under a different, nonmarket paradigm of medical care. This Article is concerned with whether the legal system, operating under these mostly common-law rules, is adequately policing the quality of care rendered in the new cost-conscious, profit-oriented health care industry of the 1990s.

The thesis of this Article is that MCOs, as distinguished from indemnity-type health insurers, should bear exclusive legal responsibility for the negligence of physicians treating their subscribers or enrollees. Such “enterprise liability” is dictated by the logic of the revolution that is occurring in American health care. Indeed, this revolution will remain incomplete as long as responsibility for patient care remains bifurcated, with some entities deemed responsible only for its financing and its cost while others are legally responsible for its provision and its quality. This bifurcation is a holdover from the era when health care and health care law were dominated by the medical profession’s own paradigm of medical care¹ and by the related notion that corporate enterpris-

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¹ This Article attributes much of the law’s current inability to make sense of modern health care to its roots in a paradigm of medical care that, among other things, insulated physicians from accountability to anyone other than individual patients and their professional colleagues. Although physician accountability to patients is intuitively appealing, not all consumers/patients are good at looking out for their own interests in

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es should not practice medicine. Because this old paradigm still influences legislatures and judicial thinking, today's MCOs, although in control of many levers that can affect the quality of care for better or for worse, are not, in the eyes of the law, routinely answerable for poor quality. Enterprise liability is the logical legal culmination of the shift to de facto corporate responsibility that is revolutionizing American medical care.

medical encounters. Not only do most of them inevitably lack good information about the relative skills of individual practitioners and the ability to assess the potential value of various interventions, but, insofar as a third party is committed to paying for the care consumed, they are also unconcerned about its cost. Thus, the old paradigm tended to exacerbate well-recognized imperfections in the market for medical care while simultaneously precluding consumers from enlisting corporate intermediaries to help them overcome their disadvantages. On the tenets and significance of the professional paradigm, see CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 112-14, 118-20 (1995) (hereinafter HAVIGHURST, HEALTH CARE CHOICES); Robert A. Berenson, Do Physicians Recognize Their Own Best Interests?, HEALTH AFF., Spring 1994, at 185; Clark C. Havighurst, The Professional Paradigms of Medical Care: Obstacle to Decentralization, 30 JURIMETRICS J. 415, 419-31 (listing 5 "themes" in "the profession's ideology") (1990); William M. Sage et al., Enterprise Liability for Medical Malpractice and Health Care Quality Improvement, 20 AM. J.L. & MED. 1, 4-5 (1994) (discussing "cultural barriers to quality-oriented malpractice reform"). See generally PAUL STARE, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (tracing development of modern American medicine).

Perhaps the most significant historical consequence of the professional paradigm of medical care was its preclusion of the corporate practice of medicine—that is, the retailing of physician services by a corporate middleman. Although occasionally embodied in or clearly inferable from legislation, the prohibition of corporate practice was most often deduced by courts in a simpler world from a conception of professionalism that emphasized personal responsibility. Corporate involvement in providing medical care was also inhibited by the medical profession's concerted actions in defense of paradigmatic values and in violation of the antitrust laws. See generally CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS 223-57, 330-67, 1114-60 (1988 & Supp. 1992); Michael A. Dowell, The Corporate Practice of Medicine Prohibition: A Dinosaur Awaiting Extinction, 27 J. HEALTH & HOSP. L. 369 (1994) (giving history and critique of doctrine); Jeffrey F. Chase-Lubitz, Note, The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry, 40 VAND. L. REV. 445, 458-64 (1987) (describing AMA's role). That the corporate practice doctrine still flourishes in some respects is apparent in a number of recent cases. See, e.g., Conrad v. Medical Bd., 55 Cal. Rptr. 2d 901, 907-09 (Ct. App. 1996) (holding recent legislation authorizing hospitals to contract with physicians did not permit their actual employment contrary to old corporate practice doctrine); Berlin v. Sarah Bush Lincoln Health Ctr., 684 N.E.2d 387, 340 (Ill. App. Ct.) (invalidating physician's employment contract with hospital under case law from 1930s), review granted, 671 N.E.2d 726 (Ill. 1996).

See generally Sage et al., supra note 1, at 4-5 (joining "a chorus of voices that proposes to reframe liability for medical malpractice on the organizations that will increasingly bear practical responsibility for providing health services"); Sharon M. Glenn, Comment, Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability, 29 WAKE
This Article begins by observing that it would be in the long-run political interest of the managed care industry for MCOs to accept legal liability for personal injuries caused by the negligence of providers treating patients under their auspices. To date, however, most MCOs have opportunistically sought to manipulate legal rules to insulate themselves from such liability. Although the legal system, borrowing principles from case law involving hospital liability for physician torts, has resisted some attempts by MCOs to distance themselves from bad outcomes, courts—again following the treatment of hospitals—have generally stopped well short of assigning enterprise liability to health plans. It is submitted here, however, that courts viewing MCOs have been too much guided by the imperfect analogy to hospitals (as well as by the old professional paradigm of medical care financing) and that the logic of enterprise liability is much stronger in the case of organized health plans. Although enterprise liability might be most readily effectuated by legislation, common-law courts in most jurisdictions could go quite far toward bringing the legal responsibilities of MCOs into line with the practical realities of managed care. In any event, enterprise liability would seem a desirable first step in establishing incentives for MCOs to ensure that care provided under their auspices meets appropriate standards of quality. To be sure, market forces themselves are helpful in keeping MCOs from systematically sacrificing the welfare of consumers in the interest of short-run corporate profits. But greater legal accountability would help both to deter system breakdowns and to maintain a political environment in which the managed care industry can strive to serve consumers well.

After first observing the connection between MCOs' legal accountability and their political legitimacy as rationers of health

FOREST L. REV. 305 (1994) (arguing for application of medical tort principles to HMOs to effect enterprise liability).


5 See infra note 26 (giving examples of state courts' policy decisions to impose vicarious liability on hospitals).
services, this Article reviews the historical movement that eventually made hospitals liable for certain physician negligence. It then takes account of the recent arrival on the scene of a new set of corporate intermediaries on which liability might even more appropriately fall. A final section takes the discussion well beyond the mundane legalities of enterprise liability into a surprising demonstration of how automatic MCO liability for physician torts could serve—without significant change in any other legal rule, state or federal—as the linchpin of a system of MCO accountability that would allow the nation finally to realize the full promise of the managed care revolution.

I. LEGAL ACCOUNTABILITY AND THE CURRENT BACKLASH AGAINST MANAGED CARE

The legal accountability of MCOs to individuals injured by the failure of health plans or their selected providers to meet appropriate quality standards is a matter of great public significance. Not only would such accountability help to promote good performance by a crucial industry, but it would also enhance the legitimacy of privately managed health care in the eyes of the public. Such legitimacy is necessary to allow the industry to operate with only limited government interference. Despite the progress that has been made in installing a market-oriented national health policy, it still remains to be seen whether American health care will be driven in the future primarily by the cost-conscious choices of consumers and their agents or by regulatory mandates imposed by legislators responding opportunistically to popular fears and powerful interest groups. The political legitimacy of managed care is important precisely because the public will not tolerate the private rationing of health care financing—even efficient rationing, entailing the rational sacrifice of some potential benefits at the margin—unless it perceives that people generally get what they pay for in purchasing managed care and can expect to have their grievances redressed if they do not.6 The market-oriented health

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6 For the author's view that the rationing of financing for marginally beneficial care is legitimate only if it is expressly authorized by explicit contracts between health plans and consumers, see HAVIGHURST, HEALTH CARE CHOICES, supra note 1, at 42-43, 149-51 (decrying
policy of the 1980s and 1990s could easily give way to heavy-handed government regulation of MCOs unless private-law remedies for torts and breach of contract are perceived to provide adequate deterrence of quality lapses.

The political legitimacy of MCOs is very much in question at the present time, as many observers are questioning the quality of the medical care being provided under their auspices. Indeed, a strong backlash against HMOs and other managed care plans is threatening to move many decisions out of the hands of competing health plans and into the hands of Congress or state legislatures. Moreover, some of the criticisms inspiring this backlash cannot be easily dismissed, partly because MCOs cannot point to clear authority in law or in their contracts with consumers for many of the economizing moves they make. In addition, MCOs enjoy substantial immunity from legal liability for personal injuries occurring when they, or providers they retain, breach their legal

“sub rosa economizing”). To be sure, rationing of health care financing raises issues distinct from quality assurance, which focuses on verifying provider competence, avoiding medical malpractice, and deterring sins of omission (which may sometimes, but not necessarily, result from cost constraints). Nevertheless, this Article argues that MCOs should bear direct legal responsibility for the quality of care, as well as being concerned about its cost, because cost-saving measures can affect patient outcomes and because dividing responsibility for quality and cost creates managerial confusion, encourages unnecessary tension between MCOs and physicians, and undermines the political legitimacy of managed care.

See, e.g., GEORGE ANDERS, HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST (1996) (describing alleged flaws in HMO systems and occasional adverse consequences); Thomas Bodenheimer, The HMO Backlash — Righteous or Reactionary?, 335 NEW ENG. J. MED. 1601 (1996) (discussing issues raised by and impact of backlash against HMOs); Milt Freundshen, H.M.O's Cope with a Backlash on Cost Cutting, N.Y. TIMES, May 19, 1996, at A1 (stating that backlash has resulted in laws in 34 states to limit managed care). To be sure, most of the complaints against MCOs are directed to their cost-cutting (rationing) activities, not to any alleged propensity to foster medical malpractice as such. See infra notes 10, 16. But see infra note 6 (explaining connection between economizing and enterprise liability).


See supra note 6 (noting problem of sub rosa rationing).
duties to patients. The political and public relations problems of the managed care industry are further magnified by the large profits some HMO companies have earned, by the premium prices paid for “covered lives” in corporate acquisitions, and by the astronomical compensation paid by some plans to CEOs whose accomplishments the public does not see in a positive light. Finally, the answers given by the managed care industry to the questions being raised are unsatisfying. Unable to say that its members are prepared to defend their actions in appropriate legal forums, the industry mostly responds by claiming that managed care is the wave of the future and by intoning some variation of the refrain, “trust us.” The industry is also not above implying that its critics are ignorant, self-interested, or reactionary.

On the other hand (although it may ultimately prove to be beside the point in the absence of clearer legal accountability), much of the evidence of quality problems in MCOs is only anecdotal, appearing in journalistic accounts. In addition, much of the criticism is misdirected or misleading in failing to explain the probabilistic

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10 This Article is principally concerned with MCOs’ ability under state law to avoid vicarious liability for the negligence of physicians they select to treat plan enrollees. An arguably more serious failure of legal accountability, and the one most often remarked upon, is the lack of adequate legal remedies for personal injuries suffered by beneficiaries of employee health plans as a result of the unauthorized rationing of benefits—that is, improper denials of financing for potentially beneficial services. Immunity in this case is supplied by the federal Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. §§ 1001-1461 (1994), which preempts state laws “insofar as they may now or hereafter relate to any employee benefit plan . . . .” See, e.g., Kuhl v. Lincoln Nat’l Health Plan, 999 F.2d 298, 304-05 (8th Cir. 1993) (holding ERISA preempted state claims for delay in scheduling deceased’s heart surgery and provided no federal right to recover monetary damages for same); Corcoran v. United Healthcare, Inc., 955 F.2d 1321, 1331 (6th Cir. 1992) (holding ERISA preempted state claims against utilization manager under employer’s self-insured plan). The immunizing effect of ERISA in cases of this kind is perhaps an additional reason for the urgency of making MCOs liable for the failings of their physicians. For ERISA’s effect on state claims against MCOs based on vicarious liability, see infra notes 105-136 and accompanying text.

11 Such extraordinary profits as have been seen in the managed care industry are not likely to continue. Whereas early entrants found ways for entrepreneurs and investors to capture much of the savings achievable by using managed care techniques to squeeze “fat” from the health care system, competitive pricing is now ensuring that most of the savings are captured by employers. Although most of these savings are presumably passed on to consumers, people tend to be unaware how much less they are paying for coverage than they would be if their care were not “managed.” Thus, the managed care industry’s public relations and political problems remain severe.
nature of medical care or to take into account the cost side of the benefit/cost trade-offs that pervade medical care but have only lately been taken into account—thanks in part to MCOs—in clinical decisions. Most empirical studies still suggest that managed care is both less costly and no more harmful to consumers than was the old, unmanaged health care system.\textsuperscript{12} Indeed, anyone who is nostalgic for the way things used to be should be reminded of the major study by the Harvard School of Public Health of malpractice in New York hospitals in the early 1980s (before managed care made significant inroads).\textsuperscript{13} That study found a huge iceberg of iatrogenic (treatment-caused) injuries, including around 7000 patient deaths in one state alone caused by legally actionable negligence in just one year.\textsuperscript{14} In addition to such evidence that the old, unmanaged health care system left much to be desired on the quality front, there are some clear reasons why managed care might represent a distinct improvement over the old system with respect to quality as well as cost. Even as they save money, MCOs can improve health status and health outcomes by such measures as encouraging prevention, coordinating and monitoring care, reducing hospitalization, eliminating unnecessary services, carefully selecting and overseeing providers, and inducing doctors (not all of whom are highly skilled) to conform to tested protocols and clinical practice guidelines. Although some specific quality failings have been documented in MCOs,\textsuperscript{15} and indeed are invited by the incentives created by some of the new methods of paying for health

\textsuperscript{12} See, e.g., Robert H. Miller & Harold S. Luft, \textit{Managed Care Plan Performance Since 1980: A Literature Analysis}, 271 JAMA 1512, 1517 (1994) (suggesting “that HMOs provide care at lower cost than do indemnity plans” and stating that HMO and indemnity plan care resulted in roughly comparable health outcomes).

\textsuperscript{13} \textsc{Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York} (1990).

\textsuperscript{14} \textit{Id.} at 11-1; Paul C. Weiler et al., \textit{A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation} 44-46 (1993); see also Robert W. Dubois & Robert H. Brook, \textit{Preventable Deaths: Who, How Often, and Why?}, 109 Annals Intern. Med. 582, 588 (1988) (finding, in study of 182 in-hospital deaths, that 14% to 27% of deaths may have been preventable).

\textsuperscript{15} See, e.g., John E. Ware, Jr. et al., \textit{Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems}, 276 JAMA 1039, 1042 (1996) (finding worse health outcomes for certain patient categories in HMOs than in fee-for-service systems).
care,\textsuperscript{16} the overall quality record of MCOs is not bad.\textsuperscript{17} Indeed, it is possible that MCOs are already so sensitive to the market's and the political system's demands for good quality that they are doing many things right even in the absence of effective legal accountability for specific breakdowns.\textsuperscript{18}

This is far from saying, of course, that health care could not be managed better. Managing medical care to get good value for money, to ensure that appropriate services are efficiently provided, to identify and implement appropriate quality standards, and to protect people from spending more on health care than its marginal benefits warrant is as profound a practical challenge as any facing our domestic institutions today. Part of the challenge to the legal system is to ensure that liability rules are conducive to good overall performance by the industry, creating appropriate incentives to prevent patient injuries while not impeding efforts by employers, health plans, and physicians to define and implement efficient levels of spending. Although this Article adopts the conventional premise that the health care industry will perform well only if legal liability for breakdowns is assigned to the appropriate parties, an equally strong reason for holding MCOs liable for physician negligence may be to legitimize managed care in the eyes of legislators and the public. Establishing enterprise liability for MCOs is the most important single thing the legal system could do to channel the revolution that is occurring in the health care


\textsuperscript{17} See Paul M. Ellwood, Jr. \\& George D. Lundberg, \textit{Managed Care: A Work in Progress}, 276 JAMA 1083, 1085 (1996) ("[W]e have no objective evidence of any overall decline in the quality of care in the new system.").

\textsuperscript{18} See \textit{id.} (describing evolving marketplace with emphasis on increasing nonlegal accountability for quality of care). It is also possible, however, that MCOs are unduly hesitant, due to liability and other fears, to fight the battle against excessive health care costs aggressively in the "benefit-cost no man's land," where sacrificing some marginal, usually speculative, benefits would be justified by cost considerations. See HAVIGHURST, \textit{HEALTH CARE CHOICES}, supra note 1, at 92-100 (discussing cost-benefit analysis and explaining inefficiencies in health care market).
marketplace and to ensure that care is managed with appropriate attention to its quality. Given its current political problems, the managed care industry would be well advised to embrace enterprise liability rather than to fight it.

II. THE LAW GOVERNING HOSPITAL RESPONSIBILITY FOR PHYSICIAN NEGLIGENCE

The evolution of corporate liability for the torts of professionals practicing in hospitals parallels a historic shift in the locus of responsibility for the quality of hospital-based medical care. Beginning in the days when most hospitals were immune from tort liability as charitable institutions, courts compensated for that immunity by expanding the liability of physicians—inventing, for example, the so-called "captain-of-the-ship" doctrine. Although physicians naturally resented being held legally liable in situations where they felt hospitals had greater control, the legal responsibility they bore both reflected and enhanced their status in hospitals. By the same token, as subsequent case law gradually expanded the legal responsibility of hospitals, physicians suffered commensurate losses of de facto autonomy. As referees in this zero-sum game, courts seemed sometimes to ratify, sometimes to impel, shifts of power from individual doctors and self-governing medical staffs to hospital governing boards. This demonstration of how changes

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20 See generally id. § 7-2b.
21 See generally Clark C. Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 Duke L.J. 1071, 1077-92 (discussing balance of power and internal organization within hospitals). Although medical staffs retain the power of self-governance and also great influence in hospitals, over time legal and other forces have made them act more and more as agents of the hospital and less and less as co-equals of the governing board who are acting on their own professional responsibility. See generally Havighurst, supra note 2, at 535-73. A series of antitrust cases has recently addressed the question of whether medical staffs are, under normal circumstances, merely administrative arms of the hospital, requiring a special showing of its members' independent stake in a particular action to establish an "intraenterprise conspiracy" under Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 769-66 (1984) (holding components of a single enterprise incapable of forming antitrust conspiracy). See generally 1 Furrow et al., supra note 19, § 10-20b (stating what must be shown to prove conspiracies between medical staffs and hospitals); William S. Brewbaker III, Antitrust Conspiracy Doctrine and the Hospital Enterprise, 74 B.U. L. Rev. 67 (1994) (evaluating antitrust conspiracy doctrine in medical staff privileges litigation).
in liability rules can lead as well as follow reallocations of power and authority in particular spheres suggests the potential significance of such rules in the world of managed care.

A. APPLYING AGENCY PRINCIPLES

Early cases on hospital liability reflected judicial doubts about whether a hospital, as a lay-controlled corporate entity, could legitimately be held liable under the principle of respondeat superior ("let the master answer") for malpractice committed by its professional employees. Because only individuals could be licensed to provide professional services, some courts reasoned, a corporation such as a hospital could not be responsible for the quality of those services even when provided by its legitimate employees.22 Under this logical corollary of the common prohibition against the corporate practice of medicine,23 some early courts required injured patients to look only to the negligent professional employee for redress of injuries. Only in time did courts finally come to apply ordinary rules of respondeat superior when, say, a nurse-employee of a hospital caused a patient's injury through professional negligence (as opposed to negligence in performing routine ministerial tasks).24 Similarly, salaried physicians (such as interns, residents, and other "house staff"), whom hospitals employ under legislative or judicial relaxations of the corporate-practice rule (or possibly in violation of a dormant rule), are now also treated as ordinary employees for purposes of imposing vicarious liability. Courts thus eventually accepted the argument that, even though a hospital could not direct professional work, it could bear legal responsibility for that work because it hired, and could fire, professional employees and could ensure that the tasks assigned to them were within their demonstrated competence.

Once hospitals could be held liable for the torts of their professional employees, it was not long before courts applied principles

23 See supra note 2 (explaining source of rule against corporate practice of medicine).
of apparent or ostensible agency to hold hospitals responsible for the negligence of physicians who, although they were independent contractors in fact, were in positions where patients might assume they were agents of the hospital.\textsuperscript{25} In this way, many hospitals have been held responsible for professional negligence in emergency rooms,\textsuperscript{26} and some have been found liable for errors by hospital-based radiologists, anesthesiologists, and pathologists (RAPs).\textsuperscript{27}

Agency principles, however, are a highly artificial and unpredictable basis for selecting cases in which to impose liability on hospitals. Thus, in a Michigan case, the court, after reciting extensive facts supporting a finding that “the plaintiff looked to the hospital for his treatment,” largely undercut its apparent theory of ostensible agency by saying that it did not mean to imply “that the hospital would escape liability even if the plaintiff knew or should have known the relationship of [the negligent physician] with the hospital.”\textsuperscript{28} Likewise, cases against hospital-based RAPs have often been complicated (and indeed have often been unsuccessful) because the hospital had advised its patients that such professionals were not employees of the institution.\textsuperscript{29}

Making an issue in

\textsuperscript{25} See generally 1 Purrow et al., supra note 19, § 7-2d (“The ostensible agency or apparent authority test then looks to the patient and his or her expectation as to treatment.”); Havighurst, supra note 2, at 592-99 (collecting cases and commentary). Cases on this subject frequently refer to the Restatement (Second) of Torts § 429 (1965) and the Restatement (Second) of Agency § 257 (1958), which in slightly varying ways support the imposition of liability on the basis of appearances, impressions, or the principal's representations.


\textsuperscript{29} See, e.g., Floyd v. Humana of Va., Inc., 787 S.W.2d 267, 269 (Ky. Ct. App. 1990) (rejecting ostensible agency theory because patient had signed hospital form upon admission stating that her physicians, including anesthesiologist, were not agents of hospital). But see Beeck v. Tucson Gen. Hosp., 500 P.2d 1153, 1168-59 (Ariz. Ct. App. 1972) (finding agency relationship existed between hospital and radiologist despite patient's contrary acknowledge-
each case of the individual plaintiff's probable Impressions of the hospital/doctor relationship raises the cost and uncertainty of litigation to no good purpose. Much better, it would seem, to resolve the issue as a matter of policy.\textsuperscript{30} By leaving hospitals immune whenever the patient either was under no illusion about the hospital/physician relationship or had not relied in some material way on a hospital-induced misperception,\textsuperscript{31} theories of

\textsuperscript{30} A number of courts, recognizing the fruitlessness of continuing to follow agency rules, have explicitly elected to impose liability on hospitals as a matter of public policy, prompting dissents protesting such judicial activism. For example, in Sampson, 1996 WL 657719, at *8, the court said that for reasons of “public policy and fundamental fairness” it “encourage[d] the full leap—imposing a nondelegable duty on hospitals for the negligence of emergency room physicians.” Id. The dissenting judge said he would “leave this difficult policy decision—with its far-reaching social and economic ramifications—to the Texas Legislature.” Id. at *12 (dissenting opinion). See also Clark, 623 N.E.2d at 56 (Moyer, C.J., dissenting) (observing “difference between the incremental development of the common law and judicial legislation,” and warning that “[i]n a time of ever-increasing medical costs and potentially drastic changes to our health care system, this court would do well to take caution in its radical redistribution of liabilities for acts of medical malpractice”). The dissenters in the latter case might be advised that at least equal danger lies in not updating old notions to accommodate new developments. See infra note 38 and accompanying text (showing how law has adapted to changing character and expanding responsibilities of hospitals), and text accompanying notes 63-74 (arguing for similar adaptation in case of MCOs).

\textsuperscript{31} See, e.g., Menzie v. Windham Community Mem'l Hosp., 774 F. Supp. 91, 97 (D. Conn. 1991) (requiring proof of reliance “[a]lthough plaintiff complains that a reliance requirement will preclude many plaintiffs from demonstrating that the hospital is liable under an agency theory”); Gilbert, 622 N.E.2d at 795 (holding that if “patient knows, or should have known, that the physician is an independent contractor,” then the hospital will not be vicariously liable). Even though it is usually hard to see in these cases any detrimental reliance of the kind that is normally a prerequisite to finding an estensible agency, most courts find a way to ignore this requirement. One court held, for example, that a hospital is “estopped to deny” that its emergency room physicians are its agents even while observing that people seek emergency care under “crisis circumstances,” suggesting that they have no opportunity to make a considered choice or to form an estoppel-triggering impression. Hannola v. City of Lakewood, 426 N.E.2d 1187, 1190 (Ohio Ct. App. 1980); see also Sampson, 1996 WL 657719, at *8 (embracing vicarious liability as matter of policy and declaring that signs placed in emergency department are insufficient to defeat vicarious liability because ruling otherwise would only “lead to more far-reaching general notices by hospitals contained in advertisements”); Clark, 623 N.E.2d at 53 (expressly dispensing with requirements of affirmative representations by hospital and proven reliance by patient in favor of generalized “agency by estoppel” theory based on hospital's holding itself out as provider of care).
apparent or ostensible agency lose sight of the policy objective of assigning liability to get hospitals and their physicians to take the measures best calculated to ensure that hospital-based medical care meets an appropriate level of quality.\footnote{Another concern of some courts in apparent agency cases is whether the alleged principal actually exercised significant control over the alleged agent. See, e.g., Crinkle v. Holiday Inns, Inc., 844 F.2d 156, 166-67 (4th Cir. 1988) (finding franchisor significantly controlled franchisee). But, in health care settings at least, some degree of control should be a policy objective in extending liability rather than a prerequisite for doing so. See infra note 74.}

Another principle of agency law that courts have sometimes invoked to make hospitals liable for the torts of independent-contractor physicians is the rule that says legal responsibility for performing inherently dangerous functions cannot be delegated to independent contractors.\footnote{See, e.g., RESTATEMENT (SECOND) OF AGENCY § 214 (1958) ("A . . . principal who is under a duty . . . to have care used to protect others . . . and who confides the performance of such duty to a servant or other person is subject to liability to such others for harm caused to them by the failure of such agent to perform the duty."); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 71, at 511-15 (5th ed. 1984) (discussing certain activities where employer’s duty of care cannot be delegated to independent contractor). The leading case applying the principle of nondelegable duty to hospitals is Jackson v. Power, 743 P.2d 1376, 1382-85 (Alaska 1987). See also Beech, 500 P.2d at 1158 (describing radiologists’ services as "an inherent function of the hospital, a function without which a hospital could not properly achieve its purpose"); Stampson, 1996 WL 657719, at *9 (imposing nondelegable duty role on hospitals for negligence of emergency room physicians). A number of cases have rejected the idea that providing medical services is enough of a hospital function or inherently dangerous enough to create a nondelegable duty. E.g., Menzie, 774 F. Supp. at 97-98; Kelly v. St. Luke’s Hosp., 826 S.W.2d 391, 395-96 (Mo. Ct. App. 1992); Albain v. Flower Hosp., 553 N.E.2d 1038, 1047-48 (Ohio 1990). See also infra note 36 (discussing effect of corporate-practice rule on applicability of nondelegation doctrine).} The doctrine of nondelegable duties is not so easy to import into the hospital context, however, because public policy—in particular the rule against the corporate practice of medicine—has long frowned upon hospitals’ employing physicians or influencing their professional work.\footnote{See supra note 2 (explaining roots of corporate-practice doctrine).} Thus, there was a certain disingenuousness in the idea expressed by an Ohio court that a hospital employing independent emergency care physicians was "artificially screen[ing] itself from liability for malpractice in the emergency room."\footnote{Hannola, 428 N.E.2d at 1190.} In fact, the law has often specifically required that medical tasks not be performed by hospitals but be performed instead by independent professionals without lay or
corporate interference.\textsuperscript{36} Courts would have to overcome this feature of the old paradigm of medical care before accepting the idea that hospitals have nondelegable duties with respect to the quality of medical care rendered on their premises.

Obviously, however, the willingness of so many courts to overlook the status of hospital-based physicians as independent contractors signifies some kind of break with the old paradigm of professionalism under which courts barred the corporate practice of medicine and other arrangements thought to contaminate the doctor-patient relationship.\textsuperscript{37} Indeed, the nominal independence of emergency room physicians and RAPs may now be seen as nothing more than an artifact of the old corporate-practice rule, not as an efficiency-driven arrangement of the kind that the law would normally respect. Likewise, lay-controlled corporations, far from being viewed as unwanted intruders in certain physician-patient relationships, are now apparently perceived as efficient loci of responsibility for the quality of at least some medical care. Thus, a number of courts imposing vicarious liability on hospitals have justified their holdings by observing the changing character and expanding responsibilities of hospitals in the modern era and their increasing advertising of themselves as providers of high-quality care.\textsuperscript{38} Courts stressing that a hospital "held out" certain doctors

\textsuperscript{36} The hospital in \textit{Jackson v. Power} argued that "[p]hysicians, not hospitals, ... have a duty to practice medicine non-negligently" and that "a hospital cannot be held to have delegated away a duty it never had." 743 P.2d at 1382. Yet the Alaska Supreme Court, in finding vicarious liability, missed the hospital's point. On the basis of regulations and accrediting standards requiring only that a hospital "provide emergency care physicians" and get its physicians to meet certain administrative standards, it concluded that "it cannot seriously be questioned that [the hospital] had a duty to provide" the emergency care itself. \textit{Id.} at 1382-83. Although this leap from individual to corporate responsibility for medical services is justified as a matter of policy, the court failed to confront the issue directly as other courts have done. See, e.g., Pamperin v. Trinity Mem'l Hosp., 423 N.W.2d 848, 857-58 (Wis. 1988) ("[W]e are not convinced that the duty to have a radiologist available is a duty which a hospital may not delegate to an independent contractor."). Numerous courts have clearly ruled in favor of liability despite the argument that hospitals cannot practice medicine. See infra notes 37-39 and accompanying text (giving examples of such holdings).

\textsuperscript{37} See, e.g., Sword v. NKC Hosps., Inc., 661 N.E.2d 10, 14 (Ind. Ct. App. 1996) (holding that "the rationale of \textit{Herman v. Baker}, 15 N.E.2d 365 (Ind. 1938)—that patients could not reasonably conclude that doctors are agents or servants of the hospitals in which they practice because hospitals cannot practice medicine—is now without foundation in law or policy").

\textsuperscript{38} See, e.g., \textit{Jackson}, 743 P.2d at 1382-85 ("Not only is this nondelegable duty rule consonant with the public perception of the hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered, it also treats tort liability..."
as its agents or that the patient “looked to” the hospital for treatment (in an emergency room or otherwise) have usually placed less weight on the individual plaintiff's actual impressions than on their perception that, in certain circumstances, the public already views hospitals as actual providers of care.  

Thus, the many courts that have employed agency principles to find a hospital liable for the torts of hospital-based physicians have clearly been comfortable with the notion that, whatever policies may have prevailed in the past, hospitals should assume more responsibility for the quality of care. Despite this implied acceptance of corporate participation in the delivery of medical care, however, judicial decisions finding hospitals vicariously liable for the torts of hospital-based physicians have not been especially controversial. Precisely because they kept the hospital’s liability derivative (that is, vicarious), they did not directly challenge the paradigm of physician responsibility and independence. Nor did they put the hospital as a corporation explicitly in the business of practicing medicine. Thus, as long as agency principles governed these cases, hospital liability was only second-page news, not a direct threat to professional hegemony.

B. DIRECT, OR CORPORATE, NEGLIGENCE

A direct challenge to the old role-defining paradigm did finally arise, however, in the Illinois Supreme Court's 1965 decision in Darling v. Charleston Community Memorial Hospital.  

Although Darling is a landmark decision in the field of hospital liability, the
result in the case was hardly surprising. Indeed, from all that appears, it could easily have been reached under the principle of ostensible agency, since the patient, rather than selecting a physician himself, had come to the hospital's emergency room, apparently counting on the hospital to provide one. Nevertheless, instead of merely finding the hospital vicariously liable for the negligent acts of its ostensible agent, the court held that the hospital itself could be found negligent for failing to supervise the incompetent care provided by that physician.\footnote{Id. at 258.} This holding was revolutionary precisely because it made explicit what had never before been more than implicit—namely, that hospitals were expected to supervise, and perhaps even to second-guess, the work of professional independent contractors. To be sure, an oversight role for hospitals vis-à-vis physicians was already implicit in earlier cases imposing vicarious liability, was gradually emerging in practice, and was embodied in various licensing and accrediting standards applicable to hospitals (on which the \textit{Darling} court relied). But no court had yet spelled out an independent hospital responsibility for the quality of care provided by physicians. This aspect of \textit{Darling} struck a responsive chord among hospital administrators, who had long sensed a need to impose more control over individual physicians and were probably glad—despite the new liability risk—to have a convincing new excuse for moving further in that direction.

Thus, the \textit{Darling} decision was an important blow against the extreme notion of professionalism embodied in the law's historic hostility to corporate practice. Later decisions in other jurisdictions have also embraced hospital liability under theories of direct or so-called "corporate" negligence.\footnote{E.g., Elam v. College Park Hosp., 183 Cal. Rptr. 156, 158-62 (Ct. App. 1982); Inisenga v. LaBella, 543 So. 2d 209, 211-12 (Fla. 1989); Thompson v. Nason, 591 A.2d 703, 707-08 (Pa. 1991).} In these cases, hospitals were held to have an independent duty to select physicians for their medical staffs with care, to monitor at least their overall performance, and to withdraw or limit their practice privileges when problems were revealed. Today's hospitals therefore have affirmative legal responsibilities going well beyond being vicariously liable to pay
claims incurred through the negligence of a subset of physicians practicing within the institution. They must also exercise appropriate oversight of all physicians on their medical staffs, not merely those (such as emergency physicians and RAPs) whom patients rely upon hospitals to select. It might seem that whatever is left of the corporate-practice doctrine goes only to the form of hospital-doctor relationships, not to the idea that hospitals can be responsible for the quality of medical work.43

C. HOSPITAL ENTERPRISE LIABILITY?

Although hospitals now bear substantial legal responsibility for the negligence of hospital-selected physicians, it would be preferable if they faced exclusive enterprise liability—not just vicarious or joint and several liability—for the torts of these physicians. Eliminating all defendants other than the hospital would significantly reduce the cost and uncertainty of litigation and would facilitate full settlements of claims.44 Partly to realize such efficiencies, most hospitals probably already act as if they were principally responsible for negligence in their emergency departments. Thus, a hospital is likely either to carry the litigation risk for emergency room doctors it employs or, if the service is operated by an independent firm, to demand contractual indemnification by the independent contractor. Arrangements with hospital-based RAPs probably vary more widely, reflecting differences in local law, but the time has probably come for all courts to acknowledge that patients rely principally on hospitals to make these services available and that patients rarely have a meaningful doctor-patient relationship with these physicians. Since courts have already gone quite far toward establishing hospital enterprise liability for the

43 Ironically, the old technical objection to corporate practice was recently reasserted in Illinois. Berlin v. Sarah Bush Lincoln Health Ctr., 664 N.E.2d 337, 340 (Ill. App. Ct.), review granted, 671 N.E.2d 726 (Ill. 1996). The pending review of this decision should reveal whether the Illinois Supreme Court still requires formal observance of the rule despite having long since (in Darling) rejected its policy rationale—that hospital corporations should not control doctors.

torts of emergency room physicians and, in some states, of RAPs, it remains only to put the issue expressly on policy grounds, getting away both from vestiges of the corporate-practice rule and from the pretense that patient perceptions are a significant consideration in assigning liability. If courts definitively impose liability on hospitals in these cases (under some variant of the nondelegable-duty principle), either legislation or private contractual indemnities could easily complete the task of making the hospital’s responsibility exclusive, both de jure and de facto, thus obviating the unnecessary issues that arise in litigation when the alleged liability of the hospital is either vicarious or joint and several in nature.

Courts making hospitals legally responsible for the quality of care rendered by physicians have so far consistently stopped short of holding hospitals vicariously liable for all physician negligence occurring in the hospital. Thus, vicarious liability remains limited to cases in which the patient “looked to” the hospital either to provide care or to select the physician who would provide it. (Recall that Darling itself was a case of this kind.) Of course, a hospital may also be directly, not vicariously, liable for injuries caused by the negligence of a physician whom the patient selected in the first instance if the jury believes the hospital should have been more vigilant in overseeing that physician’s work. But a hospital is accountable for such a physician’s performance only if it was, or should have been, aware of a specific problem—much as, in many jurisdictions, a dog owner is entitled to one free bite. In the absence of a red flag of some kind, the negligence of an ordinary staff physician is not a hospital’s responsibility. To date, therefore, courts have rigorously preserved the distinction between a patient who had a preexisting relationship with the negligent physician and one who sought care in the first instance by approaching the hospital. It is possible, of course, that the law of hospital liability has simply reached another plateau and is gathering itself for another attack on the paradigm of professional independence and responsibility. Indeed, if one simply extrapolates the historical trend toward ever-increasing hospital responsibility for care rendered in the hospital, one might conclude that it is only a matter of time before hospitals will be subject to enterprise liability for all in-hospital negligence. Nevertheless, the legal distinction between hospital-selected and patient-selected physicians is a fairly bright line. It also has a strong policy rationale.
Making hospitals liable for the torts of physicians who were selected in the first instance by the patient rather than the hospital would be a more radical step than may at first appear, since it would inevitably shift some of the ethical responsibility for the patient's care from his personal physician to an impersonal corporation. To be sure, the old rule against the corporate practice of medicine is outmoded and should preclude neither new arrangements for delivering health care nor new assignments of liability to corporate intermediaries. However, there is a great difference between allowing corporate practice and making it mandatory—in the sense that consumers have no option but to rely on a corporation, and not on an individual professional, as the provider responsible for their medical care. Although the medical profession has often invoked the alleged sacredness of the doctor-patient relationship to defend prerogatives and arrangements that were not in the overall interest of consumers, the paradigm of the responsible professional is no less attractive ethically because its name has sometimes been taken in vain. Indeed, it would seem ethically important to preserve for consumers the option of entering into a traditional doctor-patient relationship, in which the patient entrusts his welfare—and looks for indemnification in the event of injury—not to a corporation but to a personal physician. Some patients, of course, might feel more confident in relying upon a reputable corporate provider than in choosing an individual professional, about whose skill it is always difficult to know as much as one would like. But today's markets offer that option, too—in the form of MCOs.

There is thus a strong policy reason to resist recent proposals to impose on hospitals exclusive enterprise liability for the negligence of all staff physicians. These proposals target hospitals because they are convenient risk bearers, well-positioned to ensure the quality of care, and also because making them exclusively responsi-

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45 See, e.g., STARR, supra note 1, at 3-29 (discussing "social origins of professional sovereignty"); Charles D. Weller, "Free Choice as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351, 1352 (1984) (distinguishing between "guild" free choice of physician, promoted by organized medicine, and "market" free choice as required under antitrust laws).

46 See generally 2 AMERICAN LAW INST. REPORTERS STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 119-128 (1991) (exploring concerns regarding organizational liability); Abraham & Weller, supra note 44, at 420-23 (discussing scope of enterprise medical liability).
ble would increase the overall efficiency of the compensation system. The most prominent proposal to introduce enterprise liability for hospitals, advanced by Professors Kenneth Abraham and Paul Weiler, would extend hospital responsibility to encompass even out-of-hospital negligence by physicians affiliated with the institution.47 The goal in assigning liability so arbitrarily would be to focus responsibility for the quality of care, to simplify litigation and settlement negotiations, and to eliminate the need for physicians to carry their own liability insurance. Despite the expediency of such proposals, however, there are good reasons why a court or legislature should not impose enterprise liability on hospitals without regard to whether the patient initially selected the physician or the hospital as the party to be responsible for his care. Such mandatory enterprise liability would impose an unwarranted limit on the consumer’s options, foreclosing arrangements premised on individual professional responsibility. Rather than impose corporate responsibility in all circumstances, the law should be sensitive to the perceptual and ethical distinctions implicit in the different arrangements consumers choose for their medical care. This can best be done by continuing to confine hospital liability for physician torts to those relatively clear instances in which the patient in the first instance selected the hospital rather than the doctor.

Although the law governing hospital liability for physician negligence has come a long way in overcoming the old paradigm’s hostility to the corporate practice of medicine, it may soon be eclipsed by developments with respect to MCOs. Indeed, logic powerfully suggests the imposition of liability for a physician’s torts on the corporate health plan in which the consumer enrolls rather than on either the individual physician or the hospital in which the physician practices. This Article now turns to liability rules as they apply in the world of managed care, with the object of finally assigning responsibility to the most appropriate parties, gaining the benefits of enterprise liability in appropriate cases but not foreclosing arrangements in which patients continue to look to their doctors, not to corporate intermediaries, to be responsible for their care.

47 Abraham & Weiler, supra note 44, at 421-22.
III. MCO LIABILITY FOR PHYSICIAN TORTS

In recent years, a whole new set of potential bearers of legal responsibility for the quality of health care has appeared in the American marketplace. In varying degrees and in a variety of ways, MCOs engage in both financing and delivering care, and in both roles they exercise substantial influence over the personnel and institutions actually providing it. Their involvement is such that they might be expected to bear substantial responsibility when poor-quality services are provided. As yet, however, courts have been reluctant to take the step of making MCOs automatically liable for the errors of physicians whom they select in the first instance and whose performance they can substantially influence by administrative oversight or by the use of financial incentives. Nevertheless, such legal accountability, whether imposed by judicial decision or by legislation, seems imperative if consumers are to receive the quality of care they pay for. Without it, the managed care revolution, as promising as it is, may come to grief in the face of increasing public skepticism.

A. MAKING AGENCY THE ISSUE

When faced with determining the corporate liability of MCOs for the torts of professionals, courts have usually taken their cue from case law governing the liability of hospitals and, accordingly, have applied conventional agency doctrine. This approach has generally meant making health plans liable only for the acts of their agents, including apparent or ostensible ones identified by reference to plan characteristics or to the way the plan represents itself to consumers. Thus, an MCO may face potential liability only if it has in some way allowed or induced consumers to believe that the doctors on its panels were its agents and not independent contractors. For example, although the defendant in a Pennsylvania case, Boyd v. Albert Einstein Medical Center, was an HMO of the loose-knit

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48 See generally 1 Furrow et al., supra note 19, § 8-2 (discussing vicarious liability and agency principles in relation to MCOs); Mark A. Hall & William S. Brewbaker III, Health Care Corporate Law: Managed Care ch. 6 (1996) (discussing managed care liability).

individual-practice-association (IPA) variety, "comprised of participating primary physicians who are engaged in part in private practice in the HMO service area," it had called itself in a sales document "a total care program, which not only insures its subscribers but provides medical care, guarantees the quality of the care and controls the costs." The plan also stated in its master contracts with employers that it operated "on a direct service rather than indemnity basis." Such representations made it easy for the court, borrowing principles from an earlier decision allowing a jury instruction on vicarious liability for care provided by a hospital in an emergency room, to impose similar liability on the HMO.

The ease with which the court in Boyd could find an agency relationship between the HMO and its doctors is matched, however, by the ease with which other health plans can craft their contracts and sales literature to diminish the likelihood of a similar finding. Indeed, a recent review of health plans' contracts with their subscribers observes how MCO contracts and related literature frequently characterize the plans' relationships with physicians in ways seemingly calculated to permit the plan later to deny responsibility for the quality of care provided. For example, one IPA-model HMO contract was quoted as follows: "Plan Providers are solely responsible for any health services rendered to their Member patients. [The] Plan makes no express or implied warranties or representations concerning the qualifications . . . of any physician, hospital, or other Plan Provider." A similar plan specified that "Plan providers maintain the provider-patient relationship with members and are solely responsible to members for all health services." Still another declared that the plan "has no responsibility for a Provider's failure or refusal to render

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50 Id. at 1233.
51 Id. at 1232 n.6.
52 Id. at 1235. Although some of the quoted documents were given to employers, not employees, the representations therein were important because the employer was acting as the employees' agent in selecting the plan in the first instance. Another document declared that the plan "provides the physicians, hospitals, and other health professionals needed to maintain good health." Id. at 1232 n.6.
54 Havighurst, Health Care Choices, supra note 1, at 119.
55 Id.
56 Id. at 120.
Covered Services.\textsuperscript{57} It would not seem difficult for a health plan to discourage vicarious liability suits simply by writing its contracts and sales literature to conform to conventional notions of doctor-patient relationships and of the role of corporate entities in providing medical care.

To be sure, there are several reported cases, like \textit{Boyd}, in which MCOs of various kinds have been held liable for physician torts.\textsuperscript{58}

\textsuperscript{57} Id.

\textsuperscript{58} See, e.g., Decker v. Saini, No. 88-361768 NH, 1991 WL 277590, at *1 (Mich. Cir. Ct. Sept. 17, 1991) (finding that HMO could be vicariously liable for negligence of both member- and nonmember-physicians); Dunn v. Praiss, 686 A.2d 413 (N.J. 1995) (recognizing liability based on combination of respondent superior, vicarious liability, and contract); McClellan v. HMO, 604 A.2d 1053, 1056-60 (Pa. Super. Ct. 1992) (demonstrating ostensible agency and corporate negligence). These cases turn in varying degrees on contractual and other representations to the public, confirming that liability will not be found in the absence of special facts. For example, in \textit{Raglin v. HMO Illinois, Inc.}, 595 N.E.2d 163 (Ill. App. Ct. 1992), the court distinguished \textit{Boyd} and held an IPA-type HMO not vicariously liable for physician negligence despite the limitations it placed on patient choice, which "is the manner in which all HMOs operate" and "therefore . . . should not be the dispositive factor upon which the question of apparent agency turns," and the plane's oversight of quality, which "is not the type of control from which agency arises." \textit{Id.} at 158. See also Chase v. Independent Practice Ass'n, 583 N.E.2d 251, 254 (Mass. App. Ct. 1991) (finding IPA not vicariously liable for physician's alleged negligence where IPA did not retain right to control professional activities of physician), quoted \textit{infra} note 69.

Another legal theory (besides agency principles) that has been borrowed from hospital law and applied to MCOs is the principle of corporate negligence in selecting, retaining, or overseeing the work of a plan physician. \textit{See}, e.g., Elseaer v. Hospital of Phila. College, 802 F. Supp. 1286, 1291 (E.D. Pa. 1992) (recognizing duty triggered by representations of selectivity); \textit{McClellan}, 604 A.2d at 1059 ("It is reasonable . . . to require that an IPA model HMO 'select and retain only competent physicians' and 'formulate, adopt and enforce adequate rules and policies to ensure quality care for [its subscribers]'"; quoting Thompson v. Nason, 591 A.2d 703, 707 (Pa. 1991)). \textit{But see Harrell v. Total Health Care, Inc.}, 781 S.W.2d 55, 60 (Mo. 1989) (relying on state statute, court declined to allow suit against HMO for negligently retaining allegedly incompetent physician). Although it is not known how successful plaintiffs have been in finally proving MCOs' corporate negligence, it does not appear that the law gives MCOs as much reason as it might to worry about whether their doctors are negligence-prone. Thus, one HMO contract, seeking to avert liability, provides, "[i]nclusion or exclusion of a Provider or Covered Facility in any network is not an indication of the Provider's or Facility's quality or skill." \textit{Havichurst, Health Care Choices}, supra note 1, at 119. Because representations in advertising or otherwise may override such fine print, plans should certainly maintain some kind of qualifying procedure. Nevertheless, the one-free-bite principle observed in hospital liability law would presumably apply to MCOs as well. In addition, the federal Employee Retirement Income Security Act, 29 U.S.C. §§ 1144(a) (1994), may preempt state law purporting to govern MCOs in performing the administrative task of selecting physicians to provide care under employee benefit plans. \textit{See}, e.g., Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 184-85 (E.D. Pa. 1994) (finding preemption of claims against ERISA plan based on failure to provide competent physician
Courts have always stopped well short, however, of making MCOs automatically responsible for the quality of care as a matter of law. Instead, in most cases MCOs will be held liable for physician negligence only if the plaintiff makes an additional factual showing—which an MCO can make more difficult by distancing itself from its physicians and prominently disavowing any agency relationship with, or any warranty concerning, providers of any kind. Because plaintiffs' lawyers only rarely assume the extra burden of suing the plan in addition to the negligent physician, few MCOs are routinely subject to vicarious liability because such claims directly relate to the employee plan; Dalton v. Peninsula Hosp. Ctr., 626 N.Y.S.2d 362, 364 (Sup. Ct. 1995) (same). But see Dukes v. U.S. Healthcare, Inc., 67 F.3d 350, 356 (3d Cir.) (holding plaintiff's claim of corporate negligence, as well as malpractice claim for vicarious liability, not preempted, although court failed to focus on possible distinction between claims recognized by court in Kearney, cert. denied, 116 S. Ct. 564 (1995); Santitorto v. Evana, 385 F. Supp. 733, 737 (E.D.N.C. 1996) (remanding claim for negligent selection to state court because not "completely" preempted under one section of ERISA but not addressing whether § 1144(a) might preempt it in state court).

For an extreme example of such "distancing," see Chase, 583 N.E.2d at 254. Because the HMO itself had been dismissed as a defendant (presumably pursuant to a settlement), the court addressed the liability of the defendant "IPA." Finding no vicarious liability, the court stated:

VHP (the HMO) did not employ physicians directly. Instead, it contracted with IPA to arrange for medical services to its members. IPA in turn contracted with HCGO [an incorporated ob/gyn group], who in turn employed Dr. Kaufman. IPA does not pay any physician employees and functions in effect as a third-party broker, arranging for services on behalf of VHP members.

That IPA did not retain any right to control the professional activities of Dr. Kaufman and HCGO is clear from the IPA-HCGO agreement. . . . While IPA did check the credentials of the agencies with whom it contracted, it did not have the right to hire and fire individual physicians, nor to set their salaries, work schedules, or terms of employment. More importantly, IPA did not control the actual medical decisions made by HCGO and Dr. Kaufman. Although the agreement between IPA and HCGO does provide for certain cost-containment and utilization-review measures, it also makes clear that responsibility for the actual provision of medical treatment rests with HCGO and its employee-physicians.

Id.

Unlike the case of hospital emergency rooms, see supra notes 31, 36, notification of the independent-contractor relationship prevailing between an MCO and its physicians cannot be discounted as coming too late to be effective.

Plaintiffs sometimes find it possible, however, to sue a corporate principal after settling with the negligent agent under a covenant not to sue. But see Gilbert v. Sycamore Mun. Hosp., 622 N.E.2d 788, 796-98 (Ill. 1993) (holding claim against principal does not survive settlement with agent). On the possibility that juries are more generous to plaintiffs when
for medical malpractice under the law today. Only so-called staff-model HMOs—that is, those actually employing physicians on a salary—are likely to face vicarious liability on a routine basis and thus to be fully motivated to look out for the quality of care.62

What is striking here is that, in legal contemplation, most MCOs fall well short of being the revolutionary vehicles for refocusing responsibility for the delivery of health care that they are widely reputed to be. Although MCOs do refocus de facto responsibility (especially for the cost of care) in many practical ways, most modern health plans still largely escape de jure responsibility for the quality of care provided under their aegis. Without legal accountability for quality, they may go less far than efficiency would dictate in integrating the delivery of care with its financing, leaving the health care revolution incomplete. In taking responsibility for (and seemingly profiting from) cost control while denying legal responsibility for quality, MCOs also do little to diminish public skepticism concerning their dedication to patient welfare.

B. OLD PARADIGM VS. NEW REALITY

MCOs have been able to avoid legal accountability for the medical services they arrange for, manage, and finance only because the law on this subject embodies a paradigm of medical care that has not been updated to embrace the concept of corporately managed services.63 Because this old paradigm continues to condition the thinking of legislatures and courts, they remain receptive to anachronistic characterizations of the relationship prevailing between doctors and patients and of the role of private corporations in the delivery of medical care. Thus, MCOs possessing powers that traditional health insurers, cabined by the old

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63 See supra note 1 (discussing paradigm of health care that protected physician from accountability to anyone but individual patients).
paradigm, historically lacked—such as the power to select physicians, to limit their clinical options, and to reward them for withholding services—can still find supporters for the view that, as lay-controlled corporations, they are not in a position to be responsible for the quality of care. Some states’ HMO enabling acts incorporate this contradiction by, on the one hand, empowering MCOs to select physicians in a competitive market, to contract with them on the plan’s own terms, and to profit by retailing their services to consumers while, on the other hand, declaring that MCOs are not engaged in “the practice of medicine.” Several courts have interpreted such statutes as precluding HMO liability for physician negligence. Legislative of at least two states, displaying the same cognitive dissonance (or perhaps only harkening to interest groups that foster it), have gone even further and have granted MCOs express immunity from such liability. But

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64 E.g., COLO. REV. STAT. § 10-16-421(3) (1994) (“Any health maintenance organization authorized under . . . this article . . . shall not be deemed to be practicing medicine . . . .”); N.Y. PUB. HEALTH LAW § 4410 (McKinney 1993) (“The provision of comprehensive health services directly or indirectly, by a health maintenance organization through its comprehensive health services plan shall not be considered the practice of . . . medicine by such organization or plan.”).


66 See infra notes 95-99 and accompanying text (discussing health care industry opposition to legislation imposing enterprise liability).

67 E.g., ALA. CODE § 27–21A–23(d) (1986); MO. ANN. STAT. § 354.125 (West 1991). The New Jersey statute reads:

No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies.

even if local statutes leave the issue of MCO liability for resolution by common-law courts, the old paradigm may still shape the result, since health plans can apparently discourage vicarious liability suits simply by tailoring their contracts and sales literature to conform to the conventional view that only individual professionals, not corporations, provide health care. It is simply ironic that a legal system which has finally seen fit to empower MCOs to control the cost of health care remains fastidious about making them also responsible for its quality. Both legislatures and courts seem to be in de jure denial of the de facto reality of corporate medical care.

In time, of course, judicial realism, prompted in part by emergent public dissatisfaction with managed care, could reasonably be expected to override old preconceptions about the ability of MCOs to bear responsibility for the quality of the medical care they manage. Just as courts eventually came to appreciate that hospitals could be assigned principal responsibility for care provided by some hospital-based physicians, they could also be expected to gravitate in time toward routinely imposing enterprise liability for most MCO-sponsored care. Indeed, several courts have already looked beyond principles of ostensible agency and whether consumer perceptions in a particular case justified finding doctors to be agents of a plan. The court in Boyd, for example, although it had ample factual grounds for finding an ostensible agency, also observed that its holding in an earlier case extending similar liability to hospitals was based “in large part upon ‘the changing role of the hospital in society [which] creates a likelihood that patients will look to the institution’ for care.” The court went on to say that a similar rationale might apply in the case of HMOs because “the role of health care providers has changed in recent years.” Similarly, a lower court in Michigan, although

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68 See generally Sage et al., supra note 1 (discussing benefits of enterprise liability); Glenn, supra note 3, at 326-29 (discussing application of direct liability to health care organizations); see also William M. Sage, "Health Law 2000*: The Legal System and the Changing Health Care Market, HEALTH AFF., Fall 1996, at 9, 13 ("Eventually, . . . the legal system is likely to hold the organizations controlling clinical care—whether they be capitated medical groups, hospital-run networks, or insurance companies—accountable for negligent patient injury.").


70 Id.
finding a clear instance of ostensible agency, declared that "[a]s a matter of public policy, . . . it behooves the Courts to hold HMOs liable for the conduct of their participating physicians, when the facts so merit."71 Conceivably some courts are on the brink of taking what a Texas court, in a recent hospital liability case, called the "full leap" to some form of enterprise liability.72

The common-law principle of nondelegable duty offers a convenient rationale for any court that senses the impropriety of allowing a health plan to profit as a middleman in health care transactions while denying responsibility for the quality of the ultimate product. To be sure, calling a function nondelegable by a corporate entity is difficult when public policy has traditionally viewed that function as an illegitimate one for a corporation to perform.73 Nevertheless, courts should readily see that public policy now contemplates—if not nominally, at least in fact—that MCOs will exercise a high degree of corporate influence over the nature and content of people's medical care. Indeed, a court might rationally conclude that, given the extensive powers they are now allowed to exercise, corporate middlemen should not be permitted to deny or otherwise avoid legal responsibility for the quality of care. Thus, unless a state statute expressly bars lawsuits against MCOs premised on vicarious liability, courts could easily conclude that if an MCO can restrict subscribers' freedom to select a provider, can select physicians on the basis of the low fees they can command or the low costs they incur in treating patients, and can reward physicians for economizing in patient care, the MCO cannot delegate legal responsibility for the quality of care to physician independent contractors.74

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73 See supra notes 33-39 and accompanying text (explaining conflict between nondelegable duty doctrine and rule against corporate practice in context of hospital liability).

74 It would be a mistake for courts to make corporate liability turn on the degree to which the MCO in question actually exercises the enumerated powers. See infra note 80 (discussing "control" as a prerequisite of liability). The law should encourage organized health plans to assume more responsibility for the quality of care and should not immunize
It would not necessarily follow from a decision to make MCOs vicariously liable for the torts of their participating physicians that MCOs would also be responsible for the negligence of nonphysician independent contractors employed in treating their enrollees. To be sure, MCOs typically designate the hospitals, outpatient surgical facilities, diagnostic centers, clinical laboratories, pharmacies, home health agencies, and so forth to which its enrollees may be referred by participating physicians. And there is certainly some risk that they will preselect these providers on the basis of cost considerations alone or with an inadequate regard for quality. But enterprise liability would not be appropriate without an assessment of whether legal responsibility for the contracted work should be deemed nondelegable—as an MCO's responsibility for physician services arguably should be. This policy judgment should reflect efficiency concerns, such as whether the plan or the independent contractor is in a better position to monitor the latter's quality problems, to make appropriate trade-offs between quality and cost, and to take (or induce others to take) indicated steps to prevent patient injuries. \footnote{Modern thinking about tort law supports assigning liability to create incentives to ensure appropriate attention to quality and to target parties who are generally in the best position, directly or indirectly (given transaction costs), to control quality and to influence outcomes. \textit{See, e.g.}, GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 135-78 (1970) (recommending a general deterrence approach to accident liability). On the potential for improvements in the quality of MCO-financed care, see Sage et al., \textit{supra} note 1, at 12-15.}

MCO enterprise liability for provider negligence is significantly less plausible in the case of affiliated nonphysician providers than in the case of physicians. For example, the transaction costs involved in MCOs' monitoring of, and negotiating for improvements in, the quality of care provided by hospitals or other institutional providers would be quite high; on the other hand, an MCO could reasonably be expected to screen physicians on its panels, much as
hospitals have induced their medical staffs to oversee the competence and work of individual staff physicians. Likewise, MCO contracts for the services of nonphysician providers appear to be dictated by business considerations rather than by liability concerns or by the tenets of some outmoded paradigm. Indeed, given the feasibility of outsourcing and the differences in the requisite management skills and in scale economies in the different lines of business, vertical integration would rarely be as efficient operationally as relying on independent suppliers. Finally, because contracted work can be overseen by referring physicians acting on behalf of the plan as well as the individual patient, integration is not necessary to curb the cost-increasing effects of what economists call “moral hazard”—that is, the tendency of providers and patients to spend a third party’s resources more freely than they would spend the patient’s own.

The strength of the case for MCO enterprise liability for physician malpractice is underscored by comparison with the case of nonphysician providers. The principal economic function of MCOs is, in the final analysis, curbing moral hazard by vertically integrating physicians’ clinical decisions with health care finance. This goal can be accomplished most efficiently, it would appear, by bringing clinicians within the corporate sphere and by making the corporation accountable for the quality as well as the cost of the care they provide. Even if an MCO chooses to deal with medical practitioners as independent contractors and to pay them on a fee-for-service basis (a strategy that may have productivity advantages over employing physicians on a salary), its arrangements are still likely to include significant power to control, influence, or constrain clinical choices. Indeed, it is the involvement of MCOs in selecting physicians and in influencing their clinical practice that would justify courts in finding enough integration to trigger enterprise liability.

By the same token, MCOs have no comparable stake or involvement, actual or potential, in the day-to-day activities of nonphysician providers and consequently should not bear comparable

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responsibility for their torts. MCOs should, of course, be held to have an independent duty—comparable to that of hospitals under the principle of corporate negligence—to select both physician and nonphysician providers with care and to monitor their performance to detect quality problems.\textsuperscript{77} Likewise, MCOs should be vicariously liable for any negligence by participating physicians in making referrals or in monitoring the care of a referred patient.\textsuperscript{78} On the other hand, automatic vicarious (enterprise) liability for the negligence of contract care providers would be a realistic, practical, efficient, and just allocation of responsibility for quality only in the case of physicians, not nonphysicians.

A final question is whether medical specialists, or only primary care physicians, are sufficiently integrated into an MCO to warrant making the plan vicariously liable for their negligent acts. After all, the arrangements that MCOs make to obtain specialists' services often resemble their arrangements with nonphysician providers more than they resemble their contracts with primary care gatekeepers. Although a court might try to ascertain in each case the degree of integration and the amount of control exercised by the plan, automatic enterprise liability would be a sounder policy. Not only would enterprise liability avoid immersing courts in inconsequential facts, but it would also obviate MCO efforts to escape liability by distancing themselves from providers, thus limiting their ability to ensure quality. The policy goal, after all, should be to make MCOs more, not less, effective proxies for consumers in purchasing professional services, the quality of which consumers are inevitably unable to assess reliably for themselves.

Indeed, if health plans are not legally accountable for the quality of care rendered by specialists whom they authorize their primary care doctors to employ, the market failure caused by the limited ability of consumers to assess the relative competence of providers is compounded. Consumers not only lose their ability to choose their own specialists based on what limited information they have, but they also must accept the choices of middlemen who are under

\textsuperscript{77} See supra note 58 (discussing corporate negligence as theory of MCO liability for physician torts).

\textsuperscript{78} See Dunn v. Praiss, 659 A.2d 413, 420 (N.J. 1995) (finding HMO can be liable for breach of contract to provide care when participating physician commits malpractice by improper patient follow-up).
hardly any legal obligation to consider quality in making choices for them. In this respect, the need to make plans more careful about the physicians they retain is at least equally strong in the case of specialists as in the case of primary care physicians (whom consumers can sometimes select prior to choosing a plan in which the physician participates).

In any event, an MCO has too many ways to influence the clinical decisions of medical specialists to permit it to deny that it is in the business of practicing medicine or otherwise to escape liability for breakdowns of the system over which it presides. Even if the MCO pays specialists on a fee-for-service basis rather than putting them at financial risk to induce economizing behavior, enough other ways exist in which the plan could influence the quality of care to justify making it responsible for injuries caused by specialists' negligence. By the same token, the MCO is in a position to make quality a desideratum in selecting specialists and could be expected to exert a beneficial influence if motivated to do so by liability risks. For example, an MCO typically contracts for such services with a limited network of providers, and it could readily verify, and perhaps even dictate, the criteria for membership in the network and could obtain quality-related information on an ongoing basis. Two courts have already held that, even

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79 An important practical consideration strongly arguing for enterprise liability is that MCOs, if they were routinely liable for physician torts, would have stronger financial incentives to maintain quality than do individual physicians, who generally carry liability insurance that cushions the effect of any judgment and is not sufficiently experience-rated to cause the doctor to recognize or modify risky behavior. See generally Harold S. Luft et al., Risk Factors for Hospital Malpractice Exposure: Implications for Managers and Insurers, LAW & CONTEMP. PROBS., Spring 1991, at 43, 59-63 (finding reasons to justify experience rating of hospitals which would also apply to MCOs); Frank A. Sloan, Experience Rating: Does It Make Sense for Medical Malpractice Insurance?, AM. ECON. REV., May 1990, at 128 (describing limited utility of experience rating in liability insurance for physicians). Folklore suggests that many malpractice suits are not filed against negligent, even incompetent, physicians because patients are reluctant to sue a seemingly caring doctor. If enterprise liability for MCOs made such suits more likely, it would add usefully to the legal system's ability to deter bad medical practice.

without many special facts, HMOs can be held vicariously liable for the negligence of nonmember specialists to whom patients are referred by panel doctors. 81

Historically, the problem with the medical profession’s preferred paradigm of medical care was that, in foreclosing the interposition of corporate or other lay intermediaries in doctor-patient relationships, it denied consumers all allies (other than physicians) in their effort to get good value for money spent on health services. To be sure, most consumers were probably content to entrust their welfare to physicians whom they alone selected. But some consumers might have preferred instead to obtain medical services through a trusted corporate middleman possessing superior buying power, better information about competing suppliers, and greater sophistication about the value and quality of the services being purchased. 82 Although the exclusion of corporations from the market for medical services was a policy mistake even in the earliest days, it became a truly serious policy problem when the growth of health insurance removed financial constraints on clinicians’ decisions, triggering severe cost escalation. Because the old paradigm effectively precluded payers from exercising any influence over physicians, the payers were virtually powerless to curb the cost-increasing effects of moral hazard.

Certainly, the emergence of MCOs in recent years has finally given consumers the opportunity, denied them under the old

control of procedures was not sufficient control to impute agency relationship). Yet ineffective oversight and control of physicians by MCOs, together with inadequate concern about competence in selecting physicians, are major sources of quality problems in the modern era—just as hospital passivity was a problem under the old paradigm. Because of the need to induce better oversight and to increase selectivity, an MCO’s failure to exercise any control over the negligent doctor is a better reason to impose enterprise liability than not to. If quality assurance is to be achieved, control should not have to precede the imposition of liability; it should be enough that control could be predicted to follow liability.


82 Cf. Weller, supra note 45, at 1355-59 (comparing “market free choice” and “guild free choice” of provider).
paradigm, to select a corporate agent to be responsible for keeping premiums affordable and for spending their funds in appropriate ways. Ironically, however, the old paradigm still operates to allow MCOs to avoid legal responsibility for the quality of care as well as its cost. One result is an unnecessarily high degree of tension between MCOs, charged by consumers with controlling costs, and physicians, who can claim to be exclusively accountable to patients for the quality of care. Likewise, the managed care industry is coming into increasing public disrepute as anecdotal evidence of allegedly excessive concern with cost control and inadequate attention to quality accumulates.

Litigation has occasionally sought recovery from an MCO for injuries allegedly caused by its efforts, through financial arrangements and otherwise, to induce physicians to economize. Such an issue arose in one early case in which the plaintiffs claimed:

[B]ecause the Health Plan represented itself to be a "nonprofit" organization, and in fact had a system whereby the individual doctors were encouraged, by an incentive payment plan, to be conservative with reference to unnecessary tests and treatments, [the subscribers] were fraudulently led to believe that they would receive "the best quality" of care and treatment.\(^{33}\)

The court found no liability and seems in retrospect to have suppressed any skepticism about managed care in order to protect what was then (in 1979) an infant industry.\(^{34}\) Although a prote-

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\(^{34}\) The court reasoned as follows:

We note, as defendants point out, that the use of such "incentive" plans is not only recommended by professional organizations as a means of reducing unnecessarily high medical costs, but that they are specifically required by [the federal HMO Act]. We can see in the plan no suggestion that individual doctors act negligently or that they refrain from recommending whatever diagnostic procedures or treatments the accepted standards of their profession require.

_Id._ at 394; _see also_ McEllan v. HMO of Pa., 604 A.2d 1053, 1056 n.6 (Pa. Super. Ct. 1992) ("The fundamental prerogative and duty of considering and establishing social policy, including, of course, the regulation of health care providers, is vested solely in the legislature.").
tive impulse may explain some courts' reluctance to impose enterprise liability on MCOs, it is unlikely to influence judicial treatment of MCOs much longer. So far, however, the issue of incentives has arisen in only a few cases, involving not vicarious liability but negligence in the design, operation, and disclosure of cost-control mechanisms.\textsuperscript{35} Although numerous proposals and some legislation exist to curb the use (or require disclosure) of incentives that threaten to discourage needed care, the logic of using enterprise liability for physician negligence to ensure appropriate accountability has not yet occurred to either legislatures or judges, whose thinking is still cabined by the old paradigm of medical care.

The beauty of enterprise liability is that it would integrate legal responsibility for both cost and quality in corporate hands. Instead of today's paradigm-driven bifurcation of responsibility for patient care, consumers could have a single locus of total responsibility for their health care. Although large purchasers increasingly are requiring MCOs to concern themselves with quality as well as cost, the law has yet to acknowledge that a true revolution has occurred in American health care and that, in many contexts, corporate health plans have assumed effective control. Despite the old paradigm denying the legitimacy of corporate health care, MCOs should be held legally responsible when the systems over which they preside fail to meet appropriate standards of quality.

C. REASONING FROM THE CASE OF HOSPITALS

As noted earlier, some commentators have argued for imposing exclusive enterprise liability on hospitals for the torts of all physicians practicing in the institution.\textsuperscript{36} Although extending

\textsuperscript{35} For example, in Bush v. Dake, No. 86-25767-NM2 (Saginaw County Circuit Ct., Mich. Apr. 27, 1989) (unreported), reprinted in BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS & PROBLEMS 719-22 (2d ed. 1991), a gatekeeper physician whose fees were subject to a partial withhold omitted to order a Pap smear that might have detected the patient's cervical cancer. While the incentive arrangement had been approved by the state legislature, the court nevertheless found enough evidence that the HMO's incentive system contributed to inferior medical treatment to preclude summary judgment. \textit{Id.} For recent case finding nondisclosure of disincentives for referrals to be breach of fiduciary duties under ERISA, see Shea v. Esensten, 107 F.3d 623 (8th Cir. 1997).

\textsuperscript{36} See supra notes 46-47 and accompanying text (discussing these proposals).
liability so far can be questioned in the case of hospitals, enterprise liability for MCOs is not subject to the same policy objections. For one thing, the health plan, unlike a hospital, is a natural locus of responsibility for all services, outpatient as well as inpatient, provided by affiliated physicians. In addition, whereas hospital liability would arguably be inappropriate whenever the doctor-patient relationship originated outside the hospital and the hospital played no middleman role in creating it, a consumer's decision to obtain care through an MCO would seem to be a definitive election to rely principally on a corporation, rather than on an individual professional, to provide the expected care. Presumably there are no impediments (other than possibly a prohibitive cost) to purchasing conventional indemnity insurance, which finances doctor-patient relationships of the traditional, highly personalized kind. If the market now reveals a strong preference by consumers for receiving their health care from lower-cost corporate providers rather than independent professionals, the legal system should not resist the conclusion that, in some circumstances, medical care has become a corporate, not a professional, responsibility. A consumer's decision to obtain care through an HMO or other MCO should be viewed—whatever fiction the sales literature or applicable contracts seek to propagate—as a decision to place himself in corporate hands.

Of course, it might be argued that, because enrollees in an MCO can usually select a primary care physician from a panel of providers, a true doctor-patient relationship is created and should be respected by not imputing legal responsibility to the corporate entity. A choice from a limited, pre-selected pool, however, does not carry the same ethical weight as a free choice of a personal physician from all those available in the community.87 Thus, hospitals have been deemed responsible for RAPs despite the availability within the hospital of several physicians in each category from whom the patient (or her attending physician acting as her agent) could choose.88 Indeed, the liability of hospitals for

87 But see Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 188 (E.D. Pa. 1994) (denying that “ostensible agency exists merely because an HMO plan requires a beneficiary to select from a list of physicians under contract with the HMO”).
88 See supra note 29 (discussing vicarious liability of hospitals for negligence of RAPs).
physician negligence has always been linked to the hospital's ability to select physicians, to monitor their work, and to address quality problems as they arise. Today's MCOs need similar encouragement to take responsibility for the quality of care rendered by doctors they select. Only when a patient, presented with a point-of-service (POS) option, personally selects a nonparticipating or nonpreferred provider should he be required to look only to that provider and not to the plan for compensation in the event of a negligently caused injury.

Extrapolating trends from the law governing the liability of hospitals leads inexorably, in the new era of managed care, to the recognition of a new class of corporate providers that should, at least presumptively, be vicariously liable for physician negligence. Indeed, reasoning from the case of hospitals, it follows a fortiori that MCOs should bear enterprise responsibility for the quality of care provided by plan physicians. Whereas there was never any reason to believe that hospitals were systematically putting the quality of care at risk, MCOs face strong temptations to compromise quality or to induce their affiliated doctors to do so (while denying that that was the plan's intent). Precisely because MCOs can select physicians for economic reasons alone and can impose incentive systems that discourage the provision of beneficial as well as unnecessary services, the need to make them responsible for quality could hardly be clearer.\(^9\) Only the antiquated idea that

\(^9\) It might be argued that a state "any-willing-provider" (AWP) law (or an equivalent statute limiting the freedom of MCOs to exclude physicians from participating in their plans without demonstrated cause) weakens a plan's power over physicians enough to preclude enterprise liability. See generally Greaney, supra note 8, at 185-89 (discussing such statutes). Certainly such laws, as the products of medical society lobbying to weaken corporate power and to restore to physicians some of the autonomy they enjoyed under the old paradigm, strengthen physicians' job security and make it difficult for plans to exclude marginal providers. Nevertheless, the burdens they impose on MCOs are presumably no greater than the burdens hospitals face in revoking or limiting a physician's staff privileges. Moreover, it might be thought—as advocates of enterprise liability have thought in the case of hospitals—that enterprise liability is needed to induce oversight that might otherwise seem too costly to pursue. On the other hand, hospitals have so far been held vicariously liable only for the acts of hospital-based physicians, whose positions in the hospital the institution probably can terminate without also revoking their membership on the medical staff. Cf. Bartley v. Eastern Me. Med. Ctr., 617 A.2d 1020, 1022 (Me. 1992) (holding that medical staff privileges were not constructively revoked when hospital required doctors to enter into separate employment contracts).

Even though theories of direct corporate negligence must still be invoked if the concern is overindulgence of an incompetent ordinary member of the medical staff, that feature of
doctors, not an impersonal corporation, must bear direct legal responsibility for professional negligence stands in the way of desirable legal change. That idea has already given way to the logic of hospital liability and should now be swept aside to impose de jure responsibility on MCOs, the parties best situated to see the whole economic picture and to take steps to ensure that quality is maintained at the proper level.

D. LEGISLATING ENTERPRISE LIABILITY

Although courts might be expected eventually to find ways to impose vicarious liability on MCOs for physician torts, such a reassignment of legal responsibility for the quality of care is unlikely to occur soon in many jurisdictions. Judicial action to establish MCO accountability may therefore come too late to head off heavy regulation prompted by increasing public distrust of MCOs. Insofar as regulatory interventions limit the flexibility of MCOs in responding to the marginal trade-offs between costs and quality that are the central reality in modern health care, they sacrifice efficiency in resource allocation, raise costs unnecessarily, and undercut the main rationale of a market-oriented health policy. Given both the unpredictability of reform through the processes of the common law and the drawbacks of regulatory measures aimed at domesticating MCOs, legislative enactment of

hospital law arguably reflects only judicial respect for true physician-patient relationships formed outside the hospital. As the text accompanying this note has demonstrated, MCOs are much better candidates for enterprise liability. Moreover, an AWP law does not much curb the ability of MCOs to limit physician freedom and to influence clinical decisions in ways potentially harmful to patients. Thus, a plan might set compensation so low that it attracts only marginal doctors, might impose financial incentives that induce the sacrifice of essential quality, and might require physicians to adhere to dubious practice protocols or guidelines. Finally, not only are AWP laws inadequate to restore doctor-patient relationships of the kind that flourished under the old paradigm, but such laws are also preempted by ERISA insofar as they apply to MCOs administering employee health benefits. E.g., Cigna Healthplan, Inc. v. Iveyh, 82 F.3d 642, 650 (5th Cir.), cert. denied, 117 S. Ct. 387 (1996).

See generally Clark C. Havighurst, Why Preserve Private Health Care Financing?, in AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM 87 (Robert Helms ed., 1993) (questioning efficacy of private health care system in which most important decisions about health care are ultimately under control of central authority, namely courts and medical profession, which are accountable neither to consumers in marketplace nor to voters in political process; arguing that national health policy leaving vital decisions in such hands rather than making them a matter of private contract invites runaway costs).
enterprise liability may seem the preferable way to make MCOs accountable for the quality of care.\(^1\)

In theory, at least, legislation imposing enterprise liability on MCOs could represent a clean break with the past and the paradigmatic view of health care as an exclusively professional responsibility. Well-crafted legislation would perform a useful purpose if it confirmed that health care is a service for which, under certain contractual arrangements, a lay-controlled corporation may be legally as well as practically responsible. Such a clarification of the implications of the revolution that is occurring in American health care would enable courts to accept the results of that revolution and to reject counter-revolutionary arguments. A statute might also settle which managed care arrangements eclipse traditional doctor-patient relationships enough to warrant enterprise liability and when, if ever, a plan should be liable for the negligence of nonphysician providers with which it affiliates.

A tentative proposal to implement MCO enterprise liability was floated prominently in May 1993 by the task force engaged in formulating the Clinton Administration's Health Security Act, the comprehensive program for national health care reform that failed to survive the political process in 1994. The task force suggested publicly that MCOs should be liable for the negligent acts of health care providers and that physicians affiliated with such plans should no longer be personally liable for their own negligence; only physicians maintaining traditional solo practices would retain individual liability.\(^2\) Some viewed this change in the locus of legal responsibility as achieving several goals, two of which were to avoid costly multidefendant litigation and to encourage health plans to settle cases. It was also expected that health plans facing enterprise liability would screen physicians with greater care, would monitor the quality of care, and would otherwise take more responsibility for patient well-being and outcomes. In addition, physicians in solo practice were expected to join organized health plans to escape liability and the need to pay malpractice insurance premiums. Thus, the Clinton administration's analysts arrived at enterprise liability for MCOs (rather than for hospitals) by following logic not unlike that reflected in this Article.

\(^1\) See supra note 30 (discussing appropriateness of modifying law by judicial action).

\(^2\) See Glenn, supra note 3, at 309-11 (giving history of ill-fated proposal).
Although the Clinton task force proposal contemplated that all health plans would assume legal responsibility for provider negligence, a more attractive approach might be to make that assignment of liability the default position that prevails in the absence of a contrary contractual provision and from which bargaining therefore begins. The following is a possible statutory provision assigning all liability initially to the financing entity but allowing the plan explicitly to contract away its responsibility to a hospital, another corporate provider, or the patient's personal physician:

**ENTERPRISE LIABILITY**

(a) *In General.* Subject to subsection (b) but notwithstanding any other provision of law, a health plan shall bear the entire legal responsibility (as determined under state law or by contract, as the case may be), and shall alone be subject to suit, for personal injuries and other losses arising from care rendered by health care providers to enrollees under the contract between the health plan and the purchaser of coverage.

(b) *Contractual Exceptions.* A party other than a health plan may be subject to suit for personal injuries and other losses of the kind referred to in subsection (a) if the applicable contract (which contract shall be both binding on the enrollees of the health plan and enforceable by them against the health plan and health care providers with which the plan has arrangements to provide services) provides as follows—

(1) in the case of hospital care, that the hospital in which the care is rendered shall bear the entire legal responsibility and shall alone be subject to suit for any breach of duty in connection therewith;

(2) in the case of care provided through or under the auspices of an entity other than a hospital or the health plan itself, that such entity shall bear the entire legal responsibility and shall alone be subject
to suit for any breach of duty in connection there-
with; or

(3) that an individual physician who is selected by
the patient as his or her personal physician from a
universe of options not substantially limited or
preselected by the health plan shall bear the entire
legal responsibility and shall alone be subject to suit
for his or her own negligence and for any other
breach of duty in connection with care rendered to
enrollees of the plan.93

The statutory language proposed here recognizes the desirability of
preserving traditional doctor-patient relationships where circum-
stances suggest they exist. It would not, however, permit MCOs to
hide behind the fiction that MCO-selected physicians work for
patients, not for a corporate health plan. It is believed that
liability should track the practical realities of relationships between
payers, physicians, and consumer/patients and should not perpetu-
ate a paradigm that, by refusing to acknowledge the corporate
practice of medicine, fails to challenge corporate health plans to
manage care with quality as well as cost in view.94

Although legislation would certainly be the most expeditious way
to effectuate enterprise liability for MCOs, it is unlikely that any
amount of public distrust of managed care will soon yield legisla-
tion of the kind visualized here. The fate of the Clinton task force
proposal is illuminating in this regard. That proposal was quickly
taken off the table by the task force when it encountered strong

93 This language is adapted from proposed language submitted by the author to the
Clinton administration task force in 1993. HAVICHURST, HEALTH CARE CHOICES, supra note
1, at 81; see also id. at 59-60. Modifications from the original proposal in the final subsection
reflect a stronger preference for limiting the circumstances in which an MCO could disclaim
enterprise liability for physician torts. The proposal still avoids the trap into which the
original Clinton proposal, like the Abraham-Weiler proposal for hospital enterprise liability,
fell, of denying patients the option of entering into a traditional doctor-patient relationship,
compelling all consumers to look to a corporation rather than to a personal physician as the
party responsible for their care. For a discussion of the Abraham-Weiler proposal, see supra
text accompanying notes 46-47.

94 The proposed Health Security Act, S. 1757, 103d Cong. § 1407(b) (1993), would have
preempted state laws prohibiting the corporate practice of medicine to the extent that such
laws would have inhibited the organization and operation of integrated health plans.
opposition throughout the health care industry.\textsuperscript{95} The themes of
that opposition—from organized medicine,\textsuperscript{96} health insurers, and
the managed care industry—reveal both the implications that the
locus of tort responsibility has for the control of medical practice
and the degree of comfort of the major players with a state of
affairs in which health plans are not legally accountable for the
quality of care. Thus, the AMA's general counsel cited physician
fears about the loss of professional autonomy: "[The proposal] says
to doctors, 'We are going to be there, at your side, with procedure
guidelines, with oversight, with second guessing.'"\textsuperscript{97} A lawyer for
the leading trade association of HMOs stated that the proposal
"assumes a lot more control over physicians by HMOs and other
managed care organizations than is the case,"\textsuperscript{98} and an executive
of Aetna Health Plans stated, "It gets us involved in the practice of
medicine."\textsuperscript{99} One senses in the industry's resistance to MCO
enterprise liability the continued force of the old paradigm of
medical care, the determination of the medical profession to fight
for ground that is gradually being lost to corporate managers of
medical care, and the desire of MCOs to influence medical practice
without accepting legal responsibility for unacceptable outcomes.
Numerous observers have noted the powerful irony inherent in
physician resistance to a proposal to relieve them of all personal
liability for professional negligence. Although physicians often
complain bitterly about the law of medical malpractice, accountabil-
ity under the law of torts goes with the territory over which they
still aspire to rule autonomously. The irony in the physicians'
position was further compounded by the fact that plaintiffs' lawyers
also opposed the Clinton enterprise liability proposal.

\textsuperscript{95} See Havighurst, Health Care Choices, supra note 1, at 171-73 (describing proposal
and reactions to it); Abraham & Weiler, supra note 44, at 382-84 (suggesting reasons for
industry-wide criticism of enterprise liability in proposed health care reforms); Sage &
Jorling, supra note 4, at 1010-12 (describing quick and harsh condemnation of enterprise
liability by both organized medicine and managed care industry). Only a provision for state-
sponsored demonstrations of enterprise liability survived in the final administration bill.
S. 1767, § 5311.

\textsuperscript{96} Within two weeks after the enterprise-liability trial balloon was floated, the AMA sent
a letter opposing it that was cosigned by 106 medical groups, representing 500,000 of the
nation's 650,000 physicians.

\textsuperscript{97} Havighurst, Health Care Choices, supra note 1, at 171-72.

\textsuperscript{98} Id.

\textsuperscript{99} Id.
For present purposes, the lesson from this experience is that the political process is unlikely anytime soon to ratify the de facto gains of MCOs in seizing responsibility for medical care by carrying the matter to its logical legal conclusion—enterprise liability. Instead, the more likely legislative scenario is incremental regulation of the kind being promoted by organized medicine—"any-willing-provider" laws, prohibitions of so-called "gag clauses," new appeal rights for patients denied particular services, and so forth. Nevertheless, things might still turn out differently if the managed care industry were astute enough to embrace enterprise liability as an alternative to ever more intrusive regulation. Industry acceptance of enterprise liability would help MCOs consolidate their gains and, in a politically critical time, would help to legitimize the powers they exercise over physicians and clinical practice. Even without legislation to effectuate MCO enterprise liability, the industry can expect to be held liable for physician malpractice and various forms of corporate negligence in an increasing number of cases. The industry would be better advised to get whatever political advantage and cost savings are possible from openly accepting corporate responsibility for the quality of care.

IV. CONCLUSIONS ON MCO ENTERPRISE LIABILITY

Enterprise liability for MCOs—that is, vicarious liability for the negligent acts of affiliated physicians—flows logically from the most promising features of managed care itself:

- preselection of physicians,
- use of financial incentives and utilization management techniques to influence or constrain physicians' clinical choices, and
- MCOs' superior ability, using advanced information technology, to evaluate and monitor the quality and effectiveness of the care being provided to their enrollees.

As common-law courts increasingly appreciate the nature and potential significance of the managed care revolution, they will be influenced less and less by the professional paradigm of medical
care and therefore will be less inclined to accept the claim that the
good of care is the responsibility only of individual physicians
and not the business of a corporate intermediary. Once courts seek
to assign legal responsibilities, not to conform to the old paradigm,
but to obtain efficient performance under the new, market-oriented
paradigm, they should quickly identify MCOs—the entities most
likely to take appropriate quality-assurance measures (or to ensure
that others take them)—as prime candidates for enterprise liability.
Judges have often allowed their instincts about the efficient locus
of responsibility to affect their rulings in cases involving the
liability of hospitals—with the result that hospitals are now
generally liable for the negligence of emergency room physicians
and are sometimes held responsible for the negligence of other
hospital-based physicians. Similar policy considerations should
now lead them to impose vicarious liability on MCOs for poor
performance by physicians selected for inclusion in their networks.

The logic of enterprise liability for MCOs can plausibly be
questioned today only by calling attention to the apparent diver-
gence between the theory of competition among distinctive
corporate health plans and actual developments in the evolving
marketplace. In mature markets, it seems, a variety of forces,
including strong employer and employee preferences for large
physician panels, are inducing competing health plans to offer their
enrollees access to virtually all physicians—or at least to all
primary care physicians—practicing in the community. Similarly,
physicians, seeking access to as wide a patient base as possible,
have been willing to contract with virtually any available plan or
network. As a result, most of today's MCOs are not the differenti-
ated delivery systems visualized in competition theory. Instead,
they are merely financing intermediaries all offering virtually the
same product and differing from the third-party payers of the old
paradigm only in their ability to demand lower prices, including
capitation arrangements, from providers. Thus, health plans

106 See generally Robert A. Berenson, Beyond Competition, HEALTH AFF., March-April,
1997, at 171 (perceptive analysis of recent evolution of health care marketplace). It is not
clear whether Berenson, in analyzing how “recent developments have led to a different
market environment than many had expected” and “how quality improvement . . . might be
refocused to take into account how the system has actually evolved,” id. at 172, has modified
his views on the virtues of enterprise liability for MCOs. See Sage et al., supra note 1 (co-
of the main type that has emerged in practice have no obvious ability, or inclination, to influence or control individual practitioners, since any single doctor is likely to be beholden to a given plan for only a small percentage of his patients and to be uninterested in whether the plan succeeds in the competitive race. Given these realities, courts might naturally hesitate to hold MCOs responsible for the quality of care. Even though such plans may use capitation payments or other means to diminish the aggressiveness of physicians in caring for patients, their lack of organizational integration may seem reason enough to immunize them from liability for bad outcomes caused by independent-contractor physicians.

Nevertheless, despite the way the market has evolved, enterprise liability is still appropriate as a way of finally focusing responsibility on health plans and thereby inducing integration, selectivity in contracting with physicians, and appropriate attention to the quality of care. The current market is falling short of its potential precisely because it features competition only among undifferentiated health plans and lacks plans that aggressively exploit the possibilities of closer integration between financing and delivery, that involve physicians as active, committed partners, and that strive to fill different market niches by explicitly undertaking to meet differing expectations of different populations with respect to cost and quality. By the same token, significant improvements in the market’s performance and a wider range of consumer choice could be expected to result if consumers were able to differentiate between those health plans that assume responsibility for deliver-

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Footnote: 101 For the argument that the failings of the health care marketplace are traceable at the most fundamental level to the failure of health plan contracts to differentiate health plans from one another, with the result that consumers are denied an appropriate range of explicit choices and instead face not only care of uncertain quality but also sub rosa rationing, the legal authority for which is unclear, see Havighurst, Health Care Choices, supra note 1, chs. 2 & 5.
ing a certain quality of care and those that do not. To be sure, plans that make no pretense of selecting competent physicians might be allowed to contract with their subscribers to assume no liability for physician negligence. But that privilege should be denied to plans that represent themselves as taking any responsibility for quality or that materially limit consumer choice of physician. Any health plan that assumes responsibility to this degree should be treated by courts as having a nondelegable duty to provide care meeting the applicable legal or contractual standard. Enterprise liability, by increasing the interdependence of MCOs and physicians with respect to the quality and cost of care, would strengthen incentives for closer integration and further weaken the paradigmatic view that treating doctors and financing corporations have distinct functions, one of which is morally superior to the other. In this way, the full potential of corporate medicine (and fewer of its hazardous possibilities) would be realized, while consumers who prefer being cared for by an independent, responsible professional rather than by a corporation would continue to have that option.

This Article has argued that state courts have ample policy justifications for making the leap to MCO enterprise liability and that, as molders of the common law, they should move at the earliest opportunity to adapt the law to (rapidly) changing circumstances. To be sure, courts will find it difficult to impose vicarious liability on MCOs if they continue to frame the issue only in narrow terms—as whether the negligent doctor was an apparent or ostensible agent of the plan. It is simply too easy for MCOs to put patients on timely notice that its designated doctors are, technical-

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102 See supra text accompanying note 93 (setting forth statutory proposal that would achieve essentially the result contemplated).

103 Undoubtedly some plans facing enterprise liability would seek contractual indemnification from the networks or group practices with which they contract. Although this practice might place ultimate responsibility in appropriate places, many plans might find it cheaper to self-insure the liability risk, thus giving themselves an incentive to manage it. In the case of employers self-insuring health benefits for their employees, the matter might be left to contract, but a wise employer might require networks or other MCOs with which it contracts to assume the liability risk.

104 See infra text accompanying notes 141-147 (discussing feasibility of contractual specification of the standard of care and the advantages of encouraging health plans to differentiate themselves in terms of both cost and quality).
ly, independent contractors. On the other hand, given the way most MCOs operate and the usual tone and content of their public representations, it will not be hard to say that the plan "holds itself out," if not as the actual provider of care, then at least as a responsible party. Likewise, it will usually be clear—even clearer than in cases involving emergency rooms, for example—that consumers as patients "look to" the MCO to be responsible for the contracted care, relying on it to select good doctors and to monitor and motivate them to ensure appropriate quality. In any event, the managed care movement is providing powerful evidence of extensive corporate involvement in medical care and of the potentially dangerous consequences of such involvement. Thus, it should be easy for state courts to invoke the agency-law principle of nondelegable duty to frustrate MCO efforts to shift legal responsibility to independent contractors. As a doctrinal matter, common-law courts have all the tools and policymaking room they need to assign liability for poor-quality medical care to the corporate managers of that care.

Courts can no longer afford to labor under the paradigm of medical care that for so long had nearly everyone believing that medical care is always a professional, never a corporate, endeavor and that clinical choices are exclusively technical, never economic, in nature. It is simply no longer the case—and, indeed, it has not been the case since third parties began paying people's health care bills—that physicians make clinical decisions uninfluenced by the corporate actors who underwrite their prescriptions. Now that financing entities are aggressively addressing the problem of moral hazard, are taking an active interest in how their money is spent, and are managing care to ensure that physicians share that interest, it is time for them to become the primary bearers of legal responsibility when avoidable bad outcomes occur. Despite the usual conservatism of the common law, a judge-led revolution is necessary to enable liability law to catch up with contemporary reality in the health care industry. Indeed, without enterprise liability routinely imposed on MCOs either by courts or by legislatures (in states where enterprise liability can be effectuated only by statute), the purveyors of corporate medicine will remain dangerously unaccountable for the quality of care provided under their auspices.
On the other hand, if MCOs were to become legally responsible for the quality of the professional services provided by their chosen doctors, a number of good things should happen. This Article concludes by suggesting how changing the legal environment of the managed care industry in this one crucial respect could trigger specific developments that would greatly improve industry performance and enhance the welfare of consumers. Indeed, the good news is that the legal system, if it can get this one thing right, can turn MCOs into something they do not appear to be today—reasonably trustworthy purveyors of corporate medical care.

V. THREE AFTERWORDS ON THE FUTURE OF MCO ACCOUNTABILITY

This Article has been principally concerned with explicating the logic and urgency of imposing enterprise liability on modern health plans in order to ensure that effective legal oversight of the quality of medical care is not sacrificed because of anachronisms in state liability law. Yet agency issues in state law are only one part of the much more complex problem of ensuring that MCOs face appropriate legal accountability for patient injuries they could help to avoid. To sketch the remainder of the picture and to stimulate further thinking about the role of law in the health care revolution, the Article concludes by briefly observing three other dimensions of the problem. These comments, though brief, draw on recent case law to arrive at some unique insights that could be helpful in finally achieving under existing state and federal law what many observers view as unattainable without major statutory reform—suitable legal accountability for MCOs for the quality as well as the cost of medical care.

A. WILL ERISA PRECLUDE ENTERPRISE LIABILITY FOR MCOs?

A possible impediment to making MCOs vicariously liable for the negligence of the physicians they select is the federal Employee Retirement Income Security Act of 1974 (ERISA). In ERISA, Congress provided for federal oversight of the administration of

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employer-sponsored pension and welfare benefit plans, while also seeking to protect employers maintaining such plans against having to comply with varying requirements in the laws of individual states.\textsuperscript{106} The preemption provisions of ERISA have been construed to preclude, in particular, personal injury suits brought against MCOs under state law for wrongfully denying health benefits.\textsuperscript{107} Not only are such claims preempted because they "relate to" the employee benefit plan itself,\textsuperscript{108} but ERISA provides its own machinery to serve as the exclusive means by which plan beneficiaries can enforce claims for contractual benefits.\textsuperscript{109} Claims against MCOs for direct negligence in selecting a physician or in monitoring a physician's performance may also be preempted.\textsuperscript{110} Although Congress apparently did not intend to have a major impact on health care arrangements when

\begin{footnotes}
\footnote{106}{See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1672 (1995) (stating objective of ERISA § 514(a) preemption clause was to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans").}
\footnote{107}{See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1338-39 (5th Cir. 1992) (holding that ERISA preempts actions based on HMOs' wrongful denial of benefits even though ERISA provides no adequate remedy for the injured patient).}
\footnote{108}{Section 514(a) of ERISA, 29 U.S.C. § 1144(a) (1994), preempts state law insofar as it "may now or hereafter relate to any employee benefit plan." In the arcane field of ERISA law, this preemption is not "complete preemption" such as is provided in section 502(a). See infra note 109 (explaining § 502(a)'s complete preemption). Thus, it can be invoked as a defense in a state proceeding, but because it does not create federal jurisdiction, it does not require or permit removal of the case to federal court. Federal decisions finding malpractice cases and vicarious liability claims not preempted by ERISA frequently involve only the application of section 502(a).}
\footnote{109}{Section 502(a) of ERISA, 29 U.S.C. § 1132(a) (1994), provides a federal forum for recovering benefits under employee benefit plans. It has been construed to provide exclusive remedies and thus to "completely preempt" actions in state court that are simply disguised efforts to recover such benefits. E.g., Rice v. Panchal, 65 F.3d 637, 641, 646 (7th Cir. 1995) (rejecting "assertion that Rice's claim is not completely preempted simply because ERISA contains no provision that can be used to hold a plan administrator vicariously liable for the medical malpractice of doctors providing services under the Plan," and holding that claim is not "completely preempted" under § 502(a)).}
\footnote{110}{Because such claims challenge the performance of important administrative functions undertaken by MCOs in implementing employers' plans, they would seem to "relate to" such plans and thus to be preempted. See supra note 58 (discussing principle of corporate negligence in selecting, retaining, or overseeing work of plan physician); see also Rice, 65 F.3d at 644 (stating that "if Rice were claiming that Prudential was negligent when it selected Sotillo . . ., we might have a different case," thereby justifying finding of complete preemption because state court would have to engage in evaluating "the performance of the contract").}
\end{footnotes}
it passed ERISA in 1974, it has had the effect of cutting off remedies for patients injured as a result of catastrophic breakdowns in the management of care—in particular, compensation for personal injuries and punitive damages for bad faith in the administration of claims. Congress's decision to leave ERISA unamended, however, may reflect a belief that plan performance can be satisfactorily monitored by employers and that poor administration and arbitrary benefit denials are adequately deterred by fear of employers' displeasure. In any event, it seems clear that, under ERISA, state law cannot be invoked to challenge the mismanagement of care—in particular, alleged errors in an MCO's predetermination of its payment obligations.

On the other hand, claims for medical malpractice brought against MCOs under theories of vicarious liability for the negligence of affiliated physicians are probably not preempted by ERISA. A number of courts have allowed such cases to proceed in state court and to be resolved there in accordance with state law alone. In Pacificare, Inc. v. Burrage, for example, the court of appeals for the Tenth Circuit quoted approvingly the following language from an earlier district court opinion: "When an HMO plan elects to directly provide medical services or leads a participant to reasonably believe that it has [so elected], rather than simply arranging and paying for treatment, a vicarious liability medical practice claim based on substandard treatment by an agent

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111 A striking feature of ERISA is that it was not enacted as a health care measure at all. In the early 1970s, nearly all private health coverage took the form of conventional health insurance purchased by employers from nonprofit Blue Cross and Blue Shield plans or from commercial health insurers. ERISA was specifically designed not to interfere with the business of insurance or with state regulation thereof, providing in section 514(b), 29 U.S.C. § 1144(b)(2)(A) (1994), an exception (the so-called "saving clause") from the preemption provision in section 514(a) for state laws that regulate insurance. Thus, ERISA was designed principally to govern the establishment and administration of pension and welfare funds and did not purport to provide a federal substitute for state laws and regulations specifically aimed at the health care industry.

112 See Mertens v. Hewitt Assocs., 508 U.S. 258, 263 (1993) (holding personal injury damages do not constitute "other equitable relief" such as ERISA provides).


114 For the surprising conclusion that appropriate accountability can in fact be achieved under existing federal and state law without amending ERISA, see infra notes 137-140 and accompanying text.

115 59 F.3d 151 (10th Cir. 1995).
of the HMO is not preempted."116 Although recognizing that a vicarious liability claim requires reference to plan documents to determine the contractual relationship between an MCO and the physician,117 the court stated that such reference "does not implicate the concerns of ERISA preemption."118 In ruling that vicarious liability claims are not preempted, the court of appeals appeared to accept the argument that "ERISA does not preempt laws of general application—not specifically targeting ERISA plans—that involve traditional areas of state regulation and do not affect relations among the principal ERISA entities [the employer, the plan, the plan fiduciaries, and the beneficiaries]."119 Presumably, the court in Pacificare meant to ignore the probability that the liability risk would induce, though it would not compel, MCOs to rethink and restructure their relationships with providers.120

The issue of MCO vicarious liability for physician negligence is not free from doubt, however. In Jass v. Prudential Health Care Plan, Inc.,121 for example, the Seventh Circuit court of appeals held that ERISA preempted at least one kind of vicarious liability claim against an HMO.122 In that case, however, the court interpreted the complaint as alleging not merely negligent treatment by the treating doctor, but a "negligent failure to treat"—which was in turn attributable, not to the physician's independent judgment, but to the plan's refusal to authorize

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116 Id. at 155 (quoting Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 548 (S.D. Ill. 1994)).

117 Several district courts had previously used the necessity to interpret plan documents as the key to preemption and, on this basis, had found vicarious liability claims to be preempted. See, e.g., Pomroy v. Johns Hopkins Med. Servs., Inc., 868 F. Supp. 110, 114 (D. Md. 1994) (holding ERISA preempts medical malpractice claim against HMO based on vicarious liability).

118 Pacificare, 59 F.3d at 155; accord Rice v. Panchal, 65 F.3d 637, 645, 646 (7th Cir. 1995) (finding no preemption because "[w]hile the Plan will serve as evidence of [the doctor's] apparent agency, the alleged agency does not necessarily rise and fall with the Plan" and claim "can be resolved without interpreting an ERISA plan").

119 Pacificare, 59 F.3d at 154 (quoting Airparts Co. v. Custom Benefit Servs. of Austin, Inc., 28 F.3d 1062, 1065 (10th Cir. 1994) (quoting National Elevator Indus., Inc. v. Calhoon, 957 F.2d 1555, 1559 (10th Cir. 1992))).

120 But see supra notes 58, 110 (discussing effects of ERISA on claims of corporate negligence in selecting physicians or evaluating their performance).

121 88 F.3d 1482 (7th Cir. 1996).

122 Id. at 1490.
continued treatment. Although this latter fact might seem to strengthen the plaintiff's claim against the plan, it has the opposite effect in the never-never land of ERISA law, where claims for improper denial of benefits are federally preempted. Indeed, in Jass, the court had already scotched an effort by the plaintiff, apparently recognizing that she had a preemption problem, to cast her claim for benefit denial as a claim that the nurse-employee who refused to authorize the treatment had committed professional malpractice. Thus, the court's holding in Jass may be read narrowly to permit MCOs to escape from state malpractice suits only when the claim can be characterized as an indirect challenge to the plan's method of administering benefits.

Nevertheless, the Jass court also suggested in dictum that ERISA's policy of protecting employers from having to comply with diverging state requirements precluded vicarious liability suits of all kinds. The court recognized that some state legal requirements "may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding" of preemption. But it viewed state imposition of vicarious liability as intruding too far into areas of plan administration that Congress meant to protect from state action. The court did not consider, however, the effect of New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., in which the Supreme Court retreated from some earlier expansionist readings of ERISA and held that state laws of general application that are aimed at advancing general state goals, such as assuring the quality of care, may avoid preemption if they do not specifically target or disproportionately burden employee benefit plans. Also, the court in Jass did not take account of Dukes v. U.S. Healthcare, Inc., in which the Third Circuit court of appeals allowed a malpractice case

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123 Id. at 1493.
124 Id. at 1489-90.
125 Id. at 1494 ("To allow a vicarious liability claim against an ERISA Plan for the alleged negligence of a listed physician would require multi-state plans to vary their plan administration to avoid strict vicarious liability under differing state laws.").
126 Id. (quoting Pacificare of Okla., Inc. v. Burrege, 59 F.3d 151, 164 (10th Cir. 1996)).
127 Id. at 1493.
129 Id. at 1679-80.
involving allegations of an MCO's vicarious liability to proceed in state court.\textsuperscript{131} The Dukes court relied upon its view that the underlying malpractice claim concerned only "the quality of the benefits" received, not the quantity thereof and upon its belief that ERISA was not "intended as a part of a federal scheme to control the quality of the benefits received by plan participants."\textsuperscript{132} Citing Travelers, the court observed that regulating the quality of health care is an area "traditionally occupied by state regulation."\textsuperscript{133} Finally, it stated that "patients enjoy the right to be free from medical malpractice regardless of whether their medical care is provided through an ERISA plan."\textsuperscript{134} The manner in which the court relied upon the Travelers case suggested—as did the court in Pacificare—that, despite the possible impact on MCOs' administrative arrangements with their physicians, the vicarious liability claim could be resolved under state law without further regard for ERISA.\textsuperscript{135}

In short, it does not appear that ERISA will block state courts in imposing enterprise liability on MCOs.\textsuperscript{136} Thus, if state courts take to heart the message of this Article, there is likely to be no federal impediment to their creating a legal environment in which MCOs must truly integrate their doctors into their health plans, taking real responsibility for the services provided, and no longer acting merely as cost controllers. Once this crucial step is taken, liability law should have a more beneficial impact on the medical

\textsuperscript{131}Id. at 352.

\textsuperscript{132}Id. at 357.

\textsuperscript{133}Id.

\textsuperscript{134}Id. at 358.

\textsuperscript{135}Although the court observed that an ERISA preemption defense under section 514(a) could be offered in state court, its discussion suggested that state agency law, as law of general application that is focused on the quality of care and not directed at employee benefit plans as such, would not be preempted. Id. at 350. There would therefore seem to be little room for questioning the MCO's vicarious liability, as opposed to the claim of direct negligence, under ERISA in the state proceeding. See supra notes 69, 110 (discussing direct negligence claims). For another opinion purporting to address preemption only under section 502(a) that nevertheless applies tests developed under section 514(a) and thus implies that neither type of preemption would be found with respect to vicarious liability claims, see Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995).

care industry, correcting incongruities inherited from the past and permitting the public to enjoy in relative safety the efficiencies of corporate medical care. A few speculative comments on some finer points will close this discussion on a hopeful note.

B. WILL PHYSICIANS BEAR THE BURDEN OF MCO MISMANAGEMENT OF CARE?

When the court in \textit{Jass} immunized the HMO against indirect liability for not authorizing the treatment in question, it appeared to leave the treating physician at risk in the state court proceeding for not providing treatment for which the plan was unwilling to pay. The obvious question—whether the plan’s refusal to pay for the service was an adequate excuse for the doctor’s failure to prescribe it—provides an occasion to consider (with profit in the present context) the potential uses of state liability law in the age of managed care.

Certainly a physician in a case like \textit{Jass} should not be held liable simply for not providing a service that the plan had refused to cover. But neither should the doctor be off the hook entirely, since physicians, as professionals, have other duties to patients enrolled in managed care plans.\footnote{Physicians and others have worried about the fate of professionalism in the managed care revolution. This brief discussion suggests, however, that the dethroning of the organized profession as the chief arbiter of what consumers can choose in the health care marketplace should not affect the ethical foundations of professionalism itself—namely, the duty to be loyal to the client/patient and not to take advantage of his inability to evaluate the quality of service he is receiving. In the age of managed care, this means working in the patient’s interest within whatever limits and constraints the patient faces. When those limits and constraints are imposed by an MCO chosen by or for the patient in a generally free market, the physician has no ground whatever for questioning their general legitimacy and has a professional duty to work on the patient’s behalf to ensure that the plan honors its contractual obligations.} Thus, a doctor should be expected to advocate dutifully and competently, within whatever machinery the plan provides, any plausible claim the patient might have to have a needed service paid for by the plan, calling all relevant information to the attention of the utilization manager.\footnote{Compare \textit{Wickline v. State}, where the court stated: [The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care.}} In addition,
the doctor would seem to have a duty to call the patient's attention to the possibility of paying for a disallowed service out of pocket. Not only would self-payment allow the patient to receive the service—which, by hypothesis, the physician conscientiously recommends and the patient reasonably desires—but it would also

He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinative medical decisions go sour. There is little doubt that Dr. Polansky was intimidated by the Medi-Cal program but he was not paralyzed by Dr. Glassman's response nor rendered powerless to act appropriately if other action was required under the circumstances. If, in his medical judgment, it was in his patient's best interest that she remain in the acute care hospital setting for an additional four days beyond the extended time period originally authorized by Medi-Cal, Dr. Polansky should have made some effort to keep Wickline there. He himself acknowledged that responsibility to his patient.


139 This legal duty is implicit in the professional relationship. See generally Mark A. Hall, Informed Consent to Rationing Decisions, 71 MILBANK Q. 645 (1993) (discussing legal requirements of informed consent in context of managed care). Some MCOs are reported to have included controversial "gag clauses" in their contracts with physicians to prevent the physician from disparaging the plan or, in their most extreme form, revealing to the patient alternative treatment options that the plan will not cover. See generally Julia A. Martin & Lisa K. Bjorkne, The Legal and Ethical Implications of Gag Clauses in Physician Contracts, 22 AM. J.L. & MED. 433 (1995) (discussing forms of gag clauses in physician contracts, evaluating legality of these clauses and physicians' ethical obligations, and offering responses to use of gag clauses); Robert Pear, Laws Won't Let HMO's Tell Doctors What To Say: 16 States Give Patients Rights to be Informed, N.Y. TIMES, Sept. 17, 1995, at A12 (discussing state efforts to prohibit use of gag clauses). No agreement between the plan and the physician can alter, however, whatever legal duty the latter has to a patient. On the other hand, under the right circumstances, a patient might waive the right to receive such information by contract—by enrolling in a plan that expressly disclaimed its doctors' responsibility to make such information available. See HAVIGHURST, HEALTH CARE CHOICES, supra note 1, at 163-64, 208-09, 246-49, 283-84 (discussing making disclosure obligations matter of express contract between plan and consumers, some of whom might rationally prefer to leave choices to plan rather than being burdened with difficult, usually impractical choices); Hall, supra, at 663-64 (arguing that with some disclosure of rationing incentives and rules at time of enrollment in health care plan, subsequent rationing may be done without disclosure under either prior consent theory or waiver of consent theory). Although several states have adopted statutes dealing with gag clauses, such laws generally treat disclosure as discretionary with the physician and attempt merely to curb interference with that discretion to inform the patient. One might have thought, however, that the greater problem is too-ready acceptance by physicians of plan decisions, see supra notes 137-138, and that a better legislative response to the problems of managed care would be to underscore by statute that physicians have the legal duties stated in the text accompanying this note, which no gag clause then could alter.
preserve the possibility of later seeking reimbursement from the plan under ERISA, claiming the original disallowance was improper under the terms of the contract. Since the advent of managed care, physicians are no longer free (nor do they have any obligation) to spend the payer's money without appreciable restraint. Physicians should, however, be acknowledged to have a new set of professional duties in mediating between patients and the administrators of their health coverage and in helping patients cope with situations in which an MCO resists paying for a service that the physician believes the patient should receive.

If the doctor's duties in Jass had been alleged in these terms, the malpractice claim would not have been merely a backdoor attack on the plan's benefit decision under state law. Instead, the doctor's fault, if any, would have been found in his failure to work effectively for the patient within the MCO's own framework. Because the MCO was responsible for establishing that framework, it would have seemed a natural candidate for vicarious liability if its chosen doctor had failed to make the system work smoothly and effectively for the patient. Thus, if Jass had alleged, not a "negligent failure to treat," but the doctor's failure to help her cope with the plan's unwillingness to cover the desired treatment, preemption might not have been found, and a powerful case would have been made for vicarious liability.

What is suggested here, once again, is that courts should cease defining the obligations of MCOs and their affiliated physicians according to an archaic, professional paradigm of medical care under which clinical choices are viewed as technical, not economic, in nature, and MCOs are viewed as illegitimate intruders in professional relationships. Specifically, in order to ensure that the managed care revolution does not overwhelm the quality of care in displacing antiquated institutions and inefficient practices, state courts must reformulate (as aforesaid) the duties of physicians under the law of torts and must hold sponsoring MCOs vicariously liable whenever their physicians fail to protect patient welfare within the plan's own, ERISA-protected administrative framework. If legal rules were thus modified to reflect the contexts in which medical decisions are being made today, the resulting combination of state and federal remedies would ensure the substantial accountability of MCOs. Indeed, even though ERISA would
continue to bar direct attacks on MCO coverage determinations, MCOs and their physicians would have powerful inducements to ensure that benefit determinations are made with due care and full information. Although patients would still not be allowed to sue for personal injuries allegedly caused by a wrongful denial of a covered service, they could expect to be dealt with fairly and openly and to be routinely offered the opportunity to obtain desirable services at their own expense. They would also retain the right to invoke ERISA procedures, either immediately or later, to resolve the question of the plan's obligation to pay for the service in question.

The keystone of the new structure of patient rights, physician and plan obligations, and state and federal enforcement mechanisms adumbrated here is enterprise liability for MCOs. With that essential element in place, the other pieces could then fall neatly into place under existing law in nearly every state (all, it would seem, except those with statutes exempting MCOs from vicarious liability). It will no doubt come as a major surprise to most observers of health care law that nothing more than a careful rethinking and rational updating of state common-law rights and remedies is needed to achieve effective legal accountability for MCOs. Nevertheless, with a modicum of creative lawyering and judicial awareness of what is happening in the health care marketplace, the most egregious loophole in the accountability of MCOs—their freedom from sanctions for errors in benefit determinations in ERISA plans—could be narrowed almost to the vanishing point. ¹⁴⁰ This result would be accomplished not only without amending ERISA—an undertaking fraught with peril for freedom of contract and for a market-oriented health policy—but also without violating ERISA's policy against direct state interference in the administration of employee benefits.

¹⁴⁰ To be sure, patients who were unwilling or unable to finance care that the plan refused to finance would have no satisfactory recourse for an erroneous determination. However, if a plan had rather obviously erred in denying coverage for a service likely to yield a substantial medical benefit, providers might be willing to provide the service in anticipation that payment would be forthcoming in a later ERISA suit to enforce the plan's terms. Because payment would more likely be ordered if the treatment turned out well, providers and patients would be appropriately hesitant to pursue the self-payment gamble unless they expected that the outcome would justify the expense. Before discounting the self-pay option on the basis of equity concerns, the reader should attempt to appreciate its potential power both as a safety valve minimizing the practical problems of managed care and as a weapon against inefficient spending prompted by moral hazard.
C. WILL MCOS ESCAPE MALPRACTICE LIABILITY BY CONTRACT?

In *Dukes*, the court of appeals raised possible new concerns about MCO accountability for physician misconduct by suggesting that MCOs might obtain ERISA protection against malpractice claims (for their providers as well as themselves) simply by writing their contracts with employers differently.\(^{141}\) Although the court found no ERISA preemption of state malpractice claims against MCOs and their affiliated physicians, it arrived at this result by emphasizing that malpractice cases involve the enforcement of general quality standards arising under state law, not the enforcement of rights arising under the employee benefit plan itself.\(^{142}\) Indeed, the court expressly suggested that the result might have been different if there had been “an agreement to displace the quality standard found in the otherwise applicable law with a contract standard.”\(^{143}\) Although expressing no final view on “whether an ERISA plan sponsor may . . . by contract opt out of state tort law and into” a legal regime governed only by federal law and the ERISA-protected contract, it acknowledged the possibility “that an employer and an HMO could agree that a quality of health care standard articulated in their contract would replace the standards that would otherwise be supplied by the applicable state law of tort.”\(^{144}\) This reasoning obviously invites MCOs to seek the benefits of ERISA preemption by spelling out their obligations to enrollees in the employee benefit plan itself rather than leaving those duties to be defined by state tort law, courts, and juries.\(^{145}\) In that event, a federal court following the *Dukes* court’s lead would allow a plaintiff to enforce those contractual duties only through ERISA’s own enforcement mechanisms, inadequate as they are.\(^{146}\)


\(^{142}\) *Id.* at 358 (stating that plaintiffs “are not attempting to define new ‘rights under the terms of the plan’; instead, they are attempting to assert their already-existing rights under the generally-applicable state law of agency and tort”).

\(^{143}\) *Id.* at 359.

\(^{144}\) *Id.*

\(^{145}\) Courts regularly find ERISA preemption when the right the plaintiff is seeking to enforce can be ascertained only by interpreting terms in the welfare plan or contract. See *supra* notes 117-118 and accompanying text (citing cases).

\(^{146}\) Because ERISA remedies are wholly inadequate to compensate for personal injuries, *see supra* notes 112-113 and accompanying text, one member of the three-judge panel in the *Dukes* case caused the author of the opinion to add the following footnote:
Although the potential loophole in MCO accountability pointed out in the Dukes case may seem troublesome, it is also possible to glimpse through that loophole a future in which the legal obligations of MCOs would be put on an entirely new footing, with potential gains in consumer welfare. To be sure, the Dukes court has suggested a strategy that an MCO might try to follow if it were bent on fully exploiting the vagaries of ERISA to exculpate itself and its doctors from malpractice liability. Still, employers and employees would have to agree to the terms of the ERISA contract, and it is unlikely that any would do so if employees' remedies for medical malpractice were seriously at risk. At least they would not agree to surrender conventional tort rights unless those rights were replaced by an alternative regime of rights and remedies that compared favorably with those supplied by state law. In fact, one can visualize contractual alternatives to state tort law that would represent major improvements in the welfare of everyone concerned—everyone, that is, except trial lawyers and malpractice insurers.\textsuperscript{147} The Dukes opinion thus opens the tantalizing possibility that MCOs might begin to negotiate with employers to create optimal regimes for ensuring the accountability of plans and providers for injuries caused when the quality of care falls below agreed standards. In that event, ERISA would provide desirable protection against state limitations on what might be done by private contract to ameliorate the law of medical malpractice.

The tort system's mechanisms for redressing medical malpractice have been criticized on many grounds, and many of their alleged shortcomings suggest that reform of tort rights is not a zero-sum

\textsuperscript{147} See, e.g., Havighurst, Health Care Choices, supra note 1, at 265-302 (discussing benefits of private tort reform for consumer welfare); Richard A. Epstein, Medical Malpractice: The Case for Contract, 1 AM. B. RES. FOUND. J. 87 (1976) (pioneering proposal for malpractice reform by contract); Clark C. Havighurst, Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles, LAW & CONTEMP. PROBS., Spring 1988, at 143.
game for the parties immediately concerned. Instead, there is substantial room for what economists call "gains from trade"—that is, mutually beneficial contracts between consumers, employers, providers, and MCOs. For example, the current malpractice insurance and litigation system has very high administrative costs, absorbing more than half the dollars that providers pay for liability insurance; most of the monetary costs of this inefficient system are currently borne by consumers in the form of higher fees, charges, and health plan premiums. It may also be plausibly alleged that liability fears, coupled with the doubtful efficiency of the standard of care enforced through the law of medical malpractice, currently induce providers to adopt wasteful practices, the cost of which consumers also bear. The malpractice system takes nonmonetary tolls as well, partly in emotional wear and tear on the most conscientious physicians. Thus, there would seem to be strong inducements for consumers, employers, providers, and MCOs jointly to discover and agree upon new rules and procedures that reduce the uncertainty, complexity, volume, and perverse incentive effects of malpractice litigation while leaving in place incentives that ensure appropriate attention to maintaining the quality and improving the outcomes of medical care.

It remains to be seen, of course, whether there will in fact be any significant traffic on the pathway laid out by the Dukes court for circumventing state law that is potentially burdensome both to health plans and to employers seeking reasonably priced care for their employees. Nevertheless, the court made a constructive contribution when it suggested that accountability for provider negligence might be expressly provided for in an employee benefit contract and that such contract terms might, under the protections of ERISA, displace the remedies found in state law. Under the analysis suggested by the court, once the subject has been addressed in marketplace transactions between MCOs and employers acting on behalf of their employees, then, when adjudication is required, the case should be removed either to a federal forum or to an alternative forum for dispute resolution on which the parties have privately agreed.

Although inertia and the old paradigm of medical care are major obstacles to getting parties to embark on the contractual pathway suggested in Dukes, once the threat of enterprise liability for
physician malpractice and other negligence becomes palpable to MCOs, they could reasonably be expected to undertake creative efforts to specify employee rights and remedies in contracts enjoying ERISA protection. (Note how enterprise liability is again the sine qua non for stimulating MCOs finally to take seriously their responsibility for the quality of care.) If MCOs do embark on this path, the MCO accountability crisis, which is severely damaging the managed care industry's public relations today, may be solved in the long run largely through private initiatives. Rather than having their health care determined principally through direct judicial or legislative prescriptions of standards of medical care and medical practice, of MCO practices and legal obligations, of provider duties, and of patient remedies for poor-quality care, consumers would finally enjoy the benefits originally envisioned by proponents of competition in medical care—that is, a full range of options offered by health plans differentiated by contract, by price, and by the style of medicine they practice.