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Money Will Likely Be the Carrot, but What Stick Will Keep ACOs Accountable?

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Comment

Money Will Likely Be the Carrot, but What Stick Will Keep ACOs Accountable?

*Erin E. Dine**

Seeking a resolution to the wasteful and inefficient health care system in the United States, the 2010 Patient Protection and Affordable Care Act (“PPACA”) reframed the health care market, incentivizing a lower-costing, higher-quality system. In its attempt to improve patient access to a more accountable and coordinated health care system, the PPACA included and authorized the use of the Accountable Care Organization (“ACO”). Groups of health care providers collaborate through an ACO in hopes of delivering, and reaping the financial benefit from, high-quality, low-cost health care. Despite the attractive goals set by the PPACA, the reality of medical malpractice liability confronts the ACO movement.

This Article seeks to articulate the distribution of provider accountability when medical malpractice occurs within the ACO model and how to incentivize actors to participate in ACOs despite the increased liability threat. This Article submits that ACOs remain a vital part of U.S. health care reform, but the survival of the current reform is contingent on physician participation in managed care models and the delivery of low-cost, high-quality health care. This Article examines the tension inherent in cost-containment goals and the medical malpractice standard of care within a historical framework of reimbursement models. By employing a “carrot-and-stick” approach, this Article proposes the theory of enterprise insurance as the route that can simultaneously reward ACO participants with an influencing carrot and preserve quality care through an enforcing stick.

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INTRODUCTION

“So tonight, I want to talk to you about the principles that I believe must embody our efforts to reform America’s health care system: Security, simplicity, savings, choice, quality and responsibility.”¹ In 1993, President Bill Clinton spoke those words as he addressed a joint session of Congress and a listening nation regarding the need for a reformed health care system.² The appeal of the goals of his health care reform initiative notwithstanding, Clinton’s Health Security Act died just one year after its introduction to Congress in September 1993.³ Even with the disappointing end of the highly anticipated overhaul of the nation’s health care system, the United States has continued the attempt to reform the health care system to embody the principles of security, simplicity, savings, choice, quality, and responsibility.

In 2009, the United States spent \$2.5 trillion on health care, which constituted the highest health care expenditure per capita in the world.⁴ Despite spending almost twice as much on health care than any other industrialized nation, the United States spent more than half of all health care spending on “waste.”⁵ Therefore, in 2010, the Patient Protection and Affordable Care Act (“PPACA”) was the country’s historic attempt to improve its wasteful and inefficient health care system.⁶

The enactment of the PPACA sought to restructure the health care industry by introducing a health care model that would aid in the transition to a more accountable system.⁷ The PPACA was intended to

1. *Clinton’s Health Plan; Transcript of President’s Address to Congress on Health Care*, N.Y. TIMES (Sept. 23, 1993), <http://www.nytimes.com/1993/09/23/us/clinton-s-health-plan-transcript-president-s-address-congress-health-care.html?pagewanted=all> [hereinafter *Clinton’s Address to Congress Transcript*].

2. *Id.*

3. Jonathon Oberlander, *Learning from Failure in Health Care Reform*, 357 NEW ENG. J. MED. 1677, 1677 (2007), <http://www.nejm.org/doi/pdf/10.1056/NEJMp078201>.

4. *How Does ObamaCare Control Costs?*, OBAMACARE FACTS, <http://obamacarefacts.com/obamacare-control-costs/> (last visited Apr. 1, 2016).

5. PRICEWATERHOUSECOOPERS, THE PRICE OF EXCESS: IDENTIFYING WASTE IN HEALTHCARE SPENDING 1 (2010), <http://pwchealth.com/cgi-local/hregister.cgi/reg/waste.pdf>. The Institute of Medicine designates activities and resources as “waste” if they do not add value, such as inefficient claims processing, overutilization of services, misapplication of resources, and mismanagement of patients’ time. *Id.* at 3.

6. Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 982 (2010); see Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1297 (1993–94) (noting that if the current health care spending trend continues, “health care expenditures will consume almost a third of GNP by the year 2030”).

7. Social Security Act of 1935 § 1899, 42 U.S.C. § 1395jjj(a)(1) (2012), amended by Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395

improve patient access to high-quality health care by creating a nationally accessible system.⁸ Yet, a successful national health care system must achieve more than simply assuring nationwide coverage—it must achieve “accountable health care.”⁹

The health care system has struggled to hold the important stakeholders within the system appropriately accountable while simultaneously incentivizing them to produce low-cost care. The single word “accountability” incorporates a broad scope of requirements when utilized in the health care context. Accountability in health care encompasses the goals of improving quality care while simultaneously lowering the cost of care.¹⁰ Holding a provider accountable for patient health care is challenging, especially when faced with increasingly lower reimbursement rates.¹¹

The PPACA sought to achieve a coordinated and seamless system by including and authorizing the use of the Accountable Care Organization (“ACO”).¹² ACOs are defined by the Centers for Medicare & Medicaid Services (“CMS”) as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.”¹³ ACOs are directed to limit

(2010). The PPACA states that Affordable Care Organizations (“ACOs”) participating in the Medicare Shared Savings Program (“MSSP”) “shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to [them].” 42 U.S.C. § 1395jjj(a)(1).

8. Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727, 1732 (2011) (stating that the PPACA had a goal of “flawless execution” within the health care system without any defects); Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy, and Ethics*, 64 CASE W. RES. L. REV. 455, 455 (2013).

9. *Lower Costs, Better Care: Reforming Our Health Care Delivery System*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 28, 2013), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-02-28.html>.

10. Paul R. DeMuro, *Accountable Care*, HEALTH LAW., Aug. 2012, at 3 (citing Alice Gosfeld, *Accountable Care Organizations Versus Accountable Care: Is There a Difference?*, 9 J. NAT’L COMPREHENSIVE CANCER NETWORK 587, 588 (2011)).

11. The Urban Institute established that in 2015, doctors faced a reduction in both Medicare reimbursement rates by 21.2% and Medicaid reimbursement rates by 42.8%. Merrill Matthews, *Doctors Face a Huge Medicare and Medicaid Pay Cut in 2015*, FORBES (Jan. 5, 2015, 9:50 AM), <http://www.forbes.com/sites/merrillmatthews/2015/01/05/doctors-face-a-huge-medicare-and-medicaid-pay-cut-in-2015/>.

12. 42 U.S.C. § 1395jjj (establishing the MSSP and ACOs as the way groups of providers will “work together to manage and coordinate care for Medicare fee-for-service beneficiaries”).

13. Christopher E. DiGiacinto et al., *Potential Liability Risks and Solutions for Accountable Care Organizations*, AHRMNY RISK MGMT. Q.J., Summer 2013, at 1; see Jenny Gold, *Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), <http://khn.org/news/aco-accountable-care-organization-faq> (“Think of it as buying a television[;] . . . [a] TV manufacturer like Sony may contract with many suppliers to build sets.

Medicare spending and increase quality care.¹⁴ The success of ACOs achieving the main goals of the PPACA depends on the presence of three specific outcomes: (1) delivery of high-quality health care, (2) produced at a low cost, (3) by health care providers willing to work within the coordinated ACO model.

However, the ACO movement is confronted by the reality of medical malpractice liability, which is the patient remedy for injuries that result from medical error.¹⁵ The new ACO model, through its utilization of incentives to provide low-cost health care, causes an increased risk of medical malpractice liability.¹⁶ The PPACA requires ACOs to achieve quality performance standards, but these quality standards are mere guidelines and fail to establish the standard of care in a medical malpractice case.¹⁷ As a result, health care providers are precariously positioned and forced to weigh whether an ACO's potential for shared savings will outweigh the increased risk of medical malpractice liability. CMS programs¹⁸ will likely succeed at incentivizing physicians to produce lower-costing health care, but the issue of whether the goals of high-quality care and provider membership will be achieved through these programs is unclear.

Like Sony does for TVs, . . . an ACO brings together the different component parts of care for the patient—primary care, specialists, hospitals, home health care, etc.—and ensures that all of the ‘parts work well together.’”)

14. Although quality care is an important part of an ACO's success, the number one job of an ACO is to reduce costs. Peter Boland et al., *Accountable Care Organizations Hold Promise, but Will They Achieve Cost and Quality Targets?*, *MANAGED CARE* (Oct. 2010), <http://www.managedcaremag.com/archives/1010/1010.ACOs.html>. Similarly, the goal of the previous models of managed care prior to the rollout of ACOs was to control cost, allowing the comparison between models to be appropriate. William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 *LAW & CONTEMP. PROBS.* 159, 162 (1997).

15. Jenna R. Feldman, *Medical Malpractice Liability and Accountability: Potential Legal Ramifications and Solutions for Florida Accountable Care Organizations*, 69 *U. MIAMI L. REV.* 1073, 1076 (2015) (noting physicians' responses to the overwhelming pressures of medicine by over-treating patients and providing excessive health care services to avoid medical malpractice liability); see Mary Ann Chirba & Alice A. Noble, *Medical Malpractice, the Affordable Care Act and State Provider Shield Laws: More Myth than Necessity?*, *BILL HEALTH* (May 14, 2013), <http://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=1600&context=lsfp> (stating that physicians, other health care providers, Congress, and states have noted that the PPACA will “increase a provider's exposure to medical malpractice liability”).

16. See Feldman, *supra* note 15, at 1074 (recognizing that many questions relating to medical malpractice liability arise when care is provided within the ACO model, including: “If an entire ACO holds itself accountable for patient health outcomes, who is to blame for one participating provider's medical error? How can an ACO protect itself and its patients?”).

17. Chirba & Noble, *supra* note 15.

18. See *infra* text accompanying notes 115–33 (describing CMS programs, specifically the CMS Medicare Shared Savings Program).

It is undeniable that the ACO model can lead to exciting and innovating health care practices, but the uncertain liability environment can lead to hesitation and an ineffective result.¹⁹ This Article seeks to answer the question of how to hold actors accountable when medical malpractice occurs within the ACO model and how to incentivize actors to participate in ACOs despite the increased liability threat. ACOs will remain consistent actors within the future health care system.²⁰ Therefore, it is imperative to ascertain how actors will be held accountable for the injuries that may stem from the decisions and actions within the ACO model. Accountability and subsequent potential liability play an important role in patient safety.²¹ An ACO must structure its insurance and risk-financing programs in order to respond to the various risks presented.²²

This Article will propose an enterprise insurance model to better address the goal of high-quality health care by sustaining medical malpractice liability for providers as well as the goal of health care provider involvement by incentivizing membership. Part I of this Article takes a historical look at the timeline of reimbursement models and the medical malpractice risks that they implicate. Part II discusses ACOs and the tension between cost-containment goals and the medical malpractice standard of care. Part III analyzes the medical malpractice liability risk associated with ACOs and considers the enterprise liability solution. Part IV proposes that by utilizing a “carrot-and-stick”

19. Cf. MARSH & MCLENNAN COS., A NEW RISK MANAGEMENT FRONTIER: ACCOUNTABLE CARE ORGANIZATIONS 2 (Oct. 2012), <https://usa.marsh.com/Portals/9/Documents/AccountableCareOrganizations.pdf> (noting that the coordinated care that ACOs will implement should actually decrease key liability exposures).

20. *Id.* (stating that after so much uncertainty, the U.S. Supreme Court upholding of the majority of the provisions within the PPACA signified that the PPACA, and inherently ACOs, will remain a constant part of this country’s health care context); see S. Lawrence Kocot & Ross White, *How Early Accountable Care Efforts Shaped Payment Reform in the ACO and Bipartisan Reform Ever Since*, BROOKINGS INST.: HEALTH 360 (Mar. 23, 2015, 10:03 AM), <http://www.brookings.edu/blogs/health360/posts/2015/03/20-aca-accountable-care-payment-reform-mccllellan> (concluding that after the new Next Generation ACO model and continued refinement of the MSSP, “CMS has also indicated a clear commitment to continuing to advance accountable care models”).

21. See Amy Widman, *Liability and the Health Care Bill: An “Alternative” Perspective*, 1 CALIF. L. REV. CIR. 57, 57 (2010) (recognizing the efforts to restrict medical malpractice liability, but alleging that malpractice liability plays an important role in patient safety); see Sara Fritz & David Savage, *Health Reform Plan May Exempt Doctors from Suits*, L.A. TIMES (May 5, 1993), http://articles.latimes.com/1993-05-05/news/mn-31516_1_health-care-reform-plan (observing that medical malpractice reform was one of the “thorniest political issues that ha[d] arisen as a result of [President Clinton’s] pledge to reform the health care delivery system”).

22. Dana Switzer, *Accountable Care Organizations: New Opportunities, New Risks*, PHYSICIAN INSURER, First Quarter 2012, at 34.

approach, the theory of enterprise insurance can simultaneously reward ACO providers with an influencing carrot while enhancing quality of care through an enforcing stick.

I. BACKGROUND

The main driver of behavior and subsequent change within the health care system is money.²³ Accordingly, the payors and insurers who control health care payments and reimbursements also control and guide physician behavior, and subsequently, the market.²⁴ The federal government, as the largest payor in the United States, has reshaped the health care market by reorganizing the insurance market through its implementation of various reimbursement structures.²⁵ Therefore, an examination of the trends of payment models can aid in ascertaining the various behaviors that inevitably shaped the current health care system, which will prove important when attempting further health care reform.

In 2009, the United States recognized that the nation's excessive and unsustainable levels of health care spending posed a real threat to the solvency of the Medicare program and to the federal budget as whole.²⁶ At that time, more than 16% of the United States' Gross Domestic Product constituted health care expenditures.²⁷ The Medicare Trustees projected that by 2017, the fund that pays for Medicare inpatient hospital stays and services, skilled nursing services, home health, and hospice would be insolvent.²⁸ As health care resources dwindled, the federal government recognized that the health care system and its providers must become more price-sensitive.²⁹ In an effort to force this behavior upon providers, the industry introduced health care models that incentivized providers to manage and maintain patient care at low

23. PETER R. KONGSTVEDT, PROVIDER PAYMENT IN ESSENTIALS OF MANAGED HEALTH CARE 87 (6th ed. 2013).

24. *Id.*

25. TEVI D. TROY, AM. HEALTH POL'Y INST., HOW THE GOVERNMENT AS A PAYER SHAPES THE HEALTH CARE MARKETPLACE 1 (2015).

26. CTRS. FOR MEDICARE & MEDICAID SERVS., AFFORDABLE CARE ACT UPDATE: IMPLEMENTING MEDICARE COST SAVINGS 2 (2010), <https://www.cms.gov/apps/docs/aca-update-implementing-medicare-costs-savings.pdf> [<https://web.archive.org/web/20160313092432/https://www.cms.gov/apps/docs/ACA-Update-Implementing-Medicare-Costs-Savings.pdf>] [hereinafter CMS ACA UPDATE].

27. *Id.*

28. *Id.*

29. See Jack Zwanziger & Glenn A. Melnick, *Can Managed Care Plans Control Health Care Costs?*, 15 HEALTH AFF. 185, 192 (1996) ("Since provider revenue constitutes the vast bulk of total health care expenditures, any reduction in total expenditures will require lower provider revenue.").

costs. The PPACA, for example, encourages the use of ACOs as a vehicle to provide managed health care to Medicare beneficiaries.³⁰

In analyzing the federal government's involvement in health care and the implications of federal reimbursement models create, this Article's historical background will start in 1965 after the passage of the Medicare and Medicaid programs.³¹ Thus, this Part will examine the history of the federal government's reimbursement models and the medical malpractice concerns that stemmed from each model, instigating legislation and health care reform movements throughout the timeline of the health care system in the United States.

A. The Traditional Fee-for-Service Model and Its Reimbursement of Defensive Medicine

When Medicare was implemented in the United States in 1965, it reimbursed health care providers for the cost of each claim on a fee-for-service basis.³² The fee-for-service model of reimbursement for services dominated the health care industry prior to the 1980s.³³ An insurer, through this model, retroactively reimburses a health care provider after the patient receives the services.³⁴ When payors reimburse physicians through a fee-for-service model, the physician is paid for each unit of health care service that is provided to the patient.³⁵ If a patient requires more services, the insurer bears the responsibility of the extra cost and the provider is paid more.³⁶ By reimbursing for each individual service, the fee-for-service model encourages the production of services at a high-volume, regardless of the cost.³⁷ This results in

30. Boland et al., *supra* note 14.

31. See Sherry Glied, *Managed Care* 13 (Nat'l Bureau of Econ. Research, Working Paper No. 7205, 1999), <http://www.nber.org/papers/w7205.pdf> (noting that the federal government became involved in the U.S health care system once the government was directly affected by the cost of health care after the passage of Medicare and Medicaid).

32. Austin Frakt, *Accountable Care Organizations: Like H.M.O, but Different*, N.Y. TIMES (Jan. 19, 2015), http://www.nytimes.com/2015/01/20/upshot/accountable-care-organizations-like-hmos-but-different.html?_r=0 (noting that Medicare reimbursed doctors for "whatever cost they claimed, so long as it was 'usual, customary and reasonable'").

33. Jose L. Gonzalez, *A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World*, 35 HOUS. L. REV. 715, 723 (1998).

34. *Id.*

35. MARK W. FRIEDBERG ET AL., RAND CORP., EFFECTS OF HEALTH CARE PAYMENT MODELS ON PHYSICIAN PRACTICE IN THE UNITED STATES 10 (2015), http://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR869/RAND_RR869.pdf.

36. Frakt, *supra* note 32.

37. Gonzalez, *supra* note 33, at 724.

high costs, unnecessary services, and a deflated health care system.³⁸

This form of reimbursement influences physician behavior and facilitates the practice of defensive medicine by paying providers to order and perform additional tests and services and by allowing providers to profit from high-volume practice irrespective of the value of the services provided.³⁹ Defensive medicine occurs when a provider orders unnecessary tests, examinations, procedures, and services primarily to protect themselves from fear of medical malpractice liability rather than to further a patient's treatment.⁴⁰ This practice can potentially enhance patient health care outcomes because a clinically unnecessary test has the chance to reveal an undetected illness.⁴¹ In general, however, an increase in the number of medical services inherently implicates an increase in the total cost to the health care system, and as such defensive medicine leads to a much costlier health care system.⁴²

38. See *id.* (noting that the fee-for-service model of reimbursing providers retrospectively engineered an incentive to providers to deliver a high volume of services, whether those health care services were costly, excessive, or unnecessary; the provider would be subsequently reimbursed regardless); see also Kenneth R. Pedroza, Note, *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 402 (1996) (recognizing that the fee-for-service system encourages the utilization of high-cost technology).

39. Claire Bartholome, *Leveraging Our Strengths: Reinforcing Pay-for-Performance Programs As the Solution for Defensive Medicine*, 4 J. HEALTH & BIOMEDICAL L. 333, 340 (2008).

40. *Id.* at 333, 338 (noting that health care providers utilize defensive medicine as a way to lower their potential for medical malpractice liability and to protect against accusations of negligence); Laura D. Hermer & Howard Brody, *Defensive Medicine, Cost Containment, and Reform*, 25 J. GEN. INTERNAL MED. 470, 470 (2010); cf. Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 33 (1993) (noting that even though physicians may reject cost-containment efforts due to potential liability, it is also important that they "have long had a concern for quality care"; cost control is not the top priority for most physicians). Physicians' "fear" of liability is not inaccurate. ZEKE EMANUEL ET AL., CTR. FOR AM. PROGRESS, REDUCING THE COST OF DEFENSIVE MEDICINE 1 (2013), <https://cdn.americanprogress.org/wp-content/uploads/2013/06/MedicalMalpractice-11.pdf>. "More than 75 percent of physicians—and virtually all physicians in high-risk specialties such as obstetrics and gynecology and neurosurgery—face a medical malpractice claim over the course of their career." *Id.*

41. Bartholome, *supra* note 39, at 338; cf. *Many Common Medical Tests and Treatments Are Unnecessary: Learn When to Say "Whoa!" to Your Doctor*, CONSUMER REP. (June 2012), <http://www.consumerreports.org/cro/magazine/2012/06/many-common-medical-tests-and-treatments-are-unnecessary/index.htm> [hereinafter CONSUMER REP.] (noting that unnecessary x-rays and CT scans can expose patients to cancer-causing radiation, leading to additional tests and appointments with additional risks).

42. Richard A. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 343, 353 (2005) ("The U.S. Department of Health and Human Services conservatively estimates the cost of defensive medicine may approach \$100 billion per year."); Bartholome, *supra* note 39, at 338–39. In a 2011 study, the U.S. health care

The fee-for-service reimbursement model enables the over-utilization of health care services, but fails to provide a mechanism to control costs.⁴³ As such, overutilization quickly became the root of the health care crisis in the 1980s and the skyrocketing costs of medical treatment forced a new health care model to emerge.⁴⁴ Managed medical care was the industry's first attempted answer to the rising costs of health care; it eliminated the costly practice of reimbursing defensive medicine.⁴⁵

B. Managed Care Organizations and the Increased Risk of Medical Malpractice Liability

Managed care is a type of health care system that is implemented to control cost, decrease the overutilization of health care services, and increase quality care.⁴⁶ In order to control costs, the industry recognized the need to control the doctor's pen, the most expensive type of medical equipment.⁴⁷ Therefore, instead of having the insurer bear the extra cost, managed care shifts that cost risk onto the individual provider.⁴⁸

Many states, seeking to control costs, provide health care to Medicaid beneficiaries through managed care models, implemented through

system spent \$6.8 billion on the twelve most commonly overused tests and exams including electrocardiograms for heart disease and lower-back pain imaging tests. CONSUMER REP., *supra* note 41.

43. Gonzalez, *supra* note 33, at 725.

44. *Id.*; Michelle R. King, Note, *Restricting the Corporate Practice of Medicine: Subverting ERISA to Hold Managed Care Organizations Accountable for Health Care Treatment Decision—The Texas Initiative*, 23 DEL. J. CORP. L. 1203, 1203–04 (1998).

45. Gonzalez, *supra* note 33, at 726 (explaining that the over-utilization of health care permitted under the fee-for-service model led to the need for cost containment, which became “the dominant force in shaping health care policy during the last two decades”); see Lauren Fiedler Redman, *Softening the ERISA Blow: Minimizing Physician Liability for Patient Injuries Caused by Managed Care Organization Cost Containment Measures*, 35 TULSA L.J. 679, 681 (2000) (noting that managed care organizations (“MCOs”) were the answer to the growing health care cost problem because of their cost-containment initiatives); see also Fritz & Savage, *supra* note 21 (concluding that the “defensive medicine practice” adds “between \$4 billion and \$25 billion to the health care bill” each year).

46. John T. Preskitt, *Health Care Reimbursement: Clemens to Clinton*, 21 BAYLOR U. MED. CTR. PROC. 40, 41 (2008); *Managed Care*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html> (last visited Apr. 1, 2016).

47. Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER (June 1, 2009), <http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum>.

48. Frakt, *supra* note 32.

Managed Care Organizations (“MCOs”).⁴⁹ MCOs are designed to reduce the cost of health care by utilizing cost-containment models.⁵⁰ The published goal of managed care was to provide coordinated health care services that better emphasize prevention,⁵¹ but practically speaking, managed care was implemented to limit physicians’ service requests.⁵² MCOs incorporate collaborative initiatives to reduce health care costs.⁵³

The concept of “managed care” was not new,⁵⁴ but the passage of the Health Maintenance Organization Act of 1973 (“HMO Act”)⁵⁵ jump-started and incentivized the managed care health care system through the introduction of Health Maintenance Organizations (“HMOs”).⁵⁶ The HMO Act was Congress’s way to effectively encourage the implementation of managed care in the United States by requiring employers with more than twenty-five employees to offer HMO health plans to their employees.⁵⁷ The Act enabled the creation of HMOs (which operated as MCOs) by eliminating anti-managed care laws within the states to avoid the state regulatory barriers.⁵⁸

49. *Managed Care*, *supra* note 46 (“Approximately 80% of Medicaid enrollees are served through managed care delivery systems.”).

50. *See* Gonzalez, *supra* note 33, at 727 (noting that some of the main cost-containment models are “prospective fixed payments for health care rendered, quality utilization review as a means of cutting wasteful and unnecessary medical treatment and expenses, and limiting a patient’s choice of practitioners to members of a particular, preferred provider network”).

51. Judith A. Huntington, *Health Care in Chaos: Will We Ever See Real Managed Care?*, ONLINE J. ISSUES NURSING (Jan. 6, 1997), <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol21997/No1Jan97/HealthCareinChaos.html>.

52. *See* INTRODUCTION TO HEALTH SERVICES 123 (Stephen J. Williams & Paul R. Torrens eds., 7th ed. 2008) (noting that the central purpose of managed care is to reduce overall health care costs).

53. Gonzalez, *supra* note 33, at 727 (noting that the goal of implementing MCOs was to eliminate unnecessary treatment and costs by prospective fixed health care reimbursements).

54. Glied, *supra* note 31, at 12 (recognizing the long history of the managed care model, dating back to the 1930s with the Kaiser group health plan).

55. 42 U.S.C. § 300e (2012)

56. Glied, *supra* note 31, at 13. HMOs soon became the most popular type of MCO. Jay Jyoti Chaudhuri, *Managed Care Organizations in North Carolina: Tort Liability Theories and Defenses*, 23 N.C. CENT. L.J. 58, 59 (1998). HMOs rapidly spread throughout the health care industry during the 1970s and then again from 1983 until 1988. Gonzalez, *supra* note 33, at 729.

57. Phil Galewitz, *Nixon’s HMOs Hold Lessons for Obama’s ACOs*, KAISER HEALTH NEWS (Oct. 21, 2011), <http://khn.org/news/nixons-hmos-hold-lessons-for-obamas-acos/>; Twila Brase, *HMOs’ Rise Drive by Government, Not Market*, INST. FOR HEALTH FREEDOM (Mar. 29, 1999), <http://www.forhealthfreedom.org/Publications/HealthIns/HMOsRise.html>.

58. Christopher J. Conover & Ilse R. Wiechers, *HMO Act of 1973* 1 (Ctr. of Health Pol’y, Law & Mgmt., Working Paper No. I-1, 2006), <http://ushealthpolicygateway.com/wp-content/uploads/2009/07/i-1-hmo-act-of-1973.pdf>; Glied, *supra* note 31, at 13.

The model created under the HMO Act is a coordinated care system that shifts financial risk from a third-party insurance payor to the provider.⁵⁹ HMO enrollees prepay a set fee in exchange for medical care over a certain period, regardless of the actual costs of the enrollee's medical services during that period.⁶⁰ Importantly, an HMO covers both hospital and physician services.⁶¹

HMOs are not only responsible for providing the health care, but also must act as an insurer.⁶² In the insurer role, it determines the various health care services that will be reimbursed with designated premium amounts.⁶³ In an attempt to abate the overutilization of health care services that is practiced within the fee-for-service reimbursement model, the HMO only reimburses "medically necessary" health care services and utilizes a capitated form of physician compensation.⁶⁴ Under a capitated compensation plan, the physician is not reimbursed for each service, but rather the physician receives a flat monthly payment for each patient, regardless of the amount of services that the patient may require that month.⁶⁵ The physician is then responsible for managing and spending the patient funds accordingly.⁶⁶ Importantly, the HMO defines which health care services delivered within its network of providers will be reimbursed as "medically necessary."⁶⁷

As a way to deter the duplicative and high-volume treatment ritual inherent in the fee-for-service model, managed care models generally

59. Randall, *supra* note 40, at 20.

60. Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1223 (1997).

61. Randall, *supra* note 40, at 20.

62. Gonzalez, *supra* note 33, at 728.

63. *Id.* at 733.

64. Kent G. Rutter, *Democratizing HMO Regulation to Enforce the "Rule of Rescue,"* 30 U. MICH. J.L. REFORM 147, 176–77 (1996) (noting that the HMO model "exactly reverses the financial incentives of a physician accustomed to fee-for-service reimbursement: 'every time a patient comes into the doctor's office it's a liability, not an asset'"); *cf.* Wickline v. California, 239 Cal. Rptr. 810, 813 (Cal. Ct. App. 1986) (holding that even if care is "medically necessary," a third-party payor may still deny the request). The practice of reimbursing only health care services deemed "medically necessary" was a response to the traditional fee-for-service model where "providers have every incentive to engage in, and insurers had little ability to contest, medically unnecessary care." Jeffrey O'Connell & James F. Neale, *HMO's, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL'Y 287, 291 (1998). The managed care response, in effect, shifted the burden of funding unnecessary medical services from third-party payors to patients and health care providers. *Id.*

65. Rutter, *supra* note 64, at 176.

66. *Id.* at 176–77.

67. Gonzalez, *supra* note 33, at 727; *MedlinePlus*, MANAGED CARE, <https://www.nlm.nih.gov/medlineplus/managedcare.html> (last visited Apr. 1, 2016); Rutter, *supra* note 64, at 157.

incentivize physicians to provide less care, creating a clash between cost-containment initiatives and medical liability standards.⁶⁸ Understandably, physicians traditionally made medical decisions in terms of patient care. In an MCO, however, a third-party payor's interest trumps the physician's traditional role.⁶⁹ Consequently, the MCO model suppresses physicians' professional autonomy and their independent clinical decision making.⁷⁰ As MCOs emerged, it became apparent that cost-saving initiatives and other non-medical concerns were more highly valued than a patient's welfare.⁷¹ The pressure to provide care at the lowest possible cost forced health care providers to limit their patients' access to expensive specialty centers or diagnostic services, regardless of their necessity to a given patient's health.⁷² The severe consequences of a diminished medical decision-making process to produce lower-costing health care were cognizable,⁷³ but the liability for the diminished quality of care never materialized.⁷⁴

1. ERISA

Even though a physician's medical decisions were often constrained by the extensive control of the MCO, the physician was still accountable for the resulting adverse outcome, in large part because of the preemption within the Employee Retirement and Income Security Act of 1974 ("ERISA").⁷⁵ ERISA is a federal law that regulates

68. *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000) (noting that although HMOs financially incentivize physicians to provide less, the "check on this influence" is that medical providers have an "obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest").

69. Randall, *supra* note 40, at 11.

70. Mantel, *supra* note 8, at 458.

71. Gonzalez, *supra* note 33, at 730; *see* Randall, *supra* note 40, at 4 (noting that managed care has focused on the cost problem and it has lost "sight of what should be the overriding purpose of health care—the well-being of the patient").

72. Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 434 (1997).

73. Christopher Smith, *Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations*, 20 ANNALS HEALTH L. 165, 172 (2011). Within the managed care model, physicians are deprived of their medical treatment authority, a privilege that was once inherent within the health care system when the traditional fee-for-service model was nationally implemented. Gonzalez, *supra* note 33, at 730.

74. *See* Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity v. Quality to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 581–82 (2001) (noting that although the Employee Retirement Income Security Act of 1974 (ERISA) was enacted to establish uniform administration of employee benefit plans, ERISA's practical effect created a loophole were MCOs predominately avoided liability).

75. 29 U.S.C. §§ 1001–1461 (2012); Smith, *supra* note 73, at 175; *see* *Pegram v. Herdrich*,

employee and group health plans.⁷⁶ Congress enacted ERISA as a way to counteract the problems that stemmed from the mismanagement and fraudulent control over employee benefit and pension plans.⁷⁷ The intent of ERISA was to simplify employee benefit and pension plans by eliminating the need for contradictory and complex state laws.⁷⁸ ERISA includes a preemption clause that “prevents states from enforcing statutes that ‘relate to’ an ERISA plan.”⁷⁹ Although ERISA provided a more uniform administration of employee benefit plans and effectively shielded those plans from state law, it simultaneously created a major obstacle for injured plaintiffs.⁸⁰ In medical malpractice lawsuits, injured plaintiffs typically sue under state malpractice laws; by eliminating state law causes of action, ERISA unintentionally—yet drastically—diminished recovery through this type of claim.⁸¹

ERISA’s preemption restricts state law malpractice claims against MCOs involving employer-sponsored health plans, which in effect eliminates most of the recovery potential for injured plaintiffs because it treats MCOs as employer-sponsored health plans.⁸² While evidence supports the fact that cost-containment restrictions led to inadequate care, the traditional MCO model was not held accountable for the resulting injuries because under ERISA preemption the MCO could not be sued.⁸³ After the enactment of ERISA, there have been a limited

530 U.S. 211, 236 (2000) (holding HMO treatment decisions were not considered fiduciary decisions, therefore not subject to ERISA). More specifically, ERISA heavily restricted an injured plaintiff from recovering for a provider’s negligent decision making regarding “medically necessary” treatment and coverage determinations, decisions controlled in large part by the MCO. Gail B. Agrawal & Mark A. Hall, *What If You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS U. L.J. 235, 236 (2003).

76. Jack E. Morris, *Small Employers and Group Health Insurance: Should ERISA Apply?*, 52 LA. L. REV. 971, 976 (1992).

77. Bridget S. Kenney, *Chipping Away at the ERISA Shield: Managed Care Accountability and the Fifth Circuit’s Decision in Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 85 MARQ. L. REV. 481, 481 (2001).

78. *Id.* at 482.

79. *Id.* at 481.

80. *Id.* at 483; see Ochmann, *supra* note 74, at 12 (noting ERISA’s intent to supersede “conflicting or inconsistent state and local regulations”).

81. Kenney, *supra* note 77, at 481.

82. Smith, *supra* note 73, at 175–76 (“The bottom line is that the managed care system forces the physician to ration care at the bedside and then face potential malpractice liability for engaging in MCO-imposed rationing behavior.”).

83. King, *supra* note 44, at 1206–07 (noting that ERISA is a never-ending roadblock when injured patients embark on the path of suing the accountable MCO). Litigation rates for one large California health plan dropped by 25% after courts clarified ERISA’s preemption shield on state malpractice claims. Coopers & Lybrand L.L.P., *Impact of Potential Changes to ERISA: Litigation and Appeals Experience of CalPERS, Other Large Public Employers and a Large*

number of lawsuits that have survived ERISA preemption that allowed injured patients to sue their MCO.⁸⁴ Thus, after ERISA, medical malpractice litigation and the potential for injured patients to recover adequately against an MCO entity decreased,⁸⁵ and physicians were left as the remaining actors that injured patients could hold liable for the adverse events that resulted from health care services within an MCO.⁸⁶

2. The 1993 Health Care Reform and Enterprise Liability

MCOs embodied the leading cost-containment health care structure in the 1990s.⁸⁷ Even though managed care entities were widespread, the United States still generated the highest health care costs in the world and had the largest uninsured population amongst major democracies at that time.⁸⁸ Therefore, soon after his presidential election win in 1992, President Clinton created a task force to reform the health care system.⁸⁹

By 1993, over 70% of all Americans that had health insurance were insured under some managed care plan.⁹⁰ Consequently, any effective attempt at health care reform had to incorporate a managed care reform. President Clinton's 1993 health care reform package, through a proposed bill labeled the "Health Security Act," included a

California Health Plan—Report, HENRY J. KAISER FAMILY FOUND. (May 30, 1998), <http://kff.org/health-costs/report/impact-of-potential-changes-to-erisa-litigation/>.

84. Chaudhuri, *supra* note 56, at 61 (noting that although MCOs have the potential to save patients, and the health care industry, money, patients may end up bearing the costs in the long run).

85. See H. Benjamin Harvey & I. Glenn Cohen, *The Looming Threat of Liability for Accountable Care Organizations and What to Do About It*, 310 J. AM. MED. ASS'N 141, 141 (2013) (discussing the 2004 Supreme Court decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), which held that ERISA preempted state law tort claims against an employer-provided insurance plan).

86. Smith, *supra* note 73, at 176 (noting that a physician can even be held liable for not "working hard enough through appeals [of MCO utilization decisions] or otherwise to secure treatment for the patient"); see *Wickline v. California*, 239 Cal. Rptr. 810, 820 (Cal. Ct. App. 1986) (holding that although an insurance company declined a "medically necessary" extension for a patient's hospital stay, the physician was still responsible for the ultimate discharge decision); see also Frankel, *supra* note 6, at 1307 (noting that the *Wickline* court did not adjust the physician's duty of care "to compensate for the fact that he was providing services within a resource-strapped and cost-conscious [insurance] system," and if anything, that the court actually expanded a physician's duty of care when acting within a health care system that implements cost-containment measures).

87. Feldman, *supra* note 15, at 1091.

88. Derek Bok, *The Great Health Care Debate of 1993–94*, PUB. TALK (1998), <http://www.upenn.edu/pnc/ptbok.html>.

89. *Id.*

90. Glied, *supra* note 31, at 3.

comprehensive plan to solve the health care problems within the United States.⁹¹ One of the issues the Clinton Administration's Task Force on National Health Care Reform recognized was the uncertain survivability of the managed care model if negligent MCO decisions led to direct physician liability.⁹² The continuance of direct physician liability presumed the continuance of the costly practice of defensive medicine, counteracting the original theory behind managed care and its cost-containment initiatives.⁹³ For this reason, the Clinton Administration sought to instill physician immunity from medical malpractice liability by lodging full liability with the MCO; this is how enterprise liability surfaced.⁹⁴

Under the theory of enterprise liability, the health care entity relieves physicians and other medical professionals from direct personal liability by imposing financial and medical malpractice liability on a single health care organization, such as an MCO.⁹⁵ Yet, physicians disregarded and actively fought against the Clinton Administration's enterprise liability proposal, even though the theory would benefit them through immunity from direct personal liability.⁹⁶

The reason for this related back to the fact that physicians' traditional autonomy diminished with the implementation of managed care, and consequently, any proposal that threatened a complete elimination of professional autonomy caused upheaval.⁹⁷ Because participation in coordinated managed care entities further reduced a physician's autonomy in making medical decisions, physicians' contended that the implementation of enterprise liability would eliminate their remaining

91. Robert E. Moffit, *A Guide to the Clinton Health Plan*, TALKING POINTS (Heritage Found., Wash., D.C.), Nov. 19, 1993, at 1.

92. *Id.*

93. See Sage, *supra* note 14, at 166 (noting that one of the attractive benefits of enterprise liability is that "it would act as a potent counterweight to incentives to underserve captive populations of patients in managed care, while at the same time reducing physician-driven 'defensive medicine'").

94. *Id.* at 159; Randall R. Bovbjerg & Robert Bernson, *Enterprise Liability in the Twenty-First Century*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 219, 230 (William M. Sage & Rogan Kersh eds., 2006); William M. Sage & James M. Jorling, *A World That Won't Stand Still: Enterprise Liability by Private Contract*, 43 *DEPAUL L. REV.* 1007, 1008, 1010 (1994); Dana Priest, *Clinton Advisors Discuss Plan to Shift Liability from Physicians*, *WASH. POST* (May 21, 1993), <http://www.washingtonpost.com/archive/politics/1993/05/21/clinton-advisers-discuss-plan-to-shift-liability-from-physicians/b0ef149b-05c8-4682-837e-b3ff9133b60a/>.

95. Philip G. Peters, Jr., *Resuscitating Hospital Enterprise Liability*, 73 *MO. L. REV.* 369, 369 (2008); Fritz & Savage, *supra* note 21.

96. Bovbjerg & Bernson, *supra* note 94, at 230.

97. *Id.*

autonomy.⁹⁸ Ultimately, opposition and criticism of enterprise liability contributed to the death of President Clinton's health care reform bill.⁹⁹

The number of MCOs and Americans' backlash for managed care simultaneously grew rapidly in the 1990s.¹⁰⁰ The American public was concerned about the quality of care that managed care entities implemented and the lack of access to specific health care services.¹⁰¹ Physicians' hostility and blame toward managed care also influenced and possibly created the American public's concern about managed care.¹⁰² In the context of MCOs, "no" was the typical answer patients would receive when a request was submitted to "the gatekeeper" (that is, the insurance company) regarding diagnostic tests, experimental treatments, or specialty care.¹⁰³ This alienated physicians and dissatisfied patients, forcing a backlash against managed care.¹⁰⁴

After the failed attempt in 1993, in July 2009, Speaker of the House Nancy Pelosi revealed a plan to overhaul the nation's current health care system and started the conversation regarding an alternative health care reform.¹⁰⁵ The proposed system required a structure that could provide low-cost health care and ensure the improvement of insurance coverage,

98. Laura D. Hermer, *Aligning Incentives in Accountable Care Organizations: The Role of Medical Malpractice Reform*, 17 J. HEALTH CARE L. & POL'Y 271, 300 (2014). Physician autonomy is part of the medical culture and traditionally, physicians have enjoyed tremendous individual responsibilities, which is reinforced in medical malpractice liability theories. Elliot S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. w44, w54 (2007), <http://content.healthaffairs.org/content/26/1/w44.full>; see Mantel, *supra* note 8, at 458 (noting that medicine is a practice that requires complex medical decision making by physicians, leading to physicians' want for personal autonomy within their medical practice).

99. See Duncan MacCourt & Joseph Bernstein, *Medical Error Reduction and Tort Reform Through Private, Contractually-Based Quality Medicine Societies*, 35 AM. J.L. & MED. 505, 516–17 (2009) (noting that the Clinton health care plan may have been so strongly opposed as a result of the issues of enterprise liability). The enterprise theory of liability reduces physician autonomy because larger, more resourced organizations would have a "financial incentive to monitor doctors closely for indications of negligence and would reduce the number of attorneys in typical malpractice cases." Fritz & Savage, *supra* note 21.

100. Robert J. Blendon et al., *Understanding the Managed Care Backlash*, 17 HEALTH AFF. 80, 80 (1998).

101. *Id.* at 83–84.

102. Ezekiel J. Emanuel, *Why Accountable Care Organizations Are Not 1990s Managed Care Redux*, 307 J. AM. MED. ASS'N 2263, 2263 (2012).

103. *Id.*; see Randall, *supra* note 40, at 35 ("It is unfair to both encourage and entice providers to practice cost control and then hold them individually responsible for consequent injuries. But it is no more fair to allow the injuries of innocent patients to go uncompensated.")

104. Emanuel, *supra* note 102, at 2263.

105. Noam N. Levey, *Q&A: House Speaker Nancy Pelosi Tackles Healthcare Overhaul Questions*, L.A. TIMES (July 18, 2009, 5:15 PM), <http://latimesblogs.latimes.com/washington/2009/07/house-speaker-nancy-pelosi-tackles-healthcare-overhaul-questions.html>.

choice, and patient safety.¹⁰⁶

On March 23, 2010, President Obama signed the PPACA into law.¹⁰⁷ The PPACA was intended to expand access to health care insurance, reduce the cost of health care, and improve the quality of patient care.¹⁰⁸ The PPACA was this country's fresh attempt at a reform in the health care market, but it also encompassed various trends from past health care models and reimbursement structures to create a modernized, coordinated health care model.

II. DISCUSSION

A. Accountable Care Organizations

Lawmakers recognized that reforming Medicare, especially during the baby boomer retirement era, could reduce the national debt.¹⁰⁹ The PPACA is a broad statute that encompasses many aspects of health care in the United States, but its main goal is to target the high cost of health care, with specific focus on Medicare.¹¹⁰ The PPACA sought to reduce costs by incentivizing providers to collaboratively form a network that can coordinate and manage the care of a large patient population,¹¹¹ in hopes that a network of providers can deliver more cost-effective health care relative to individual physicians or single hospitals.¹¹² The PPACA implemented the ACO model as the structure to accomplish that goal. Health care providers within an ACO collaborate to manage,

106. *Id.*

107. See Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. TIMES (Mar. 23, 2010), http://www.nytimes.com/2010/03/24/health/policy/24health.html?_r=0 (noting that the PPACA was “the most expansive social legislation enacted in decades”).

108. Nicole Martingano-Reinhart, *Gainsharing and the Patient Protection and Affordable Care Act*, 43 SETON HALL L. REV. 1325, 1326 (2013).

109. Gold, *supra* note 13; Barbara J. Zabawa et al., *Adopting Accountable Care Through the Medicare Framework*, 42 SETON HALL L. REV. 1471, 1471 (2012). Prior to the PPACA's implementation of ACOs, the Medicare Payment Advisory Commission (“MedPAC”) in 2009 reported to Congress the cost saving and quality care improvements that could be implemented with the creation of ACOs. Smith, *supra* note 73, at 184.

110. See CTRS. OF MEDICARE & MEDICAID SERVS., THE AFFORDABLE CARE ACT: LOWERING MEDICARE COSTS BY IMPROVING CARE, <https://www.cms.gov/apps/files/aca-savings-report-2012.pdf> [<https://web.archive.org/web/20150329132148/http://www.cms.gov/apps/files/aca-savings-report-2012.pdf>] (last visited Apr. 1, 2016) (noting the Obama Administration's main goal with the PPACA was to lower Medicare costs to not only improve the quality of care, but sustain the Medicare program).

111. Participation in CMS programs is conditioned on the ACO agreeing to manage the care of at least 5000 Medicare fee-for-service beneficiaries. Switzer, *supra* note 22, at 34.

112. Gold, *supra* note 13.

deliver, and coordinate the health care for their designated Medicare beneficiaries.¹¹³ The ACO is structured to accomplish the goals of low-cost, high-quality health care because providers acting within an ACO share the financial risk of health care costs.¹¹⁴

The traditional fee-for-service payment system is not eliminated with the implementation of ACOs.¹¹⁵ Medicare will still reimburse health care providers within the ACO on a fee-for-service basis, but CMS, the government agency responsible for administering federal health care plans, offers incentives for providers to practice medicine more cost-effectively.¹¹⁶ One incentive scheme, for example, is the Medicare Shared Savings Program (“MSSP”), which incentivizes health care providers by distributing bonus payments if Medicare spending is below a certain target.¹¹⁷ There are other programs that an ACO can join,¹¹⁸ but this Article will focus on the MSSP because the MSSP is the specific ACO program that the PPACA references and outlines.¹¹⁹ Important in the construction of ACOs, the financial benefits do not automatically result from membership in a MSSP. Instead, an ACO

113. 42 C.F.R. 425.100(a) (2015).

114. Jo Cavallo, *Accountable Care Organizations May Be at Risk for New Medical Liability*, ASCO POST (July 10, 2013), <http://www.ascopost.com/issues/july-10-2013/accountable-care-organizations-may-be-at-risk-for-new-medical-liabilities/>.

115. Gold, *supra* note 13.

116. *Id.*

117. *Id.*; PACIFIC HEALTH CONSULTING GROUP, *ALIGNING HIGHER PERFORMANCE THROUGH SHARED SAVINGS PROGRAMS* 12 (2014), http://www.careinnovations.org/uploads/Aligning_Higher_Performance.pdf.

118. The Pioneer program and the Next Generation program are both options for ACOs. The Pioneer program is a model that encourages participation from experienced health care organizations that have previously established a coordinated health care infrastructure and system. *Pioneer ACO Model*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://innovation.cms.gov/initiatives/Pioneer-aco-model/> (last visited Apr. 1, 2016). The Pioneer Model offers more financial incentives, but also requires a greater undertaking of risk compared the MSSP. The Next Generation program, introduced by CMS in 2015, requires an ACO to take on a greater amount of risk, but allows it to gain a greater portion of financial savings compared to the Pioneer program. *Affordable Care Act Initiative Builds on Success of ACOs*, U.S. DEPT. HEALTH & HUMAN SERVS. (Mar. 10, 2015), <http://www.hhs.gov/about/news/2015/03/10/affordable-care-act-initiative-builds-on-success-of-acos.html>.

119. PPACA, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010) (demonstrating that section 3022 of the PPACA created the MSSP); Feldman, *supra* note 15, at 1078. The Shared Savings Program is outlined in Section 1395jjj(a)(1), which states:

The Secretary shall establish a shared savings program Under such program—(A) groups of providers of services and suppliers meeting criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization; and (B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings.

Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395.

only receives the benefits of the MSSP if it successfully delivers high-quality health care while simultaneously lowering the overall cost of that care.¹²⁰

1. Low-Cost and High-Quality Goals

ACOs are set up to achieve CMS's goals of high-quality health care at lower costs through their inherent collaborative nature as well as through CMS's incentivizing programs, particularly through the MSSP. When an ACO participating in the MSSP succeeds in providing health care to its Medicare beneficiaries at a cost lower than the threshold set by CMS, the ACO receives financial benefits, or what the PPACA refers to as "payments for shared savings."¹²¹ The payments for shared savings include a percentage of the difference between the anticipated cost of health care for the ACO's beneficiaries and the amount the ACO actually spent on its beneficiaries.¹²² However, CMS only awards these payments to an ACO if it also succeeds in meeting the quality performance standards set forth by the PPACA.¹²³ Therefore, the providers delivering health care to Medicare beneficiaries within an ACO only receive the MSSP savings if they meet cost *and* quality standards.¹²⁴

2. Quality

Both ACOs and earlier models of MCOs share cost-containment goals, but the drafters of the PPACA took initiative to avoid the quality care drawbacks of MCOs by implementing standardized measures.¹²⁵

120. Switzer, *supra* note 22, at 34. ACOs' task of providing high-quality care at low prices has proven to be very difficult. In 2013, only fifty-two out of the 220 ACOs participating in the MSSP met CMS quality-of-care benchmarks and kept health care spending within the set targets. Melinda K. Abrams et al., *The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years*, COMMONWEALTH FUND (May 7, 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years>. CMS recognized the difficulty ACOs were having in their attempts to satisfy all quality and cost benchmarks, thus resulting in CMS "allowing providers to take it slow by adopting the one-sided risk model for at least three years and by getting credit for simply reporting on quality measures in the first year." *Id.*

121. 42 U.S.C. § 1395jjj(a)(1)(B) (2012); *Shared Savings Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/shared-savingsprogram/index.html?redirect=/sharedsavingsprogram> (last updated June 12, 2015, 1:29 PM); *see also* Gold, *supra* note 13 (demonstrating that the traditional carrot-and-stick approach is implemented with ACOs in that "providers make more if they keep their patients healthy").

122. 42 U.S.C. § 1395jjj(d)(2).

123. *Id.*

124. Smith, *supra* note 73, at 166.

125. Harvey & Cohen, *supra* note 85, at 141 (noting that the addition of quality care and

CMS established thirty-three quality measures—or benchmarks—that an ACO must meet in order to receive the MSSP incentivizing financial bonuses.¹²⁶ These measures encourage providers to keep patients healthy, thereby rewarding quality and cost reduction.¹²⁷ The thirty-three quality measures are compiled into four different domains: (1) Patient/Caregiver Experience, (2) Care Coordination and Safety, (3) Preventative Health, and (4) At-Risk Populations.¹²⁸ For an example of what role the measures play, the Care Coordination and Safety domain contains quality goals that are meant to coordinate and efficiently transition health care away from the acute care setting, specifically the quality measure labeled “all-conditions readmissions.”¹²⁹ This accounts for the number of beneficiaries that were readmitted to a hospital for a preventable condition within thirty days after initial discharge.¹³⁰ Decreasing the rate of preventative readmissions will not only reduce the total of cost of care, but will also provide a continuous, high-quality patient recovery.¹³¹

Every ACO must report on each of the thirty-three quality measures and reach a minimum threshold for quality care. The measures were included within the CMS incentive plan in order to avoid the negative consequences that can result when providers streamline their focus on saving money rather than providing the necessary care.¹³² The quality measures do not define the medical malpractice standard of care, but rather are merely standards that a given ACO must meet in order to receive the MSSP’s financial benefits.¹³³

quality outcome measures into the MCO model will give ACOs a better opportunity to achieve the cost-containment goals without simultaneously producing poor-quality patient care).

126. Switzer, *supra* note 22, at 34.

127. Gold, *supra* note 13.

128. Robert A. Gerberry et al., *Measuring Up: Will Your Physician Meet the Thirty-Three Quality-Reporting Metrics Under the CMS Shared Savings Program?*, PHYSICIAN ORGS., June 2012, at 5, 6, <http://www.thecamden.org/wp-content/uploads/Quality-Reporting-Metrics-Under-the-CMS-Shared-Savings-Program.pdf>.

129. TIANNA TU ET AL., MHA ACO NETWORK & LEAVITT PARTNERS, THE RIGHT CARE FOR THE RIGHT COST: POST-ACUTE CARE AND THE TRIPLE AIM 4 (2014), http://www.mhainc.com/uploadedFiles/Content/Resources/MHA_Leavitt%20Partners%20White%20Paper%20091814.pdf.

130. *Id.*

131. *Id.*

132. Gold, *supra* note 13.

133. Stephen Ubl, *ACOs: Improved Care or Roadblocks to Innovation?*, HEALTH AFF. BLOG (Apr. 25, 2011), <http://healthaffairs.org/blog/2011/04/25/acos-improved-care-or-roadblocks-to-innovation/> (noting that an ACO that achieves the standardized quality measures does not ensure individual quality care in terms of particular patients).

3. Participation

The idea that ACOs have the infrastructure to deliver higher-quality health care at a lower cost is an attractive theory, but ACOs have not yet established a success story.¹³⁴ ACOs have the potential to achieve cost-containment goals because they do have the infrastructure to coordinate care, specifically with chronic disease management.¹³⁵ Nonetheless, the success of ACOs is contingent on physician involvement and active participation.¹³⁶ In order to succeed, a particular ACO must first achieve provider buy-in before even attempting to achieve the necessary coordination amongst its health care providers.¹³⁷ Although the concept of low-costing, high-quality health care sounds ideal, convincing skeptical, independent physicians to participate in a structure that can increase their medical malpractice liability, while simultaneously lowering their financial return is, understandably, proving to be a difficult task.¹³⁸

B. The Threat of the MCO Taint

The practices of gatekeeping and service denial controlled the undesirable reputation of the managed care entities that consumed the

134. See Hermer, *supra* note 98, at 272 (hedging that while there is excitement about the potential for success, “it is by no means clear that ACOs will succeed, whether individually or in the greater goal of changing our health care delivery system”).

135. See John Andrews, *No ACOs Without Coordination*, HEALTHCARE IT NEWS (Apr. 24, 2015, 1:23 PM), <http://www.healthcareitnews.com/news/no-acos-without-coordination> (noting that coordination is necessary for the ACO because managing patients with chronic diseases is very difficult without a coordinated infrastructure). Managing chronic diseases is extremely important if the health care industry seeks to succeed in lowering the total cost of health care in the United States. JESSIE GERTEIS ET AL., AGENCY FOR HEALTHCARE RES. & QUALITY, MULTIPLE CHRONIC CONDITIONS CHARTBOOK: 2010 MEDICAL EXPENDITURE PANEL SURVEY DATA 7 (2015), <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf>. In 2010, 86% of all health care spending in the United States was on patients with one or more chronic medical conditions. *Id.* Therefore, the United States cannot successfully hinder the increasing health care costs without addressing the management of chronic disease. CTRS FOR DISEASE CONTROL & PREVENTION, THE POWER OF PREVENTION: CHRONIC DISEASE . . . THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY 7 (2009), <http://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf>.

136. See PAUL GARDNER ET AL., ROBERT WOOD JOHNSON FOUND., THE IMPACT OF ACCOUNTABLE CARE: PHYSICIAN PARTICIPATION IN ACCOUNTABLE CARE ORGANIZATIONS 1 (2015), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420214 (“Physician involvement is essential to achieve the goals of improving outcomes while lowering costs, as ACOs seek to coordinate care across all locations of care.”).

137. Hermer, *supra* note 98, at 272.

138. See *id.* (recognizing that the ACO structure is devised to lower the volume of health care services, which in turn will lower physician financial returns, because the amount of services that physicians can receive reimbursement for will in turn decrease).

1990s.¹³⁹ Moving forward, some wonder if the cost-containment goals of ACOs will inevitably lead the health care industry to the same consequences that the original managed care entities produced.¹⁴⁰ For example, the first managed care entities restricted physicians from providing essential services and burdened them with a constant struggle with the gatekeeping insurance company as to whether a particular service would be reimbursed.¹⁴¹ Therefore, physician hesitation in immediate participation in ACOs is understandable.

Compared to the traditional managed-care era, physicians bear more administrative and financial responsibility from the recent roll out of different payment and reimbursement models.¹⁴² Health care providers acting within the ACO model are responsible for controlling the cost of care while improving the quality, responsibilities that resemble the traditional managed care models. Physician responsibilities may have expanded in the recent system change, but ACOs offer a response to the system changes as well as the shortcomings in traditional MCOs.¹⁴³

More than twenty-five years have passed since the managed care backlash in the 1990s.¹⁴⁴ Since that time, the health care system has acquired an understanding of the path to coordinated care and gained insight into containing health care expenditures.¹⁴⁵ Additionally, the current health care system has access to more data and more evidence encompassing various practice outcomes, cost implications, and the utilization of services.¹⁴⁶ Also, the advancement of electronic health records (“EHR”) has increased the ability to coordinate patient care and has generated enormous datasets calculating the various outcomes across the nation’s patient population.¹⁴⁷ Furthermore, ACOs’

139. Emanuel, *supra* note 102, at 2263 (“Managed care alienated many physicians by excluding many of them from networks, intensely bargaining on payments, empowering primary care physicians as gatekeepers, and requiring prior authorizations for many tests and treatments.”).

140. *Id.*; Frakt, *supra* note 32; *see supra* Part I.B.

141. Emanuel, *supra* note 102, at 2263.

142. Frakt, *supra* note 32.

143. *See id.* (“[B]y and large, [ACOs] are devised more in response to the shortcoming of HMOs than as a copy of them.”).

144. *See supra* text accompanying notes 100–04.

145. Emanuel, *supra* note 102, at 2263.

146. *Id.*

147. *See id.* at 2264 (noting that almost 100% of ACO entities will use EHRs, thereby “enabling smart predicting modeling, patient monitoring, and performance management of the delivery system”). EHRs have the potential to improve the quality of care, but EHRs can also increase the risk of malpractice liability. Feldman, *supra* note 15, at 1087. Although data breaches, implicating violations of the Health Insurance Portability and Accountability Act

increased access to and knowledge of outcome data and EHR can potentially aid physicians in their attempt to manage risk more effectively.¹⁴⁸

Both MCOs and ACOs carry the responsibility to manage capitated payments and patient risk.¹⁴⁹ But, the management of payment and risk was a difficult task for MCOs, which were operating without the data sets and experience that are now available to ACOs.¹⁵⁰ The management of patients is different within the ACO structure as compared to the care provided by MCOs, such as an HMO. In the 1990s, HMOs were insurers that decided and ordered which services physicians were allowed to deliver to their patients, therefore creating a friction between insurers and providers and their patients.¹⁵¹ ACOs allow various providers to collaboratively deliver health care and decide which services will be reimbursed.¹⁵²

Though attractive changes appear within the ACO model, there are still looming similarities between the ACO and the managed care past. The ACO is structured so that providers are responsible for both the financial and quality outcomes. This means that the providers delivering services within the ACO are also subjected to the same medical malpractice concerns that faced providers in MCOs.¹⁵³ Despite the MSSP setting quality standards, those benchmarks likely do not deter the looming threat of medical malpractice liability. Physicians are therefore trapped in weighing these potential financial benefits of an ACO against the increased risk of medical malpractice liability.

Providers delivering care within the original MCOs also weighed the cost of care with the quality of care, but were typically focused on the cost rather than the quality. The debate continues as to whether traditional MCOs actually lowered costs,¹⁵⁴ but the incentives to

("HIPAA"), likely will be more prevalent with EHR implementation, there is also a risk of malpractice with EHR implementation, including "the loss of important information within the vast sea of running notes in a patient's file and the temptation to simply cut and paste, thereby omitting potentially important pieces of information and creating errors-by-omission in a patient's file." *Id.*

148. Emanuel, *supra* note 102, at 2264.

149. *Id.*

150. *Id.*

151. Frakt, *supra* note 32.

152. *Id.*

153. See *supra* text accompanying notes 68–74 (describing the malpractice concerns that correlated with managed care cost-containment initiatives).

154. David M. Cutler & Louise Sheiner, *Managed Care and the Growth of Medical Expenditures* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 6140, 1997) ("The growing dominance of managed care has helped control health care costs increases."); see Emanuel, *supra*

produce low cost diminished the quality of care within MCOs,¹⁵⁵ implicating medical malpractice liability. At the time of the managed care roll out, scholars noted the difficulty in ascertaining how actors within MCOs would be held responsible for the quality of medical services;¹⁵⁶ the same dilemma that now faces the industry with the implementation of ACOs.

After the highly anticipated goals of the MCO structure were quashed, the need to fix the system that MCOs left in its wake was apparent.¹⁵⁷ Today's health care system is drastically different than it was in the 1990s and the new ACO model will have more opportunities to succeed in achieving the low-cost, high-quality goals. Yet, new opportunities can lead to even more uncertainty as to how to teeter the totter of cost-containment and quality care.¹⁵⁸ An analysis as to whether physicians will be subject to higher medical malpractice while acting within an ACO is important because increased liability will be a major contributor to a physician's decision to participate and provide care in an ACO model.

III. ANALYSIS

New health care models give rise to new malpractice risks, claims, and concerns.¹⁵⁹ Medical malpractice liability is a major concern for physicians, but the PPACA has had no impact on limiting that concern.¹⁶⁰ Although ACO entities will share similar characteristics

note 102, at 2263 (“Whatever its failings, managed care did succeed on at least one important metric: it controlled cost.”); cf. Alan B. Krueger & Helen Levy, *Accounting for the Slowdown in Employer Health Care Costs* 10 (Nat'l Bureau of Econ. Research, Working Paper No. 5891, 1997) (noting that although the cost of employer-provided health insurance premiums has decreased, managed care is not the cause of that reduction).

155. See, e.g., *Wickline v. California*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986) (noting that a patient's health care and a physician's medical decisions were negatively impacted by the managed care system). Between 1997 and 2000, the average jury verdict doubled, and in 2000, the average “jury verdict in a malpractice trial was 3.5 million dollars.” Anderson, *supra* note 42, at 347.

156. Gonzalez, *supra* note 33, at 736 (noting that there was great conflict within MCOs between the physician's fiduciary duty and the entity's monetary and financial interests); see Pedroza, *supra* note 38, at 399 (“As courts tried to fit this new form of health care into old liability systems, problems arose.”).

157. Emanuel, *supra* note 102, at 2263.

158. See generally *id.* (comparing and contrasting the PPACA with previous health care reform initiatives in the 1990s, and arguing that while the PPACA will likely not fail in the same ways that 1990s health reforms did, there is not much certainty that ACOs will successfully control costs).

159. O'Connell & Neale, *supra* note 64, at 288.

160. Feldman, *supra* note 15, at 1082.

with other managed care entities, ACOs will present varying structures, different models of governance, and diverse relationships.¹⁶¹ Therefore, a deeper analysis as to whether ACOs can achieve the quality and cost-containment goals of the PPACA, whether ACOs will be subject to heightened medical malpractice liability, and what type of liability could be imposed on the ACO is necessary before proposing an incentive model.

A. Achievement of Quality and Cost-Containment Goals

Many question whether an ACO can simultaneously achieve both cost-cutting and quality goals.¹⁶² The ACO model offers shared savings if providers can meet cost-containment goals—goals likely achieved as a result of lower orders of tests and examinations. Yet, this outcome may be counteractive and difficult to achieve for specific medical practices, particularly oncologists and cancer care, because it does not take into account the reality of increased costs of cancer care when determining the financial success of the ACO.¹⁶³ Even outside this

161. Switzer, *supra* note 22, at 35.

162. Lola Butcher, *Concerns About CMS ACO Proposal*, 33 ONCOLOGY TIMES 40 (2011), http://journals.lww.com/oncology-times/Fulltext/2011/05250/Concerns_about_CMS_ACO_Proposal.10.aspx (discussing the concerns that oncologists have regarding the ACO model and how it will be implemented in terms of cancer care); Rita E. Numerof, *Why Accountable Care Organizations Won't Deliver Better Health Care—and Market Innovation Will*, HERITAGE FOUND. (Apr. 18, 2011), <http://www.heritage.org/research/reports/2011/04/why-accountable-care-organizations-wont-deliver-better-health-care-and-market-innovation-will> (concluding that the “laudable” goal of an ACO to lower health care costs, but improve the quality of health care, is incorporated in a “model that does not exist in practice”); see Mark McClellan, *Changes Needed to Fulfill the Potential of Medicare’s ACO Program*, HEALTH AFF. BLOG (Apr. 8, 2015), <http://healthaffairs.org/blog/2015/04/08/changes-needed-to-fulfill-the-potential-of-medicare-aco-program-2/> (recognizing that the low-cost, high-quality care goals are difficult to sustain simultaneously because while some ACOs have sustained the quality benchmarks, they have failed to reduce spending); see also Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1392, 1427 (2012) (“There is a very real risk . . . that some ACO providers may go beyond trimming fat and deny or delay providing their patients appropriate medical interventions in order to maximize their shared savings or profit margins.”).

163. Butcher, *supra* note 162 (demonstrating the threat that ACOs may prematurely order patients with cancer to hospice care in exchange for a lower total in costs of care for that particular patient). Although ACOs seem to focus on quality care by implementing standardized quality care measures, contrary to HMOs, these measures do not relate to cancer care, “leaving oncologists unable to prove the value of the care they provide.” *Id.* The threat is also apparent in terms of patients with congestive heart failure (“CHF”) when a particular ACO has a more cost-saving initiative in place in terms of CHF hospital admissions. Harvey & Cohen, *supra* note 85, at 141. If the patient with CHF suffers a poor outcome as a result of the ACO’s hospital admission standards, the ACO will not be afforded preemption for a state law tort claim and therefore could be held liable for state law malpractice. *Id.*

context, new developments of innovative technologies and drugs will continue, but due to their likely high expense, providers within an ACO are unlikely to utilize them. Financial pressures of the ACO will outweigh the potential health care benefits of the patient.¹⁶⁴

Producing low-cost health care is imperative for the viability of the ACO model and the entire health care system, but low-cost health care will not emerge without some risk and sacrifice. The inherent tension between lowering the cost of care and the threat of medical malpractice liability was evident with the first MCO models;¹⁶⁵ the PPACA, through the MSSP, attempted to counteract this issue by setting and implementing standardized quality measures within the ACO. The addition of quality measures into the managed care model will give ACOs a better opportunity to achieve cost containment goals without sacrificing poor patient care; however, the quality measures will not prevent the ACO or the providers within it from medical malpractice liability.¹⁶⁶ ACOs will not be shielded from liability because the benchmarks do not define the medical malpractice standard of care that hold health care providers liable in medical malpractice causes of action.¹⁶⁷ Thus, although the quality benchmarks will incentivize providers to deliver better care, these benchmarks will not eliminate the risk of medical malpractice liability.

Further, physicians providing care within an ACO will likely have a greater threat of medical malpractice liability because the tension between high quality and low cost remains with the ACO; ACOs will likely hold more control over their member physician's decisions;¹⁶⁸ and the ERISA preemption will not shield the ACO, as it did the

164. Butcher, *supra* note 162.

165. See *supra* text accompanying notes 68–74 (describing the malpractice concerns that correlated with managed care cost-containment initiatives); Harvey & Cohen, *supra* note 85, at 141 (noting that the “inevitable tension between cost containment and medical liability” is apparent).

166. Harvey & Cohen, *supra* note 85, at 141.

167. Ubl, *supra* note 133 (noting that an ACO that achieves the standardized quality measures does not ensure individual quality care in terms of particular patients); see Smith, *supra* note 73, at 192 (recognizing that similar to MCOs, the PPACA “does not address the intersection of cost containment concerns and malpractice liability standards for ACO physicians and providers”); cf. Abrams et al., *supra* note 120 (noting that due to CMS recognition of the difficulty that stems from ACOs attempting to reach both quality and cost standards, “CMS is allowing providers to take it slow by adopting the one-sided risk model for at least three years and by getting credit for simply reporting on quality measures in the first year”). While ACOs will not be required to satisfy all thirty-three quality-care benchmarks, it will be important for ACOs to still monitor and identify reaching quality benchmarks during this safety period.

168. Harvey & Cohen, *supra* note 85, at 141.

HMOs.¹⁶⁹ The likely areas that ACOs can be exposed to liability could include denying treatment, physician negligence, inadequately coordinating patient care in terms of case management, violating billing and contract requirements, inadequately selecting health care providers, deficient and harmful coverage determinations in terms of patient claims, and the failure to comply with federal statutes and regulations.¹⁷⁰ For example, while the ACO structure may incentivize and pressure physicians to avoid offering specific procedures or examinations, the physician's risk of a lawsuit for the failure to diagnose a condition or properly treat a patient is heightened as a result of the cost-containment pressures.¹⁷¹ There has been no ACO litigation to date, and therefore providers can only predict the extent of the medical malpractice liability risk.¹⁷² But there are indicators that may implicate an increased risk of medical malpractice liability for an ACO and its participating providers, including the absence of the ERISA shield and the PPACA's failure to identify a standard of care and its requirement of evidence-based medicine.

1. ACO Liability Increases Without the ERISA Shield

As previously discussed, ERISA regulates group health plans and includes a preemption clause that "prevents states from enforcing statutes that 'relate to' an ERISA plan."¹⁷³ In 2000, the U.S. Supreme Court unanimously held that an HMO's treatment decisions, acting through the physician-employee, are not considered fiduciary acts under ERISA; as such, a patient could not recover from state law remedies if patient injury resulted from coverage determinations made by an HMO.¹⁷⁴ In *Pegram v. Herdrich*, after the plaintiff demonstrated pain in her groin, the physician discovered an inflamed mass in her abdomen.¹⁷⁵ Despite the discovery of the inflamed mass, the physician decided to delay an ultrasound order and subsequently designated a time

169. See *supra* Part I.B.1-2 (comparing and contrasting ERISA's preemptive effect with regard to ACOs and HMOs).

170. *Likely Areas the Accountable Care Organizations Can Be Sued*, HCP NAT'L INS. SERVS., INC. (June 22, 2015), <http://www.hcpnational.com/aco-liability-exposures-their-providers-employees-health-plans-and-even-their-it-cloud-providers/>.

171. Feldman, *supra* note 15, at 1085.

172. *Id.*

173. Kenney, *supra* note 77, at 481.

174. *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000). The managers and administrators of an employee benefit plan are held to specific standards of conduct and fiduciary responsibility, as set by ERISA. EMP. BENEFITS SECURITY ADMIN., U.S. DEP'T LABOR, MEETING YOUR FIDUCIARY RESPONSIBILITIES (2010), <http://www.dol.gov/ebsa/pdf/fiduciaryresponsibility.pdf>.

175. *Pegram*, 530 U.S. at 211.

when the plaintiff could return for another check.¹⁷⁶ Before the physician's designated waiting time for the ultrasound order elapsed, the plaintiff's appendix ruptured, causing an injury of peritonitis.¹⁷⁷ The physician who wrongly decided to delay the ultrasound order was an employee of the defendant HMO.¹⁷⁸

The Court recognized the argument that the HMO's cost-containment initiatives influenced the physician's decision to delay the ordering of an ultrasound for the plaintiff and "blinded" the physician's medical viewpoint.¹⁷⁹ Yet, the Court held that despite ERISA's imposition of fiduciary obligations on employee health plan administrators, specifically the HMO in *Pegram*, mixed eligibility and treatment decisions are not subject to ERISA fiduciary requirements.¹⁸⁰ The Court, in effect, blocked the plaintiff's recovery against the HMO and created a substantial burden for future plaintiffs injured as a result of managed care.

The Court stated that pure coverage decisions—whether a service was considered a "covered procedure" under a health care plan—would not fall under the new category of mixed eligibility and treatment decisions.¹⁸¹ On the other hand, the Court found the following to be mixed decisions and thus not subject to fiduciary requirements of an HMO pursuant to ERISA:

physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities . . . ; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition.¹⁸²

Importantly, the Court noted that these mixed decisions are likely subject to state medical malpractice law.¹⁸³

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.* at 219.

180. The Court in *Pegram* recognized the impracticality of distinguishing eligibility decisions and treatment decisions. It determined that HMOs make "mixed eligibility and treatment decisions," or "decisions relying on medical judgment in order to make plan coverage determinations." *Id.* at 212.

181. Timothy S. Jost, *Pegram v. Herdich: The Supreme Court Confronts Managed Care*, 1 *YALE J. HEALTH POL'Y, L. & ETHICS* 187, 190 (2001).

182. *Pegram*, 530 U.S. at 229; *see also* Jost, *supra* note 181, at 190 (noting that the new category of "mixed eligibility and treatment decisions" will "sweep in the vast majority of decisions currently made by managed care plans").

183. *Pegram*, 530 U.S. at 235–36.

While *Pegram* afforded MCOs some “breathing space” due to the ERISA preemption,¹⁸⁴ ACOs will not enjoy the ERISA shield of medical malpractice liability protection despite still encountering the same difficulty as HMOs in trying to contain costs while also providing quality care. ERISA’s preemption clause protects employer-sponsored health plans from state malpractice law; however, ACOs are legal structures, not employer-sponsored health plans and, therefore, injured plaintiffs *can recover* against ACOs pursuant to state law malpractice claims.¹⁸⁵ Consequently, the lack of the ERISA preemption shield can subject ACOs and their participating providers to a heightened risk of medical malpractice liability.

2. PPACA

The PPACA does not address, and therefore does not limit, the threat of medical malpractice liability in its implementation of ACOs.¹⁸⁶ First, the PPACA did not design a medical malpractice standard of care applicable to the ACO model and the actors providing health care within it.¹⁸⁷ Although CMS requires ACOs to achieve quality benchmarks, those benchmarks do not set forth the standard of care for medical malpractice liability; they are merely standards that a given ACO must meet in order to receive the shared savings of the MSSP.¹⁸⁸ As previously discussed with traditional managed care entities,¹⁸⁹ a physician is held to a standard of care that defines what a reasonable physician would do under similar circumstances, and cost-containment initiatives are not included within that standard of care.¹⁹⁰ The PPACA

184. Neville M. Bilimoria, *HMOs Continue Losing Ground on Liability Issues at State Level*, MANAGED CARE, July 2000, <http://www.managedcaremag.com/archives/0007/0007.liable.html>.

185. Smith, *supra* note 73, at 195.

186. DiGiacinto et al., *supra* note 13, at 1. There is no separate cause of action for injured plaintiffs, but on the other end of the spectrum, the PPACA also failed to shield physicians and other health care providers from medical malpractice liability. *Id.*

187. Smith, *supra* note 73, at 192.

188. *See id.* at 189 (noting that although the quality measures do not define a medical malpractice standard of care, they could correlate with medical malpractice liability in that they include measures on “rates of hospital readmission, medication management and reconciliation, measurements related to health care acquired conditions, mammography screens, colorectal cancer screenings and monitoring related to diabetes, coronary artery disease, heart failure and hypertension”); *see also* Ubl, *supra* note 133 (noting that an ACO that achieves the standardized quality measures does not ensure individual quality care in terms of particular patients).

189. *See supra* text accompanying notes 68–72 (explaining that, as MCOs emerged, non-medical concerns were more highly valued than a patient’s welfare).

190. *See* Smith, *supra* note 73, at 176 (noting that a physician can even be held liable for not “working hard enough through appeals [of MCO utilization decisions] or otherwise to secure treatment for the patient”); *see also* Wickline v. California, 239 Cal. Rptr. 810, 820 (Cal. Ct. App.

requires ACOs to reduce the cost of health care, but fails to incorporate the new cost-containment goals into the traditional medical malpractice standard of care.¹⁹¹ Under the traditional malpractice standard of care, a physician has the duty to make medical decisions that are in the best interest of the patient, regardless of the treatment cost or cost-effectiveness.¹⁹² Thus, having a non-cost-conscious standard of care define a physician's duty of care clashes with the cost-containment initiatives of ACOs and consequently subjects a physician to an increase of medical malpractice liability risk because of the inevitable correlation between cost reduction and quality reduction.¹⁹³

Second, the PPACA's requirement that ACOs use evidence-based medicine also may increase the risk of medical malpractice liability for ACOs.¹⁹⁴ CMS requires ACOs to create and implement processes that promote evidence-based medicine.¹⁹⁵ This requirement may force physicians to be held to a heightened standard of care.¹⁹⁶

While the PPACA fails to address the threat of medical malpractice liability on ACOs, ACOs still face the same tension inherent in cost-cutting and the delivery of quality health care because cost and efficiency are not incorporated in the medical malpractice standard of care.¹⁹⁷ Therefore, it is imperative to conduct an analysis as to how physicians will be held liable for patient injuries arising out of the ACO model by analyzing the liability incurred when negligence arose in under MCOs.¹⁹⁸

1986) (holding that despite an insurance company declining a "medically necessary" extension for a patient's hospital stay, the physician was still responsible for the ultimate discharge decision); *see also* Frankel, *supra* note 6, at 1307 (recognizing that the court in *Wickline* did not "adjust the treating physician's duty of care to compensate for the fact that he was providing services within the resource-strapped and cost-conscious Medi-Cal system").

191. *See* Smith, *supra* note 73, at 192 (discussing the shortcomings of the PPACA).

192. *See* Feldman, *supra* note 15, at 1090 (outlining the requirements under the traditional malpractice standard of care).

193. *Id.*

194. *See* Peter Orszag, *Malpractice Methodology*, N.Y. TIMES (Oct. 20, 2010), http://www.nytimes.com/2010/10/21/opinion/21orszag.html?_r=0&pagewanted=print (noting the adverse effects of the PPACA's requirement that ACOs use evidence-based medicine).

195. *See* ADVISEN, INC., THE LIABILITY IMPLICATIONS OF HEALTHCARE REFORM 4 (2013), <http://www.onebeaconpro.com/sites/OneBeaconProfessional/documents/advisen/AdvisenHealthcareReformWhitepaper.pdf> (discussing the requirements CMS places on ACOs).

196. *Id.*

197. *See* Smith, *supra* note 73, at 192 (explaining that physicians face pressures aside from those addressed by the PPACA).

198. *See* Gold, *supra* note 13 (noting that the linchpin of the MSSP's ACO program is the primary care physician).

B. Potential Liability for ACOs and Its Participating Providers

Trying to fit the noisy, inharmonious, and multi-layered medical malpractice liability debate into the even more complicated and muddled ACO model is troublesome. Despite this difficulty, identifying potential liabilities within an MCO can aid in analyzing an ACO's potential scope of liability if an adverse event occurs within the ACO's coordinated health care model. At this time, there is no litigation implicating ACO-related medical malpractice, therefore analyzing comparable litigation involving other managed care entities might inform a determination of the scope of ACO liability.¹⁹⁹

1. Joint and Several Liability

Physicians and other health care providers participating in an ACO agree to jointly coordinate care of a population of Medicare beneficiaries.²⁰⁰ Because joint coordination correlates with joint accountability,²⁰¹ the concept of joint and several liability may function within an ACO context.²⁰² An injured plaintiff may hold two or more health care providers liable from an error under the common-law doctrine of "joint and several liability" when two or more providers contributed to the plaintiff's alleged injury.²⁰³ In so doing, an injured plaintiff can recover the full amount of damages from any of the contributing actors.²⁰⁴

Medical malpractice lawsuits are prone to the "shotgun method," where an injured plaintiff will include any provider, employer, employee, or related entity even remotely connected to the error in a given lawsuit.²⁰⁵ If an error results from care within an ACO, injured plaintiffs will likely attempt to sue the ACO as well as the treating physicians involved in the plaintiff's care. An analysis as to the increased liability an ACO may encounter relates to the individual liability a physician practicing *within* an ACO may encounter. Therefore, a coordinated model of health care implicates the concept of

199. Feldman, *supra* note 15, at 1091 ("[T]here is no ACO-related medical malpractice litigation to analyze, [therefore] many scholars have turned to MCOs for comparison.").

200. Smith, *supra* note 73, at 184.

201. *Id.*

202. *Id.* at 195.

203. Richard W. Wright, *The Logic and Fairness of Joint and Several Liability*, 23 MEMPHIS ST. U. L. REV. 45, 46 (1992).

204. *Id.*

205. Julia D. Bobbitt, Jr., *Will ACOs Raise (or Lower) Liability Risks for Physicians*, ACCOUNTABLE CARE NEWS (Health Policy Publ'g, LLC, Modesto, Cal.) Sept. 2014, at 1, http://www.smithlaw.com/media/alert/265_acnews0914Bobbitt.pdf.

joint and several liability because there are many providers jointly coordinating and offering care to a given patient or Medicare beneficiary.²⁰⁶

2. Direct and Institutional Liability

Traditionally, physicians were the actors within the health care system that felt the most pain from the medical malpractice lawsuit pinch. With the wave of consolidation and the PPACA, the pinch may be shifted to modern MCOs within the industry.²⁰⁷ Even without claims against the individual physician, organizations that manage patient care, MCOs, are responsible when their actions directly result in adverse or harmful consequences.²⁰⁸ When injury results from negligent staff, poor physician credentialing, or substandard monitoring, an MCO could be held directly liable.²⁰⁹ Furthermore, defective policies and procedures that lead to adverse decision making may lead to an MCO's direct liability.²¹⁰

Additionally, hospitals and other health care entities are subjected to institutional liability when the policies or direct actions of those entities proximately cause a plaintiff's injuries.²¹¹ Direct corporate negligence, or institutional negligence, was applied to an HMO in *Jones v. Chicago HMO Ltd. of Illinois*.²¹² *Jones*, the first case that held an HMO liable for its administrative and managerial responsibilities and duties,²¹³ was a landmark decision by the Illinois Supreme Court that demonstrated that an HMO can be liable for institutional negligence as a result of negligent care provided by a physician within an HMO's network.²¹⁴ In

206. *Id.* at 1 (“When two or more persons are ‘jointly and severally liable’ for a tortious act, each party is independently liable for the full extent of injuries stemming from that tortious act.”).

207. See Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation As a Curative Tool*, 4 DREXEL L. REV. 41, 47 (2011) (discussing the additional potential pressures faced by modern MCOs).

208. Sage, *supra* note 14, at 174.

209. *Id.*

210. See *id.* (recognizing that the court in *Wickline* failed to find negligence, but signaled the possibility of holding a third-party entity liable for defective cost-containment policies and procedures).

211. See Harvey & Cohen, *supra* note 85, at 141 (discussing instances in which hospitals are subject to institutional liability).

212. See *Jones v. Chi. HMO Ltd. of Ill.*, 730 N.E.2d 1119, 1135 (Ill. 2000) (applying institutional negligence to an HMO).

213. Bilimoria, *supra* note 184.

214. *Jones*, 730 N.E.2d at 1122, 1128; see also Bruce Japsen, *HMO Liability Increases: Illinois Justices Allow Direct Lawsuits by Patients*, CHI. TRIB. (May 19, 2000), http://articles.chicagotribune.com/2000-05-19/news/0005190241_1_managed-care-plans-primary-care-doctors (discussing the landmark decision in *Jones*).

Jones, the plaintiff brought a medical malpractice suit against her HMO after the plaintiff's infant child sustained permanent brain damage as a result of the physician's failure to diagnose an ear infection and subsequent bacterial meningitis.²¹⁵ The plaintiff alleged that the defendant HMO was liable for the baby's injuries because it negligently assigned more patients to the physician—who misdiagnosed the plaintiff's baby—than he was capable of serving.²¹⁶ The court found that the HMO could be liable under institutional negligence for assigning more patients to the physician than he could handle because the physician had almost double the amount of patients compared to the numbers of other primary care physicians,²¹⁷ and a jury could reasonably discern that the plaintiff's baby's injuries "resulted from [the physician's] inability to serve an overloaded patient population."²¹⁸

A recent 2014 settlement in Nevada, in an amount of \$2.5 billion, demonstrates the disastrous effects that can result from the negligent management over a health care system.²¹⁹ The settlement resulted from a suit against Health Plan of Nevada, an HMO, for its alleged negligence in including a harmful and substandard endoscopy clinic on its list of approved providers and for failing to monitor the health care services delivered by its approved health care providers.²²⁰ Nevada's largest hepatitis C outbreak was linked to one of the HMO's approved providers—the endoscopy clinic operated by the physician Dr. Dipak Desai.²²¹ The low-cost services that Dr. Desai's clinic offered were attractive to any cost-conscious HMO, but Dr. Desai cut many corners and failed to provide safe care.²²² For example, the clinic failed to disinfect equipment, performed swift and unsafe procedures, and

215. *Jones*, 730 N.E.2d at 1123.

216. *Id.* at 1132.

217. In *Jones*, the physician that failed to diagnose the plaintiff's baby's ear infection managed more than 6000 patients, but the plaintiff's expert testified that an HMO normally does not assign more than 3500 patients to a single primary care physician. *Id.*

218. *See id.* at 1132–34 (finding that the HMO "had a duty to its enrollees to refrain from assigning an excessive number of patients" to a given physician).

219. *See* David Siegel, *United Healthcare Settled \$2.5B Hep-C Suit Before Trial*, LAW360 (Nov. 12, 2014, 1:41 PM), <http://www.law360.com/articles/595317/united-healthcare-settles-2-5b-hep-c-suit-before-trial> (discussing the recent negligent management settlement).

220. *Id.*

221. *Id.* As a result of the "greatest public health crisis ever," Dr. Desai was also criminally charged with defrauding the federal government and for second-degree murder in connection with the hepatitis C outbreak. Jeff German, *Hepatitis C Outbreak Dr. Dipak Desai Sentenced to Federal Prison for Fraud*, LAS VEGAS REV. J. (July 9, 2015, 11:17 AM), <http://www.reviewjournal.com/news/las-vegas/hepatitis-c-outbreak-dr-dipak-desai-sentenced-federal-prison-fraud>.

222. *See* Siegel, *supra* note 219 (discussing the basis for the settlement).

injected inadequate doses of sedatives—practices that led to the hepatitis C outbreak and subsequent class action litigation.²²³

A plaintiff's claim that an ACO's cost-containment policies or utilization goals proximately caused that patient's injuries may subject the ACO to a type of institutional liability.²²⁴ This is significant because as more physicians begin to enter into ACOs, and more services are reimbursed through "bundled" payments,²²⁵ physicians will likely become salaried employees of the corporation and not independent contractors, and consequently, institutional liability could be imposed on the ACO more readily.²²⁶

Furthermore, ACOs are health care providers subjected to likely institutional and direct medical liability if injury incurs.²²⁷ In the context of ACOs, courts may apply the direct corporate negligence theory if they find ACOs provide direct patient care, similar to hospitals.²²⁸ Whether the provider exercised reasonable care under tort law might depend on whether the physician reasonably relied on an organization's cost-containment efforts.²²⁹ Due to the control an ACO will assert over health care providers acting within the ACO model, an ACO "will almost certainly face the prospect of liability" as a result of its cost-containment initiatives and waste reductions requirements.²³⁰

Most cases relating to MCOs will not, hopefully, involve a public outbreak of hepatitis C similar to the case in Nevada,²³¹ but it is apparent that applying institutional liability to ACOs may have a "chilling effect" not only on the overall costs of liability and damages, but on the ACO structure itself.²³² The idea of shifting through an

223. *Id.*

224. See Harvey & Cohen, *supra* note 85, at 141 (noting that an ACO may be subject to institutional liability).

225. Rather than paying for services per unit, payors may reimburse providers through a one-time bundled payment for all services necessary to treat a specific condition. Suzanne Delbano, *The Payment Reform Landscape: Bundled Payment*, HEALTH AFF. BLOG (July 2, 2014), <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>. "[B]undled payments asks providers to assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications." *Id.*

226. See Furrow, *supra* note 207, at 105 (noting the vulnerability of ACOs to liability).

227. *Id.*; see also Hermer, *supra* note 98, at 295 (explaining that ACOs are subject to liability).

228. Smith, *supra* note 73, at 196; Agrawal & Hall, *supra* note 75, at 241.

229. See Randall, *supra* note 40, at 43 (outlining tort law analysis as applied to cost-containment efforts).

230. Hermer, *supra* note 98, at 295.

231. See Siegel, *supra* note 219 (discussing the hepatitis C case in Nevada).

232. Harvey & Cohen, *supra* note 85, at 141 (arguing that asserting institutional liability onto an ACO will result in increased discovery, complexity, costs, and medical malpractice claims).

entity's books or an ACO's boardroom in order to discover policies that are inherent in an ACO model, but could lead to potentially harmful quality results, constitutes a major threat to the ACO structure.²³³ For instance, the potential for an ACO beneficiary to allege that an ACO policy such as physician incentive payments, a policy built into the ACO structure, proximately caused an injury, is a daunting risk that ACOs will face if courts implement institutional liability.²³⁴ As owners of an ACO entity, individual physicians will be indirectly responsible for the claims against the entity, subjecting those physicians to increased liability.

3. Vicarious Liability

Under the theory of vicarious liability, a “blameless” person may be liable for the negligent acts of another as a result of their relationship; this is a potential result for MCOs.²³⁵ Courts have traditionally applied vicarious liability, through the theory of respondeat superior, to hold employers liable and wholly responsible for the negligent acts of their employees.²³⁶ Therefore, HMOs have been held vicariously liable for the acts of employed physicians through respondeat superior.²³⁷ Additionally, HMOs can even be held liable for the negligent acts of *non-employee* physicians through the theory of ostensible (or apparent) agency.²³⁸

In *Petrovich v. Share Health Plan of Illinois, Inc.*, the Illinois Supreme Court, in ascertaining whether an HMO may be held liable for medical malpractice—an issue of first impression for Illinois—held that an HMO can be vicariously liable for medical malpractice of an

233. See Feldman, *supra* note 15, at 1088 (noting threats faced by ACOs).

234. See Harvey & Cohen, *supra* note 85, at 141 (alleging that the threat of institutional liability will cause providers to fear the daunting medical malpractice system, resulting in a major hesitation to commit to a full cost-containment ACO model).

235. See Chaudhuri, *supra* note 56, at 63 (noting that imposing vicarious liability on a “blameless” actor relates in large part to the amount of control the “blameless” actor has on the negligent tortfeasor). The three theories of respondeat superior, apparent agency, and nondelegable duties all fall under the vicarious liability umbrella and have subjected HMOs to liability. *Id.* The theory of respondeat superior and the subsequent “control test” are typically applied within the employer-employee context wherein the employer has the ability to not only absorb the cost but distribute the cost to society. *Id.*

236. See Sage, *supra* note 14, at 173 (explaining that courts typically apply the theory of vicarious liability to hold employers liable for the actions of their employees).

237. *Id.* at 174.

238. See *id.* (noting that when an HMO “holds itself out” as having a high-quality health care system filled with a great staff, an HMO can be held liable for the staff's negligent acts, regardless of the staff's employment status with the HMO).

independent contractor through the theories of apparent and implied authority.²³⁹ The *Petrovich* court altered the liability landscape for HMOs “by adding more theories under which members can sue managed care plans for negligence.”²⁴⁰ The plaintiff in *Petrovich* brought suit against her physician, an independent contractor, and the HMO alleging negligence in the physician’s failure to timely diagnose cancer.²⁴¹ The defendant HMO was an entity that paid for the medical care by contracting with physicians as independent contractors.²⁴² Although vicarious liability cannot be applied to the actions of independent contractors, the doctrine of apparent authority may be imposed on HMOs, thus creating vicarious liability.²⁴³ The court also allowed liability to be imposed on the HMO based on the theory of implied authority because when “an HMO effectively controls a physician’s exercise of medical judgment, and [if] that judgment is exercised negligently, the HMO cannot be allowed to claim that the physician is responsible for the harm that results.”²⁴⁴ Under *Petrovich*, organizations are accountable for their agents’ tortious actions and thus liable. This holding will require attention from various MCOs now that the threat of a lawsuit will “counterbalance the HMO goal of cost containment.”²⁴⁵

Contrary to the Illinois Supreme Court decision in *Petrovich*, the New York Supreme Court, Appellate Division, in *Jones v. U.S. Healthcare*, held that an HMO could not be held vicariously liable for the malpractice of the doctors and the hospital because they were independent contractors.²⁴⁶ The plaintiff in *Jones* brought suit under the theory that the defendant HMO was vicariously liable for the doctors’ and hospital’s malpractice in prematurely discharging the patient.²⁴⁷ The HMO did not initially permit the patient to remain

239. *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756, 760 (Ill. 1999).

240. *Bilimoria*, *supra* note 184.

241. *Petrovich*, 719 N.E.2d at 760.

242. *Id.* at 763.

243. *See id.* at 765 (noting that in order to prove apparent authority, the patient must prove “(1) that the HMO held itself out as the provider of health care, without informing the patient that the care is given by independent contractors, and (2) that the patient justifiably relied upon the conduct of the HMO by looking to the HMO to provide health care services, rather than to a specific physician”).

244. *See id.* at 772 (noting that an HMO may exert so much control over a physician that the physician’s status as an independent contractor may be negated; however, that is determined on a case-to-case basis).

245. *Id.* at 764.

246. *Jones v. U.S. Healthcare*, 723 N.Y.S.2d 478, 489–90 (N.Y. App. Div. 2001).

247. *Id.* at 478.

admitted at the hospital for more than twenty-four hours, but the court found that the doctors had independent authority in the discharge decision and the doctor must exercise his or her judgment in deciding whether a patient's admission at a hospital for more than twenty-four hours is "medically justified."²⁴⁸

While it is not conclusive whether courts will hold MCOs vicariously liable, the courts that have held MCOs vicariously liable in the past determined that MCOs (as the principal) are only vicariously liable for a physician's (as the agent) negligent act if the physician's negligent act occurred within the scope of the physician's employment and it can be proven that the MCO exerted direct control over the physician.²⁴⁹ MCOs are generally not held liable under the theory of vicarious liability when the physician is not employed or when the MCO's control over the physician is based on the MCO's indirect influence through utilization review or financial incentives.²⁵⁰ Various courts appear to apply different theories of liability under which injured patient-members of HMOs could sue their HMO for medical malpractice.²⁵¹ Physicians, individually and as a member of a MCO, are exposed to increased medical malpractice liability when they deliver managed care in such a liability framework.²⁵² Consequently, defining a solution that incentivizes physicians to participate in managed care is essential to ensure managed care's survivability in the health care system.

C. Solutions

The physicians acting within an ACO not only bear the financial risk in coordinating patient care, but they also will likely bear the liability risk when the coordination fails. ACO membership could instigate many financial and legal obligations, duties that cause physicians to consider whether participation in an ACO is in their best interest. The ACO model cannot achieve the PPACA's goals unless physicians are incentivized to not only participate in the ACO model, but also to actively coordinate and manage patient care. Therefore, identifying a solution that encompasses the PPACA's quality and cost-containment

248. *Id.*

249. Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. Rev. 1929, 1944 (2003).

250. *See id.* (discussing limitations to MCO vicarious liability).

251. *See* Bilimoria, *supra* note 184 (noting that courts apply different theories of liability under which HMOs can be sued).

252. Dionne Koller Fine, *Physician Liability and Managed Care: A Philosophical Perspective*, 19 GA. ST. U. L. REV. 641, 643 (2003).

goals, but also encourages physician participation is imperative.

There are many solutions that have been proposed,²⁵³ but a solution has not been identified that will provide the correct mechanism to invoke physician participation as well as produce the high-quality care that the PPACA and the nation seek. The most-discussed solution in the realm of managed care entities is enterprise liability. Although the discussion of enterprise liability seemed to disappear with the health care reform bill in the 1990s,²⁵⁴ the discussion has had a recent resurgence in the ACO context.²⁵⁵ Within the traditional health care system, balancing the threat of medical malpractice and cost-containment initiatives appears to be ineffective and at times, impossible. Enterprise liability can potentially eliminate one of those factors, the threat of medical malpractice on a physician.²⁵⁶

Implementation of enterprise liability would effectively eliminate medical malpractice liability, null the legal standard of care, and create immunity for the physicians practicing within the given entity. The threat of medical malpractice liability is an inevitable stress for physicians. By eliminating that threat, enterprise liability could provide an enticing solution for physicians nervous about expanded medical malpractice liability.²⁵⁷ However, the implementation of enterprise liability could potentially produce counteractive consequences.

A physician's moral agent is medical malpractice liability, bound in

253. Some of the main solutions include a limitation of damages in negligence cases, a no-fault insurance regime, and imposing clinical practice guidelines as the standard of care. The PPACA did not touch the medical malpractice reform when implementing ACOs, but lawmakers have the opportunity to eliminate the medical malpractice liability for physicians who follow clinical practice guidelines or evidence-based guidelines. Feldman, *supra* note 15, at 1082 (noting the missed opportunity to correlate clinical practice guidelines to the medical malpractice standard of care and the PPACA's failure to include measures implementing a medical malpractice reform). The PPACA implemented clinical practice guidelines to increase the quality of care produced by MCOs. Therefore, in order to reduce the negative implications of medical malpractice liability and still receive quality health care, clinical practice guidelines may act as a possible solution. *Id.*

254. See *supra* Part I.B.2 (discussing the history of enterprise liability).

255. See Hermer, *supra* note 98, at 273 (stating that enterprise liability has the potential to "substantially remove liability pressures from physicians, encourage teamwork among health care practitioners, urge creation of systemic solutions to health care quality problems, and . . . compensate patients who are injured as a result of negligence"); Peters, *supra* note 95, at 369 (arguing for the adoption of enterprise liability).

256. See Kristie Tappan, *Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform*, B.C. L. REV. 1095, 1098 (2005) (noting that enterprise liability would effectively "shift liability entirely away from individual healthcare providers to hospitals or similar institutions").

257. *But see* Peters, *supra* note 95, at 369 (arguing that elimination of the theory of enterprise liability from the discussion of medical malpractice liability is a serious mistake).

the tort law system.²⁵⁸ Medical malpractice liability effectively incentivizes physicians to make moral judgments with the acknowledgement that they will be held accountable for negative consequences.²⁵⁹ Although the enterprise theory of liability would reduce a physician's fear of a medical malpractice suit,²⁶⁰ a complete elimination of accountability could potentially decrease the quality care.

Enterprise liability is demonstrated in many employer-employee relationships when the business is held liable for the injuries resulting from the individual carelessness of a worker.²⁶¹ Unlike custodial crews, janitors, and assembly line workers,²⁶² physicians are typically required to exercise individual medical judgment and typically enjoy freedom from enterprise oversight.²⁶³ The United States experienced the negative consequences that result when a third party attempts to hinder physician medical decision making in the context of HMOs.²⁶⁴ Enterprise liability is an attractive model because of its ability to eliminate medical malpractice liability for a physician. Yet, it could also simultaneously eliminate physician autonomy, rendering similar consequences that derived from HMOs' control over physician decisions.

Physicians enjoy professional autonomy, but professional autonomy is also necessary in promoting safe, quality care in the health care industry. In *Wickline v. State of California*, a third-party payor discontinued the plaintiff's hospital admission eligibility and the plaintiff was subsequently prematurely discharged from a hospital, causing injuries that later resulted in the amputation of the plaintiff's leg.²⁶⁵ Although the plaintiff's physician concluded that it was

258. Gonzalez, *supra* note 33, at 738.

259. *Id.*; cf. Anderson, *supra* note 42, at 347 (claiming that medical liability will not deter a physician's actions because the industry argues that "[a] severely injured plaintiff is likely to be compensated in court whether or not the doctor was at fault").

260. Tappan, *supra* note 256, at 1116-17.

261. Peters, *supra* note 95, at 373 (concluding that "liability for individual error is never born [sic] exclusively by the person who made the error"—rather, it is usually shifted to the corporate entity). Since the 1970s, enterprise liability has been a concept within the legal world. See Furrow, *supra* note 207, at 101.

262. See Peters, *supra* note 95, at 373 (arguing that in most business arenas, the enterprise is held liable under a theory of enterprise liability when, for example, a shopper slips on a pickle jar in the store or when a defective weed-cutter malfunctions, creating injury, even though the janitor or assembly-line worker was individually negligent).

263. *Id.* at 373.

264. See *supra* Part I.B (discussing the consequences that result when a third party attempts to hinder physician medical decision making in the context of HMOs).

265. *Wickline v. California*, 239 Cal. Rptr. 810, 811 (Cal. Ct. App. 1986).

“medically necessary” for the plaintiff to remain admitted to the hospital, the third-party payor denied the request for the extension of stay and the plaintiff was subsequently discharged.²⁶⁶

The plaintiff received medical benefits under California’s Medi-Cal Act (“Medi-Cal”), a medical assistance program.²⁶⁷ Medi-Cal required a prior authorization for medical services before payment on a patient’s Medi-Cal benefit plan.²⁶⁸ The third-party payor’s cost-containment initiatives caused the discontinuation of the plaintiff’s eligibility for hospital stay reimbursements, which subsequently caused the plaintiff to be discharged. However, the California Court of Appeals reversed the jury finding of liability and held that the “decision to discharge is . . . the responsibility of the patient’s own treating doctor”; the physician was liable, not the third-party payor, because the physician did not protest the third-party payor’s denial of the hospital stay extension.²⁶⁹ The court further found that a third-party payor, as a matter of law, cannot be held liable for injury that result from inappropriate medical decisions, even if those “medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms.”²⁷⁰

The *Wickline* court attempted to illustrate that while cost-containment measures may inherently impact medical decisions, they should not corrupt medical judgment.²⁷¹ Yet, the effect of this decision led physicians to disregard the newly implemented cost-containment initiatives of MCOs because the threat of medical malpractice liability was too high. *Wickline* demonstrated that physicians are legally held as the primary medical decision makers, but whether physicians are in reality the primary medical decision makers is questionable.²⁷²

266. *Id.* at 815.

267. *Id.* at 812.

268. *Id.*; Stephen J. Schanz, Case Note, *Wickline v. State of California: Closing the Door of Third-Party Payor Liability?*, 22 TORT & INS. L.J. 331, 331 (1987).

269. *Wickline*, 239 Cal. Rptr. at 819.

270. *Id.*; Schanz, *supra* note 268, at 331. A third-party payor, however, can be held liable when “medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient’s behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.” *Wickline*, 239 Cal. Rptr. at 819. Therefore, the appellate court in *Wickline* did not eliminate all causes of action against third-party payors that stem from medical injuries resulting from the review process. Frankel, *supra* note 6, at 1305.

271. *Wickline*, 239 Cal. Rptr. at 820.

272. See Schanz, *supra* note 268, at 335 (recognizing that even with an increase of health care cost-containment programs and models, physicians are not only the primary decision makers in terms of patient health care, but they “are faced with primary exposure for negligent decisions

Wickline also shows the negative effects that can result when the various stakeholders fail to have aligned incentives. A successful system will only result when the incentives of patients, physicians, hospitals, and insurers are aligned.

The *Wickline* court was the first to approach the newly implemented cost-conscious health care system.²⁷³ In *Wickline*, the continued hospital stay would have resulted in additional costs, but it also would have prevented the injury and loss of a leg. A health care system's cost-containment efforts must align within quality goals and physicians must be held accountable for the injuries that result when cost-containment goals are prioritized over quality.

Enterprise liability may appear attractive to practicing physicians, especially after court decisions like *Wickline*,²⁷⁴ in that they would not be held individually liable, neither financially nor professionally, for medical malpractice. Enterprise liability can effectively remove the medical malpractice liability pressures, an attractive, and likely incentivizing, idea for physicians.²⁷⁵ Nonetheless, the enterprise liability model is not an attractive model in terms of reaching the current health care industry's goals of patient safety and quality care.²⁷⁶ In the current health care reform, patient safety and quality care must be the reformers' primary objective.²⁷⁷ Therefore, just as enterprise liability was originally discarded in large part due to physicians' fear of

relating thereto").

273. Frankel, *supra* note 6, at 1306.

274. *Wickline*, 239 Cal. Rptr. at 820.

275. See Hermer, *supra* note 98, at 273 (noting that in the era of health care consolidation, consolidating liability for all health care providers within an ACO through a theory of enterprise liability may be the answer to how ACOs should be held accountable "as a means of rationally revamping our medical liability system"); Peters, *supra* note 95, at 369 (noting that enterprise liability, specifically in the hospital context, is a more effective theory of liability in reducing the extreme fear of personal medical malpractice liability that practicing physicians face). Yet, liability pressures might not be easily removed. Overall, society's

[f]ear of litigation has undermined our freedom to make sensible decisions. Doctors, teachers, ministers, even little league coaches, find their daily decisions hampered by legal fear Law is supposed to set the boundaries of legal action, so that people know where they stand. Law should make us feel comfortable doing what's reasonable and nervous doing what's wrong. Today Americans are nervous doing almost anything.

Anderson, *supra* note 42, at 349 (citation omitted).

276. See THOMAS BAKER, THE MEDICAL MALPRACTICE MYTH 98 (2005) ("Malpractice lawsuits promote patient safety both through visible public policy efforts and through less visible changes in hospitals and other health-care organizations.").

277. See Furrow, *supra* note 207, at 44 ("A solution that merely further limits the amount or availability of compensation to injurious person is a questionable solution.").

losing professional autonomy,²⁷⁸ enterprise liability should now be discarded because of its threat on patient quality care.²⁷⁹

D. Shifting the Discussion to Medical Malpractice Insurance

Although ACOs may incorporate more risk, the ACO structure may also act as “a prospect of a greater reward,” incentivizing participation.²⁸⁰ As ACOs continue to grow, creating a larger risk pool, the decision to assume more of their own entity’s risk may be a potential alternative, and ACOs could do so by potentially taking on the role as their own insurer.²⁸¹

Two professors originally developed the theory of enterprise liability as a result of their study for the American Law Institute.²⁸² They noted that enterprise liability was created as a method that can effectively diminish the number of participants involved in a malpractice suit.²⁸³ Significantly, they further noted that the theory of enterprise liability was initially “designed to create a bigger insurance pool from which to compensate the victim of negligence.”²⁸⁴ The theory of enterprise liability was devised as a method to spread risk and to increase the number of participants in an insurance pool; therefore, a reform mechanism that encompasses medical insurance rather than medical liability theory may act as a better solution to the current health care liability problems.

278. See *supra* text accompanying notes 97–99.

279. See Randall, *supra* note 40, at 34 (“[I]f cost containment becomes simply an excuse for sacrificing quality care, those whose benefit should be the focus of the entire system—the patients—will suffer.”).

280. Jason Kimpel & Nick Manetto, *Final ACO Rules and How Captives Could Play a Role*, D.C. CAPTIVE INS. NEWSL., Fourth Quarter 2011, at 7, <http://www.faegrebdc.com/webfiles/ACO%20Rules.pdf>; see Hermer, *supra* note 98, at 298–99 (noting that insuring via a captive insurance company allows excess premiums to either be held in reserve, invested, or distributed to the insureds as a profit).

281. See Harvey & Cohen, *supra* note 85, at 142 (noting that an ACO acting as its own insurer could result in a model such as Partners HealthCare’s acquisition of Neighborhood Health Plan, resembling MCOs, and potentially earning a preemption from state law malpractice claims pursuant to ERISA). Furthermore, creative health care provider models will require the development of creative and effective insurance programs. MARSH & MCLENNAN COS., *supra* note 19, at 9. Coordinated care will likely lead to a decreased risk in traditional exposures, but it will likely simultaneously create increased risk in unknown areas inherent with the implementation of a new health care model. *Id.*

282. Fritz & Savage, *supra* note 21. See generally REPORTERS’ STUDY: ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY (AM. LAW INST. 1991) (discussing the development of the theory of enterprise liability).

283. Fritz & Savage, *supra* note 21.

284. *Id.*

Attempting to reform the health care system by focusing on liability is an inefficient and inadequate response to the medical malpractice “crisis.”²⁸⁵ Health care reforms will not effectively improve medical malpractice until first addressing the overarching medical malpractice insurance problem.²⁸⁶ Driving the reform discussion toward implementing a new liability theory has failed to gain traction;²⁸⁷ as such, discussing a new insurance theory appears worthwhile.

IV. PROPOSAL

The United States has struggled to achieve the ultimate goal of low-cost, high-quality health care.²⁸⁸ The tort system produces a compensatory effect,²⁸⁹ therefore eliminating its deterrent presence within the health care system will prove harmful. While solely relying on the tort system to reform the health-care system might induce quality care, the low-cost goal will likely falter.

It is undeniable that the traditional fee-for-service system cannot achieve the PPACA’s low-cost goals. Therefore, entities such as ACOs, which manage the care of a large patient population, have the greatest potential amongst the current health care models to achieve the goals of the PPACA.²⁹⁰ Although the MSSP likely will succeed in incentivizing

285. Sage & Kersh, *Introduction to MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM*, *supra* note 94, at 1, 5.

286. *Id.* at 5; see Fritz & Savage, *supra* note 21 (demonstrating the incomplete response of a tort reform without an insurance response—“while malpractice insurance premiums rose during the 1980s, the number of malpractice suits actually fell”). Medical malpractice raises concern because of the increasing premium costs; therefore, “medical liability insurance deserves careful attention in any discussion of medical malpractice reform.” Thomas Baker, *Medical Malpractice Insurance Reform: “Enterprise Insurance” and Some Alternatives*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM*, *supra* note 94, at 267, 277.

287. See Frankel, *supra* note 6, at 1299–300 (recognizing that proposals such as the implementation of enterprise liability and the abolition of joint and several malpractice liability “have responded far more to their drafters’ need to negotiate interest-group support than to the dramatic changes in the institutional structure of American health care brought about by the last decade’s crisis in medical costs”).

288. See Karen Davis et al., *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, COMMONWEALTH FUND (June 16, 2014), <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror> (noting that although the “United States health care system is the most expensive in the world . . . the [United States] fails to achieve better health outcomes than the other countries”). The United States ranks last out of eleven nations overall when comparing efficiency, equity, and health care outcomes. *Id.*

289. Hermer, *supra* note 98, at 274.

290. See Davis et al., *supra* note 288 (recognizing that while the United States did not achieve the highest scores on safety and coordinated health care, the adoption of “payment systems that reward high-quality care, and a team approach to management of chronic conditions” can improve the health care in the nation).

health care providers to produce low-cost health care, it likely will fail in shielding the providers within the ACO from liability when the quality of care inevitably decreases.²⁹¹ It is unattractive to physicians to join a health care model that not only reduces the financial return, but also increases their medical malpractice liability.²⁹² Therefore, in order to sustain the ACO model, the market must propose a solution that encourages high-quality care and ACO participation, and simultaneously assigns accountability when patient injury stems from negligent care within the ACO. In order to implement an incentivizing, yet deterrent model of care, the United States can take a “carrot-and-stick” approach.

The carrot-and-stick approach utilizes a combination of both positive and negative reinforcements to motivate a person’s behavior.²⁹³ Ascertaining the most effective carrot-and-stick approach within the health care system to provide effective results, however, has proven to be a difficult and unsuccessful task.²⁹⁴ ACOs will fail without the voluntary memberships of providers and will not succeed unless the ACO’s goals and the providers’ goals align.²⁹⁵ Quality inherently diminishes when providers are incentivized to produce low-cost health care. Implementing a concept called enterprise insurance within an ACO could align the two sets of marching orders by creating incentives not only for low-cost care, but for high-quality care as well.²⁹⁶

A. The Concept of Enterprise Insurance

The concept of enterprise insurance provides insurance coverage for all liabilities, including medical malpractice liability, which would arise out of services performed within the scope of a specific practice.²⁹⁷

291. See *supra* Part II.A.2 (discussing the quality of ACOs).

292. Mark E. Wilson & Rose Willis, *Physician Participation in the MSSP: The Risks May Be Greater Than the Rewards*, A.B.A. HEALTH ESOURCE (A.B.A. Health L. Sec., Chi. Ill.), Oct. 2011, https://www.americanbar.org/content/newsletter/publications/aba_health_esource_home/aba_health_esource_1110_wilson.html.

293. Michael J. Frank et al., *By Carrot or by Stick: Cognitive Reinforcement Learning in Parkinsonism*, 306 SCIENCE 1940, 1940 (2004), <http://science.sciencemag.org/content/306/5703/1940.full-text.pdf+html>.

294. See *supra* Part III.C (analyzing possible solutions).

295. See Hermer, *supra* note 98, at 291 (noting that traditional physician autonomy and the collaborative goals of the ACO will not result in a successful ACO).

296. Frankel, *supra* note 6, at 1317.

297. Baker, *supra* note 286, at 268. If a hospital utilizes enterprise insurance, the hospital’s liability insurance would cover all services that were performed in their facility. *Id.* at 268. For example, if a birth were performed at the hospital, the hospital’s liability insurance would cover any liability arising from the birth whether the liability stemmed from a failed device, a nurse’s

Therefore, this Article proposes that enterprise insurance can be implemented in the ACO context, in that the ACO would provide medical malpractice insurance coverage for participating health care providers. The ACO would, in theory, act as its own insurance company controlling the underwriting, investment, and claims.²⁹⁸

By implementing a theory of enterprise insurance within the ACO context, the ACO would not become legally liable for the negligent acts of a participating provider; rather, the ACO would simply provide liability insurance.²⁹⁹ Importantly, the concept of enterprise *insurance* differs from the recently discussed concept of enterprise *liability*.³⁰⁰ For example, under the concept of enterprise *liability*, if ACO services cause a patient's injury, the enterprise, or ACO, would formally be liable for the patient injury, eliminating any physician liability.³⁰¹ Conversely, under the concept of enterprise *insurance*, the enterprise would provide the medical malpractice insurance for its providers and would pay the damages for the patient injury.³⁰² Thus, under enterprise insurance, the ACO would provide the liability insurance, but "the legal responsibility, and corresponding moral authority, would continue to rest with the individual provider."³⁰³

Enterprise insurance takes a carrot-and-stick approach by encouraging high-quality care and ACO participation, but also by simultaneously assigning accountability when patient injury stems from negligent care within the ACO. Enterprise insurance can provide the "carrot," or the positive reinforcement, by offering financial benefits if the enterprise succeeds in producing quality care and subsequently low medical malpractice claims.³⁰⁴ Enterprise insurance can also constitute the "stick," or the negative reinforcement, because legal medical malpractice liability will still remain with the physician if an error

wrongful charting, or a physician's wrongful diagnosis. *Id.*

298. James A. Christopherson, *The Captive Medical Malpractice Insurance Company Alternative*, 5 ANNALS HEALTH L. 121, 121 (1996).

299. *Id.* at 268.

300. *See supra* Part III.C (discussing enterprise liability as a potential solution to the current health care reform).

301. Baker, *supra* note 286, at 268.

302. *Id.*

303. *Id.* Although physicians would still assume legal liability, the elimination of insurance liability within the theory of enterprise insurance would eliminate the enormous stress that results from high-cost insurance premiums that burden physicians, specifically in high-risk specialty practice. *Id.* at 279.

304. *See supra* Part IV.A.2 (discussing that money could act as the carrot in the carrot-and-stick approach).

occurs.³⁰⁵

Medical malpractice liability has an intimidating presence in the health care system.³⁰⁶ ACOs appear to be an effective and promising model to improve quality care, but malpractice liability is an additional tool that has demonstrated results in improving the quality of patient care.³⁰⁷ Physicians feel the pressure from liability, and therefore lifting that pressure could lead to drastic and harmful results.³⁰⁸

Limiting the potential for injured patients to recover is not the first or last step in a successful health care reform.³⁰⁹ If liability does not attach to individual physicians providing care within an ACO, an ACO's cost-containment incentives will outweigh any intention to provide quality care. As discussed *infra*, mandatory quality measures apply to ACOs; however, the quality benchmarks set by CMS likely will not succeed in single-handedly upholding the highest quality patient care that the industry requires and deserves.³¹⁰ Accordingly, the medical liability

305. BAKER, *supra* note 276, at 177; see *supra* Part IV.A.1 (noting that medical malpractice could act as the stick in the carrot-and-stick approach).

306. See Furrow, *supra* note 207, at 106 (claiming that medical liability may have the potential to influence the number of adverse medical events that face the modern health care system and reduce that number to zero); see also BAKER, *supra* note 276, at 93 (noting that “medical malpractice lawsuits are the reason that we know what we know about the extent of medical mistakes and injuries” and that “medical malpractice lawsuits improve patient safety”).

307. See Furrow, *supra* note 207, at 66 (noting that the PPACA strives to improve patient care with subsidies, projects, commissions, and research, but fails to implement any regulations regarding medical liability; a tool that has created beneficial pressure on health care providers to produce quality care); cf. Isaac Gorodetski, *Does Medical Malpractice Liability Lead to Better Quality Health Care?*, POINTOFLOW.COM (Aug. 3, 2012), <http://www.pointoflaw.com/archives/2012/08/does-medical-malpractice-liability-lead-to-better-quality-health-care.php> (recognizing that a study analyzing dates from 1979 to 2005 found a “statistically insignificant link between more extensive medical malpractice liability and better quality health care” and concluded that exposing doctors to greater medical malpractice liability will not result in better patient care).

308. See U.S. CONGRESS, OFF. OF TECH. ASSESSMENT, OTA-H-602, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 75 (1994) [hereinafter OFFICE OF TECHNOLOGY ASSESSMENT] (noting that the principal objective of medical malpractice liability is to deter physicians from rendering low-quality health care); see also Michael Frakes, *Does Medical Malpractice Deter? The Impact of Tort Reforms and Malpractice Standard Reforms on Healthcare Quality* (Cornell Legal Studies, Research Paper No. 12-29, 2012), <http://www.law.northwestern.edu/research-faculty/colloquium/law-economics/documents/Frakes-Medical-Malpractice-Tort-Reforms.pdf> (“Despite the fundamental role of deterrence in the theoretical justification for medical malpractice law, surprisingly little evidence has been put forth to date being on its existence and scope.”); cf. Daniel P. Kessley, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSP. 93, 94 (noting that medical malpractice litigation is meant to steer doctors into taking “appropriate precautions against accidental harm,” but that this wheel usually performs poorly).

309. OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 308, at 45.

310. See *It's Not Enough to Prove Standard of Care Was Breached: Legislation Curtails Plaintiff Attorneys' Ability to Misuse Guidelines*, AHC MEDIA (June 1, 2015), <http://www.ahc>

system remains a key component in shifting the health care model to a more comprehensive and collaborative patient safety solution.³¹¹

Medical malpractice liability's deterrent effect is a necessary component in the success story of achieving high-quality care.³¹² However, liability may threaten the survivability of the ACO structure if providers are not incentivized to participate in the ACO structure.³¹³ As a way to incentivize participation, money will likely act as the "carrot" in the proposed approach.

Physicians purchase medical malpractice insurance to manage the liability that may arise if their care causes patient injury.³¹⁴ By implementing the basic idea of enterprise insurance within the ACO model, physicians participating in the ACO could purchase medical malpractice liability coverage through the ACO rather than from a third-party commercial insurance company.³¹⁵

Purchasing medical malpractice liability insurance through the enterprise rather than from a third-party commercial insurance company will provide immediate financial benefits because third-party insurance premiums have significantly increased.³¹⁶ Third-party commercial insurance companies are in the insurance business to make a profit, but in the wave of lower reimbursements, health care providers cannot afford to continue to rely on third-party payors' profit-making approach

media.com/articles/135485-its-not-enough-to-prove-standard-of-care-was-reached (noting that any federal guidelines of quality measures are not to be construed as the legal standard of care that physicians are held to in any medical malpractice lawsuit).

311. See Furrow, *supra* note 207, at 49; see also *Hospital Errors Are the Third Leading Cause of Death in U.S., and New Hospital Safety Scores Show Improvements Are Too Slow*, LEAPFROG GROUP (Oct. 23, 2013), <http://www.hospitalsafetyscore.org/newsroom/display/hospitalerrors-thirdleading-causeofdeathinus-improvementstooslow> (noting that 440,000 Americans die each year from preventable hospital errors, placing "medical errors as the third leading cause of death in the United States").

312. See Hermer, *supra* note 98, at 274 (stating that medical liability law provides "an incentive for physicians, hospitals, and other health care providers to render careful and high-quality care, or at the very least to avoid harming patients").

313. See *supra* Part III.A (noting that ACOs will likely be subjected to increased medical malpractice liability risk).

314. BAKER, *supra* note 276, at 14.

315. *Id.* at 67; see Hermer, *supra* note 98, at 298 (noting that though enterprise insurance was not traditionally utilized, "[a]s consolidation continues in the health care sector, it is likely that enterprise insurance will also become more common"). Hermer notes that enterprise insurance has the potential to offer large financial benefits to "larger health care entities with an employed physician staff." *Id.* This Article argues that whether physicians are employed by the large health care organization or participate within the large ACO health care model, eliminating the common practice of physicians purchasing individual malpractice insurance from third-party commercial insurance companies is imperative.

316. Christopherson, *supra* note 298, at 121.

for medical malpractice insurance.

Not only will physicians have the opportunity to retrieve financial benefits from evading commercial insurance companies, if the ACO implements the concept of enterprise insurance, physicians could also receive additional financial benefits if the enterprise avoids medical malpractice claims. If the ACO and its providers limit adverse events, in effect limiting medical malpractice claims and subsequent payouts, they could potentially reap the benefits. When physicians purchase medical malpractice liability insurance through a commercial insurance company, the physician will not reclaim the payment, otherwise known as the insurance premium, if the physician does not incur medical malpractice claims that year. Contrary to the commercial insurance practices, however, ACO participants will have the opportunity to share in the distribution of savings from unused premium dollars through enterprise insurance if the frequency of adverse events decrease.

B. The Concept of Enterprise Insurance Actualized Through a Captive

An insurance-based theory of medical malpractice was not practical when physicians typically acted on their own or acted on behalf of their own small physician group because the risk pool would be too small to implement an effective insurance system. That problem has diminished in the modern and coordinated health care system, and, as such, ACOs may consider acting as an insurance company and seek a captive insurance model in order to avoid increased premiums for malpractice insurance by private insurance companies.³¹⁷

ACOs could practically implement the theory of enterprise insurance through a captive insurance structure.³¹⁸ A captive insurance company is a type of insurance company—in the form of self-insurance—that is owned by a parent company and insures the risks of that parent.³¹⁹ A captive actuarially funds liability, uses an established infrastructure that can effectively manage claims, and implements a risk management system.³²⁰ Instead of purchasing insurance from a commercial

317. *See id.* (noting that the steady rise of malpractice insurance premiums has forced health care providers to seek alternative sources of insurance other than the traditional large commercial insurance companies).

318. *See* Gavin Souter, *Captives Crucial to Managing Enterprise Risks*, BUS. INSIDER (Feb. 4, 2015, 12:23 PM), <http://www.businessinsurance.com/article/20150204/NEWS06/150209927> (“Captive insurers can be the foundation of an enterprise risk management program for companies seeking to advance their risk management strategies.”).

319. Richard M. Colombik, *Captive Insurance Companies for Closely Held Business and Their Owners*, 19 EXPERIENCE, No. 1, 2009, at 42.

320. Robert W. Mulcahey, *Private Responses to the Crisis*, 13 ANNALS HEALTH L. 617, 622

insurance company, including medical malpractice insurance, the health care organization—an ACO in this case—could create a subsidiary that assumes some or all of the organization’s medical malpractice financial liability through direct insurance or reinsurance.³²¹

A commercial insurance company assesses risk from the year’s medical malpractice lawsuits, including the few, but damaging, large verdicts and settlements that occurred in many different health care organizations over the year.³²² A captive, on the other hand, assesses risk from its own medical malpractice lawsuits in a year, and therefore assesses its own loss history instead of the industry’s loss history.³²³ A captive could act as a great solution to rising malpractice insurance premiums as well as provide financial benefits to physicians in small physician groups participating in a given ACO model.³²⁴ A successful captive requires the “right attitude and long-term view going into them”³²⁵ and the overall long-term and innovative theory behind ACOs and the PPACA generally support the requisite mind frame. Implementing enterprise insurance through a captive can result in many advantages, including financial benefits and control and subsequent quality care.

1. Financial Benefits

The theory of enterprise insurance within an ACO promotes many benefits in reaching the PPACA’s goals of patient safety and quality care.³²⁶ Although the United States might not be facing a “medical malpractice crisis,”³²⁷ premium costs for medical malpractice insurance

(2004).

321. Christopherson, *supra* note 298, at 121.

322. *Id.* at 123.

323. *Id.*

324. *See id.* at 140 (noting a health care organization can add value and attract physicians with a captive through its ability to offer reduced medical malpractice premium rates); *see* Anderson, *supra* note 42, at 345 (recognizing that the high malpractice insurance premiums have left some physicians uninsurable). Yet, tax-exempt organizations, like an ACO, must recognize that unrelated business income is taxable and therefore a captive may “jeopardize the system’s tax-exempt status.” Christopherson, *supra* note 298, at 140.

325. Mulcahey, *supra* note 320, at 622.

326. Anesthesiology is one medical specialty that undertook a complete safety reform in the wake of consistent and large medical malpractice lawsuits. BAKER, *supra* note 276, at 92. “Anesthesiology has become safer, and anesthesiologists now pay less for malpractice insurance than most of their hospital-based colleagues.” *Id.*

327. *Id.* at 1; *cf.* Anderson, *supra* note 42, at 347 (noting that the “volume of malpractice litigation alone is sufficient to qualify as a crisis,” but also that average medical malpractice claims are increasing at “unprecedented rates”).

are increasing.³²⁸ The high-level premium prices place a stress upon the industry because even with fluctuating insurance premium prices, base premiums do not decrease to the original level and physician compensation shows no sign of an increase to match the rising insurance premiums.³²⁹

Physicians spend more than \$6.4 billion a year on insurance premiums and hospitals spend half of that amount.³³⁰ The excessive amount that physicians spend on medical malpractice insurance up front will likely not decrease with the implementation of ACOs, but participants in ACOs would recover unused premium money on the back end if malpractice claims within an individual ACO were lower than anticipated in a given year.

Similar to other insurance systems, physicians currently pay a premium and will never see that money again regardless of whether a medical malpractice claim was filed that year. In a captive insurance system, however, physicians will spend the premium up front, but the excess premium not spent on malpractice claim payouts that would have translated to commercial insurance company profit, could now translate to profit for the ACO and for its participating physicians.³³¹

Additionally, an ACO that manages its own captive could invest the retained income from its captive's premiums and capital, which is particularly important during the period between a filed claim and when the claim is actually paid, a time period where commercial third-party insurance companies traditionally invested the health care organization's money.³³² Understandably, health care providers acting

328. Mulcahey, *supra* note 320, at 618 (noting that the cost of physicians' medical malpractice premium ranges from 15% to 100%).

329. *Id.*

330. *Understanding Medical Malpractice Insurance*, TRUSTED CHOICE, <https://www.trustedchoice.com/professional-liability-insurance/medical-malpractice/> (last visited Apr. 1, 2016).

331. This Article discusses a practical ACO that will incentivize physicians, however, it is important to remember that a single ACO will not only include physicians as participants, but large organizations such as a hospital or health plan. If an ACO does decide to follow the self-insurance or captive insurer route, one question that does arise when multiple large organizations are included in a single entity is whether the ACO will be "able to retain similar risk." Switzer, *supra* note 22, at 34. This question emerges within the discussion of ACOs and captive insurance because large organizations like hospitals and health plans might already retain their own liability risk through a self-insurance trust or captive insurer. *Id.* Although inclusion of a larger health care organization might raise additional questions, the involvement of larger health care organizations within an ACO is imperative. McClellan et al., *supra* note 6, at 983. "Hospitals should be encouraged to participate, because improving hospital care is likely to be essential to success." *Id.*

332. See Christopherson, *supra* note 298, at 123 (recognizing that when a captive invests its loss reserves, that investment can produce large returns due to the long period of time that

within the ACO model will continue to practice the traditional and costly way unless the ACO model imposes financial incentives to encourage a different practice model.³³³ ACOs would likely find appealing the financial return that could result from a captive insurance company.³³⁴

ACOs are meant to encourage broad participation from various actors within the health care system.³³⁵ Although individual physicians in a private practice cannot practically set up a captive, individual physicians that participate in an organization that shares risk between hospitals, health systems, health plans, and other physicians would presumably find the benefits of a captive attractive. Due to the unique structure of an ACO and the various actors involved in a single ACO model, an ACO has the potential to achieve the goal of effectively spreading risk across a spectrum.³³⁶ Furthermore, with the major health

medical malpractice claims take to resolve).

333. See Noah, *supra* note 60, at 1229 (noting that moderate financial incentives have the potential to change physician behavior).

334. GEORGE O'DONNELL, AON CONSULTING, EMPLOYEE BENEFIT CAPTIVES: THEIR ROLE IN MANAGING ENTERPRISE RISK 2 (2008), http://www.aon.com/about-aon/intellectual-capital/attachments/human-capital-consulting/Benefits_Captives_041608.pdf. There are three ACO models that are part of systems that self-insure for their employees and their employees' families—this Article discusses a self-insurance model regarding medical malpractice for the health care providers within an ACO. SHARON SILOW-CARROLL & JENNIFER N. EDWARDS, COMMONWEALTH FUND, EARLY ADOPTERS OF THE ACCOUNTABLE CARE MODEL: A FIELD REPORT ON IMPROVEMENTS IN HEALTH CARE DELIVERY 13 (2013), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Mar/1673_SilowCarroll_early_adopters_ACO_model.pdf. One model, NewHealth, “receives 50 percent of any savings it achieves,” demonstrating the potential for savings in any ACO self-insurance model. *Id.*

335. McClellan et al., *supra* note 6, at 983.

336. See Mulcahey, *supra* note 320, at 620 (noting that physician groups, unlike hospitals, cannot manage malpractice claims within the traditional physician group infrastructure). Although the ACO's captive deals with the amount of risk and not the right amount of porridge, the overall principle behind Goldilocks and the Three Bears stands strong. A small physician group is unable to effectively control a captive and effectively save money through an enterprise insurance model because the risk pool is too small. A large commercial insurance company is unable to sustain low-cost medical malpractice insurance premiums because commercial insurance companies insure other lines of insurance, not just medical malpractice, and as such the risk pool is too large. Evidence of this fact is that “two percent of claims are responsible for about half of the compensation provided to plaintiffs,” but only two percent of physicians are responsible for the large claims. Anderson, *supra* note 42, at 346. By creating its own captive, an ACO could utilize its large pool of participants and spread risk better than an individual physician group. Christopherson, *supra* note 298, at 124. Additionally, ACOs could manage purely medical malpractice claims, contrasting a commercial insurance company that manages a variety claims. See *id.* (recognizing that a health care entity's captive can manage claims more effectively and can efficiently reduce total costs); Charles K. Whitehead, *The Goldilocks Approach: Financial Risk and Staged Regulation*, 97 CORNELL L. REV. 1267, 1295 (2012) (noticing that in the “Goldilocks world,” the correct option “should not be too strong or too weak

care providers participating in a given ACO, a unified malpractice insurance company allows for a “unified legal defense among multiple defendants,” potentially eliminating the excessive costs and time that correlate with a multi-defendant lawsuit.³³⁷

2. Control and the Subsequent Quality

A captive may also be an attractive option for an ACO because they allow corporate control over the captive; reduce premiums that do not reflect profits for commercial insurers or expenses related to any other non-associated risk and for for-profit corporations permit tax deductions on premiums paid to the captive.³³⁸

A captive that is managed and controlled by an ACO could better reduce total losses and could manage claims within the individual entity compared to a commercial insurer.³³⁹

Due to its large infrastructure and increased access to greater resources, the ACO will have the ability to control adverse events.³⁴⁰ The ACO would, in theory, act as its own insurance company controlling the underwriting, investment, claims, and quality of the captive insurance company.³⁴¹ This control would allow an ACO and health care providers participating in the ACO to reduce their “risk-funding costs.”³⁴² The ACO would continue to pay premiums, but the premium money would be controlled by the ACO and distributed to the ACO instead of a third-party commercial insurance company.³⁴³

but should strike a balance that is ‘just right’); see Nathan A. Adams, *Florida’s Blame Amendment: Goldilocks and the Separate but Equal Doctrine*, 24 ST. THOMAS L. REV. 1, 18 (2012) (identifying the “Goldilocks Principle” as the idea that “something must fall within certain margins, as opposed to reaching extremes, to be valid”).

337. Christopherson, *supra* note 298, at 122; see Fritz & Savage, *supra* note 21 (noting that one cause of high-price malpractice suits is the number of defendants and the number of attorneys involved in a single suit); see also O’Connell & Neale, *supra* note 64, at 288 (recognizing that one of the reasons that the current medical malpractice system inadequately provides recovery potential for victims is the “tremendous transaction costs upon all concerned”).

338. Eleanor D. Kinney, *The Potential of Captive Medical Liability Insurance Carriers and Damage Caps for Real Malpractice Reform*, 46 NEW ENG. L. REV. 489, 497 (2012).

339. Christopherson, *supra* note 298, at 123.

340. See Bill Asyltne et al., *Accountable Care Organizations—Physicians/Hospital Integration*, HEALTH LAW., Aug. 2009, at 2, 8 (noting that ACOs have the potential to unite the sometimes conflicting interests of physician and hospitals, and to maintain “an infrastructure to collect and measure the efficiency and quality of care delivered . . . achieving better results in public reporting of quality and costs”).

341. Christopherson, *supra* note 298, at 121.

342. See *id.* (noting that if a captive effectively manages their organization’s risks, the organization can reduce the overall cost of insurance by eliminating the overheard costs of commercial independent insurance companies).

343. Even though the captive is a separate subsidiary or a sister corporation, the insured, the

C. The Implementation of Enterprise Insurance Would Be Successful

Enterprise insurance would be successful because previous health care entities that have similar characteristics of enterprise insurance existed. An entity functioning as the insurer and the health care provider is not a novel idea: the traditional HMO model also functioned as both the health insurer and health care provider.³⁴⁴ HMOs received a monthly fee for each patient enrollee, which the HMO managed and spent in providing health care services to the patient. Although the cost of an HMO enrollee's health care was set for a given period, if the HMO did not utilize the entire expected cost set out for a specific enrollee, the difference between the paid cost and the utilized cost was retained by the HMO, and "[t]herefore, many HMO doctors earn[ed] more if they prescribe[d] less care."³⁴⁵ In effect, if less care was provided, the HMO, acting as the health insurer, would retain more money because less claims for health care services were submitted. The HMO model's inherent practice of less care in an attempt to retain more money led to predictably negative results.³⁴⁶

If, however, the ACO model acts as the medical malpractice insurer instead of the patient health insurer, the ACO would retain more money not for less care, but for less malpractice claims. Shifting the focus from less care to better care with an ACO model of enterprise insurance would likely produce overall positive outcomes.³⁴⁷

The cyclical nature of medical malpractice insurance premiums produces yet another reason why enterprise insurance through a captive may act as a practical and effective model.³⁴⁸ It was "financial trends and competitive behavior in the insurance industry" that originally caused the increased medical malpractice insurance premiums.³⁴⁹ The

ACO in this case, has a "high degree of control" over the insurer, the captive. *Id.* The ACO would be "directly involved in major decisions made by the captive regarding underwriting, investment policies, claims management, and quality improvement." *Id.*

344. Noah, *supra* note 60, at 1223.

345. Steven R. Buchholz, *Health Maintenance Organization's Gatekeeper: Opening the Gate to Liability Through Ostensible Agency Theory*, 21 W. ST. U. L. REV. 241, 242 (1993).

346. Noah, *supra* note 60, at 1228; see Alan L. Hillman et al., *HMO Managers' Views on Financial Incentives and Quality*, 10 HEALTH AFF. 207, 207 (1991) ("The U.S. General Accounting Office (GAO) has cautioned that some financial incentives may reduce quality of care in HMOs.").

347. See Noah, *supra* note 60, at 1228 (noting that improving access to care and lowering costs of care are important initiatives, but a health care solution must also address quality care).

348. See BAKER, *supra* note 276, at 3 (noting that "frivolous litigation or runaway juries" do not drive the increased medical malpractice insurance premiums, but rather the overall market causes the insurance's cyclical increase).

349. *Id.*

litigation environment, lawyers, and injured patients were simply the messengers, not the cause, of the medical malpractice crises that occurred in the 1970s, the 1980s, and the early 2000s.³⁵⁰ By insuring only medical malpractice liability, the ACO's captive could eliminate the additional costs associated with insuring other types of liability. Because the captive would only insure medical malpractice liability, it would act as a practical and effective tool that could potentially generate large financial benefits to the ACO and its providers because it would avoid increased premium rates that result from the financial trends of other markets.³⁵¹

Further, there are practical ways to implement enterprise insurance. Congress has the ability to enact legislation that would require all ACOs to implement a theory of enterprise insurance. Tom Baker, a widely recognized expert on insurance law, proposed the Patient Protection and Healthcare Responsibility Act ("PPHRA").³⁵² One goal of the PPHRA is to require health care organizations to adopt the enterprise insurance theory and to "obtain liability insurance for all the medical professionals who provide services using the organization's facilities."³⁵³ Congress could enact legislation like the PPHRA, and in doing so, has the capability to drastically improve the health care system by mandating the adoption of the enterprise insurance theory as a prerequisite in creating an ACO eligible for MSSP benefits.

D. Counterarguments

Enterprise insurance presents an attractive model that could incentivize physicians to join the ACO movement as well as produce quality health care, while simultaneously holding physicians accountable if patient injury occurs. Nonetheless, if enterprise insurance were as attractive as it appears, it could be argued that the lack of its implementation thus far demonstrates a problem with the model.³⁵⁴ Accordingly, there are counterarguments to the enterprise insurance model.

350. *Id.*

351. *See id.* at 67 (noting that the enterprise insurance theory "cannot eliminate the insurance underwriting cycle, but [it] can make sure that doctors do not bear the brunt of the next hard market").

352. *Id.* at 158.

353. *Id.* at 164.

354. Hermer, *supra* note 98, at 298.

1. The Relationship Between the Lack of State Damages Caps and Captives

One argument is that captive insurance companies would not achieve the financial benefits in states that do not have medical malpractice damages caps.³⁵⁵ States that have implemented medical malpractice damages caps hope to decrease provider malpractice insurance premiums and provide the ability for captives to better manage risk.³⁵⁶ Additionally, it is argued that damages caps allow captives to quickly settle cases because both parties are aware of the maximum payout amount.³⁵⁷

States have implemented caps on damages as a way to reduce the frequency and severity of plaintiff recovery on medical malpractice claims.³⁵⁸ Additionally, damages caps are utilized as a tool for insurers to effectively predict the potential for medical liability in a given market.³⁵⁹ Consequently, damages caps could control the high cost of medical insurance by enabling insurers to provide lower medical malpractice premiums for providers because they could more effectively predict the risk and severity of a medical malpractice claim with damages caps.

By instituting a captive insurance company as a way to insure providers' medical malpractice liability, ACOs have the potential to remediate and deflect potential claims in an effective manner.³⁶⁰ An ACO can gain knowledge through damages caps to proactively remediate claims by knowing the maximum extent of liability.³⁶¹ With the imposition of damages caps, additional and grave punitive damages would not be at issue and an ACO could manage claims more effectively and just.³⁶² Therefore, implementing enterprise insurance through a captive in a state without damages caps may eliminate the ability to effectively manage risks and claims and could counteract the advantages of self-insurance. The effectiveness of the "stick" in the

355. See Kinney, *supra* note 338, at 491 (explaining that damages caps are imperative for captive insurance companies' financial success because damages caps allow captive insurance companies and health care providers to know the "full extent of their liability").

356. Clifton Barnes, *States Consider Medical Malpractice Caps . . . Again*, BAR LEADER, Sept.–Oct. 2003, http://www.americanbar.org/publications/bar_leader/2003_04/2801/malpractice_caps.html.

357. Kinney, *supra* note 338, at 491.

358. *Id.* at 493.

359. *Id.*

360. *Id.* at 499.

361. *Id.* at 500.

362. *Id.*

carrot-and-stick approach would be compromised by state implementation of mandatory damages caps. Mandatory damages caps can erode the ideal incentive scheme envisioned in the enterprise insurance proposal.

2. Enterprise Insurance Controlling Total Quality Care

Another counterargument is that the implementation of enterprise insurance is not enough to control the quality of health care inside and outside the ACO.³⁶³ The enterprise insurance concept proposed in this Article allows ACO-participating physicians to purchase medical malpractice insurance through their ACO. Medicare beneficiaries treated within an ACO, however, are only a percentage of the patients that the participating physicians treat. Consequently, the quality incentives the ACO may provide through the implementation of enterprise insurance can only be applied to a small percentage of the total patient population.³⁶⁴ Further, an ACO would be unable to implement quality standards for physicians treating patients outside the ACO.³⁶⁵

Although physicians practice both inside and outside the ACO, the ACO can draw lines in its coverage of medical malpractice liability.³⁶⁶ Physicians can purchase medical malpractice insurance through the ACO that will cover lawsuits resulting from care provided to Medicare beneficiaries within the ACO and can purchase insurance through a commercial insurer to cover lawsuits arising outside the ACO.³⁶⁷ Minor administrative complications may initially result from the purchase of two medical malpractice insurance policies,³⁶⁸ but the ability to treat certain patients inside the ACO and certain patients outside the ACO can correlate with physicians' ability to keep track of two medical malpractice insurance policies.

The purchasing of two policies does not have to be the only answer to the criticism. While the ACO only provides care to Medicare beneficiaries, it can still allow physicians to purchase through the ACO their medical malpractice insurance that covers all patient care, creating a culture of quality care. The captive has a better chance of managing

363. See Hermer, *supra* note 98, at 299 (arguing that risk and quality goals can only be achieved with the implementation of enterprise liability, rather than enterprise insurance).

364. *Id.*

365. *Id.*

366. Baker, *supra* note 286, at 289.

367. *Id.*

368. *Id.*

risk and allocating funds if there are more participants and more dollars involved. Therefore, the ACO can still act as the insurer for participating physicians even if services were provided outside the ACO.

E. The Advantages of Enterprise Insurance Outweigh the Disadvantages

Despite its possible drawbacks or flaws, the potential benefits of enterprise insurance outweigh any of its disadvantages. As previously discussed, the structure of an ACO implicates the possibility of an injured plaintiff suing multiple providers within an ACO under joint and several liability.³⁶⁹ Joint and several liability has the potential to produce damaging effects and severe consequences, especially if one party is underinsured.³⁷⁰ Therefore, it is in an MCO's best interest to ensure its physicians have a reasonable medical malpractice insurance policy.³⁷¹ Enterprise insurance has the ability to ensure that the physicians providing care within an ACO have a reasonable malpractice insurance policy.

The pricing shock of insurance premium fluctuations contributes to the alleged "crisis" in rising malpractice insurance premiums.³⁷² Yet, if ACOs implement captive insurance models, utilizing the theory of enterprise insurance, the ACO will have an incentive to monitor physicians' care in order to reduce the potential of malpractice claims and to increase the potential of financial benefits.³⁷³ Furthermore, physicians will have an incentive to produce quality care in order to avoid legal liability and to reap the financial benefits of decreased medical malpractice payouts. The ACO model implemented by the PPACA also has its own quality and cost-saving requirements that will additionally monitor physicians' treatment and care. As one prominent

369. See *supra* text accompanying notes 363–65 (addressing the argument that the implementation of enterprise insurance is not enough to control the quality of health care inside and outside the ACO).

370. Richard A. Hinden & Douglas L. Elden, *Liability Issues for Managed Care Entities*, 14 SETON HALL LEGIS. J. 1, 59 (1990).

371. *Id.* at 59.

372. Furrow, *supra* note 207, at 48.

373. Cf. Mulcahey, *supra* note 320, at 621 (recognizing that the implementation of a risk retention group is not simple, the organizations must have an "infrastructure to manage claims," an effective and efficient risk management program, and an institution that objectively identifies patient safety issues within their health care system). The infrastructure issues that face an organization that undertakes the role of a risk retention group may be overwhelming, but these issues will have to be solved on the front end because serious consequences have the potential to arise in the near future from merely fixing the problems on the back-side. *Id.*

pioneer in health law explained, “[l]itigation should be viewed as a productive patient safety tool, one with sharp edges that help increase attention to medical errors.”³⁷⁴ Eliminating the threat of litigation through concepts such as enterprise liability would soften the edges of one of the main tools that aids in promoting high-quality care, a result the current health care industry cannot afford. Enterprise insurance preserves the threat of litigation, but apportions the associated costs in a way that incentivizes physician behavior that results in high-quality care.

CONCLUSION

The survival of the reformed managed care model is contingent on physicians producing low-cost, high-quality health care.³⁷⁵ It is apparent that as courts tried to fit the managed health care system into precedential medical malpractice liability systems, complications and problems resulted.³⁷⁶ Because lawyers are unable to reengineer the entire health care system, change must come from the system’s inner components.³⁷⁷

ACOs hold great promise in changing the current health care system in a positive way,³⁷⁸ but medical malpractice liability should not simultaneously change as well. Medical malpractice liability poses a substantial threat on health care providers, but the elimination of physician liability under the theory of enterprise liability will substantially threaten patient safety and quality care. Enterprise liability does not generate a threatening “stick” to balance the incentivizing “carrot,” lacking the “unified strategy” that the current system desperately requires.³⁷⁹

Alternatively, implementing the theory of enterprise insurance through captive insurance companies would likely act as an effective

374. Furrow, *supra* note 207, at 50.

375. *Pegram v. Herdrich*, 530 U.S. 211, 220 (2000).

376. *See Pedroza, supra* note 38, at 401.

377. Furrow, *supra* note 207, at 106; *see Fritz & Savage, supra* note 21 (noting that even Clinton’s administration recognized that change will not occur if lawyers are acting directly within the doctor-patient relationship); Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice “Crisis,”* 23 *STAN. L. & POL’Y REV.* 477, 483 (2012) (noting that some physicians believe lawyers are actually to blame for “what they view as a medical liability system run amok”).

378. *MARSH & MCLENNAN COS., supra* note 19, at 1.

379. *See Frankel, supra* note 6, at 1299 (highlighting that, despite Congress’s attempted demonstration of cost-containment efforts and a commitment to malpractice reform, these two important commitments have failed to present a “unified strategy”).

and balanced carrot-and-stick approach. The “stick” of enterprise insurance, medical malpractice liability, would likely pressure providers to produce quality care. The “carrot” of enterprise insurance would further incentivize providers to deliver quality care because they would reap the financial benefits that stem from claim-free practice. The health care system is drastically changing, forcing other health care liability and financial structures to change as well. The PPACA and its goal of high-quality health care at sustainable costs will not be achieved unless coordinated and integrated change can occur.

Even though it is imperative to incentivize providers to join the coordinated care movement that has been encouraged by the historic enactment of a national health care reform, the country cannot lose sight of the real reasons why change must occur. When the focus of creating a better health care system shifts to protecting providers rather than patients, the discussion must end. The central purpose of medical care is to care for patients, which should remain the focus regardless of what system or what entities are created through health care reform. Imposing a system that shields providers from medical malpractice liability while allowing them to reap financial benefits for less care shifts the focus away from patient-centered medical care. Without physicians participating, managing, and delivering care, the goals of managed care would almost certainly remain unfulfilled. Incentivizing physicians to participate in an innovative health care system will inevitably occur, but enforcing safeguards for patient care must definitively occur. “After all, the patient is the *raison d’être* for the entire system.”³⁸⁰

380. Randall, *supra* note 40, at 4.