

# Expanded Managed Care Liability: What Impact On Employer Coverage?

Before turning up the heat on managed care plans, legislators should consider the implications for the health care system.

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**PROLOGUE:** Unlike most other industrialized nations, which compel employers to contribute to, if not cover the entire cost of, health insurance, the U.S. employer-based system is voluntary. Neither federal nor state laws require employers (except in Hawaii) to finance insurance coverage for employees and their families. Under this voluntary approach a large (64 percent in 1996) but declining number of all nonelderly Americans receive health benefits through the workplace. But what happens if the federal government, through legislated policies, upsets the balance of interests that persuade most large, if not all small and medium-size, employers to offer their employees health insurance? In this penetrating paper David Studdert and three colleagues examine this question in the context of the intense congressional debate over whether patients should be allowed to sue managed care companies.

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**ABSTRACT:** Policymakers are considering legislative changes that would increase managed care organizations' exposure to civil liability for withholding coverage or failing to deliver needed care. Using a combination of empirical information and theoretical analysis, we assess the likely responses of health plans and Employee Retirement Income Security Act (ERISA) plan sponsors to an expansion of liability, and we evaluate the policy impact of those moves. We conclude that the direct costs of liability are uncertain but that the prospect of litigation may have other important effects on coverage decision making, information exchange, risk contracting, and the extent of employers' involvement in health coverage.

EXPOSING ORGANIZATIONS THAT ADMINISTER employer-based health benefit plans to civil litigation and tort liability has emerged as the most contentious aspect of the patient-protection bills debated in the 105th and 106th Congresses.<sup>1</sup> Leading proposals from both sides of the aisle have included provisions that would reduce barriers to lawsuits against plans for withholding coverage or failing to deliver needed care. Specifically, these provisions seek to undo a degree of legal immunity conferred by the Employee Retirement Income Security Act (ERISA) of 1974, as it has been interpreted by the federal courts.<sup>2</sup>

Efforts to expand managed care liability appear to be driven by many of the same forces that animate patient-protection bills in general. The conventional wisdom is that managed care organizations face a conflict between quality and cost control.<sup>3</sup> Anecdotes abound of needy patients denied benefits as a result of aggressive cost cutting.<sup>4</sup> Spurred on by public opinion, which has galvanized against managed care, politicians therefore would arm patients with greater ability to seek legal redress for "excesses" in cost containment, especially stinting on coverage of necessary services.

Proponents of liability "reform"—consumer advocates, physicians and their organized representatives, and (quietly) the personal-injury bar—deploy several policy arguments.<sup>5</sup> First, they assert that freeing up access to legal remedies will compensate patients who suffer physical or financial injury as a result of decisions made negligently, in "bad faith," or in breach of contractual obligations. Second, they argue that legal checks on managed care practices will sound a warning to health plans about the limits of public tolerance, thereby improving the quality of care. Third, they observe that clearing avenues to suits against plans will correct a stark deficiency in health plans' accountability compared with that of physicians and hospitals, an imbalance that runs counter to plans' growing power over clinical care.

Health plans and businesses that provide health coverage to their employees, together with the trade organizations that represent

them, dominate the other side.<sup>6</sup> These groups occasionally object that liability proponents overestimate health plans' role in medical decision making and idealize the potential for litigation to influence quality of care. But such objections have been drowned out by the stance taken by physicians. That organized medicine set aside its long-standing opposition to clinical liability of any kind to join the supporting camp has diverted attention from the long-running debate over the pros and cons of tort law as a quality-improvement tool. Rather, most objections have been based on the collateral consequences that expanded liability may have for the employment-based health care system. For example, health plans assert that litigation, whether actual or threatened, must result in premium increases. Employers add that such hikes, plus the fear of direct liability, will prompt them to trim benefit packages or terminate coverage altogether.<sup>7</sup>

In this paper we explore the likely responses of health plans and ERISA plan sponsors to the expansion of liability, and their policy impact. We conducted informal interviews with more than fifty persons involved in health care delivery and planning, including senior legal personnel at health plans, employers, representatives of organized labor, benefits consultants, external counsel, academics, and provider-group administrators. We synthesize our findings into an analysis of four issues: (1) health care costs and access to coverage; (2) coverage decision-making practices; (3) dissemination of information; and (4) litigation against entities other than health plans ("spillover" liability). We leave discussion of the effect of liability reform on compensating tort victims to another forum.

## ERISA Preemption

ERISA has become a lightning rod for invective against managed care, for two principal reasons. First, the Supreme Court's 1987 decision in *Pilot Life Insurance Co. v. Dedeaux* made it difficult to sue insurers that administer employee benefits under state common law.<sup>8</sup> *Pilot Life* held that state tort claims against insurers "relate to" employee benefit plans and are therefore subject to ERISA preemption but are not "saved" as laws regulating insurance. Second, ERISA itself provides minimal remedies for personal injury. Participants and beneficiaries may sue to recover benefits due and to enforce or clarify rights under their ERISA plan; they also may sue for violations of the trustees' or administrators' fiduciary duty to act in the best interests of the plan.<sup>9</sup> But compensation for other forms of economic loss, pain and suffering, and punitive damages is not available.<sup>10</sup> As a result, suing under ERISA for a substandard coverage decision that has already caused injury, including loss of opportu-

nity to benefit from the treatment at issue, is rather like chasing tickets to a show that has already left town.

ERISA's grip over litigation against health plans has loosened somewhat in recent years.<sup>11</sup> For example, courts sometimes allow health plans to be held "vicariously" liable for medical malpractice committed by affiliated physicians and even for negligently selecting and monitoring their medical personnel.<sup>12</sup> In addition, Texas, Missouri, and Georgia have enacted statutes attempting to hold health plans liable for medical malpractice without impinging on ERISA, and several other states are considering similar bills.<sup>13</sup> Although these are notable developments, none is likely to lead to a dramatic expansion in opportunities for recovery against health plans. Courts continue to dismiss tort claims relating to coverage denials as precluded by ERISA, and even state legislative initiatives are subject to legal challenge because they lack the power to trump federal law.<sup>14</sup>

Unless the Supreme Court modifies *Pilot Life* and distinguishes suits against managed care organizations that sell services to employee benefit plans from suits against the plans themselves, or else treats state managed care statutes as insurance laws that are saved from preemption, lower courts will still be largely unable to offer redress to injured parties because of ERISA.<sup>15</sup> Judge William Young asked readers of his recent opinion denying recovery to the plaintiff: "Does anyone care? Do you?"<sup>16</sup> A number of the patient-protection bills promoted in Congress would answer in the affirmative.

■ **The proposals.** The 105th and 106th Congresses saw more than a half-dozen managed care bills rise to prominence. House Republicans passed the Patient Protection Act (H.R. 4250) in July 1998 after bypassing committee deliberation and floor debate; amid divisive debate, the Senate passed the Patients' Bill of Rights Plus Act (S.B. 1344) a year later. Because the Republican leadership is fiercely opposed to placing "the scalpels of litigation in trial lawyers' hands," neither bill amends ERISA to expand patients' opportunities to sue health plans, an omission that Democrats have decried as unacceptable.<sup>17</sup> With a presidential veto of S.B. 1344 promised, however, and new bipartisan proposals circulating that expand liability, the issue is unlikely to go away.<sup>18</sup>

The liability provisions proposed to date vary across three key dimensions. First, they differ with respect to preemption. Several attempt to fix the ERISA "problem" from within by augmenting the limited federal remedies set forth in the act while maintaining preemption of related state law. Others seek to repeal ERISA preemption of suits alleging delay or denial of benefits, thus opening the way for state legislatures and courts to assume more or less unfettered jurisdiction. Because states' responses are unpredictable, the

latter approach represents the more radical version of liability reform, and a more noxious outcome for opponents.

Second, the bills differ in allowable remedies. Some would permit patients to seek the full menu of common-law remedies, including economic, noneconomic (pain and suffering), and punitive damages. Others make lesser concessions, excluding noneconomic and punitive damages or predicating their availability on a plan's failure to follow the recommendation of an independent review panel. Third, alongside or in lieu of private rights to sue, several bills impose civil monetary penalties on plan administrators for unreasonable delays or denials of covered benefits. The fines are typically assessable by a government agency for designated violations—for example, coverage practices that seriously jeopardize a patient's health.

■ **Interview methods and analysis.** To assess the potential impact of expanded liability, we interviewed a range of persons involved in health care delivery and planning between September 1998 and January 1999 (Exhibit 1). Our primary focus was health plans and employers, although we also interviewed attorneys with experience in benefits and malpractice law, medical-group administrators, other researchers, trade-association officials, benefits consultants, and government officials with expertise in health care regulation.

**EXHIBIT 1**  
**Profile Of Organizations And Persons Interviewed For Study Of Managed Care Liability**

Type of organization	Description	Number	Who was interviewed	Number
Health plan	National: each with more than 5 million enrollees	2	Counsel	6
	Regional: Midwest/South, Central, West/Southwest, range from 600,000 to 10 million enrollees	4	Medical director	4
	California-based: range from fewer than 500,000 to more than 1 million enrollees	2	Executive/manager	4
	Texas-based: fewer than 500,000 enrollees	1		
Employer	Multistate: range from more than 80,000 employees in 28 states; more than 50,000 employees in 45 states; and approximately 30,000 employees in 16 states	5	Benefits manager	4
			Counsel	3
			Executive/senior management	3
	Single state: 8,000 employees; 2,500 employees; 40 employees; and 25 employees	4	Senior manager	2
	Purchasing consortia (California and Midwest)	3		
Attorney	ERISA/benefits law experts in private practice	7	Defense bar	3
			Plaintiff bar	3
			General employment law	1
Medical group	Large multispecialty groups in Florida and California	2	Senior manager	2
Research institute/university	Leading researchers on employment-based health insurance, ERISA, or managed care liability	8	Professor	4
			Institute-based researcher	4
Trade association	Health insurer organizations, integrated health systems committee, benefits administrators organization	4	Senior executive	4
			Counsel	2
Benefits consultant	Firms in New York and Washington, D.C.	2	Senior consultant	2
Government	Federal and state regulatory agencies	2	Official with expertise in benefits policy	5
			Attorney	1

**SOURCE:** Authors' classification and description of interviewee group.

**NOTE:** ERISA is Employee Retirement Income Security Act.

We did not use a structured interview format, nor did we pose a prespecified list of questions. Rather, through use of open-ended questions we elicited information about coverage decision-making practices and anticipated responses to managed care litigation. Interview content was adapted to the interviewee's expertise and the role of his or her organization. For example, our discussions with medical directors at health plans typically focused on particulars of coverage decision making; information about practices that may occasion "spillover" liability came mainly from discussions with employers and provider groups; and practicing attorneys fielded questions about the bases and potential for particular kinds of lawsuits in a new ERISA environment.

The following discussion represents our own theoretical analysis of the potential systemwide impact of heightened managed care liability. The information and viewpoints elicited during the course of the interviews informed and helped to shape this perspective, so we draw upon them throughout the analysis. However, we do not attempt to present the responses we obtained in a comprehensive manner, nor do we claim that those responses reflect the views of other organizations or individuals. In addition, we recognize that some interviewees had personal stakes in derailing legislation that might promote managed care litigation.

### **Cost And Access To Coverage**

■ **Plan response options.** Cost is the most common objection to tort liability. In the medical malpractice context, critics of unconstrained liability argue that it provokes an inefficient response in terms of clinical practice ("defensive medicine"), while wasting more than half of the dollars recovered on lawyers' fees and other administrative expenses.<sup>19</sup> Organized medicine's dislike of managed care notwithstanding, these same arguments apply to litigation over coverage determinations. When health plans are faced with a new liability threat, they can insure (or self-insure) against the increased risk, or they can "manage" it by liberalizing coverage approval. Either approach must be paid for, at least in part, by raising premiums, reducing profits, or (subject to regulatory constraints on insured plans) curtailing benefits.

Furthermore, if expanded liability greatly increases costs, access to health insurance may be diminished in a couple of ways. First, health plans may avoid controversial services and litigious groups of beneficiaries; this parallels physicians' exiting high-risk fields because of malpractice liability. Second, because the U.S. health care system depends on voluntary sponsorship of coverage by private employers, employers may trim the packages they sponsor, thrust-

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ing larger portions of care into the uninsured category. Some may even abandon the provision of health benefits altogether.

Many of these responses are generic to any cost increase. However, the threat of litigation is distinctive because of the extent to which perception can overshadow reality in driving corporate behavior. As Paul Weiler has noted, litigation in the health care context tends to have “far more emotional force and political salience than [the] bare dollar figures imply.”<sup>20</sup> Decisionmakers are prone to overestimating both the risk and the costs of litigation.<sup>21</sup> Even when they are informed about the distribution of litigation outcomes, firms show a propensity to respond inefficiently and overreact to the small possibility of having to pay large penalties for certain behavior.<sup>22</sup> Personal injury lawsuits, in particular—with their emotive flavor, bad press, long time frames, and specter of punitive damages—threaten to provoke an exaggerated behavioral response.<sup>23</sup> A small number of lawsuits over wrongfully denied or delayed coverage thus may lead health plan administrators to raise premiums to a level disproportionate to the actual costs of litigation. Employers, on the other hand, may hurry to avoid a legal quagmire by reducing insurance sponsorship rather than evaluating dispassionately the cost consequences reasonably attributable to lawsuits.

A key finding from our interviews is that little uniformity can be expected across plans and employers in the course they elect to chart among these options. Prevailing market forces and regulatory constraints in particular areas will exert a strong influence on the type of response. Variations in response often will be attributable to plan-specific factors such as enrollee population, product mix, and size. For example, healthy populations with more insurance options may be less vulnerable to exaggerated responses, fee-for-service products may generate less additional exposure than tightly managed operations, and smaller plans may not have the luxury of awaiting test cases before responding strategically.

All of the employers we interviewed expressed greater concern about premium hikes in general than those that might be specifically attributable to elevated liability risk. Two reported ongoing internal discussions about the attractiveness of a defined-contribution approach. Such discussions apparently had been motivated by discontent with managed care, the prospect of cost increases, and a sense that their capacity to meet employees' health care expectations was

waning. On the other hand, a leading benefits consultant to employers in the Midwest and Northeast argued that large efficiency improvements still were possible. He anticipated that many of his clients would resist premium increases and would expect plans to offset the cost of increased risk through efficiency gains.

The vice-president for regulatory affairs at one of California's largest health maintenance organizations (HMOs) indicated that her organization would be extremely unlikely to raise premiums in response to litigation-related expenditures. Rather, she thought a reduction in benefits likely, initiated by either plans or purchasers, in which a "first generation" of services would disappear, including dental benefits, vision care, and certain pharmaceuticals through use of narrower formularies. If liability proved particularly expensive, a "second generation" of benefits reduction might follow, consisting of "lifestyle" therapies such as alternative medicine and treatments for impotence and hair loss. Significantly, these responses merely reduce the overall cost of coverage, not liability exposure.

■ **Measuring the economic impact.** A number of studies have attempted to gauge the specific cost of lifting ERISA preemption. In a study commissioned by the American Association of Health Plans (AAHP), the Barents Group gathered data on current liability insurance costs to physicians and hospitals and forecast that managed care premiums would increase 2.7–8.6 percent through the five-year period 1999–2003.<sup>24</sup> Two other studies—one by Muse and Associates for a consumer group, the Patient Access to Responsible Care Alliance, and another by the nonpartisan Congressional Budget Office (CBO)—predicted smaller premium rises.<sup>25</sup> Surveying expert opinion, the CBO estimated a 60–75 percent increase in health plans' liability costs, resulting in a 1.2 percent rise in premiums for employer-sponsored health insurance over a ten-year period. The Muse study suggested that eliminating ERISA preemption would result in an increase of no greater than 0.2 percent of average managed care premiums; it contended further that this extra cost might be offset by savings from a decline in medical injury costs in a legal environment where fewer medically necessary services are denied. Overall, these studies vary widely in the types of costs they build into their estimates and in other aspects of their methodologies; they also make many bold economic and behavioral assumptions about the postreform litigation environment.

A purportedly more sophisticated approach takes advantage of a special window on unencumbered claiming that already exists. ERISA's provisions—and hence its preemptive effect—do not apply to all types of employee benefit plans. Governmental and church plans, and plans maintained solely for the purpose of complying



with various compensation and insurance laws, are not covered by the act.<sup>26</sup> Hence, privately insured, non-ERISA employees are a significant population—approximately thirty million persons, or 18 percent of employer-insured workers.<sup>27</sup> Health plans' experience with this group of workers could provide important clues to the implications of liability reform. A study by Coopers and Lybrand pursued this approach, investigating litigation rates among two large groups of state government employees and one group of local government employees. Applying a unit cost of \$100,000 per case to an annual incidence of 0.3–1.4 lawsuits per 100,000 enrollees, investigators calculated that similar rates in the ERISA population would add direct litigation costs of between three and thirteen cents per enrollee per month, a trivial percentage of premium.<sup>28</sup>

Although we were unable to obtain quantitative data from interviewees about their experience with workers in non-ERISA plans, we did not gain the impression that lawsuits are rampant, or even frequent, in this population. Furthermore, there was nothing to suggest that such workers are treated any differently than their ERISA-plan counterparts by utilization reviewers or other administrators. However, a majority of interviewees from health plans raised doubts about the comparability of the two groups. First, some asserted that their sociodemographic characteristics differ in ways that understate the expected volume of litigation—not an altogether convincing argument, given available information about the profile of government- and nongovernment-insured persons and the results of previous research on various types of patients' propensity to sue.<sup>29</sup> Second, we heard that interest in lawsuits among non-ERISA insured persons is inhibited by requirements in many public employees' insurance plans that administrative remedies be exhausted before suits may be filed. Third, several interviewees opined that the plaintiff bar has been so discouraged from coverage litigation by ERISA that it has not pursued non-ERISA lawsuits—despite “sentinel” cases such as *Fox v. Health Net* in 1993 and *Goodrich v. Aetna U.S. Healthcare* in 1999, both of which resulted in multimillion-dollar damage awards in favor of non-ERISA enrollees. This last explanation, if correct, suggests that explicit amendments to ERISA might, over a period of time, release a sizable wave of litigation.

“Uncertain” is therefore our best guess as to the direct economic impact of expanding liability.<sup>30</sup> Of course, uncertainty itself can destabilize insurance markets and therefore add to the cost of liability coverage. Nonetheless, passive responses to heightened liability—health plans absorbing or insuring against claims and employers reducing coverage rather than paying increased premiums—will probably prove less significant to the evolution of the system than

active changes in the roles and responsibilities of these key industry participants. We now turn to these.

### **Coverage Decision Making**

“Risk loading” premiums to fully cover the cost of expanded liability would, in theory, leave coverage decision making essentially unaffected. On the other hand, health plans might reduce their exposure (but still incur premium increases) by liberalizing standards for coverage. Several of the studies described before acknowledge the influence of changing coverage approval thresholds on costs. However, only the Barents Group study attempts to build this effect into its cost calculations, and it does so crudely: The authors posit that strict utilization management practices eliminate a percentage of defensive medicine (as it has been estimated in the malpractice context) and then assume that these “savings” would disappear under the threat of liability.

Our interviews demonstrated divergent views about the effect of liability on coverage standards. For example, a senior executive at a relatively small plan in Texas (fewer than 100,000 insured lives) indicated that his organization had already liberalized coverage decision making in response to the enactment of that state’s managed care liability law. Balancing marginal treatment costs against risks of litigation, the plan had decided to approve certain treatments, such as magnetic resonance imaging (MRI) procedures, that it would not have approved prior to the legislative change. Although the plan had not yet been sued under the state statute, and premium increases had not yet occurred, both were regarded as imminent. Nearly all of those interviewed at health plans speculated that their utilization management practices would be similarly shocked into submission if ERISA preemption were relaxed. One exception is the California HMO executive mentioned above: She suggested that purchasers there would insist that the line be held on utilization review, thereby creating the need to offset new litigation-induced costs by paring benefits.

Relaxation of coverage standards is not the only possible “active” response to litigation among managed care organizations. The threat of litigation also will likely lead plans to pay greater attention to the process of making coverage decisions. A number of our health plan interviewees predicted that documentation would receive higher priority; they also anticipated greater use of attorneys and risk managers at every stage of business operations. In addition, we expect that plans will be more likely to refer cases for external review, to shelter responsibility for denials in an expert, economically disinterested party. Even without legal mandates, a number of

plans have extended external review rights to enrollees.<sup>31</sup>

Another procedural possibility is that health plans may request or require beneficiaries to use alternative dispute-resolution programs in the event of injury instead of going directly to court. Mandatory arbitration is well established for medical malpractice claims but has seemed less useful for coverage decisions because of ERISA preemption (and because the connection between benefits determinations and personal injury was weaker before managed care).<sup>32</sup> Alternative dispute resolution can reduce litigation expense and exposure to punitive damages; properly conducted, it also can increase access to compensation for injured plaintiffs. Recent judicial decisions have expanded health plans' ability to compel arbitration by holding various state laws protecting consumers' rights to be preempted by the Federal Arbitration Act.<sup>33</sup>

An important question, not directly addressed in our interviews, is whether these procedural changes will merely increase bureaucracy or actually improve the quality of coverage decisions. For example, well-conducted mediation can reduce conflict and lead to quality improvement.<sup>34</sup> One factor that may prove critical is health plans' willingness and ability to capture professional ideals such as beneficence, open communication, and active patient participation in the coverage process. Drawing on lessons learned from physicians' experiences with medical malpractice litigation, health plans may discover that a trusting relationship between patient and institution—not merely reliance on impersonal concepts of procedural fairness—is the best protection against liability.

## Information Dissemination

Increased liability can be expected to affect the availability and quality of information shared among purchasers, health plans, and consumers. ERISA specifies several areas of mandatory disclosure, and courts have implied additional information requirements into the act's fiduciary-duty provisions.<sup>35</sup> State courts also are imposing informational requirements through non-ERISA fiduciary law.<sup>36</sup> However, ERISA preemption and limits on remedies available under the act render these rights to information difficult to enforce. One effect of expanded liability, therefore, might be to invigorate existing mechanisms designed to promote disclosure.

Heightened liability exposure also may alter the content of purchasing contracts negotiated between employers and health plans and may stimulate greater specificity about coverage definitions and decision-making functions. For example, contractors may be motivated to unbundle catchall terms such as *medical necessity* into a taxonomy of clinical scenarios or to develop detailed protocols for

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determining when treatments are experimental. In addition, responsibilities for utilization review activities between the main parties to managed care contracts—employers, plans, and providers—may be explained in greater detail. Furthermore, because courts construe employers’ purchase of policies as creating a direct contractual relationship between health plans and enrollees, greater specificity in purchasing contracts likely would be complemented by more detailed disclosures in material given to persons at the point of enrollment. This type of disclosure would be aimed at putting consumers on notice about the features of managed care.<sup>37</sup> Several multimillion-dollar judgments against health insurers not shielded by ERISA have been based on discrepancies between health plans’ marketing materials and formal plan documents.<sup>38</sup>

We tested these hypotheses in discussions with plan, employer, and legal interviewees and found a mixture of opinion about the likelihood that managed care litigation would change information-dissemination practices. A majority espoused the view that heightened exposure would result in increased specificity and a greater tendency to clarify roles. One interviewee remarked on the possibility of “900-page purchasing contracts,” with an accompanying “incomprehensible road map” of benefits coverage. Another predicted that contractual expansion would likely be determined by “problem” areas—those types of treatments that reveal themselves over time to be particularly frequent or expensive targets of litigation. If plans chose not to allow wholesale coverage of such treatments, they might use the contract to carefully delineate them as excluded.

On the other hand, a spirited minority of interviewees did not support the view that the minutiae of coverage decision making would find their way into purchasing contracts. Two arguments were invoked. First, some claimed that it is prudent risk management practice for both health plans and purchasers to retain “wiggle room” with respect to covered benefits. In other words, a degree of discretion in defining key contractual terms, such as *medical necessity*, may actually operate to a defendant’s advantage in subsequent litigation.<sup>39</sup> Second, several argued that contractual precision has not occurred because it cannot: The coverage decision-making enterprise is fundamentally resistant to *ex ante* elaboration. They opined that nearly limitless combinations of patient characteristics and circumstances of treatment doom such efforts to failure.

Many of the same officials who foresaw greater specificity in purchasing contracts agreed that risk reduction would necessitate accompanying disclosures at the point of enrollment. One interviewee, a legal expert and former plan executive, commented that a drive toward greater specificity in employer/plan contracts will logically be accompanied by more "fine-print details" for prospective enrollees, with plans' policy literature becoming "more like company prospectuses."

The effect of greater contractual precision on quality of care is ambiguous. On the one hand, prespecification of covered services between purchasers and plans through guidelines or clinical scenarios may decrease the possibility of coverage determinations that are arbitrary, erroneous, or unjust. On the other hand, quality may suffer if the specifications are too insensitive to handle important clinical idiosyncrasies in individual cases. Similarly, it is difficult to estimate the benefits of a litigation-induced expansion of consumer information.<sup>40</sup> Information dissemination is recognized as a key to effective competition among health plans; it also facilitates self-help and the exercise of various legal rights.<sup>41</sup> However, available evidence suggests that consumers have limited ability and propensity to use information about plans and providers to modify their health care choices.<sup>42</sup> Even intelligent and motivated consumers will have a difficult time translating fine-grain contractual details into personal decisions about health care. Moreover, increasing litigation exposure may channel disclosure into formal, stylized mechanisms that hamper its usefulness and accessibility.

### **'Spillover' Liability**

Popular diatribes against managed care vilify insurance companies and utilization review contractors as the embodiment of profit-motivated, corporate interference with altruistic professional judgment. Accordingly, bills relaxing ERISA's barriers to lawsuit specify the "group health plan," "HMO," "health insurance issuer," or "utilization management program" as the principal target of liability. As the direct vendor to group purchasers, and the issuer of coverage for enrollees, the health plan stands as the pivotal corporate entity in most managed care programs and thereby assumes significant responsibility for the quality of care delivered, including the appropriateness of administrative decisions about coverage.

However, tort liability typically follows function, not form, raising the risk of legal exposure up and down the chain of which the health plan is merely a key link. A nuanced, multifactorial view of legal duty and causation dominates U.S. law.<sup>43</sup> Policy-laden reasoning, in which the law seeks to identify the "truly" culpable entity or

“least cost avoider” of injury, also influences assignment of liability.<sup>44</sup> Thus, as the law around liability for coverage decisions matures, courts may well come to view these events not as discrete “yes/no” determinations made by a utilization reviewer or medical director, but as processes shaped by a range of influences and actors, any one of which may be answerable in whole or part for errors. In analyzing the implications of expanding managed care liability, it is therefore critical to recognize the potential for “spillover” liability; with it may come unanticipated consequences for the structure of managed care and the roles that employers and health care providers play in it.

■ **Employers.** Many interviewees remarked upon a trend toward greater involvement in benefits administration by group purchasers, particularly large, multistate employers. Based on accounts from plan and employer interviewees, we conclude that employers may find themselves held legally accountable for their role in coverage decision making at two levels: product selection and care management.

In selecting their products, employers negotiate service contracts with plans on a periodic basis, typically annually. New plans are solicited from time to time through a request for proposals (RFP) process, and sophisticated employer-purchasers deftly short-list and select among candidates. All of the firms we interviewed reviewed service proposals, reputations, and fee submissions as standard practice. At least one, a Fortune 100 company, went considerably further, soliciting the help of independent benefits consultants and actuaries to assess quality information (including Health Plan Employer Data and Information Set, or HEDIS, scores), the composition of provider panels, utilization management practices, and appeals and grievance procedures.

Employers also frequently have input into product design. Benefit packages are tailored to employers’ needs, with group purchasers negotiating not only covered services but also cost-sharing arrangements, rules for dependent eligibility, and the like. “Off-the-shelf” purchasing is least likely among large employers and for self-insured products. Employers’ involvement in this area may be accelerating because of recent advances in quality measurement and the resumption of significant increases in insurance premiums.<sup>45</sup>

Once a health plan has been selected and product details hammered out, day-to-day management of services falls to the plan or its designees. However, we heard consistently, from a range of interviewees, that employers are not necessarily remote from these functions. First, through their human resources or benefits administration departments, employers may assess ongoing performance, including collecting data on enrollee satisfaction, monitoring complaints and grievances, reviewing utilization patterns, and deciding

on coverage policies for cutting-edge technologies or treatments that become available within a contract period.

Second, we confirmed that employers can and do intervene in special cases. Special dispensation may be granted for the company executive who seeks an experimental treatment that would not otherwise be covered by the employer's plan. Alternatively, an employer may waive an annual or lifetime cap on services for a longtime employee whose child suffers from a chronic illness. Such ad hoc intervention may be initiated by both small and large employers. Smaller employers may intervene inclusively because of the immediacy of management/employee relations, or exclusively because of the relatively large impact special-case determinations are likely to have on future premiums. Large employers' proclivity to intervene stems from familiar relationships between the firm's human resource managers and the plan's benefits administration personnel.

Third, several of our employer interviewees indicated that their firms entertained final appeals for benefits denials. Ultimate authority for decisions is influenced by ERISA's requirement of "named fiduciaries" such as trustees and administrators, who assume fiduciary duties to the ERISA plan and thereby incur potential liability.<sup>46</sup> While most employers confine their workers to the appeals and grievance procedures conducted by the health plan, some maintain an informal petition process through which needy patients may plead their case. One employer interviewed provided for this type of override in contracts with health plans, although the employer did not provide information about how frequently it was invoked or how the cost of care so approved was allocated.

Outside of the context of gender or disability discrimination, litigation against employer-purchasers for decisions about health benefits is virtually unheard-of today. However, the activities described above make employers, which often have "deep pockets," potentially attractive defendants in personal injury suits in a changed ERISA environment.<sup>47</sup> For example, employer audits at the point of plan selection or an ongoing role in quality assurance may provide the basis for allegations of corporate negligence.<sup>48</sup> Courts also may regard an employer's power to entertain final appeals as evidence of a level of control sufficient to support a vicarious-liability claim.<sup>49</sup> Similarly, granting special dispensation for coverage of particular individuals or treatments may cast the employer in the role of decisionmaker more generally and subject its procedures and motivations to close scrutiny under tort, contract, trust, and employment law. Although several of the congressional bills have attempted to exclude suits against employers, generally for political reasons, they nonetheless tend to tie legal responsibility to an entity's function

rather than to its identity, which necessarily creates risks for plan sponsors. This is especially true if courts come to accept the institutional nature of modern health care and therefore view patient injury as the result of an interconnected series of activities that begins with a purchasing decision and concludes, at the “sharp end” of coverage decision making, with care at the bedside.

If employers are indeed playing active roles—and potentially negligent or discriminatory ones—there are certainly strong normative arguments for ensuring that they are not shielded from liability, especially when they exert the same kind of control over clinical decisions for which many now seek to hold health plans accountable. Why, then, might the prospect of employers’ legal exposure give policymakers pause? The answer is that it may chill useful behavior as well, thereby compounding other pressures on the employment-based health care system. For example, “direct contracting” between employers and health care providers, whatever its benefits, may fall victim to fears of unconstrained liability.<sup>50</sup> In addition, employers may choose to be less vigorous information intermediaries and patient advocates, functions that arguably are indispensable to effective competition and consumer protection in managed care. At the margin, the risk of liability may induce some employers to shift from a defined-benefit to a defined-contribution approach, which distances them from plan selection as well as from coverage and treatment decisions. This virtually assures legal immunity but wholly sacrifices potential gains from active employer sponsorship.

■ **Health care providers.** Different but analogous issues arise with respect to spillover liability of physicians and other health care providers. One of the most dramatic developments in health care markets over the past decade has been the proliferation of contracts that transfer insurance risk to provider organizations.<sup>51</sup> The physician groups and networks that have formed or expanded to accept risk increasingly demand the freedom to manage it. Hence, many utilization review decisions—particularly those involving determinations of medical necessity—are now delegated to provider entities. This reverses the conventional financial incentives of health plans and physicians, potentially transforming their advocacy roles as well.<sup>52</sup> In short, the risk-bearing provider group introduces yet another locus of sensitive coverage decisions that sits outside the conventional health plan.

Our discussions with plan officials confirmed that formal utilization review activities may be carried out by the plan, by provider groups, by both entities, or by designees of either. Utilization review functions are often coupled with risk transfer under the service contract between plans and provider organizations, especially when



*“If coverage litigation flourishes, providers’ behavior will become a central issue in the assignment of liability.”*

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the latter are large, well established, and equipped with a good information technology infrastructure. Even when utilization review functions are passed along under “full-risk” contracts, however, the health plan retains some role in setting coverage standards, monitoring utilization review, conducting audits, and operating appeals and grievance procedures. Some states mandate that ultimate responsibility for these activities remain at the plan level.<sup>53</sup> Several states also prohibit health plans from requiring physicians to indemnify them for the plan’s errors under “hold-harmless” clauses.<sup>54</sup>

Nonetheless, trends in health care delivery dictate that if coverage litigation flourishes, so will circumstances in which providers’ behavior, not just that of plans and plan sponsors, becomes a central issue in the assignment of liability.<sup>55</sup> This will thrust a host of difficult legal and ethical issues into the spotlight.<sup>56</sup> For example, the law of medical malpractice that typically governs physician behavior is keyed to a standard of care set by the profession, while coverage law accords much greater deference to private preferences expressed through contract.<sup>57</sup> A related difficulty is that professional-liability laws have been shaped by the unique structural features of medical malpractice and may not adapt smoothly to the coverage context. Specifically, malpractice insurance may exclude liability arising from administrative duties, and state-law caps on damages may not shield new types of provider organizations from potentially crippling judgments.<sup>58</sup>

More generally, the challenge of assigning liability to providers for benefits decisions taps into ongoing legal and ethical debate about the nature of physicians’ duties to individual patients, as opposed to the welfare of enrolled populations in a resource-constrained environment.<sup>59</sup> This is particularly true when provider groups act as ERISA fiduciaries. Ignoring policy arguments favoring professional control of managed care, a respected appellate court ruled that offering physicians financial incentives to promote cost-consciousness constitutes a breach of fiduciary duty under ERISA if the physicians also own the health plan.<sup>60</sup> Managed care litigation may well be a catalyst for wider engagement with these profound questions. However, a courtroom, in the midst of a liability inquiry, is hardly the ideal forum in which to attempt to resolve them.

**M**OST ANALYSES OF MANAGED CARE LIABILITY focus on conventional measures of tort law such as compensating victims and deterring negligence. Because the current reform debate involves changes to ERISA, however, the policy implications of expanded liability for the employment-based health insurance system become paramount. Using a combination of empirical information and theoretical analysis, we have attempted to assess the likely responses of employers and the health plans and providers with which they contract. We conclude that the direct costs of liability are uncertain but that the prospect of litigation may have other important effects on coverage decision making, information exchange, risk contracting, and the extent of employers' involvement in health coverage. Before legislators turn up the legal heat on managed care organizations, they should carefully consider the broader implications of global warming in the health care system.

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## NOTES

### 24 LIABILITY & COVERAGE

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47. Employers will emerge as particularly well heeled defendants if common forms of insurance—such as "directors and officers" policies—are flexible enough to cover their exposure for coverage decision-making activity.
48. See *Pedroza v. Bryant*, 101 Wash. 2d 226 (Wash. 1984); *McClellan v. HMO of Pennsylvania*, 604 A.2d 1053 (Pa. Sup. Ct. 1992); and *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58 (Mo. 1989).
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