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ARTICLES

CUTTING COSTS—CUTTING CARE: CAN TEXAS MANAGED HEALTH CARE SYSTEMS AND HMOS BE LIABLE FOR THE MEDICAL MALPRACTICE OF PHYSICIANS?

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I. INTRODUCTION

The front cover of the March 9, 1929 *Saturday Evening Post* depicts a Norman Rockwell painting of an overweight doctor holding a doll.[1] Stethoscope in hand, the doctor examines the doll intently to ease the obvious fear of the doll's young, ponytailed owner. Rockwell entitled the painting, simply, *Doctor and Doll.* We are not told the physician's name. Plain old "Doc" will have to do. Doc was a family friend who cared for us, our parents, and our children. The compassionate physician knew not only our physical ailments, but our vices and virtues as well. *Doctor and Doll* reminds us that practicing medicine once included the house call and the practice of "pay when you can" billing.[2]

Though Doc is sorely missed, he had to go. Many consider his death a homicide, justified in the name of streamlining the delivery of health care and holding down costs.[3] In the name of progress,

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1. *See* SATURDAY EVENING POST, Mar. 9, 1929 (cover illustration) (including picture of Rockwell's painting on cover page).

2. *See* Alexander M. Capron, *Containing Health Care Cost: Ethical and Legal Implications of Changes in the Method of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 709 (1986) (discussing changes in delivery of health care, which were provoked in part by alterations in financing of health care and resulting increase in competition between providers). Some commentators contend that the "pay when you can" business model encourages health care spending by offering an incentive to deliver excessive services, while providing no incentive to keep health care costs down. *See id.* (discussing disadvantages of "pay when you can" system); 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, 14–17 (1993) (suggesting that early reimbursement plans encouraged physicians to provide unnecessary and expensive treatment).

3. *See* Victor R. Fuchs, *No Pain, No Gain*, 269 JAMA 631, 636 (1993) (predicting that escalating health care expenditures will consume one-third of Gross National Product by year 2030 unless they are contained); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1721 (1987) (discussing common health maintenance organization (HMO) requirements, such as prospective payments, advance authorization procedures, limited reimbursement levels, preadmission review, and mandatory second opinions, as attempts to reduce overall health care costs); Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1300–01 (1994) (positing that problem with "traditional" methods of delivering treatment is that physicians prescribe significant amounts of care, yielding some health benefits to patients, yet these benefits are

Americans now seek health care in medical centers rather than relying upon house calls.[4] Brokered managed care has become an integral part of the attempt to streamline the delivery of modern health care.[5] The medical brokers can be credited with expanding our vocabulary to include "precertification," "copayment," and the most evolved of all—"preexisting condition," concepts which have replaced the obviously outmoded "pay when you can" business model.[6]

Medical brokers have been very successful in their exploits. Dramatic increases in health care costs have allowed the medical brokers' managed health care delivery systems to grow rapidly.[7]

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not cost-justified from society's perspective); Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier of Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 114 (1992) (stating that insurance companies and private employers are moving from fee-for-service health care plans to aggressive managed-care plans in attempt to contain medical costs).

4. *See* 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, 11 (1993) (reviewing historical development of modern health care system and proliferation of hospitals in United States).

5. *See* Diane M. Janulis & Alan D. Hornstein, *Damned If You Do, Damned If You Don't: Hospitals' Liability for Physicians' Malpractice*, 64 NEB. L. REV. 689, 691–92 (1985) (observing that delivery of health care is increasingly controlled by large, national corporations, such as HMOs, and attributing increase in HMO control to shift from patients' dependence on house calls to hospitals for delivery of primary medical care); Arnold S. Relman, *Is Rationing Inevitable?*, 322 NEW ENG. J. MED. 1809, 1809 (1990) (stating that managed-care goals of eliminating useless and excessive treatment encouraged by "pay when you can" billing are necessary to avert medical expenditures crisis).

6. *See* Josephine Aiello, *Serious and Unstable Condition: Financing America's Health Care*, 30 HARV. J. ON LEGIS. 553, 556 (1993) (defining preexisting condition as patient's disease or genetic condition discovered prior to issuance of insurance policy); Paul J. Feldstein, *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310, 1311 (1988) (explaining precertification as process in which review panel, staffed by HMO personnel, reviews each physician's request for authorization to treat HMO plan subscriber); Ellen M. Yacknin, *Helping the Voices of Poverty to Be Heard in the Health Care Reform Debate*, 60 BROOK. L. REV. 143, 153 n.39 (1994) (describing copayment as amount paid by health care patients when receiving medical services).

7. *See* Barry R. Furrow, *The Changing Role of the Law in Promoting Quality Health Care: From Sanctioning Outlaws to Managing Outcomes*, 26 HOUS. L. REV. 147, 151 (1989) (stating that in 1987, almost 60% of 160 million citizens with employer-sponsored health insurance were enrolled in managed health care plans, which represented increase of 5 to 10% from 1980); Ellen M. Yacknin, *Helping the Voices of Poverty to Be Heard in the Health Care Reform Debate*, 60 BROOK. L. REV. 143, 153 n.39 (1994) (noting that United States citizens now spend more per capita on health care as percentage of Gross National Product than citizens of any other country).

One common form of managed care is the health maintenance organization (HMO).[8] An HMO is a quasi-insurance arrangement that provides health care to subscribers for a prepaid monthly fee.[9] Generally, HMOs are attractive because they purport to offer health care at a lower cost to the consumer.[10] However, these "savings" come at the expense of the subscribers' freedom to choose their health care provider and the providers' freedom to choose treatment methods.[11]

While HMOs can save patients money in monthly premiums, they can cost patients in the long run. For example, in an effort to cut costs, an HMO health care broker can establish a scheme that discourages doctors from referring patients to specialists, even when such referrals are in the patients' best interest.[12] Similarly, an HMO can apply inappropriate criteria in determining how long patients should remain in the hospital.[13] These HMO actions can be tragic for patients. Discouraging referrals and denying payment

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8. *See* Barry R. Furrow, *The Changing Role of the Law in Promoting Quality Health Care: From Sanctioning Outlaws to Managing Outcomes*, 26 HOUS. L. REV. 147, 150 n.13 (1989) (noting that term "managed care" refers to organizations, such as HMOs, that attempt to control utilization of medical services).

9. *See* Jan Lewis, *HMO Liability for Negligent Patient Care*, TRIAL, Sept. 1990, at 73 (providing classifications and descriptions of four types of HMOs). Throughout the remainder of this Article, the terms "subscriber" and "patient" are used interchangeably.

10. *See* Lani Luciano, *How to Cut Your Expenses 20% (and Live Better Too)*, MONEY, Dec. 1991, at 70 (estimating that family of four could save $1000 per year by switching from traditional health insurance to HMO); *see also* United States Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 591 (1st Cir. 1993) (suggesting that HMOs are attractive to consumers because HMOs control costs by encouraging competition).

11. *See* Jan Lewis, *HMO Liability for Negligent Patient Care*, TRIAL, Sept. 1990, at 73 (noting that HMOs reduce health care costs by "restricting patients' choice of providers, limiting access to specialists, and using financial incentives to encourage providers to limit testing, hospitalization, and referrals").

12. *See* 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, 11, 31 (1993) (noting that American Medical Association initially feared HMOs would eventually require physicians to make treatment decisions based on HMOs' interests rather than on patients' interest, and stating that HMOs often financially penalize physicians for making inappropriate referrals).

13. *See* E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1724 (1987) (asserting that health care providers and hospitals are pressuring physicians to discharge patients earlier and perform more outpatient treatment based merely on financial considerations).

for continued hospitalization can result in harms to HMO patients ranging from the loss of a leg to death.[14]

This Article argues that HMOs should be liable for negligent or reckless patient care and for their member-physicians' malpractice.[15] Part II of this Article discusses four of the standard HMO models widely recognized today. Part III explores the theories that are available under Texas law to impute vicarious liability to HMOs based on member-physician malpractice. Part IV examines the available theories for imposing liability directly on HMOs for their own tortious conduct. Part V evaluates possible HMO defenses. Finally, Part VI considers the effect of HMO liability on health care costs.

II. STANDARD HMO MODELS

Health care brokers have developed four standard models of HMOs—the "staff model," "group model," "network model," and "independent practice association" (IPA) model.[16] HMOs operating under the "staff model" employ physicians directly and provide facilities and administrative staffs.[17] The physicians are usually paid a salary, plus incentive bonuses based on the profitability of the HMO.[18] In Texas, the staff model HMO is prohibited by the

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14. *See* Wickline v. California, 239 Cal. Rptr. 810, 817 (Ct. App. 1986) (reviewing expert testimony which indicated that patient would not have lost leg if HMO had approved eight-day hospitalization extension); Boyd v. Albert Einstein Medical Ctr., 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988) (suggesting that HMO's intervention in patient's treatment could have contributed to patient's heart attack and subsequent death).

15. Few reported cases discuss HMO liability directly; however, hospital liability based on the acts of physicians is closely analogous to HMO liability. *See Boyd*, 547 A.2d at 1234 (recognizing validity of analogy and deeming it instructive in adjudication of claim against HMO); *cf.* De Modena v. Kaiser Found. Health Plan, Inc., 743 F.2d 1388, 1394 (9th Cir. 1984) (suggesting that preferential treatment of hospitals over HMOs would establish unfair market advantage for hospitals), *cert. denied*, 469 U.S. 1229 (1985).

16. *See* 1 RICHARD L. GRIFFITH & DEWEY W. JOHNSTON, TEXAS HOSPITAL LAW 136 (2d ed. 1992) (listing and discussing four traditional types of HMOs). A new HMO scheme, called a point-of-service (POS) health care plan, has recently emerged. *See* Ellise Pierce, *A New Kind of Managed Care*, DALLAS BUS. J., Aug. 7, 1992, at 17 (explaining structure of POS health care plans). Under the POS scheme, patients pay the traditional HMO a nominal charge if they visit an HMO doctor, but pay a slightly higher fee if an independent physician is used. *Id.*

17. 1 RICHARD L. GRIFFITH & DEWEY W. JOHNSTON, TEXAS HOSPITAL LAW 136 (2d ed. 1992).

18. *Id.*

Texas Medical Practice Act,[19] which forbids the corporate practice of medicine.[20]

HMOs that base their operations on the group model contract with, rather than employ, groups of physicians to provide care to HMO subscribers, usually at a facility operated by the HMO.[21] Each physician group receives a fixed fee per patient, whether or not care is actually provided to the patient.[22] The third type of HMO—the network model—is somewhat similar to the group model because physicians are usually paid a set fee per patient.[23] However, under the network model, multiple physician groups and individual physicians contract with the HMO to provide care at the physicians' own facilities.[24]

The IPA model is markedly different from the staff, group, and network models. Under the IPA model, HMOs contract with IPAs, which in turn contract with individual physicians to provide care to HMO subscribers at the physicians' facilities.[25] Physician compensation is often based on some usual, customary, and reasonable scheme, with a fixed percentage withheld from each payment.[26] The amount withheld may equal twenty to thirty percent of the potential fee, which the physician can recover only by achieving preset cost-containment goals.[27] Increasingly, attorneys and courts across the country are questioning the potential for HMO liability based on IPA model and other HMO arrangements.[28]

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19. TEX. REV. CIV. STAT. ANN. art. 4495b (Vernon Supp. 1995).

20. *Id.* §§ 3.07(e), (f), 3.08(15); *see* Guerrero-Ramirez v. Texas State Bd. of Medical Examiners, 867 S.W.2d 911, 921 (Tex. App.—Austin 1993, no writ) (discussing prosecution for corporate practice of medicine under Texas Medical Practice Act).

21. 1 RICHARD L. GRIFFITH & DEWEY W. JOHNSTON, TEXAS HOSPITAL LAW 136 (2d ed. 1992).

22. *Id.*

23. *See id.* (stating that physicians under "network model" can be paid either flat fee per patient or flat fee per service rendered).

24. *Id.*

25. 1 RICHARD L. GRIFFITH & DEWEY W. JOHNSTON, TEXAS HOSPITAL LAW 136 (2d ed. 1992).

26. *Id.*

27. *Id.*

28. *See* Jan Lewis, *HMO Liability for Negligent Patient Care*, TRIAL, Sept. 1990, at 73, 78 (stating that growing number of courts recognize that HMOs should be liable for negligent patient care, and concluding that HMOs need to implement schemes that minimize costs without compromising level of care). HMO liability has also received increasing attention in the popular press. *See Beware of Your HMO*, NEWSWEEK, Oct. 23, 1995, at 54, 54–56 (noting recent coverage of managed-care casualties, and offering suggestions on how

III. VICARIOUS LIABILITY FOR MEMBER-PHYSICIAN MALPRACTICE

Given the degree of control that HMOs exercise over member-physicians under any of the above models, Texas courts should hold HMOs liable for their member-physicians' malpractice under the doctrine of vicarious liability. Texas courts recognize various theories of vicarious liability, including respondeat superior, apparent agency, agency by estoppel, and the concept of nondelegable duties. Each variation of vicarious liability is examined in turn below as it applies to HMO liability for member-physician malpractice.

A. *Respondeat Superior*

Texas courts impose vicarious liability upon an entity when there is some special relationship between the entity and the tortfeasor.[29] Traditionally, the master-servant relationship has been the most common relationship to which Texas courts have applied vicarious liability through the doctrine of "respondeat superior."[30] The doctrine of respondeat superior is based on the premise that when an innocent party is injured through tortious conduct committed in the furtherance of a business enterprise, the enterprise should bear the loss as a legitimate business expense.[31] Under this doctrine,

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to avoid becoming victim of HMO cost-containment measures); Stephen J. Chernaik, *Insurance Liability*, CHI. TRIB., July 24, 1995, at N8 (asserting that insurance company and HMO profitability is product of shifting responsibility for HMO actions to physicians, and calling for federal law to make HMOs legally responsible for results of HMO medical decisions); Dana Priest, *Clinton Advisors Plan to Shift Liability from Physicians*, WASH. POST, May 21, 1993, at A10 (relating that many in health care industry feel that as HMOs assume more responsibility for patient care, liability will encourage HMOs to have direct interest in attempting to avoid malpractice by improving quality of HMO physicians and monitoring their performance).

29. *See* Rourke v. Garza, 530 S.W.2d 794, 803–04 (Tex. 1975) (noting that merely appointing employees to decision-making positions may create vicarious liability, which is usually premised on specific employment relationship).

30. *See* O.P. Leonard Trust v. Hare, 305 S.W.2d 833, 835–36 (Tex. Civ. App.—Texarkana 1957, writ dism'd) (noting "well settled" doctrine of respondent superior, under which masters are unquestionably liable for tortious conduct of servants acting within authorized course and scope of employment); *see also* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 69, at 499–508 (5th ed. 1984) (discussing master-servant relationship and doctrine of imputed negligence).

31. Knutson v. Morton Foods, Inc., 603 S.W.2d 805, 807 (Tex. 1980). In *Knutson*, the Texas Supreme Court stated that the policy behind vicarious liability under the theory of respondeat superior is based on the notion that the employer, who profits from the em-

courts deliberately place the risk of loss upon the business entity because it can better absorb the loss and shift the cost to society as a whole.[32]

In deciding whether to hold HMOs vicariously liable under the doctrine of respondeat superior, Texas courts must consider the following central issues: (1) whether the tortfeasor is the HMO's servant; and (2) whether the tortious conduct occurred in furtherance of the business enterprise.[33] Because this Article focuses on HMO liability for substandard patient care, it assumes that the event which produced liability occurred in furtherance of delivering medical care to the subscriber, and discusses only the issue of whether the tortfeasor is the HMO's servant.

Since the 1964 decision of *Newspapers, Inc. v. Love*,[34] Texas law has been well settled that respondeat superior is available when a master-servant relationship exists.[35] A logical starting point for determining whether this relationship exists is an inquiry into the definition of "servant." A servant is a person who is employed to perform services for a master, and who is subject to the master's actual control, or his right to control.[36] Thus, the element of con-

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ployee's activities, should also share the losses caused by those activities. *See id.* (observing that doctrine is deliberate allocation of losses that are sure to occur in conduct of enterprise, and noting that employers are usually in better position to distribute costs); *see also* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 69, at 500 (5th ed. 1984) (justifying allocation of vicarious liability as "required cost of doing business"). *See generally* John H. Wigmore, *Responsibility for Tortious Acts: Its History—II*, 7 HARV. L. REV. 383, 383–441 (1894) (analyzing development of respondeat superior doctrine).

32. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 69, at 500–01 (5th ed. 1984) (explaining underlying policies justifying allocation of costs to employer).

33. *See* RESTATEMENT (SECOND) OF AGENCY § 219 (1957) (requiring master-servant relationship for imposition of liability, and reiterating requirement that servant act within scope of employment); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 69, at 499–500 (5th ed. 1984) (stating that employers are responsible for their employees' tortious conduct when employees are acting within scope of employment).

34. 380 S.W.2d 582 (Tex. 1964).

35. *See Newspapers, Inc.*, 380 S.W.2d at 585–88, 592 (reviewing Texas case law on respondent superior, implicitly accepting doctrine, and concluding that *actual exercise* of control must be present to establish master-servant relationship); *see also O.P. Leonard Trust*, 305 S.W.2d at 836 (concluding that employer is liable for employee's tortious conduct when employee is acting within scope of employment).

36. *See* RESTATEMENT (SECOND) OF AGENCY § 220(1) (1957) (defining servant as one who is subject to master's control over details of work to be done).

trol is the foundation of the master-servant relationship.[37] A master's control may be evidenced by his authority to determine the tools or appliances the servant will use in performing the work, dictate where the work will be performed, or regulate working hours.[38]

Courts have generally treated physicians as independent contractors, rather than servants.[39] However, many HMOs exercise traditional master-servant control over their member-physicians, which suggests that physicians should be classified as servants in the HMO context.[40] For example, HMOs often require physicians to provide their services at a facility owned by the HMO,[41] limit physicians to treating only HMO patients,[42] dictate the physicians' working hours,[43] compensate physicians on a per capita basis, rather than under a traditional fee-for-service scheme,[44] and control which medications physicians can prescribe.[45] Thus, HMOs

37. *See Newspapers, Inc.*, 380 S.W.2d at 588–89 (holding that actual control must be demonstrated to prove master-servant relationship).

38. *See* United States Fidelity & Guar. Co. v. Goodson, 568 S.W.2d 443, 447 (Tex. Civ. App.—Texarkana 1978, writ ref'd n.r.e.) (listing various ways in which master can exercise control over servant).

39. *See* Berel v. HCA Health Servs. of Tex., Inc., 881 S.W.2d 21, 23 (Tex. App.—Houston [1st Dist.] 1994, writ denied) (noting that physician selected by patient is generally considered independent contractor of hospital at which physician has staff privileges); Dumas v. Muenster Hosp. Dist., 859 S.W.2d 648, 651 (Tex. App.—Fort Worth 1993, no writ) (acknowledging general rule that physician is considered independent contractor of hospital at which he or she has staff privileges); *see also* Mitchell v. Sheppard Memorial Hosp., 797 S.W.2d 144, 146 (Tex. App.—Austin 1990, writ denied) (concluding that physicians were not employees of hospital).

40. *Cf.* Young v. Baylor Univ. Medical Ctr. Found., 607 S.W.2d 651, 654 (Tex. Civ. App.—Fort Worth 1980, no writ) (holding hospital vicariously liable for physician's negligent amputation of plaintiff's leg because hospital allowed physician to act negligently on its premises with its instrumentalities).

41. *See* Dunn v. Praiss, 606 A.2d 862, 868 (N.J. Super. Ct. App. Div. 1992) (finding that doctor was HMO employee because services were performed at HMO facility and doctor was not free to accept or reject patients).

42. *Id.*

43. *See* Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 507–08 (1988) (noting that physician enrollment in HMO may require direct HMO control over physician's working hours, and stating that HMOs may induce greater efficiency by scheduling more patient visits daily for their physicians).

44. *Dunn*, 606 A.2d at 868.

45. *See* Gina Kolata, *F.D.A. Panel Recommends Keeping Sleeping Pill on Market*, N.Y. TIMES, May 19, 1992, at C3 (reporting that large HMO would not allow physicians to prescribe Halcion for HMO subscribers).

appear to exercise enough control over their member-physicians to justify imposing vicarious liability under respondeat superior principles.[46] Even if these control mechanisms are not present, however, Texas courts may still hold HMOs vicariously liable based on concepts of agency law.

B. *Apparent Agency*

In contrast to respondeat superior principles, under which the element of control is critical, the concept of apparent agency focuses solely on appearances.[47] Using the apparent agency concept, courts have imposed liability when a principal's actions create the impression in a third party that another person has authority to act for the principal.[48] A Texas court of appeals has defined an "apparent" or "ostensible" agent as "one whom the principal, either intentionally or by want of ordinary care, induces third persons to

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46. *Cf. Berel*, 881 S.W.2d at 24 (stating that if hospital retains right to control work, master-servant relationship exists and authorizes application of respondeat superior liability); Steven R. Owens, Note, Pamperin v. Trinity Memorial Hospital *and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency*, 1990 WIS. L. REV. 1129, 1136 (noting that hospitals often control who works in emergency room, determine what equipment is available, set staffing levels, and exercise subtle controls restricting physicians' medical freedom).

47. *See* Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 546 (1990) (noting that crucial determinant under principles of apparent agency is whether agent *appears* to act on behalf of principal). *Compare* RESTATEMENT (SECOND) OF AGENCY § 219 (1957) (stating that master is liable under agency principles for torts of his or her servant acting outside scope of employment when servant purports to act within scope of authority and there is reliance upon apparent authority) *with* RESTATEMENT (SECOND) OF TORTS § 317 (1964) (noting that master has duty to control conduct of servant when servant is on master's premises, using master's property, and master knows, or has reason to know, that he or she should exercise control over servant).

48. Shadel v. Shell Oil Co., 478 A.2d 1262, 1265 (N.J. Super. Ct. Law Div. 1984); *see also* RESTATEMENT (SECOND) OF AGENCY § 267 (1957) (stating that by holding out servant as agent, principal is liable for servant's tortious conduct). This concept is also recognized in the Restatement (Second) of Torts, which provides:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

RESTATEMENT (SECOND) OF TORTS § 429 (1965).

believe to be his agent, though he has not, either expressly or by implication, conferred authority on him."[49]

In Texas, an HMO subscriber must prove three essential elements to establish vicarious liability through the doctrine of apparent agency.[50] First, the subscriber must reasonably believe in the physician's authority.[51] Second, the HMO must have committed some act or omission that generated this belief.[52] Finally, the subscriber must have justifiably relied in some way on this belief.[53] It is unclear, however, upon what the patient must have relied. Some cases suggest that the patient must have relied upon the representation of authority.[54] Other cases indicate that the patient must have relied upon the apparent-agent physician's skill.[55] The latter view is more closely in line with the Restatement (Second) of Agency[56] and the Restatement (Second) of Torts.[57]

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49. Walter E. Heller & Co. v. Barnes, 412 S.W.2d 747, 755 (Tex. Civ. App.—El Paso 1967, writ ref'd n.r.e.).

50. *See* Nicholson v. Memorial Hosp. Sys., 722 S.W.2d 746, 750 (Tex. App.—Houston [14th Dist.] 1986, writ ref'd n.r.e.) (listing elements of apparent agency claim necessary to establish apparent agency vicarious liability); Brownsville Medical Ctr. v. Gracia, 704 S.W.2d 68, 74 (Tex. App.—Corpus Christi 1985, writ ref'd n.r.e.) (explaining that liability can result when principal either holds out agent and induces third party's reliance, or when principal negligently allows third party to believe agent represents principal); *see also* Boyd v. Albert Einstein Medical Ctr., 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988) (holding that principal is liable for third person's tortious conduct if principal held out third person as agent to induce injured party's reliance).

51. *Nicholson*, 722 S.W.2d at 750.

52. *Id.*

53. *See id.* (stressing that third party's reliance must be reasonable and justifiable); *see also* Davis v. Mutual Life Ins. Co., 6 F.3d 367, 373 (6th Cir. 1993) (upholding jury instruction which stated that defendant was not vicariously liable for acts of agent if plaintiff knew or should have known that agents were acting beyond scope of granted authority), *cert. denied*, 114 S. Ct. 1298 (1994).

54. *See Nicholson*, 722 S.W.2d at 750 (holding that justifiable reliance on representation by third party is element for establishing ostensible agency); *see also Davis*, 6 F.3d at 374 (finding defendant liable for acts of agent outside scope of authority when defendant's own conduct led third party to reasonably believe in agent's authority and rely upon it).

55. *See* Brown v. Coastal Emergency Serv., 354 S.E.2d 632, 636 (Ga. Ct. App. 1987) (intimating that injured party must rely upon skill of apparent agent), *aff'd sub nom.* Richmond Co. Hosp. Auth. v. Brown, 361 S.E.2d 164 (Ga. 1987); *Shadel*, 478 A.2d at 1264 (noting that reliance on skill of apparent agent is prerequisite to liability).

56. *See* RESTATEMENT (SECOND) OF AGENCY § 267 (1957) (addressing "reliance upon care or skill of apparent servant or other agent").

57. *See* RESTATEMENT (SECOND) OF TORTS § 429 cmt. a (1964) (noting that employer may face liability for independent contractor's negligence even if injured party did not rely upon representation of authority by contractor to act on behalf of employer).

Although many factual situations give rise to apparent agency, Texas courts have found apparent agency in cases involving hospitals and physicians only in limited circumstances.[58] Nonetheless, apparent agency liability should arise when a patient receives treatment in an HMO clinic and reasonably believes that the attending physician is an employee or agent of the facility.[59] In addition, if the facility, rather than the patient, selects the physician, courts should find that an apparent agency relationship exists.[60] Finally, courts should consider the billing method in applying the concept of apparent agency.[61] Given an appropriate set of facts, Texas courts should use apparent agency to hold HMOs vicariously liable for their member-physicians' malpractice.

C. *Agency by Estoppel*

A concept related to apparent agency is that of "agency by estoppel."[62] Although some courts consider these two doctrines synonymous,[63] and though they often coexist, these two doctrines are indeed separate.[64] The primary difference is that, unlike apparent agency, agency by estoppel does not require reliance upon the prin-

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58. *See* Baptist Memorial Hosp. Sys. v. Smith, 822 S.W.2d 67, 76–77 (Tex. App.—San Antonio 1991, writ denied) (limiting finding of apparent agency relationship between physician and hospital to facts demonstrating that hospital intentionally or carelessly caused patient to believe physician was employee of hospital); *Brownsville Medical Ctr.*, 704 S.W.2d at 75 (finding apparent agency relationship between negligent physician and hospital based on evidence indicating that hospital administrator was responsible for staffing emergency room and testimony stating that there was no way for patients to know that emergency room physicians were independent contractors).

59. *See* Smith v. St. Francis Hosp., Inc., 676 P.2d 279, 280–81 (Okla. Ct. App. 1983) (basing HMO's liability on finding that patient reasonably believed physician was employee of HMO).

60. *Compare Nicholson*, 722 S.W.2d at 750 (holding that no agency relationship exists when physician admits his own patient) *with Brownsville Medical Ctr.*, 704 S.W.2d at 74–75 (holding that emergency room physician was apparent agent of hospital because hospital chose physician).

61. *See Brownsville Medical Ctr.*, 704 S.W.2d at 75–77 (determining that hospital's billing for doctor's emergency room services was factor in evaluating claim of apparent agency).

62. *See* Baptist Memorial Hosp. Sys. v. Smith, 822 S.W.2d 67, 76–77 (Tex. App.—San Antonio 1991, writ denied) (demonstrating close relationship between apparent agency and agency by estoppel).

63. *See* Smith v. St. Francis Hosp., Inc., 676 P.2d 279, 282–83 (Okla. Ct. App. 1983) (predicating liability on hybrid of apparent agency and agency by estoppel doctrines).

64. *See Baptist Memorial Hosp. Sys.*, 822 S.W.2d at 76 (acknowledging that, in Texas, agency by estoppel is separate theory from apparent agency).

cipal's overt representation.[65] A court may base agency by estoppel on an HMO's failure to take reasonable steps to notify the patient that no master-servant relationship exists between the treating physician and the HMO.[66]

In *Grewe v. Mt. Clemens General Hospital*,[67] the Michigan Supreme Court determined that agency by estoppel exists when three requirements are met.[68] First, the treating physician must reasonably appear to be an employee or agent of the institution.[69] Second, the institution must fail to inform the patient otherwise.[70] Finally, the patient must have "changed positions" in reliance upon the incorrect belief that an agency relationship existed.[71] Although a defendant may attempt to use the last requirement as a defensive concept, the "changed position" requirement is easily established by medical malpractice plaintiffs. The payment of money or the suffering of some loss satisfies the change in position requirement.[72] Thus, by definition, a patient injured by an HMO member-physician's malpractice would have suffered a loss and accordingly changed her position.

Notably, a Texas court of appeals acknowledged, but failed to adopt, slightly different requirements for establishing agency by estoppel.[73] In *Baptist Memorial Hospital System v. Smith*,[74] the Texas

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65. *Compare* RESTATEMENT (SECOND) OF AGENCY § 267 (1957) (requiring justifiable reliance by third person in agency relationship to impose liability under apparent agency) *with id.* § 8B(1)(b) (focusing liability in agency by estoppel situation on actions of principal when principal does not clarify to third person facts inducing changes in position by third person).

66. *See id.* § 8B(1)(b) (stating that liability attaches when principal has knowledge that third person believes agency relationship exists and principal fails to take reasonable steps to correct third person's mistaken belief).

67. 273 N.W.2d 429 (Mich. 1978).

68. *See Grewe*, 273 N.W.2d at 433 (estopping hospital from denying physician was employee); *see also Baptist Memorial Hosp. Sys.*, 822 S.W.2d at 76 (concluding that agency by estoppel was created by mere appearance that emergency room physician was employee of hospital).

69. *Grewe*, 273 N.W.2d at 433.

70. *Id.*

71. *See* RESTATEMENT (SECOND) OF AGENCY § 8B(3) (1957) (defining phrase "changed position" as "payment of money, expenditure of labor, suffering a loss, or subjection to legal liability").

72. *Id.*

73. *See Baptist Memorial Hosp. Sys.*, 822 S.W.2d at 77 (discussing test for agency by estoppel, which requires representations leading patient to believe that negligent physician was agent of hospital and proof that patient relied upon agency relationship).

74. 822 S.W.2d 67 (Tex. App.—San Antonio 1991, writ denied).

court noted the Ohio Supreme Court's test to establish agency by estoppel between a hospital and a physician, which requires a plaintiff to show that: (1) the hospital made representations which led the plaintiff to conclude that the negligent physician operated under the hospital's authority as an agent; and (2) the plaintiff was induced to rely upon the apparent agency relationship.[75] In the Ohio Supreme Court opinion establishing this test, the Ohio Supreme Court discussed agency by estoppel, but the Ohio court's language closely paralleled an apparent agency analysis.[76] Clearly, behavior that fulfills the Ohio court's test will also meet the standard requirements for establishing apparent agency.[77] If a hospital or an HMO, acting as a principal, makes the representations envisioned by the Ohio test, it would appear to the patient that the physician was an employee; thus, the facility would have failed to inform the patient otherwise. The Ohio test, therefore, fails to maintain the distinction between agency by estoppel and apparent agency,[78] because it disregards the Restatement (Second) of Agency position that the mere failure to inform the patient that no

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75. *Baptist Memorial Hosp. Sys.*, 822 S.W.2d at 77 n.9 (citing Albain v. Flower Hosp., 553 N.E.2d 1038, 1049–50 (Ohio 1990), *overruled by* Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46 (Ohio 1994)). In *Clark*, the case that overruled the decision referred to by the court in *Baptist Memorial Hospital System,* the Ohio Supreme Court lessened the burden on plaintiffs seeking to establish agency by estoppel between a hospital and physician by requiring only a showing that: (1) the hospital held itself out as a provider health care service; and (2) the patient reasonably relied upon the hospital, as opposed to the negligent physician, to provide competent health care. Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 53 (Ohio 1994).

76. *Compare* Albain v. Flower Hosp., 553 N.E.2d 1038, 1049 (Ohio 1990) (approving doctrine of agency by estoppel in hospital context and stressing requirement that plaintiff show induced reliance), *overruled by* Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46 (Ohio 1994) *with* RESTATEMENT (SECOND) OF AGENCY § 8 (1957) (requiring that apparent agents manifest their authority to represent principal to third person).

77. *See* RESTATEMENT (SECOND) OF AGENCY § 8B(1)(a) (1957) (noting that if principal carelessly or intentionally causes third person to believe agency relationship exists, principal may be liable for third person's injury).

78. *Compare Albain*, 553 N.E.2d at 1049 (listing requirements of agency by estoppel before finding that hospital led patient to believe that negligent physician was operating as agent under hospital's authority and plaintiff was induced to rely upon "ostensible agency") *with* RESTATEMENT (SECOND) OF AGENCY § 8B(1)(b) (1957) (noting that person not party to transaction purported to have been conducted on his or her behalf may nevertheless be liable to persons who change their position if he or she, knowing of such mistaken belief, fails to take reasonable steps to notify such persons of their mistaken belief).

employer-employee or principal-agent relationship exists may also establish agency by estoppel.[79]

The test's underinclusiveness stems from its failure to recognize the principles upon which apparent agency and agency by estoppel rest. Apparent agency is based on the third person's (the patient's) reasonable interpretation of a communication from the principal (an HMO).[80] The critical perspective is that of the patient, and the critical inquiry is whether the patient could reasonably interpret the HMO's communication to mean that the physician was the HMO's agent.[81] In contrast, agency by estoppel is based on a duty, tested by community standards, which requires the HMO to act.[82] Simply put, the HMO has a duty to disclaim an agency relationship when one reasonably appears to exist.[83] The breach of this duty is

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79. *See* RESTATEMENT (SECOND) OF AGENCY § 8B(1)(b) (1957) (stressing that principal with knowledge of third party's mistaken belief that agency relationship exists must take reasonable steps to correct misbelief).

80. *See id.* § 27 (noting that apparent authority is created by spoken or written words or conduct of principal which, when reasonably interpreted, causes third person to believe principal consents to actions purported to be done on his or her behalf).

81. *See Baptist Memorial Hosp. Sys.*, 822 S.W.2d at 76–77 (reasoning that patient could reasonably interpret hospital clerk's statement referring to "our doctors" and hospital advertisement touting emergency rooms "staffed twenty-four hours a day by licensed physicians" as statements affirming existence of agency relationship between negligent emergency room physician and hospital); *see also* RESTATEMENT (SECOND) OF AGENCY § 8 (1957) (noting that apparent agency is based on "holding out" of ostensible agent by ostensible principal such that reasonable plaintiff would conclude agency relationship exists); 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, 56 (1993) (emphasizing that existence of apparent or ostensible agency is determined by reasonable reliance of patient, even when no employment relationship exists between treating physician and HMO or hospital); *cf.* Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier of Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 128 (1992) (stressing that insurer must ensure that policy beneficiaries understand role of utilization-review entity and its relationship with insurer).

82. *See* McDuff v. Chambers, 895 S.W.2d 492, 498 (Tex. App.—Waco 1995, writ requested) (noting that principal is estopped from denying agency relationship if principal fails to correct mistaken reasonable belief in agency relationship generated by either affirmative act or neglect by principal); Wyndam Hotel Co. v. Self, 893 S.W.2d 630, 633 (Tex. App.—Corpus Christi 1994, writ denied) (stressing that agency by estoppel may arise due to principal's failure to disclaim agency relationship); *see also* Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier of Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 126 (1992) (suggesting that insurer should clearly disclaim any warranties and agency relationship between treating physician and HMO in insurance policy to avoid liability under agency by estoppel for member-physician's malpractice).

83. *See Grewe*, 273 N.W.2d at 434 (affirming finding of liability because hospital failed to give plaintiff notice that physician was not agent of hospital).

what establishes the estoppel ramifications.[84] Therefore, agency by estoppel liability should attach when an HMO fails to disclaim an agency relationship that reasonably appears to exist, rather than when a patient has merely relied upon affirmative representations indicating the existence of an agency relationship. This analysis resembles the Michigan Supreme Court's test, and should be adopted by Texas courts.

D. *Nondelegable Duty*

Apart from respondent superior or agency concepts, another tool exists that Texas courts may use to hold an HMO vicariously liable for a physician's malpractice—the concept of a nondelegable duty. Under this concept, HMOs should be liable for their member-physicians' malpractice because HMOs have a nondelegable duty to provide quality health care.[85] Generally, courts will impose liability based on a nondelegable duty when the responsibility is so important to the community that the law should not permit an actor to transfer that responsibility to another.[86]

In *Jackson v. Power*,[87] the Alaska Supreme Court found the concept of a nondelegable duty particularly applicable to the health care setting.[88] The court held that a hospital has an independent and nondelegable duty to provide nonnegligent medical care in its emergency room.[89] Even though the negligent physician was an independent contractor, the court held that the hospital was vicari-

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84. *See* RESTATEMENT (SECOND) OF AGENCY § 8B (1957) (stating that agency by estoppel arises when principal has engaged in misleading conduct and fails to take reasonable steps to deny agency relationship with third party); *see also* Diane M. Janulis & Alan D. Hornstein, *Damned If You Do, Damned If You Don't: Hospitals' Liability for Physicians' Malpractice*, 64 NEB. L. REV. 689, 697 (1985) (noting that estoppel to deny agency relationship arises solely as result of patient's reasonable reliance on agency relationship and hospital's failure to disclaim agency relationship).

85. Although most attorneys associate the concept of "duty" with direct liability based in negligence law, here it is properly classified as a vicarious liability concept because the basis for the liability stems from the tort of another. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 71, at 511 (5th ed. 1984) (noting that nondelegable duty is vicarious liability concept).

86. *Id.* at 512.

87. 743 P.2d 1376 (Alaska 1987).

88. *See Jackson*, 743 P.2d at 1384 (stating that hospital's duty to provide emergency room physicians is justified by importance of emergency room treatment to community and by statute creating hospital regulatory scheme).

89. *Id.* at 1383–85.

ously liable for the doctor's malpractice because the hospital had a nondelegable duty.[90] As discussed below, Texas courts have already expressed concern about health care quality, and have placed certain duties upon hospitals to ensure patient safety.[91] Therefore, Texas courts should adopt the nondelegable duty analysis in *Jackson*, and continue protecting patients from unsafe medical environments.

IV. Direct Liability for Member-Physician Malpractice

In addition to vicarious liability for member-physician malpractice, Texas HMOs should face direct liability for their own tortious conduct under the doctrine of corporate negligence. Texas HMOs should also be held directly liable for their subscribers' injuries when the injuries are caused by the HMO's negligent selection or retention of an incompetent member-physician, and when their cost-containment schemes adversely impact physicians' medical determinations.

Since the landmark decision of *Darling v. Charleston Community Memorial Hospital*,[92] courts have used the theory of corporate negligence to hold hospitals directly liable for their own tortious conduct.[93] In *Darling*, a high school athlete arrived at a hospital emergency room seeking medical attention for a broken leg.[94] The

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90. *Id.*

91. *See* Brownsville Medical Ctr. v. Gracia, 704 S.W.2d 68, 77 (Tex. App.—Corpus Christi 1985, writ ref'd n.r.e.) (stating that hospital may face liability for negligently transferring patient); Hilzendager v. Methodist Hosp., 596 S.W.2d 284, 286 (Tex. Civ. App.—Houston [1st Dist.] 1980, no writ) (stating that hospital has duty to provide for care of patients, and degree of care mandated is such reasonable attention as patients' mental and physical conditions may require); *see also* Valdez v. Lyman-Roberts Hosp., Inc., 638 S.W.2d 111, 114 (Tex. Civ. App.—Corpus Christi 1982, writ ref'd n.r.e.) (suggesting that hospital was liable for failing to admit seriously ill person simply because she did not have doctor practicing at hospital).

92. 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).

93. *E.g.*, Tucson Medical Ctr., Inc. v. Misevch, 545 P.2d 958, 960 (Ariz. 1976); Kitto v. Gilbert, 570 P.2d 544, 550 (Colo. Ct. App. 1977); Mitchell County Hosp. Auth. v. Joiner, 189 S.E.2d 412, 414 (Ga. 1972); Johnson v. St. Bernard Hosp., 399 N.E.2d 198, 204 (Ill. App. Ct. 1979); Ferguson v. Gonyaw, 236 N.W.2d 543, 550 (Mich. Ct. App. 1976); Bost v. Riley, 262 S.E.2d 391, 395–96 (N.C. Ct. App. 1980); Corleto v. Shore Memorial Hosp., 350 A.2d 534, 536–37 (N.J. Super. Ct. App. Div. 1975); *see* Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier of Medical Malpractice Claims?*, 41 Drake L. Rev. 113, 126–27 (1992) (noting that corporate negligence theory is often used to hold hospitals liable for inadequately investigating negligent physicians before granting staff privileges).

94. *Darling*, 211 N.E.2d at 255.

attending physician, an independent contractor, negligently performed an orthopedic procedure.[95] The physician's negligence resulted in considerable leg tissue damage, which ultimately led to the amputation of the athlete's leg.[96] The court found that the hospital owed an independent duty to provide nonnegligent care to its patients, which it breached by allowing an incompetent physician to practice in its emergency room without hospital supervision.[97]

The notion of direct corporate liability has been well received by the courts—at least twenty-seven jurisdictions have adopted the doctrine either explicitly or implicitly.[98] While the direct corporate liability doctrine has been applied most frequently to hospitals, courts are beginning to apply it to HMOs as well.[99] In fact, the

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95. *Id.*

96. *Id.* at 256.

97. *See id.* at 258 (concluding that jury could properly find hospital was negligent in failing to adequately supervise physicians).

98. *E.g.*, Jackson v. Power, 743 P.2d 1376, 1385 (Alaska 1987); Purcell v. Zimbelman, 500 P.2d 335, 343 (Ariz. Ct. App. 1972); Bell v. Sharp-Cabrillo Hosp., 260 Cal. Rptr. 886, 897 (Ct. App. 1989); Krane v. St. Anthony Hosp., 738 P.2d 75, 78 (Colo. Ct. App. 1987); Buckley v. Lovallo, 481 A.2d 1286, 1289 (Conn. App. Ct. 1984); Register v. Wilmington Medical Ctr., 377 A.2d 8, 10 (Del. 1977); Insinga v. LaBella, 543 So. 2d 209, 214 (Fla. 1989); *Mitchell County Hosp. Auth.*, 189 S.E.2d at 414; *Darling*, 211 N.E.2d at 257–58; Sibley v. Board of Supervisors, 477 So. 2d 1094, 1099 (La. 1985); Copithorne v. Framingham Union Hosp., 520 N.E.2d 139, 143 (Mass. 1988); *Ferguson*, 236 N.W.2d at 550; Gridley v. Johnson, 476 S.W.2d 475, 484–85 (Mo. 1972); Foley v. Bishop Clarkson Memorial Hosp., 173 N.W.2d 881, 884–85 (Neb. 1970); Oehler v. Humana, Inc., 775 P.2d 1271, 1272 (Nev. 1989); *Corleto*, 350 A.2d at 539; Bush v. Dolan, 540 N.Y.S.2d 21, 23 (App. Div. 1989); Blanton v. Moses H. Cone Memorial Hosp., 354 S.E.2d 455, 459 (N.C. 1987); Benedict v. St. Luke's Hosp., 365 N.W.2d 499, 504 (N.D. 1985); Albain v. Flower Hosp., 553 N.E.2d 1038, 1048 (Ohio 1990), *overruled by* Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46 (Ohio 1994); Thompson v. Nason Hosp., 535 A.2d 1177, 1182 (Pa. Super. Ct. 1988), *aff'd*, 591 A.2d 703 (Pa. 1991); Shamburger v. Behrens, 380 N.W.2d 659, 665 (S.D. 1986); Park N. Gen. Hosp. v. Hickman, 703 S.W.2d 262, 266 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.); Pedroza v. Bryant, Inc., 677 P.2d 166, 170 (Wash. 1984); Roberts v. Stevens Clinic Hosp., 345 S.E.2d 791, 798 (W. Va. 1986); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 164–65 (Wis. 1981); Sharsmith v. Hill, 764 P.2d 667, 672–73 (Wyo. 1988).

99. *See* Harrell v. Total Health Care, Inc., No. WD 39809, 1989 WL 153066, at *6 (Mo. Ct. App. Apr. 25, 1989) (recognizing potential applicability of corporate liability to HMOs when HMOs limit patients' choice of physicians), *appeal transferred and decision rendered*, 781 S.W.2d 58 (Mo. 1989) (en banc); *see also* McClellan v. Health Maintenance Org., 604 A.2d 1053, 1058–60 (Pa. 1992) (recognizing similarity of hospitals and HMOs in relation to application of direct corporate liability). In *Harrell*, the Missouri Court of Appeals noted the potential existence of a direct duty between an HMO and a patient regarding the selection of physicians. *Harrell*, 1989 WL 153066, at *5. However, the Court of Appeals transferred the case to the Supreme Court of Missouri for final disposition, where decision was rendered without comment on this duty. *See* Harrell v. Total Health Care, Inc., 781 S.W.2d

exclusive-provider selection process used by many HMOs has led some commentators to conclude that direct corporate liability is more appropriately applied to HMOs than to hospitals.[100]

Jurisdictions that have accepted the direct corporate liability doctrine have done so based on many policy considerations. A common basis for adopting direct corporate liability is the public's perception of hospitals as providers of nonnegligent health care.[101] This rationale is especially applicable to HMOs because subscribers often visit HMO clinics for health care. Furthermore, some courts accept direct corporate liability because the health care institution, as compared to the patient, is clearly in a superior position to evaluate the competence and performance of physicians and other staff members.[102]

Direct corporate liability is particularly appropriate when an HMO exercises an exclusive right to select a physician for the patient.[103] The threat of direct liability creates a financial incentive for health care institutions to carefully consider the interests of their subscribers.[104] Given the degree of control that HMOs exert directly over physicians, and consequently over HMO subscribers' medical care, courts should vigorously encourage HMOs to act appropriately.[105] However, absent a recognition of direct corporate

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58, 58–61 (Mo. 1989) (rendering decision on statutory and constitutional grounds with no analysis of direct duty or corporate liability doctrine).

100. *See* Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1321 (1994) (noting that application of corporate negligence doctrine is justified by role HMOs play in initial selection of patient's physicians).

101. *See Pedroza*, 677 P.2d at 169 (citing public's perception of contemporary hospital as "multifaceted health care facility" as justification for acceptance of direct corporate liability).

102. *See id.* at 169–70 (noting that hospitals are in better position than state regulatory agencies or patients to monitor physicians' performance because physicians' medical practices "can be observed on a regular basis at the site where care is being rendered"); *see also* Barry R. Furrow, *The Changing Role of the Law in Promoting Quality in Health Care: From Sanctioning Outlaws to Managing Outcomes*, 26 HOUS. L. REV. 147, 178–80 (1989) (implying that health care institution is in position of control over physicians).

103. *See* Diane M. Janulis & Alan D. Hornstein, *Damned If You Do, Damned If You Don't: Hospitals' Liability for Physicians' Malpractice*, 64 NEB. L. REV. 689, 703 (1985) (recognizing failure to exercise reasonable care in retention and selection of physicians as largest expansion of liability under corporate negligence doctrine).

104. *See Pedroza*, 677 P.2d at 170 (noting that most effective method for health care institutions to reduce burden of malpractice insurance is to avoid corporate negligence).

105. *See* Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1302

liability for member-physician malpractice, Texas courts could still hold HMOs directly liable for negligent selection or retention of member-physicians and for negligent cost containment.

A. *Negligent Selection or Retention*

Texas courts have recognized that health care institutions have a duty to act prudently when selecting an employee or agent.[106] However, as illustrated in *Jeffcoat v. Phillips*[107] and *Park North General Hospital v. Hickman*,[108] the scope of this duty continues to evolve. In *Jeffcoat*, a physician performed an appendectomy in Medical Arts Hospital.[109] The patient sued Medical Arts for negligently allowing the treating physician to practice in the hospital.[110] The hospital prevailed on a motion for summary judgment, which was affirmed on appeal; however, the appellate court recognized that health care institutions risk liability when they breach a duty owed directly to their patients.[111] The court specifically acknowledged that a hospital must exercise reasonable care in selecting or retaining its agents or employees.[112]

(1994) (asserting that HMO cost-containment methods that force physicians to alter treatment based on economic concerns conflict with physicians' obligation to provide treatment without reference to resources); Steven R. Williams, Note, Pamperin v. Trinity Memorial Hospital *and the Evolution of Hospital Liability: Wisconsin Adopts Apparent Agency*, 1990 WIS. L. REV. 1129, 1136 (noting that courts have begun to realize degree of influence exerted by managed-care providers over health care decisions and have begun to allocate liability accordingly).

106. *See* Park N. Gen. Hosp. v. Hickman, 703 S.W.2d 262, 266 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.) (finding that hospital has duty to exercise reasonable care in choosing medical staff); Jeffcoat v. Phillips, 534 S.W.2d 168, 172–73 (Tex. Civ. App.—Houston [14th Dist.] 1976, writ ref'd n.r.e.) (noting that hospital may be liable for negligent selection or retention of employee); Sandone v. Dallas Osteopathic Hosp., 331 S.W.2d 476, 480 (Tex. Civ. App.—Amarillo 1959, writ ref'd n.r.e.) (recognizing potential for liability based on allegation that hospital failed to prudently select employee).

107. 534 S.W.2d 168 (Tex. Civ. App.—Houston [14th Dist.] 1976, writ ref'd n.r.e.).

108. 703 S.W.2d 262 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.).

109. *Jeffcoat*, 534 S.W.2d at 170.

110. *Id.* at 170–71. The plaintiff took the position that the hospital knew, or should have known, that the physician was incompetent. *Id.*

111. *See id.* at 172 (recognizing that hospital may be held liable for breach of duty owed directly to patients, such as duty to provide effective facilities and equipment).

112. *Id.*; *see also* Steele v. St. Joseph's Hosp., 60 S.W.2d 1083, 1086 (Tex. Civ. App.—Fort Worth 1933, writ ref'd) (concluding that hospital is not liable for employee's tortious conduct unless hospital was negligent in retention or employment of tortfeasor). *See generally* Jack W. Shaw, Jr., Annotation, *Hospitals' Liability for Negligence in Selection or Appointment of Staff Physician or Surgeon*, 51 A.L.R.3d 981, 983 (1973) (noting that some

In upholding summary judgment for the hospital, the court focused on the fact that the patient, rather than the hospital, selected the treating physician.[113] The court noted that the plaintiff had an ongoing relationship with the physician prior to the hospital's involvement.[114] Moreover, the court found that the plaintiff had specific knowledge of the physician's skills and nevertheless employed the physician to perform the procedure.[115] While the court's legal analysis is questionable,[116] the rule of the case is clear—absent an employer-employee, principal-agent, partnership, or joint venture relationship, a health care institution is not liable for negligent selection or retention if the patient chooses the attending physician.[117]

Almost a decade after the *Jeffcoat* decision, a Texas appellate court recognized in *Hickman* that the law of negligent selection or retention had evolved, and held that a health care institution clearly owes a duty to use reasonable care in selecting physicians for its medical staff and in granting admitting privileges.[118] In holding the hospital liable, the *Hickman* court relied on both the gen-

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jurisdictions hold employers liable for injuries to third persons caused by incompetent or unfit employees, and characterizing employers' negligence as typically either hiring employees with knowledge of employees' incompetence or failing to exercise reasonable care to discover incompetence).

113. *See Jeffcoat*, 534 S.W.2d at 173 (noting that majority of states consider physicians with staff privileges independent contractors if patient chooses doctor).

114. *See id.* (stating that plaintiff's ongoing relationship with physician was independent from patient's relationship with hospital).

115. *See id.* (explaining that defendant-doctor had performed same procedure on plaintiff's daughter 16 months prior to plaintiff's injury).

116. The court apparently confused the distinction between vicarious liability principles and direct liability based on the negligence of the institution. For example, the court recited the general rule of vicarious liability that a hospital is not liable for the acts of independent contractors, and recognized that a majority of states consider a patient-selected physician to be an independent contractor. *Id.* at 172 (citing Jim M. Perdue, *The Law of Texas Medical Malpractice*, 11 HOUS. L. REV. 302, 337 (1974)). From this, the court declared that "a hospital is not liable for granting or continuing surgical privileges where the patient has chosen the physician." *Id.* at 173. However, this type of logic blurs the distinction between vicarious liability and direct liability by making a vicarious liability relationship the prerequisite for holding a hospital directly responsible for its own wrongful conduct.

117. *Jeffcoat*, 534 S.W.2d at 173.

118. *Hickman*, 703 S.W.2d at 266. The *Hickman* decision provides an illuminating discussion of the development of hospital liability law in this area up to 1985. *See id.* at 264 (citing numerous decisions that addressed duties of hospitals associated with hiring physicians).

eral evolution of the law and the hospital's own actions.[119] Specifically, the court noted that the hospital had established internal regulations that required a hospital committee to investigate a physician's professional competence when the physician applied for admitting privileges[120] and to thereafter evaluate the physician's clinical competence and judgment on an annual basis.[121] The hospital in *Hickman* failed to abide by its own internal regulations.[122] The court found that the internal regulations disregarded by the hospital represented the standard of care adopted by other hospitals in the community[123] and, therefore, held that the hospital was liable for deviating from this widely adopted standard of care.[124] The *Hickman* court shifted the relevant direct-liability inquiry from whether some vicarious-liability-producing relationship exists[125] to simply whether the health care institution deviated from an applicable standard of care.[126] Thus, the *Hickman* court avoided the analytical problem in *Jeffcoat* and applied the appropriate framework for determining whether liability for negligent selection exists.

While Texas courts have only dealt with the standard of care required of hospitals in physician selection, a Missouri court has recognized that HMOs have a similar duty to use reasonable care when selecting their member-physicians.[127] The Missouri court

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119. *See id.* at 264–65 (discussing evolution of hospital law, and detailing evidence offered by plaintiff concerning hospital's procedure for appointing physicians).

120. *See id.* (describing steps required by hospital's regulations, such as credentials committee's examination of character, competence, qualifications, and ethical standing of physician prior to staff appointment).

121. *See id.* (outlining criteria that hospital used to evaluate physicians).

122. *See Hickman*, 703 S.W.2d at 266 (noting that testimony at trial indicated that hospital failed to investigate negligent physician's credentials and competency prior to granting admitting privileges).

123. *Id.* at 265.

124. *Id.* at 266.

125. *Cf. Jeffcoat*, 534 S.W.2d at 173 (characterizing doctor as independent contractor, rather than employee of hospital, and ultimately concluding that hospital was not liable for negligence of independent contractor).

126. *See Hickman*, 703 S.W.2d at 266 (recognizing that health care institution owes duty to its patients to exercise reasonable care in selecting medical staff, and concluding that when this duty is breached, institution should face liability for resulting damage).

127. *See* Harrell v. Total Health Care, Inc., No. WD 39809, 1989 WL 153066, at *5 (Mo. Ct. App. Apr. 25, 1989) (finding that HMOs have duty of care in selecting physicians), *appeal transferred and decision rendered*, 781 S.W.2d 58 (Mo. 1989) (en banc).

reached this conclusion in *Harrell v. Total Health Care, Inc.*,[128] a case involving a patient who had consulted her HMO primary-care physician for treatment of urinary stress incontinence.[129] After examining the patient, the primary-care physician concluded that the patient should consult a urologist.[130] Pursuant to HMO regulations, the primary-care physician selected a urologist from a list provided by the HMO.[131] The urologist selected by the primary-care physician negligently performed surgery on the patient.[132] Consequently, the patient brought separate actions against the urologist for malpractice and against the HMO under the corporate negligence theory.[133]

The *Harrell* court carefully analyzed the HMO's physician-approval process.[134] In the initial stages of the process, the HMO would send solicitation brochures to prospective physicians,[135] and would follow up with applications to all physicians who wanted to participate.[136] The approval process varied, depending on whether

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128. No. WD 39809, 1989 WL 153066 (Mo. Ct. App. Apr. 25, 1989), *appeal transferred and decision rendered*, 781 S.W.2d 58 (Mo. 1989) (en banc).

129. *Harrell*, 1989 WL 153066, at *1. In HMO terminology, primary-care physicians provide general medical care. *See id.* at *2 (describing role of primary-care physicians in HMOs). Generally, an HMO subscriber must select a primary-care physician from an approved list provided by the HMO. *See id.* (examining procedural requirements of HMO membership). Thereafter, the patient must seek treatment for all medical problems from the selected primary-care physician. *Id.* Only after the primary-care physician decides that consultation or special treatment is required may the subscriber seek care from a specialist. *See id.* (clarifying parameters of health care that primary-care physicians may provide). The specialist is then selected by the primary-care physician from a list provided by the HMO. *Id.* at *2.

130. *Id.* at *2.

131. *See id.* at *3 (discussing procedure used to select urologist, and noting that HMO's member-physicians agreed to observe limitations on fees and use only certain laboratory facilities and other conditions intended to minimize costs). The HMO subscribers were also encouraged to utilize HMO member physicians. *See id.* (noting that HMO members treated by HMO member-physicians were not billed for services because fees were paid directly to member-physicians by HMO, leaving subscribers who used services of physicians not under contract with HMO with no enforceable claim under policy for medical expense payments).

132. *See id.* at *2 (asserting that preliminary investigation into urologist's credentials and reputation would have revealed that, as of date of contract with urologist, he was defendant in several malpractice suits, four of which had been concluded in favor of HMO patients).

133. *Harrell*, 1989 WL 153066, at *1.

134. *Id.* at *2–3.

135. *Id.* at *2.

136. *Id.* at *2–3.

the applicant was applying for a primary-care position or a position as a specialist.[137] For primary-care applicants, a six-member credential committee reviewed the application for irregularities.[138] For specialists, a three-member "Provider-Professional Relations Committee" reviewed the application in a similar fashion.[139] Neither committee investigated the applicants' standing in the medical community, and neither committee conducted personal interviews with the applicants.[140] The committees merely determined whether the applicants held medical licenses, had admitting privileges at some hospital, and could prescribe narcotics.[141] Ultimately, the HMO would accept a physician if the application appeared normal.[142] The HMO inquired further into a physician's qualifications only after the physician admitted his or her first patient to the hospital.[143]

These approval practices led the *Harrell* court to conclude that the HMO was potentially liable for the negligent selection of the urologist who negligently performed surgery on the plaintiff.[144] Reasoning that these practices exposed patients to unreasonable risks, the court stated:

> In this arrangement where Total Health Care collects a premium for the expense of medical care and limits the choice by the subscriber to physicians acceptable to Total Health Care, there is an unreasonable risk of harm to subscribers if the physicians listed by Total Health Care include doctors who are unqualified or incompetent. The presence of that risk gives rise to a common law duty owed by Total Health Care to conduct a reasonable investigation of physicians to

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137. *Harrell*, 1989 WL 153066, at *2-3.

138. *Id.* at *2.

139. *Id.* at *3.

140. *Id.*

141. *Harrell*, 1989 WL 153066, at *3.

142. *See id.* at *2–3 (noting that if nothing unusual appeared on application form and all answers to questions on application were appropriate, physicians were enrolled as members and eligible for referrals from HMO).

143. *Id.*

144. *Id.* at *6. The court found that the HMO failed to investigate the physician's competence. *Id.* Although the court recognized a viable cause of action based on negligent selection of the treating physician, the court ultimately transferred the appeal to the Missouri Supreme Court, which held that the HMO was shielded from liability by a state statute granting immunity to nonprofit health service corporations. Harrell v. Total Health Care, Inc., 781 S.W.2d 58, 64 (Mo. 1989).

> ascertain their reputation in the medical community for competence.[145]

This language clearly echoes the reasoning of the *Hickman* court. Both *Harrell* and *Hickman* found liability under a traditional common-law negligence analysis.[146] By applying the analytical principles of these cases, Texas courts should hold HMOs directly liable for negligently selecting physicians.

B. *Negligent Cost Containment*

Texas courts should also hold HMOs liable for negligent cost containment. Although HMOs are profitable and attractive to consumers because they can reduce medical care costs,[147] HMO cost-containment schemes can ultimately harm patients. The two primary cost-containment methods used by HMOs are utilization review and financial incentives.[148] Generally, utilization review includes precertification and notification schemes.[149] Precertification

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145. *Harrell*, 1989 WL 153066, at *5.

146. *Compare Hickman*, 703 S.W.2d at 266 (holding that hospital had duty to exercise reasonable care in retention and selection of medical staff and duty to periodically review and monitor staff's competency) *with Harrell*, 1989 WL 153066, at *5 (deciding that risk of harm to patients gives rise to common-law duty to conduct reasonable investigation of member-physician's competency).

147. *See* Michael Daly, *Attacking Defensive Medicine Through the Utilization of Practice Parameters: Panacea or Placebo for the Health Care Reform Movement?*, 16 J. LEGAL MED. 101, 115 (1995) (asserting that managed care is predicated on belief that incentives are most effective means of cost containment); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 537 (1990) (stating that increasing HMO enrollment is due to assumption that fee-for-service system inflates health care costs); *see also* Lani Luciano, *How to Cut Your Expenses 20% (and Live Better Too)*, MONEY, Dec. 1991, at 70 (touting HMOs as easy mechanism for reducing medical costs). A survey of 222 employee groups concluded that HMO utilization review reduced medical expenses by 8.3%, hospital admissions by 12.3%, hospitalization days by 8.0%, and hospital expenditures by 11.9%. Paul J. Feldstein et al., *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310, 1313 (1988). Although this study demonstrated the potential cost savings from utilization review, it did not address the costs borne by plan subscribers and physicians. *Id.* at 1314.

148. *See* John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 192–93 (1989) (listing various methods employed by government and industry in attempt to reduce health care costs).

149. *See* Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1653 (1992) (noting that purpose of prospective utilization review is to require medical necessity determinations prior to treatment); Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier of Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 116–17 (1992) (asserting that, while providers' utilization-

is a mechanism that requires a physician to contact an HMO representative prior to admitting a patient to a hospital.[150] An HMO representative, or "gatekeeper," has the authority to approve or deny the request for admission and limit the time that the patient is allowed to remain in the hospital.[151] Similarly, notification schemes require the physician to contact the HMO reviewer both prior to admitting a patient to the hospital and during the patient's hospital stay.[152] Notification ignites an internal cost-watching machine and may result in an in-hospital review by an HMO employee.[153]

Financial incentives to cut costs take many forms. For example, an HMO may use capitation payments, allowances, or a target-utilization scheme. Capitation payments are payments made to physicians on a per-patient-per-month basis, regardless of what, if any, services are performed.[154] Conversely, allowances provide for the

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review decisions merely deny or approve payment for proposed care and physician and patient have ultimate decision to decide whether to proceed with treatment, utilization-review decisions usually bind patients because of lack of alternative means to pay for uncovered medical expenses).

150. Paul J. Feldstein et al., *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310, 1311 (1988).

151. David J. Oakley & Eileen M. Kelley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT & INS. L.J. 624, 635 (1988). One court, recognizing the influence of HMO utilization-review procedures, stated:

> By its very nature, a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary, faced with the knowledge of specifically what the plan will and will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits.

Corcoran v. United HealthCare, Inc. 965 F.2d 1321, 1332 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992).

152. *See* David J. Oakley & Eileen M. Kelley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT & INS. L.J. 624, 636 (1988) (asserting that purpose of notification is to notify HMO, rather than to request permission to admit patient).

153. *Id.*

154. *Id.*; *see* 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, 30 (1993) (defining capitation payments as set fee per HMO enrollee, and asserting that capitation payments are attempt to manipulate physician behavior by shifting risk of loss from HMO to physicians).

physician to be paid on a limited fee-for-service basis with some percentage withheld.[155] Under this formula, an amount is "allowed" for the physician's yearly costs.[156] The previously withheld portion is returned to the physician if the actual fees paid fall within the yearly allowance;[157] however, the HMO keeps the withheld fees if the physician exceeds the allowance.[158] Finally, under the target-utilization method, the physician and the HMO or IPA negotiate a target expenditure amount.[159] The physician receives an incentive bonus if the total costs for the physician's patients fall below the target.[160] If the yearly costs exceed the target expenditure amount, however, the physician does not receive a bonus.[161] Because utilization-review and financial-incentive programs approach cost containment differently, this Article analyzes the liability for each approach separately.

1. Utilization-Review Liability

Wickline v. California[162] is arguably the most widely recognized case regarding utilization-review liability.[163] In *Wickline*, the patient sought treatment from her physician for back and leg problems.[164] After unsuccessful physical therapy, the physician admitted her to a local hospital and consulted a specialist in peripheral vascular surgery.[165] The specialist determined that the patient suffered from a disease known as Leriche's Syndrome.[166] Due to arteriosclerosis, the patient's aorta became obstructed just above

155. David J. Oakley & Eileen M. Kelley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT & INS. L.J. 624, 636 (1988).

156. *Id.*

157. *Id.*

158. *See id.* (explaining that allowance method is mechanism for reducing health care costs).

159. David J. Oakley & Eileen M. Kelley, *HMO Liability for Malpractice of Member Physicians: The Case of IPA Model HMOs*, 23 TORT & INS. L.J. 624, 636 (1988).

160. *Id.*

161. *Id.*

162. 239 Cal. Rptr. 810 (Ct. App. 1986).

163. *See* John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 198–99 (1989) (discussing importance of *Wickline* decision).

164. *Wickline*, 239 Cal. Rptr. at 812.

165. *Id.* A peripheral vascular surgeon specializes in surgery on any blood vessel in the body, except the heart. *Id.*

166. *Id.*

its dividing point for carrying blood to the legs.[167] The treating physician concluded that the patient's only alternative was partial removal of her artery and installation of an artificial replacement.[168]

The patient received medical care under the California medical assistance program known as Medi-Cal.[169] Similar to many HMOs, this program required a patient's physician to receive authorization from Medi-Cal before admitting the patient to a hospital and obtain further authorization if the hospital stay exceeded the time approved during precertification.[170] The patient experienced complications after surgery, and the physician requested an eight-day extension of the patient's hospital stay.[171] A Medi-Cal employee denied this request and instead granted only a four-day extension.[172] A general surgeon subsequently decided to limit the hospital stay based solely on information conveyed by a Medi-Cal nurse over the telephone.[173] Although a Medi-Cal specialist was available for consultation, the general surgeon limited the hospital stay without consulting a vascular surgeon based on symptoms that were irrelevant to the patient's circulatory problems.[174]

After four days, the treating physicians discharged the patient in accordance with the Medi-Cal authorization form.[175] Shortly thereafter, the patient lost circulation in her leg and developed a severe infection.[176] Attempts to treat the infection with medication were unsuccessful, and the patient's leg was subsequently ampu-

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167. *Id.* Arteriosclerosis is the thickening of the walls of the arteries, which reduces or blocks the flow of blood. *Id.* (citing DORLAND'S ILLUSTRATIVE MEDICAL DICTIONARY 137 (27th ed. 1988)).

168. *Wickline*, 239 Cal. Rptr. at 812.

169. *Id.*

170. *See id.* (noting that Medi-Cal authorized ten days of initial hospitalization); *see also* Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1302 (1994) (asserting that 95% of all employees enrolled in health care plans are subject to precertification requirement).

171. *See Wickline*, 239 Cal. Rptr. at 813 (stating that all physicians concurred in finding that it was medically necessary for patient to remain in hospital).

172. *Id.* at 814.

173. *See id.* (noting that Medi-Cal consultant did not actually review form requesting extension prior to making decision).

174. *See id.* at 815 (asserting that denial of extension was not based on factors "an ordinary prudent physician" would have considered relevant).

175. *Wickline*, 239 Cal. Rptr. at 815.

176. *Id.* at 816.

tated.[177] In the treating physician's expert medical opinion, the patient would not have lost her leg if the eight-day extension had been granted, because the circulatory problems and the infection would have been detected and treated at an earlier stage.[178]

The patient subsequently sued Medi-Cal in a California superior court.[179] The court focused on Medi-Cal's legal responsibility for an injury when a cost-containment program affects the treating physician's medical judgment.[180] The court noted that utilization-review programs create especially high risks for patients, because an erroneous decision in a prospective review process may result in permanent disability or death.[181]

Given the potentially grave results of such errors, the court applied a traditional negligence analysis to determine the third-party payor's potential liability.[182] Specifically, the court found:

> The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms. . . .[183]

Ultimately, however, the court refused to hold the payor liable because the treating physician did not question the decision to limit the hospital stay, and Medi-Cal's action conformed to the applicable statutory law.[184] The attending physician's inaction presumably broke the chain of causation and allowed Medi-Cal to escape liabil-

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177. *Id.* at 816–17.

178. *Id.* at 817.

179. *Wickline*, 239 Cal. Rptr. at 810.

180. *Id.* at 811–12.

181. *Id.* at 812. The court noted that risks resulting from utilization-review programs are much higher than retrospective cost-containment measures when the payee reviews the medical bills after the fact to determine whether the treatment was medically necessary. *Id.*

182. *See id.* at 819–20 (stating that determination of standard of care is made based on usual standards of care within medical community).

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

184. *See id.* at 819–20 (concluding that, although negligent physician was intimidated by Medi-Cal program, he was not paralyzed or powerless to give patient appropriate care). The court determined that a "physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care." *Id.* at 819. *But see* Wilson v. Blue

ity.[185] Although the court did not find liability in *Wickline*, it left the door open to subsequent claims against third-party payors.

Wickline's restrictive causation analysis was subsequently rejected in *Wilson v. Blue Cross*.[186] The plaintiff in *Wilson* entered the hospital seeking treatment for major depression, and his physician determined that he needed three to four weeks of in-patient care.[187] After ten days of treatment, the plaintiff's insurance company refused further payment.[188] Because the plaintiff could not afford the care, he was discharged from the hospital.[189] He committed suicide twenty days later.[190] The plaintiff's parents brought an action against the insurance company and the treating physician.[191]

On appeal from a summary judgment in favor of the insurance company,[192] the *Wilson* court identified the key issue as "the extent to which *Wickline* extends beyond the context of Medi-Cal patients to an insured under an insurance policy issued in the private sector."[193] In answering this question, the court specifically rejected the *Wickline* causation analysis and instead applied the causation analysis found in section 431 of the Restatement (Second) of Torts.[194] Under the Restatement analysis, an "actor's conduct is a legal cause of harm to another . . . if his conduct is a substantial factor in bringing about the harm."[195] In *Wilson*, the court found ample evidence that the insurance company's decision to deny further hospitalization was, in fact, a "substantial factor in bringing

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Cross, 271 Cal. Rptr. 876, 880 (Ct. App. 1990) (stating that above-quoted language in *Wickline* was mere dicta and failed to correctly state law of California).

185. *See Wickline*, 239 Cal. Rptr. at 819 (noting that Medi-Cal was not party to physician's medical decision and, therefore, could not be held liable if decision was negligently made).

186. 271 Cal. Rptr. 876, 880 (Ct. App. 1990).

187. *Wilson*, 271 Cal. Rptr. at 877.

188. *Id.*

189. *Id.* at 877–78.

190. *Id* at 877.

191. *Wilson*, 271 Cal. Rptr. at 876.

192. *Id.* at 876–77.

193. *Id.* at 878.

194. *Id.* at 883; *see* RESTATEMENT (SECOND) OF TORTS § 431 (1965) (explaining standard for determining point at which actor's negligent conduct amounts to legal cause of harm to another).

195. RESTATEMENT (SECOND) OF TORTS § 431 (1965).

about the decedent's demise."[196] Therefore, the court remanded the case to the trial court to determine whether the insurance company's denial of continued hospitalization was, in fact, a substantial factor in the wrongful death of the plaintiff.[197]

What effect, if any, these cases will have in Texas is unclear. However, Texas courts have followed the Restatement's substantial-factor causation analysis in other contexts.[198] In *Lear Siegler, Inc. v. Perez*,[199] for example, the Texas Supreme Court found the Restatement's discussion of legal cause to be instructive in the products liability context:

> In order to be a legal cause of another's harm, it is not enough that the harm would not have occurred had the actor not been negligent. . . . [T]his is necessary, but it is not of itself sufficient. The negligence must also be a *substantial factor* in bringing about the plaintiff's harm. The word "substantial" is used to denote the fact that the defendant's conduct has such an effect in producing the harm as to lead reasonable men to regard it as a cause, using that word in the popular sense, in which there always lurks the idea of responsibility. . . .[200]

Thus, if a Texas HMO's cost-containment scheme causes harm to a patient, the HMO should be liable under a *Wickline-Wilson* policy analysis and Texas causation principles.

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196. *Wilson*, 271 Cal. Rptr. at 883.

197. *Id.* at 885.

198. *See* Union Pump Co. v. Allbritton, 898 S.W.2d 773, 775, 780 (Tex. 1995) (examining liability for defective pump, defining "cause in fact" as defendant's act or omission that is substantial factor in bringing about injury, and noting that actor's conduct cannot be substantial factor contributing to injury if injury would have occurred without actor's negligence); Prudential Ins. Co. v. Jefferson Assocs., 896 S.W.2d 156, 161 (Tex. 1995) (stating that plaintiffs must prove actual causation-in-fact to recover on misrepresentation and concealment claims).

199. 819 S.W.2d 470 (Tex. 1991).

200. RESTATEMENT (SECOND) OF TORTS § 431 cmt. a (1965) (emphasis added), *quoted in*, Lear Siegler, Inc. v. Perez, 819 S.W.2d 470, 472 (Tex. 1991); *see* Wolf v. Friedman Steel Sales, 717 S.W.2d 669, 672 (Tex. App.—Texarkana 1986, writ ref'd n.r.e.) (explaining that Texas law "provides that an intervening cause reasonably foreseeable by the defendant is not such a new and independent cause as to break the chain of causation between the defendant's negligence and the injury . . . to the extent of relieving the defendant of liability for injury"). Based on *Lear Siegler, Inc.* and *Wolf*, if an HMO's action was a substantial factor in the refusal of needed treatment, and the HMO could have reasonably foreseen that its refusal to pay would prompt the physician to withhold care, the HMO should be liable for the harm.

2. Liability Due to Financial Incentives

In addition to utilization-review liability, a Texas HMO may face liability because of the financial incentives it provides to member-physicians. The two principal theories that support this type of liability are (1) negligence in forming financial incentive arrangements, and (2) claims based on tortious interference with the physician-patient relationship.[201]

a. Negligent Formulation of Incentives

Texas courts have recognized that health care institutions might face legal responsibility for negligently forming or enforcing their own rules or policies.[202] Thus, if the incentive arrangement between the HMO and physician leads to poor patient care, the HMO could face liability.[203] Concern over incentive arrangements prompted Congress to enact an amendment to the Omnibus Budget Reconciliation Act of 1986[204] that prohibits hospitals and HMOs from making payments, directly or indirectly, to a physician as an inducement to reduce or limit services provided to any Medicare or Medicaid beneficiary.[205] Congress's concerns were appar-

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201. *See* Bush v. Dake, No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County, Apr. 27, 1989) (recognizing that HMO financial incentives may contribute to malpractice), *reprinted in* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 385–86 (1991); Bellefonte Underwriters Ins. Co. v. Brown, 663 S.W.2d 562, 573 (Tex. App.—Houston [14th Dist.] 1983) (stating that insurance company may face liability for soliciting conspiracy to deny treatment due under contractual agreement between parties), *rev'd on other grounds*, 704 S.W.2d 742 (Tex. 1986).

202. *See* Deerings W. Nursing Ctr. v. Scott, 787 S.W.2d 494, 496 (Tex. App.—El Paso 1990, writ denied) (concluding that failure to discover 56 prior theft convictions before hiring nurse constitutes negligent hiring); Park N. Gen. Hosp. v. Hickman, 703 S.W.2d 262, 266 (Tex. App.—San Antonio 1985, writ ref'd n.r.e.) (concluding that hospital has duty to exercise reasonable care in selecting medical staff).

203. *See* Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier of Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 115 (1992) (suggesting that, depending upon degree of intervention, HMO procedures may substitute opinion of HMO administrator for that of medical professionals actually providing care, which could be grounds for direct liability).

204. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313(c), 100 Stat. 2003 (codified as amended at 42 U.S.C. § 1320a-7a(b)(1) (1988)).

205. *Id.* The law's enactment was delayed with respect to HMOs pending a Department of Health and Human Services investigation. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6207(a), 103 Stat. 2245 (noting delay in effective date of physician-incentive rules).

ently well founded, as evidenced by a recent study which indicates that incentive arrangements actually affect physician behavior.[206]

Considering state, federal, and professional concerns over the formation of incentives within the health care industry, the lack of relevant case law is surprising. However, one recent case suggests a willingness to apply negligence principles to find liability when the financial incentive arrangement contributes to poor patient care.[207] In *Bush v. Dake*,[208] an unreported Michigan case, the plaintiff sought treatment from an "approved" primary-care physician for a gynecological problem.[209] Although the physician prescribed medication, the plaintiff's problem persisted for several months.[210] After six months, the physician referred the patient to a specialist in obstetrics and gynecology.[211] The gynecologist performed a test for sexually transmitted diseases,[212] and instructed the patient to return for more testing after her next menstrual cycle if the bleeding persisted.[213] When the bleeding continued, the patient attempted to obtain a second referral from the primary-care physician pursuant to HMO requirements.[214] The primary-care physician refused her request, and the patient was admitted to the emergency room for her condition approximately two months later.[215] When a biopsy revealed cervical cancer,[216] the patient

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206. *See* Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW. ENG. J. MED. 86, 90 (1989) (suggesting that HMO member-physicians structure patient treatment around yearly HMO budget).

207. *See* Bush v. Dake, No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County, Apr. 27, 1989) (holding that triable issue of fact existed as to whether cost-containment procedures contributed to improper treatment), *reprinted in* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 384–86 (1991). *But see* Sweede v. Cigna Healthplan of Delaware, Inc., 1989 WL 12608, at *5 (Del. Super. Ct. Feb. 2, 1989) (holding that connection between financial incentives and physician's medical decision was "too remote to be of significant probative value").

208. No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County, Apr. 27, 1989), *reprinted in* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 384 (1991).

209. *Id.* at 385.

210. *Id.*

211. *Id.*

212. Bush v. Dake, No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County, Apr. 27, 1989), *reprinted in* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 385 (1991).

213. *Id.*

214. *Id.*

215. *Id.*

sued the HMO asserting that the HMO's financial incentives resulted in a failure to diagnose her cancer in a timely manner.[217]

Although the court appeared concerned about whether the HMO system itself represented sound public policy, it refused to rule on the issue.[218] However, the court found that a material fact issue existed as to whether the financial incentives proximately caused the malpractice.[219] Accordingly, the court remanded the case for trial because the plaintiff had presented evidence that the incentive program contributed to the delay in diagnosis and treatment.[220] The court cited *Wickline*, presumably for the proposition that if the fact finder determined that the incentive arrangement contributed to the patient's harm, the HMO should be legally responsible.[221] Thus, although there are few cases on point, a *Wickline-Wilson* analysis may prove successful in negligent formulation of incentive cases given the right set of facts.

b. Tortious Interference

A slightly different theory under which HMOs could be held liable for using financial incentives is the doctrine of tortious interference with a contractual relationship.[222] Texas first recognized a

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216. Bush v. Dake, No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County, Apr. 27, 1989), *reprinted in* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 385 (1991).

217. *Id.*

218. *See id.* (noting that soundness of social policy justifying HMO system is question best left to legislature).

219. *Id.* at 386.

220. Bush v. Dake, No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw County, Apr. 27, 1989), *reprinted in* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 386 (1991).

221. *See id.* (suggesting that HMO's incentive program contributed to improper treatment (citing Wickline v. California, 228 Cal. Rptr. 661, 670 (Ct. App. 1986))).

222. *See* Black Lake Pipe Line Co. v. Union Constr. Co., 538 S.W.2d 80, 91 (Tex. 1976) (recognizing recovery for tortious interference with contractual relationship, and requiring showing that interference was without right or justification); Finn v. Schammel, 412 N.W.2d 147, 154 (Wis. Ct. App. 1987) (requiring proof of affirmative acts by defendant that induce doctor to breach contract); *see also* RESTATEMENT (SECOND) OF TORTS § 766, § 766 cmt. u (1977) (stating that one who intentionally interferes with performance of contract is liable for resulting breach, and noting that equitable relief is available under appropriate circumstances); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 129, at 978–79 (5th ed. 1984) (explaining that tortious interference theory may also lie in equity, such as in actions seeking injunctive and restitutionary relief, though relationship not reduced to contract).

cause of action for improper interference with a contractual relationship in *Raymond v. Yarrington*,[223] in which the Texas Supreme Court determined that a cause of action exists when a party induces another to breach an existing contract.[224]

More recently, a Texas court determined that four elements must exist to establish a cause of action for tortious interference.[225] These factors are: "(1) that a contract subject to interference existed; (2) the act of interference was willful and intentional; (3) the intentional act was a proximate cause of the plaintiff's damages; and (4) actual damages or loss occurred."[226] The defendant's act need not result in an actual breach of contract.[227] Rather, "all invasions of contractual relations, including any act which retards, makes more difficult or prevents performance" will establish the cause of action.[228]

The physician-patient contractual relationship seems especially worthy of protection, as one court recognized:

> When an ailing person selects a physician to treat him, he does so with the full expectation that such physician will do his best to restore him to health, and the contract into which they enter is deserving of more attention from the law than a businessman's expectation of profit from a purely commercial transaction.[229]

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223. 96 Tex. 443, 73 S.W. 800 (1903).

224. *See Raymond*, 96 Tex. at 452, 73 S.W. at 803 (holding that party has clear right to performance of contract entered into with another, and concluding that knowingly inducing other party to violate contract "is as distinct a wrong as it is to injure or destroy his property").

225. *Bellefonte Underwriters Ins. Co.*, 663 S.W.2d at 573 (citing Armendariz v. Mora, 553 S.W.2d 400, 404 (Tex. Civ. App.—El Paso 1977, writ ref'd n.r.e.)).

226. *Id.*

227. *Id.*

228. *Id.*; *see* Tippett v. Hart, 497 S.W.2d 606, 611 (Tex. Civ. App.—Amarillo) (stating that any tortious act that injures property and interferes with contract performance is actionable), *writ ref'd per curiam*, 501 S.W.2d 874 (Tex. 1973).

229. Hammonds v. Aetna Casualty & Sur. Co., 237 F. Supp. 96, 101 (N.D. Ohio 1965). Hammonds filed a negligence action against a hospital, which was insured by Aetna, after his hospital bed collapsed. *Id.* at 98. Aetna obtained Hammonds's medical records from his physician, who was also Aetna's insured, by falsely representing to the doctor that Hammonds had filed a complaint against the doctor. *Id.* Aetna allegedly forced the doctor to cease treating Hammonds based on this representation. *Id.*

Texas courts recognize a contractual relationship between physicians and patients. *See* Pope v. St. John, 862 S.W.2d 657, 660 (Tex. App.—Austin 1993, no writ) (concluding that physician-patient relationship is based on "at least an implied contract" that physician will use ordinary care to avoid injury to patient); Fought v. Solce, 821 S.W.2d 218, 220 (Tex. App.—Houston [1st Dist.] 1991, writ denied) (stating that contractual relationship be-

Further, the financial incentives that may interfere with the physician-patient relationship are especially hazardous. These incentives can expose patients to an unreasonable risk of harm due to premature discharge from a hospital.[230] Similarly, financial incentive arrangements may discourage or limit the attending physician's ability to diagnose or treat a medical condition in a timely manner.[231] These particular dangers led one commentator to declare that "the HMO scenario is precisely the situation wherein the tort of interference with physician-patient relationship might be most effectively and meaningfully invoked."[232]

However, one cannot tortiously *interfere* with one's own relationship.[233] Courts generally do not consider a contracting party's agent to be an interfering third party; rather, the agent assumes the original contracting party's identity.[234] Thus, an HMO might argue that it has a contract for care with the patient or an agency relationship with the physician. It is unlikely, however, that an HMO would make such an argument in light of the potential for vicarious liability discussed above. Nevertheless, Texas HMOs are hardly defenseless because there remain two especially tough obstacles to imposing liability on HMOs.

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tween physician and patient is created by either express or implied agreement); Childs v. Weis, 440 S.W.2d 104, 106–07 (Tex. Civ. App.—Dallas 1969, no writ) (noting that physician-patient relationship is contractual, wholly voluntary, and created by agreement).

230. *See* Joanne B. Stern, *Malpractice in the Managed Care Industry*, 24 CREIGHTON L. REV. 1285, 1293 (1991) (discussing various risks created by HMO incentive programs).

231. *See* E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1724 (1987) (suggesting that HMOs encourage physicians to treat patients at minimal cost by reducing capitation payments for improper referrals or for exceeding target-utilization goals).

232. Joanne B. Stern, *Malpractice in the Managed Care Industry*, 24 CREIGHTON L. REV. 1285, 1295–96 (1991).

233. *See* Transcontinental Gas Pipe Line Corp. v. American Nat'l Petroleum Co., 763 S.W.2d 809, 821 (Tex. App.—Texarkana 1988) (noting that party to contract could not be held to have interfered tortiously with that contract), *rev'd on other grounds*, 798 S.W.2d 274 (Tex. 1990).

234. *See* Victor M. Solis Underground Util. & Paving Co., Inc. v. Laredo, 751 S.W.2d 532, 535 (Tex. App.—San Antonio 1988, writ denied) (finding no cause of action for contract interference against contracting party's agent).

V. BARRIERS TO IMPOSING LIABILITY

A. *ERISA Preemption*

The first obstacle to imposing liability on an HMO for poor patient care is the Employee Retirement Income Security Act of 1974 (ERISA).[235] Although Congress enacted ERISA to protect employees, the preemption clause, as interpreted by the United States Supreme Court and the Texas Supreme Court, severely limits this protection.[236] There are three ERISA sections that deal with preemption—the express preemption clause, the "savings clause," and the "deemer clause." The express preemption clause dictates that any state law, whether based on common law or statute, is preempted if it relates to any covered benefit plan.[237] The savings clause excludes from preemption state laws regulating insurance, banking, or securities.[238] Finally, the deemer clause provides that an employee benefit plan shall not be deemed an insurance company or insurer for savings clause purposes.[239]

The initial inquiry, therefore, is whether an employee benefit plan is covered by ERISA.[240] The term "employee benefit plan" is defined by ERISA to include both pension plans and employee welfare plans.[241] An employee pension benefit plan is one that provides income deferral or retirement income.[242] An employee

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235. 29 U.S.C. §§ 1001-1461 (1988 & Supp. V 1993). Because an extensive exposition on ERISA law is beyond the scope of this Article, only those provisions that directly affect HMO liability are discussed. For an excellent discussion of ERISA generally, see Mary A. Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 268–94 (1990).

236. *See* Cathey v. Metropolitan Life Ins. Co., 805 S.W.2d 387, 390–91 (Tex. 1991) (concluding that plaintiff's claims were preempted by ERISA and, therefore, not actionable under Texas Deceptive Trade Practices Act); *see also* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44–45 (1987) (reviewing ERISA preemption clauses and summarizing congressional intent).

237. 29 U.S.C. § 1144(a) (1988). Commonly known as the "preemption clause," this section states that "except as provided in sub-section (b) of this section [the savings clause], the provisions of this sub-chapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." *Id.*

238. *Id.* § 1144(b)(2)(A).

239. *Id.* § 1144(b)(2)(B).

240. *See* Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619, 623 (1994) (noting that primary inquiry in determining scope of ERISA is into meaning of phase "relate to," and secondary inquiry is into meaning of term "plan").

241. 29 U.S.C. § 1002(3) (1988).

242. *Id.* § 1002(2)(A)(i), (ii).

welfare benefit plan includes any program providing benefits for illness, accident, disability, or death.[243] Significantly, ERISA explicitly exempts governmental employee benefit plans from its coverage.[244] For ERISA purposes, a governmental plan is defined as "a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing."[245] Thus, when a governmental employee covered by a governmental plan is injured, ERISA preemption is not an issue.

As previously stated, under ERISA's express preemption clause, any state law cause of action, whether based on common law or statute, is preempted if it "relates to" any covered benefit plan.[246] Thus, the key issue with regard to HMO liability is whether the applicable state law relates to a covered employee plan.[247] The United States Supreme Court has determined that the phrase "relates to" should be construed expansively.[248] The Court has also determined that, in addition to laws directly affecting an employee plan's operation, laws that have a "connection with or reference to such a plan" are deemed to relate to the plan for preemption purposes.[249] The preemption provision has limits, however, as the Court has recognized that ERISA does not preempt all causes of action. Specifically, the Court recognized that "[s]ome state actions may affect employee benefit plans in *too tenuous, remote or peripheral* a manner to warrant a finding that the law 'relates to' the plan."[250]

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243. *Id.* § 1002(1)(A).

244. *Id.* § 1003(b)(1).

245. 29 U.S.C. § 1002(32) (1988).

246. *See id.* § 1144(a) (stating that ERISA preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 1003(a) of this title and not exempt under Section 1003(b) of this title"); *see also* Rodriguez v. Pacificare of Tex., Inc., 980 F.2d 1014, 1017 (5th Cir. 1993) (concluding that state remedy was precluded because HMO plan provided by plaintiff's employer related to employee benefit plan).

247. *See Cathey*, 805 S.W.2d at 389–90 (determining when state law relates to employee benefit plan for purposes of ERISA).

248. *Pilot Life Ins. Co.*, 481 U.S. at 47.

249. Shaw v. Delta Air Lines, 463 U.S. 85, 97 (1983).

250. *Id.* at 100 n.21 (emphasis added) (citing AT&T v. Merry, 592 F.2d 118, 121 (2d Cir. 1979)).

Lower courts have struggled in applying these imprecise guidelines in specific cases.[251] Nonetheless, it appears that courts will find that ERISA preempts any claim against an HMO which utilizes cost-containment measures if the HMO coverage is part of a covered employee benefit plan.[252] For example, the United States Court of Appeals for the Fifth Circuit has held that ERISA preempts a claim against an HMO for negligent utilization review.[253] Additionally, the Texas Supreme Court has held that ERISA preempts a claim based on the refusal to pay for care.[254]

ERISA should not, however, preclude a claim against an HMO that is based on vicarious liability principles. Many courts have held, in substance if not in form, that ERISA does not preempt claims that are based on agency principles because they are too remote or tenuous to relate to an employee plan.[255] For example,

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251. *Compare* Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272, 1276 (6th Cir. 1991) (concluding that state law claims of promissory estoppel, negligent misrepresentation, breach of contract, and breach of good faith are preempted by ERISA as grounds for recovery of employee health care benefits), *cert. dismissed*, 113 S. Ct. 2 (1992) *and* National Alcoholism Programs v. Palm Springs Hosp. Employee Benefit Plan, 825 F. Supp. 299, 305 (S.D. Fla. 1993) (holding that ERISA preempted employee's state law claim under Florida Unfair Trade Practices Act to recover benefits under employer-provided health care plan) *with* Hospice of Metro Denver v. Group Health Ins., 944 F.2d 752, 756 (10th Cir. 1991) (concluding that subscriber's promissory estoppel state law claim was not preempted by ERISA) *and* Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236, 250 (5th Cir. 1990) (holding that hospital's claim against employee's group health insurer under deceptive trade practices provision of Texas Insurance Code was not preempted by ERISA).

252. Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier of Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 133 (1992) (observing that ERISA constitutes considerable obstacle to plaintiffs' negligence claims against insurers or employers based on utilization-review liability).

253. Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1329 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992).

254. *See Cathey*, 805 S.W.2d at 388–91 (concluding that cause of action pertaining to health plan's refusal to continue payments for participant of group is preempted by ERISA).

255. *See, e.g.*, Jackson v. Roseman, 878 F. Supp. 820, 826 (D. Md. 1995) (holding that issues relating to vicarious liability of HMO do not implicate ERISA so as to justify removal to federal court); Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 548 (S.D. Ill. 1994) (declaring that medical malpractice claim based on HMO doctor's substandard treatment of patient is not preempted by ERISA); Dearmas v. Av-Med, Inc., 865 F. Supp. 816, 818 (S.D. Fla. 1994) (holding that ERISA does not preempt claim alleging that HMO is vicariously liable for its treating physicians' actions); Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 186–88 (E.D. Pa. 1994) (deciding that, although court lacked jurisdiction, plaintiff's claim against HMO for actions of HMO's treating physician was viable action); Smith v. HMO Great Lakes, 852 F. Supp. 669, 671–72 (N.D. Ill. 1994) (concluding that

in *DeGenova v. Ansel*,[256] the plaintiff brought an action against his insurance carrier based on agency theories.[257] As part of a cost-containment scheme, the insurance company required DeGenova to have a second physician examine him before the company would pay for nasal surgery.[258] The insurance company selected the physician and made the appointment for DeGenova.[259] During the second examination and without DeGenova's consent, the physician negligently removed a nasal polyp.[260] Under these facts, the court found that the insurance company could be held liable on an agency, or ostensible agency, theory.[261] The court dispensed with ERISA preemption by determining that the claim against the insurance company did not relate to an employee benefit plan for preemption purposes.[262] Specifically, the court recognized a distinction between claims based on general tort theories and claims based on compliance with the plan's second opinion requirement.[263] The court reasoned that because DeGenova's claim against the insurance company was based on tort principles for personal injuries, the insurance company could not hide behind ERISA.[264]

Similarly, in *Independence HMO, Inc. v. Smith*,[265] another court specifically held that an HMO can be liable for a contracting physician's malpractice.[266] This court also recognized a distinction between tort claims and claims for benefits under a covered benefit

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plaintiff's state law negligence claim against HMO for HMO doctor's action was not preempted by ERISA); Independence HMO, Inc. v. Smith, 733 F. Supp. 983, 988 (E.D. Pa. 1990) (finding that vicarious liability claim by plaintiff against HMO was not precluded by ERISA).

256. 555 A.2d 147 (Pa. Super. Ct. 1988). Although *DeGenova* is a traditional health insurance case, it raises the same ERISA preemption issue as cases involving HMOs. *See DeGenova*, 555 A.2d at 148 (holding that patient's action against insurance company for acts of agent-doctor were not preempted by ERISA).

257. *Id.*

258. *Id.* at 150.

259. *Id.* at 148.

260. *DeGenova*, 555 A.2d at 148.

261. *Id.* at 150.

262. *Id.*

263. *Id.*

264. *See DeGenova*, 555 A.2d at 150 (stating that "since appellants' claims are only remotely related to ERISA, it cannot be said that Congress intended to preempt such actions when enacting the statute").

265. 733 F. Supp. 983 (E.D. Pa. 1990).

266. *Independence HMO, Inc.*, 733 F. Supp. at 988.

plan.[267] The court characterized malpractice claims as "run-of-the-mill" state law claims that are distinguishable from claims for denying benefits under an employee plan.[268] This distinction was subsequently used by the same court in *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*[269] to prevent an HMO from using ERISA to shield itself from liability.[270] In *Elsesser*, the court ruled that an agency-based malpractice claim against the HMO was not preempted by ERISA.[271] The court noted that claims against the HMO for its own negligence and for breach of contract were sufficiently related to a covered plan and were therefore preempted.[272] Other courts have followed this reasoning.[273]

The reasoning underlying the distinction between negligence and breach of contract claims for ERISA preemption purposes is sound. If ERISA was interpreted to preempt all claims that affect an HMO or increase plan operation costs, such as vicarious liability claims under appropriate circumstances, then HMOs would have a unique status in the law.[274] HMOs would enjoy a "charmed exist-

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267. *See id.* (concluding that vicarious liability claim against HMO for member-physician malpractice is not related to denial of rights under employee benefit plan, but rather is claim seeking redress for injuries sustained by physician that HMO selected).

268. *Id.* at 989.

269. 802 F. Supp. 1286 (E.D. Pa. 1992).

270. *Elsesser*, 802 F. Supp. at 1290.

271. *Id.*

272. *Id.* at 1290–91.

273. *See Dearmas*, 865 F. Supp. at 817–18 (noting that ERISA preempts claims against HMO for negligence in administration of plan benefits, but does not preempt vicarious liability actions based on acts of physicians); Burke v. Smithkline Bio-Science Lab., 858 F. Supp. 1181, 1184 (M.D. Fla. 1994) (holding that ERISA does not preempt medical malpractice actions); Paterno v. Albuerne, 855 F. Supp. 1263, 1263–64 (S.D. Fla. 1994) (distinguishing between preempted claims involving administration of plan and nonpreempted vicarious liability tort actions); *HMO Great Lakes*, 852 F. Supp. at 672 (holding that vicarious liability claims are not preempted because they are not "functional equivalent" of claims for benefits); Kohn v. Delaware Valley HMO, Inc., No. CIV.A.91-2795, 1992 WL 22241, at *4 (E.D. Pa. Feb. 5, 1992) (noting that medical malpractice claim does not "relate to" benefit plan because it does not arise out of ERISA plan's contract). *But see* Ricci v. Gooberman, 840 F. Supp. 316, 317–18 (D.N.J. 1993) (opining that medical malpractice claims are preempted by ERISA because they arise out of delivery of negligent medical care).

274. *See* 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, 8 (1993) (arguing that HMOs are in best position to reduce risk of inadequate care, yet tort law has failed to develop adequate theories to shift risk of injury due to cost-containment schemes from patient to HMO). Complete ERISA preemption of

ence that was never contemplated by Congress."[275] In *Mackey v. Lanier Collection Agency & Service*,[276] the United States Supreme Court specifically determined that "run-of-the-mill state law claims such as . . . torts committed by an ERISA plan" are not preempted.[277] Thus, when properly interpreted, ERISA should only preempt claims against HMOs for harm caused by negligent selection or retention of member-physicians and negligent cost-containment schemes because these claims more directly relate to HMO plan operation than do claims for medical malpractice based on vicarious liability principles.

B. *Texas's Prohibition on the Corporate Practice of Medicine*

The second defense, or barrier to liability, is the statutory prohibition on the corporate practice of medicine.[278] Specifically, the Texas Medical Practices Act prohibits "the practice of medicine by any person, partnership, association, or corporation not duly licensed to practice medicine."[279] Additionally, the Texas Health Maintenance Organization Act makes this prohibition specifically applicable to HMOs.[280]

Texas's prohibition on the corporate practice of medicine led one court to hold that an HMO cannot be liable for a member-physician's malpractice.[281] In *Williams v. Good Health Plus, Inc.*,[282] a patient sued her physician and HMO when the physician negli-

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state-law remedies means that patients injured as a result of HMO utilization-review activities will have no state or federal remedy. *Id.* at 73.

275. United Wire v. Morristown Memorial Hosp., 995 F.2d 1179, 1194 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993).

276. 486 U.S. 825 (1988).

277. *Mackey*, 486 U.S. at 833.

278. *See* TEX REV. CIV. STAT. ANN. art. 4495b, §§ 3.07(f), 3.08(15) (Vernon Supp. 1995) (prohibiting unlicensed practice of medicine); Flynn Bros., Inc. v. First Medical Assocs., 715 S.W.2d 782, 785 (Tex. Civ. App—Dallas 1986, writ ref'd n.r.e.) (holding that Texas Medical Practices Act prohibits corporations composed of lay persons from exercising control over medical practice).

279. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.08(15) (Vernon Supp. 1995).

280. *See* TEX. INS. CODE ANN. art. 20A.26(c) (Vernon Supp. 1995) (noting that nothing in Texas Health Maintenance Organization Act should be construed as permitting HMOs to practice medicine); *see also id.* art. 20A.06(a) (stating that power of HMOs includes, but is not limited to, furnishing or arranging for medical care services).

281. *See* Williams v. Good Health Plus, Inc., 743 S.W.2d 373, 378 (Tex. App.—San Antonio 1987, no writ) (rejecting claim against HMO for medical negligence).

282. 743 S.W.2d 373 (Tex. App.—San Antonio 1987, no writ).

gently performed a procedure on her thumbnail.[283] After reviewing the applicable statutory law, the court held that the action against the HMO was essentially a medical negligence claim, and because the HMO could not legally practice medicine, it could not do so negligently.[284] Thus, the statutory prohibition on the corporate practice of medicine may preclude recovery from an HMO in an action based on some institutional medical malpractice theory.[285]

The prohibition on the corporate practice of medicine does not, however, preclude all recovery against an HMO for its physicians' malpractice. Specifically, any action against an HMO based on an agency theory should survive a *Williams*-type attack. The *Williams* court specifically stated that the plaintiff was not entitled to a claim based on an agency theory only because she had not raised those theories at trial.[286] Further, other courts have held that ERISA does not preempt medical malpractice claims against HMOs based on apparent agency or other vicarious liability theories.[287] Thus, statutory prohibitions on the corporate practice of medicine should only bar actions against health care institutions premised on the *institution's* negligent practice of medicine;[288] vicarious liability claims against HMOs should remain viable.

VI. The Effects of HMO Liability on Health Care Costs

Any discussion of HMO liability naturally raises concerns about the impact that imposing such liability would have on health care costs. Health care costs in the United States have increased dra-

283. *Williams*, 743 S.W.2d at 374.

284. *Id.* at 378.

285. *See* Paterno v. Albuerne, 855 F. Supp. 1263, 1264 (S.D. Fla. 1994) (stating that causes of action involving institutional malpractice, such as disbursement and administration of pension or employee benefit funds, go to core function of ERISA and, as such, are preempted).

286. *Williams*, 743 S.W.2d at 379.

287. *E.g.*, Jackson v. Roseman, 878 F. Supp. 820, 826 (D. Md. 1995); Dearmas v. Av-Med, Inc., 865 F. Supp. 816, 818 (S.D. Fla. 1994); Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 188 (E.D. Pa. 1994); *Paterno*, 855 F. Supp. at 1263–64; Independence HMO, Inc. v. Smith, 733 F. Supp. 983, 988 (E.D. Pa. 1990).

288. *See Williams*, 743 S.W.2d at 378 (finding negligence claim against HMO barred as matter of law because Texas prohibits corporate practice of medicine).

matically in recent years.[289] One report indicates that health care expenditures doubled between 1960 and 1988.[290] In an attempt to control rising costs, the number of HMOs and other managed health care entities has also risen drastically.[291] Over one-half of the Americans covered by employee health plans utilize some form of managed care.[292] Many Americans are concerned about the economic impact of liability associated with health care.[293] Yet, even with rapid increases in the number of patients receiving care from HMOs,[294] courts have only recently begun determining the legal ramifications of such arrangements.

In this process, the competing goals of the HMO and the injured patient—cost containment versus compensation for harm—represent the competing policy considerations of the tort process generally.[295] The respective goals of HMOs and patients, though, are not as diametrically opposed as it would seem. Patients may recover for injuries sustained in the course of treatment by an HMO physician without dramatically increasing the cost to the HMO of providing care.[296] A recent study funded jointly by the Texas Med-

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289. *See* Theodore R. Marmor & Mark A. Goldberg, *Roundtable on the Defeat of Reform: Reform Redux*, 20 J. HEALTH POL. POL'Y & L. 491, 491 (1995) (noting that health care costs are increasing at twice rate of inflation, despite health care reform and advances in managed care system).

290. *See* Mary A. Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 260 (1990) (indicating that, as percentage of Gross National Product, health care costs doubled from 1960 to 1988).

291. *See* Barry R. Furrow, *The Changing Role of the Law in Promoting Quality in Health Care: From Sanctioning Outlaws to Managing Outcomes*, 26 HOUS. L. REV. 147, 151 (1989) (noting that enrollment in health care management entities rose six-fold between 1980 and 1987).

292. *Id.*

293. *See* TONN AND ASSOCIATES, MEDICAL AND HOSPITAL PROFESSIONAL LIABILITY: A REPORT PREPARED FOR THE TEXAS HEALTH POLICY TASK FORCE 2 (1992) (examining diverging opinions regarding effect of malpractice liability on health care costs); Annetta Miller et al., *Can You Afford to Get Sick?*, NEWSWEEK, Jan. 30, 1989, at 44 (relating concern over increasing costs of health care).

294. *See* Barry R. Furrow, *The Changing Role of the Law in Promoting Quality in Health Care: From Sanctioning Outlaws to Managing Outcomes*, 26 HOUS. L. REV. 147, 151 (1989) (noting that HMOs and other managed-care entities climbed from servicing 5 to 10% of America's employees to approximately 60% from 1980–1987).

295. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 4, at 20–26 (5th ed. 1984) (discussing factors affecting tort liability, such as morality, punishment, administrative convenience, and compensation).

296. *See* TONN AND ASSOCIATES, MEDICAL AND HOSPITAL PROFESSIONAL LIABILITY: A REPORT PREPARED FOR THE TEXAS HEALTH POLICY TASK FORCE 88 (1992) (noting that medical malpractice payments constitute only 0.62% of Texas health care expendi-

ical Association, Texas Hospital Association, and the Texas Trial Lawyers Association found that:

> changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas. Medical professional liability costs for premiums and indemnity payments are estimated to be less than one percent of health care expenditures, both in Texas and the U.S. as a whole.[297]

Thus, from a cost-benefit standpoint, little justification exists for denying an injured victim compensation from an HMO.

VII. CONCLUSION

Texas courts utilize many legal tools to protect citizens from unreasonable risks of harm. Texans who look to medical brokers for health care face equivalent, if not greater, risks of harm from medical malpractice than do patients in hospitals. Further, given the high degree of control that HMOs exercise over patient care, subscribers face additional threats of harm due to improper action by the HMO itself. Texas courts have been vigilant in their efforts to protect hospital patients from both the malpractice of physicians practicing in hospitals and from the wrongful actions of the hospital itself. Implicitly, Texas courts have determined that the minor financial burden on health care costs created by finding liability for medical negligence is vastly outweighed by the deterrent effects of such liability and the need to compensate victims. This reasoning is also appropriate in the HMO context. Therefore, no reason exists for refusing to protect Texans simply because they are receiving care from an HMO.

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tures, and concluding that changes in liability system will have minimal impact on total health care expenditures).

297. *Id.*