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Putting Health Care Providers at a Loss and Consumers at Risk: Why HMOs Should be Held Accountable for the Financial Instability of Their Delegated Networks.

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PUTTING HEALTH CARE PROVIDERS AT A LOSS AND CONSUMERS AT RISK: WHY HMOs SHOULD BE HELD ACCOUNTABLE FOR THE FINANCIAL INSTABILITY OF THEIR DELEGATED NETWORKS

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I. INTRODUCTION

Many Americans today rely on managed care to cover the costs of health expenses.[1] In 1999, private health insurance spent $375 billion on care, which amounted to only 33.1% of personal health care expenses.[2] The current state of managed care is forcing consumers to deal with an ever-growing increase of payments for care.[3] Additionally, health care providers are assuming the risk of loss for services performed.[4] As a re-

1. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 505 (4th ed. 2001); *see also* James H. Fleming, *Developments in Managed Care Organization Liability: The Defense Perspective*, 50 A.L.I.-A.B.A. COURSE OF STUDY 37, 39 (Aug. 24, 2000), *available at* WESTLAW SF50 ALI-ABA 37 (emphasizing that a majority of Americans receive health care services through prepaid managed care). Managed care resulted from a medical inflation crisis. Symposium, *Provider Issues in the Managed Care Lite Era*, Fourteenth Annual Health Law Conference 1 (Apr. 2002) (on file with the *St. Mary's Law Journal*).

2. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 505 (4th ed. 2001). There are over 70 million people enrolled in HMO plans. AM. MED. ASS'N, BANKRUPTCIES IN HEALTH CARE: A PHYSICIAN'S GUIDE 1, *at* http://www.ama-assn.org/ama/downloads/psa/pdf/BankruptciesFinal.pdf (last visited Oct. 7, 2003) (on file with the *St. Mary's Law Journal*).

3. *See* Joe Carlson, *Workers Are Taking the Hit for Rising Health Care Costs*, THE EXPRESS-TIMES, Dec. 12, 2002, at A1 (discussing that the rise in health care costs is forcing employees to pay more for benefits); *see also* USWA HEALTH CARE WORKERS COUNCIL, *Funding of Health Care in the United States*, *at* http://www.uswa.org/hcwc/industry-overview/usfunding.htm (last visited May 9, 2003) (comparing, among other things, out-of-pocket expenditures between hospitals, clinics, and nursing homes) (on file with the *St. Mary's Law Journal*).

4. Gayle L. Holland, *Health Maintenance Organizations: Member Physicians Assuming the Risk of Loss Under State and Federal Bankruptcy Laws*, 15 J. LEGAL MED. 445, 446 (1994); *see also* Cheryl Jackson, *IPA Law Comes Too Late for Some Doctors: Two Texas IPAs File for Bankruptcy Protection Before a New State Law Protecting Doctors in Such Groups Takes Effect*, AM. MED. NEWS, Aug. 13, 2001, at 15 (showing how the Medical Select Management bankruptcy has left many doctors wondering if they will ever get paid); Julie A. Jacob, *Physicians, Southwest Texas HMO Sue to Force Texas IPA into Bankruptcy*, AM. MED. NEWS, Feb. 5, 2001, at 19 (demonstrating physicians' concerns over HMO's non-payment for services performed). *But see* Steve McDermott & Melody Newsom, *Quantum*

sult, managed health care is in a downward spiral.[5] While many factors contribute to the loss-spreading among health care providers and their patients, a major factor is the increasing trend of financial instability among delegated networks of health maintenance organizations (HMOs).[6] Recent developments indicate a rising trend of bankruptcies by health care provider groups, specifically Independent Practice Associations (IPAs).[7]

In Texas, Quantum Southwest Medical Associates (Quantum), one of the state's largest IPAs, filed for Chapter 11 bankruptcy on July 18, 2001.[8] At this time, the San Antonio-based medical group owed an estimated

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Bankruptcy Updates, BEXAR COUNTY MED. SOC'Y, (Oct. 8, 2001), *at* http://www.bcms.org/Current%20News/Quantum%20Filings/Quantum_Updates.htm (reporting that as a result of the bankruptcy proceedings on July 27, 2001, PacifiCare is guaranteeing payment be made for services rendered between July 18 and August 31, 2001; therefore Quantum contracted providers may not decline PacifiCare patients since they will receive payment) (on file with the *St. Mary's Law Journal*).

5. *See* David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000) (indicating the breadth of problems facing the managed care industry); *see also* Susan Page, *Gore Wants Feds to Run Health Care for All*, USA TODAY, Nov. 15, 2002, at 6A (commenting that the health care system in America is in impending crisis). Former Vice President Al Gore believes a "single-payer" system regulated by a governmental agency would ensure quality health care for all Americans. *Id.*; *see also* Mark A. Kadzielski et al., *Managed Care Contracting: Pitfalls and Promises*, 20 WHITTIER L. REV. 385, 408 (1998) (predicting that managed care contracting will have more pitfalls than promises in the future).

6. Cheryl Jackson, *IPA Law Comes Too Late for Some Doctors: Two Texas IPAs File for Bankruptcy Protection Before a New State Law Protecting Doctors in Such Groups Takes Effect*, AM. MED. NEWS, Aug. 13, 2001, at 15; *see also* W. Scott Bailey, *Health-care Management Firm QualityCare to Close*, SAN ANTONIO BUS. J., Sept. 7, 2001, at 1, *available at* http://sanantonio.bizjournals.com/sanantonio/stories/2001/09/10/story2.html (announcing that another medical group, QualityCare, is facing insolvency along with Quantum); Julie A. Jacob, *PacifiCare Faces Lawsuit over Bankrupt IPAs: The Insurer Claims the Suit Brought by the Texas Attorney General Has No Merit*, AM. MED. NEWS, Mar. 4, 2002, at 24 (indicating that three IPAs filed for bankruptcy in 2001 leaving over $70 million combined in unpaid claims).

7. David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000); *see also* W. Scott Bailey, *Health-care Management Firm QualityCare to Close*, SAN ANTONIO BUS. J., Sept. 7, 2001, at 1, *available at* http://sanantonio.bizjournals.com/sanantonio/stories/2001/09/10/story2.html (proclaiming that QualityCare is the latest casualty of IPA failures); Julie A. Jacob, *PacifiCare Faces Lawsuit over Bankrupt IPAs: The Insurer Claims the Suit Brought by the Texas Attorney General Has No Merit*, AM. MED. NEWS, Mar. 4, 2002, at 24 (mentioning that three IPAs contracting primarily with PacifiCare went insolvent in 2001).

8. Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 4, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC); Travis E. Poling, *Medical Firm Goes Bankrupt*, SAN ANTONIO EXPRESS-NEWS, July 20, 2001, at 1E, *available at* 2001 WL 24769513; Steve McDermott & Melody Newsom, *Quantum Bankruptcy Updates*, BEXAR COUNTY MED.

$20 million in debts to various creditors, primarily health care providers.[9] The recent collapse of Quantum, a delegated network of PacifiCare, caught many health care providers associated with the group by surprise.[10] PacifiCare, one of the largest HMOs in Texas,[11] was involved with two other delegated network insolvencies in the state.[12] Heritage Southwest Medical Group of Dallas and Medical Select Management in Fort Worth both filed for bankruptcy just before the Quantum collapse.[13]

SOC'Y, (Oct. 8, 2001), *at* http://www.bcms.org/Current%20News/Quantum%20Filings/Quantum_Updates.htm (on file with the *St. Mary's Law Journal*).

9. *See* Julie A. Jacob, *Don't Get Caught Unaware If Your IPA Fails: The Bankruptcies of Four IPAs in Texas Highlight the Importance of Being Alert to the Warning Signs That an IPA May Be in Financial Trouble*, AM. MED. NEWS, (Dec. 17, 2001), http://www.ama-assn.org/sci-pubs/amnews/pick_01/bil21217.htm (writing that Quantum has accumulated a debt of $50 million in unpaid claims); Travis E. Poling, *Medical Firm Goes Bankrupt*, SAN ANTONIO EXPRESS-NEWS, July 20, 2001, at 1E, *available at* 2001 WL 24769513 (indicating Quantum had debts of $27.3 million and assets of only $15.4 million).

10. Julie A. Jacob, *Don't Get Caught Unaware If Your IPA Fails: The Bankruptcies of Four IPAs in Texas Highlight the Importance of Being Alert to the Warning Signs That an IPA May Be in Financial Trouble*, AM. MED. NEWS, (Dec. 17, 2001), http://www.ama-assn.org/sci-pubs/amnews/pick_01/bil21217.htm; *see also* Travis E. Poling, *Medical Firm Goes Bankrupt*, SAN ANTONIO EXPRESS-NEWS, July 20, 2001, at 1E, *available at* 2001 WL 24769513 (claiming that Quantum predicted it would increase its patient population by five times in 2.5 years on an internet site just before announcement of its bankruptcy filing).

11. *Largest HMOs*, HOUS. CHRON., *available at* http://www.chron.com/content/chronicle/special/02/100/charts/hmo.htm (last visited Oct. 7, 2003) (on file with the *St. Mary's Law Journal*); *see also* Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (indicating that 300,000 Texans were enrolled with PacifiCare as of January 2000) (on file with the *St. Mary's Law Journal*).

12. Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 27; *see also* Bob Richter, *PacifiCare Vows to Defend Itself; HMO Says It Has Already Paid Millions in Claims Directly or to Its Providers*, SAN ANTONIO EXPRESS-NEWS, Feb. 13, 2002, at 1C, *available at* 2002 WL 13903149 (commenting that Quantum is one of the delegated networks that had filed for bankruptcy); Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118 (noting that three of PacifiCare's IPAs have recently become insolvent); Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (acknowledging that three of PacifiCare's delegated networks have filed for bankruptcy) (on file with the *St. Mary's Law Journal*). IPA bankruptcies are a continuing problem in California as demonstrated by Southern California Physicians Individual Practice Association's recent filing for bankruptcy in April 2002. Laurence Darmiento, *IPA Failure*, 24 L.A. BUS. J. 9, 9 (2002), *available at* 2002 WL 11232270 (discussing reasons the IPA became insolvent after attempting to dissolve itself without bankruptcy protection).

13. Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 6; Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118.

The recent insolvencies of these IPAs raise many questions about PacifiCare's supervision over its delegated networks.

The reasons for recent turmoil within the managed care system are: increases in health care costs, growing demand for care, possible abuse of care between providers and patient, disorganization among the delegated networks, and adverse effects of the capitation fee system.[14] Regardless of the cause, the HMO is responsible for overseeing the functions of its delegated networks.[15] When an IPA becomes unstable, the growing concern that arises is that the health care provider is not being compensated for services performed on HMO enrollees.[16] As a result, providers limit the care their patients receive.[17] Consequently, patients are forced to find new doctors and hospitals or switch to a different health plan,[18]

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14. Interview with Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 24, 2001) (on file with the *St. Mary's Law Journal*); *see also* David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000) (providing a reason why HMOs have become insolvent).

15. Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*); *see also* Hugh M. Barton, *HMO Verses Doctor*, TEX. B.J., Jan. 2003, at 37 (mentioning that the Texas Attorney General filed suit against an HMO for not properly monitoring its delegated networks).

16. Cheryl Jackson, *IPA Law Comes Too Late for Some Doctors: Two Texas IPAs File for Bankruptcy Protection Before a New State Law Protecting Doctors in Such Groups Takes Effect*, AM. MED. NEWS, Aug. 13, 2001, at 15; *see also* Julie A. Jacob, *Don't Get Caught Unaware If Your IPA Fails: The Bankruptcies of Four IPAs in Texas Highlight the Importance of Being Alert to the Warning Signs That an IPA May Be in Financial Trouble*, AM. MED. NEWS, (Dec. 17, 2001), http://www.ama-assn.org/sci-pubs/amnews/pick_01/bil21217.htm (suggesting that physicians not being paid is a common warning that an IPA is struggling). An enrollee is defined as a person who is a member of a health care plan, including covered dependents. TEX. INS. CODE ANN. § 843.002(8) (Vernon 2003) (formerly Article 20A.01 of the Texas Insurance Code).

17. *See* Cheryl Jackson, *IPA Law Comes Too Late for Some Doctors: Two Texas IPAs File for Bankruptcy Protection Before a New State Law Protecting Doctors in Such Groups Takes Effect*, AM. MED. NEWS, Aug. 13, 2001, at 15 (discussing that people might be without their primary doctor because the providers will refuse to sign unstable contracts); *see also* Lynell Burkett, *HMO Dogfight Could Bite Perry*, SAN ANTONIO EXPRESS-NEWS, Aug. 5, 2001, at 2G, *available at* 2001 WL 24771280 (stating that when insurers go bankrupt, providers are left picking up the pieces); Julie A. Jacob, *PacifiCare Faces Lawsuit over Bankrupt IPAs: The Insurer Claims the Suit Brought by the Texas Attorney General Has No Merit*, AM. MED. NEWS, Mar. 4, 2002, at 24 (pointing out that physician practices are severely hurt when compensation is not given for services rendered).

18. *See* Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118 (noting the resulting disruptions in patient care when HMOs place patient interests below financial ones). Other reasons, such as rate increases, have forced San Antonio employers to seek new health plans. Travis E. Poling, *HMO's Rate Increase Has Schools Scrambling; Contracts Prove Useless As Districts See Costs Rise As Much As 72%*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2001, at 1A, *available at* 2001 WL 28783567. PacifiCare

which prevents consumers from receiving adequate health care.[19]

Health care in America is a vital industry and must become a stable resource for society. The recent financial problems in the health care industry indicate that resolution of the ever-growing problem facing the health care industry is quickly needed. Although there are many different proposed solutions to improving a consumer's access to health care, many health care providers agree that strict accountability by PacifiCare and other HMOs is necessary.[20]

This Comment explores why HMOs such as PacifiCare should be held accountable for the financial instabilities of their delegated networks. Part II discusses the organization of the managed care system, including descriptions of certain entities, the function of a capitated fee system, and the assessment of Texas laws currently enforcing managed care in the state. Incorporated in this discussion is a look at the risks delegated networks bear when contracting with HMOs to provide payment for individualized care. Part III analyzes the increasing trend of financial instability by presenting the views of the HMOs, the delegated networks, the health care providers, and the consumers enrolled in the health plan. Also explored are possible methods of resolving the existing problem such as: (1) eliminating the capitation fee system that is predominantly used in managed care; (2) eliminating the delegated network structure; (3) implementing a "double pay" law that forces HMOs to pay twice when their delegated entity fails to pay providers; and (4) establishing a managed care state agency to specifically oversee health care management issues. Part IV of this Comment concludes that the struggles of delegated networks are a direct result of the lack of oversight by their HMOs. Thus, implementation and enforcement of laws that hold HMOs responsible for the financial instabilities of their delegated networks and discouraging managed care organizations (MCOs) from cutting corners to generate a profit are immediate solutions to the growing problem of placing health care providers at a loss and consumers at risk.

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has raised premiums by as much as seventy-two percent, forcing many to find cheaper health plans. *Id.*

19. Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118.

20. *See* Lynell Burkett, *HMO Dogfight Could Bite Perry*, SAN ANTONIO EXPRESS-NEWS, Aug. 5, 2001, at 2G, *available at* 2001 WL 24771280 (discussing doctors' complaints and the corresponding proposed legislative elements to address them).

II. BACKGROUND

A. *Creation of Managed Care System*

Managed care encompasses health care delivery arrangements through cost containment tactics and risk distribution among payers and providers.[21] The development of health insurance gave rise to managed care in the United States.[22] The concept of purchasing health insurance was a reaction to health care providers seeking a more consistent flow of revenues.[23] As a result, managed care transitioned from fee-for-service payment directly from consumers to a capitated system.[24] In a capitated payment system, health care providers are paid a fixed amount to treat individual patients despite the amount of services given.[25] In addition to the payment system, managed care involves administrative protocols that provide for a review of the care demanded by patients and providers.[26] Generally, managed care represents a synthesis of medical care financing and medical care delivery.[27] Since its inception in the 1990s, managed

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21. Rebecca L. Jackson & Karen W. Levy, *Innovations in Managed Care*, *in* HEALTH CARE REFORM LAW INSTITUTE 1994, at 249, 251 (PLI Commercial Law & Practice Course, Handbook Series No. A-700, 1994), *available at* WESTLAW 700 PLI/Comm 249; *see also* James H. Fleming, *Developments in Managed Care Organization Liability: The Defense Perspective*, 50 A.L.I.-A.B.A. COURSE OF STUDY 37, 39 (Aug. 24, 2000), *available at* WESTLAW SF50 ALI-ABA 37 (defining managed care as a comprehensive system focusing on controlling costs); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 537 n.12 (1990) (defining managed health care).

22. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 505 (4th ed. 2001); *see also* James H. Fleming, *Developments in Managed Care Organization Liability: The Defense Perspective*, 50 A.L.I.-A.B.A. COURSE OF STUDY 37, 39 (Aug. 24, 2000), *available at* WESTLAW SF50 ALI-ABA 37 (advancing that economic pressure due to rising health care costs led to the emergence of managed care).

23. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 506 (4th ed. 2001).

24. *Id.* at 508; *see also* James H. Fleming, *Developments in Managed Care Organization Liability: The Defense Perspective*, 50 A.L.I.-A.B.A. COURSE OF STUDY 37, 39 (Aug. 24, 2000), *available at* WESTLAW SF50 ALI-ABA 37 (commenting that Americans have moved away from fee-for-service to prepaid managed care).

25. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 508 (4th ed. 2001); André Hampton, *Markets, Myths, and a Man on the Moon: Aiding and Abetting America's Flight from Health Insurance*, 52 RUTGERS L. REV. 987, 1016 (2000).

26. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 508 (4th ed. 2001). When managed care developed in the 1990s, HMOs had the upper hand in preventing a rise in health care costs, but this has been followed by a backlash against insurers that gives patients more power. Peter Landers & Amy Dockser Marcus, *You Can Make Them Pay: New Ways to Appeal Make It Easier to Take on Health Insurers and Win*, WALL ST. J., Sept. 17, 2002, at D1.

27. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 508 (4th ed. 2001).

care has been the primary method of providing and receiving health care services in America.[28]

1. What Is an HMO?

A Health Maintenance Organization is defined as:

> [a]n entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: 1) an organized system for providing healthcare or otherwise assuring healthcare delivery in a geographic area; 2) an agreed upon set of basic and supplemental health maintenance and treatment services[;] and 3) a voluntarily enrolled group of people (members).[29]

The characterizing feature of an HMO is its exchange of a fixed fee from each consumer enrolled under the health plan for a commitment to provide specified managed care in a cost-effective manner.[30] In addition, premiums are paid in advance to the HMO rather than directly to the health care provider.[31] The fixed premium is redistributed by the HMO monthly to the health care provider in a fixed amount.[32] In turn, the HMO assumes the monetary risk of providing the care promised.[33] Because of the risk involved, the HMO seeks to deliver care in a cost-effec-

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28. *See* NAT'L COMM. FOR QUALITY ASSURANCE, *The State of Managed Care Quality, 2001, Managed Care and the U.S. Health Care Industry*, *at* http://www.ncqa.org/somc2001/INTRO/SOMC_2001_INDUSTRY.htm (last visited Oct. 7, 2003) (reporting that about 560 HMOs existed in 2000 with an estimated 80 million enrollees) (on file with the *St. Mary's Law Journal*).

29. KAISER PERMANENTE, *Health Care Dictionary: Part II*, *at* http://www.kaiserpermanente.org/locations/oh/about/dictionary2.html#h (last visited Oct. 7, 2003) (on file with the *St. Mary's Law Journal*); *see also* Rebecca L. Jackson & Karen W. Levy, *Innovations in Managed Care*, *in* HEALTH CARE REFORM LAW INSTITUTE 1994, at 249, 252 (PLI Commercial Law & Practice Course, Handbook Series No. A-700, 1994), *available at* WESTLAW 700 PLI/Comm 249; Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 539 (1990) (placing emphasis on the prepaid services compared to that of the fee-for-service practice). The description of a Texas HMO is codified in the Texas Insurance Code. *See* TEX. INS. CODE ANN. § 843.002(15) (Vernon 2003) (formerly Article 20A.02 of the Texas Insurance Code) (discussing that a prepaid service plan falls within the codified definition of an HMO).

30. David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000).

31. Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990).

32. *Id.*

33. David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000); *see also* Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate*

tive manner.[34] If the enrollee of the plan rarely becomes ill, then the HMO benefits from the premium.[35] Conversely, if the enrollee experiences more sickness than predetermined, the HMO is generally responsible for providing all services agreed upon, even if it exceeds the premium amount.[36] Therefore, the HMO attempts to minimize costs by limiting the amount of services rendered,[37] and cracking down on unnecessary treatments.[38]

An HMO functions in four predominant forms:[39] (1) staff; (2) medical group; (3) IPA; and (4) network models.[40] A staff model HMO represents a complete hands-on approach by the managed care organization.[41]

Liability, Independent Contractors, and the Ostensible Agency Doctrine, 15 J. CORP. L. 535, 540 (1990) (noting that the income of the provider is unrelated to the services performed).

34. David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000); *see also* Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990) (explaining that an HMO enrollee pays a fixed premium, and therefore, there is a risk that the HMO system will lose money if the amount of services provided exceeds the amount of premium paid). An HMO limits a patient to a network of physicians, and the patient must first be referred to a specialist by a primary-care doctor. Travis E. Poling, *Demand for HMO Care Is Fading Away; Medical Care Plans Moving Toward Increased Choice*, SAN ANTONIO EXPRESS-NEWS, Oct. 21, 2001, at 1K. In contrast, a PPO enables a member to see any primary-care doctor or specialist for an extra fee. *Id.*

35. David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000).

36. *Id.*

37. Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990).

38. *See* Peter Landers & Amy Dockser Marcus, *You Can Make Them Pay: New Ways to Appeal Make It Easier to Take on Health Insurers and Win*, WALL ST. J., Sept. 17, 2002, at D1 (commenting that HMOs have kept their costs at a minimum by strictly limiting treatment). HMOs use several different mechanisms to control costs. These methods include providing financial incentive to physicians, creating networks, gatekeeping, profiling, preauthorization, and clinical guidelines. Meredith B. Rosenthal & Joseph P. Newhouse, *Managed Care and Efficient Rationing*, 28 J. HEALTH CARE FIN. 1, 3 (2002), *available at* 2002 WL 22457421.

39. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 552 (4th ed. 2001); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990).

40. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 552 (4th ed. 2001); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990); *see also* David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000) (describing each of the four types of HMO models).

41. *See* Thomas W. McCandlish, *Representing Physicians in the Development of Managed Care Plans*, A.L.I.-A.B.A. COURSE OF STUDY 139, 145 (Sept. 26, 1991), *available at* WESTLAW C653 ALI-ABA 139 (advancing that the providers in a staff model are considered salaried employees and the HMO is the employer); Earlene P. Weiner, Note, *Man-*

In this model, the HMO owns most of the health care facilities and maintains health care providers as employees.[42] The providers devote all of their practice to treating patients enrolled in the particular HMO.[43] The staff model leaves little room for HMOs to avoid responsibility for the services performed by their employees.[44] The group model HMO contracts with physicians, who are part of a single practice group.[45] In the IPA model, the HMO procures a mixture of health care providers to provide services for the HMO enrollees.[46] The network model HMO consists of several practice groups that have the option of seeing both

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aged Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine, 15 J. CORP. L. 535, 540 (1990) (indicating that staff model providers are salaried employees that focus all of their time on HMO members).

42. David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000).

43. Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990).

44. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 552 (4th ed. 2001); David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7., (July 25, 2000); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990).

45. *See* David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 540 (1990); *see also* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 552 (4th ed. 2001) (referring to the group model HMO as a medical group HMO); Thomas W. McCandlish, *Representing Physicians in the Development of Managed Care Plans*, A.L.I.-A.B.A. COURSE OF STUDY 139, 145 (Sept. 26, 1991), *available at* WESTLAW C653 ALI-ABA 139 (establishing that the medical groups contract for a capitation rate with the HMO).

46. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 552 (4th ed. 2001); David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 541 (1990); *see also* Thomas W. McCandlish, *Representing Physicians in the Development of Managed Care Plans*, A.L.I.-A.B.A. COURSE OF STUDY 139, 145 (Sept. 26, 1991), *available at* WESTLAW C653 ALI-ABA 139 (emphasizing that the IPA calculates the method of payment to its physicians). Some advantages of an IPA model include the following: (1) it is cost effective and competitive compared to other managed care systems; (2) IPAs do not rely on much capital to function; (3) it permits physicians to affiliate with other entities; (4) it permits relatively easy adjustments to the size of a network; and (5) IPAs reduce the HMO's political decision-making that is sometimes necessary to be profitable. Gail P. Heagen, *Integrated Delivery System Development*, *in* HEALTH CARE M & A: HOW TO STRUCTURE THE TRANSACTION 1998, at 381, 400-01 (PLI Corporate Law Practice Course, Handbook Series No. B4-7234, 1998), *available at* WESTLAW 1045 PLI/Corp 381. However, IPAs are not always tightly meshed to unite physicians to the group and practice common objectives. *Id.* at 401. In addition, IPAs demand strong leadership from physicians, which is hard to find. *Id.*

enrollees of the particular plan and other HMO consumers.[47] PacifiCare serves as both an IPA and network HMO model.[48] All HMO models share the basic characteristic of providing comprehensive medical care to an enrolled population that has paid in advance to receive such services.[49]

2. Capitated Fee System

The managed care system emphasizes a reduction in health care cost growth by creating financial incentives for providers to control such costs.[50] These financial incentives stemmed from the federal government's desire to limit the increasing medical expenses sustained by Medicare patients.[51] A popular method of controlling cost is through a capitated fee system.[52] Capitation entails an enrollee paying a set price

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47. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 552 (4th ed. 2001); David B. Tatge, *Triage for Troubled HMOs*, 36 Bankr. Ct. Dec. (LRP) No. 7, at 8 (July 25, 2000); Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 541 (1990); *see also* Kevin P. McNamee, *Business and Health Sense: Understanding Managed Care Terms*, ACUPUNCTURE TODAY (Aug. 2001), *at* http://www.acupuncturetoday.com/archives2001/aug/08mcnamee.html (addressing the difference between a group model and a network model by explaining that a network model contracts with multiple physician groups) (on file with the *St. Mary's Law Journal*).

48. TEX. DEP'T OF INS., *HMO Profile for PacifiCare of Texas, Inc.*, *at* http://www.tdi.state.tx.us/company/hmo/05871.html (last visited Oct. 7, 2003) (on file with the *St. Mary's Law Journal*).

49. Earlene P. Weiner, Note, *Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine*, 15 J. CORP. L. 535, 541 (1990); *see also* Kevin P. McNamee, *Business and Health Sense: Understanding Managed Care Terms*, ACUPUNCTURE TODAY (Aug. 2001), *at* http://www.acupuncturetoday.com/archives 2001/aug/08mcnamee.html (discussing that an enrollee prepays for the financing and delivery of health care services by the HMO) (on file with the *St. Mary's Law Journal*).

50. Belinda G. Noah, *Preventive Law for the Managed Care Industry: Curing the Class Action Disease*, 69 DEF. COUNS. J. 203, 204 (2002); James H. Fleming, *Developments in Managed Care Organization Liability: The Defense Perspective*, 50 A.L.I.-A.B.A. COURSE OF STUDY 37, 43-44 (Aug. 24, 2000), *available at* WESTLAW SF50 ALI-ABA 37; *see also* Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STAN. L. & POL'Y REV. 433, 434 (1998) (expressing that HMOs reduce cost by capitation).

51. Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STAN. L. & POL'Y REV. 433, 434 (1998).

52. *See* Kenneth J. Pippen, *Increasing Consumer Power in the Grievance and Appeal Process for Medicare HMO Enrollees*, 33 U. MICH. J.L. REFORM 133, 134 (1999) (recognizing the concern that the capitation system gives HMOs incentive to maximize profits by reducing services and providing inferior care). *See generally* Ian Hill et al., *Achieving Service Integration For Children with Special Health Care Needs: An Assessment of Alternative Medicaid Managed Care Models*, 5 J. HEALTH CARE L. & POL'Y 208, 217 (2002) (stating that capitated fees are included in the Oregon Health Plan through which a majority of Medicaid populations are enrolled).

for medical coverage to the HMO, in exchange for an HMO's agreement to provide medical coverage.[53] In turn, the HMO distributes a fixed payment to a health care provider, regardless of the quantity of service provided to the enrollee.[54] Since the risk is delegated to the health care provider, the only way a provider will generate earnings is if the service rendered costs less than the capitated fee received.[55] Thus, a provider must minimize costs and practice preventive care.[56] The HMO uses this method to make the provider responsible for most of the care by way of budgeting.[57] The provider continues to have the professional obligation

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53. Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STAN. L. & POL'Y REV. 433, 434 (1998); *see also* Kenneth J. Pippen, *Increasing Consumer Power in the Grievance and Appeal Process for Medicare HMO Enrollees*, 33 U. MICH. J.L. REFORM 133, 133 n.2 (1999) (stating what a capitated fee plan entails); Travis E. Poling, *HMO's Rate Increase Has Schools Scrambling; Contracts Prove Useless As Districts See Costs Rise As Much As 72%*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2001, at 1A, *available at* 2001 WL 28783567 (recognizing that the physician group would receive a set amount from the HMO).

54. *See* Bakke Chiropractic Clinic, S.C. v. Physicians Plus Ins. Corp., 573 N.W.2d 542, 543 (Wis. Ct. App. 1997) (discussing that under a capitated fee system, Physician Plus Insurance Corporations paid providers a fixed amount for each enrollee despite the amount of care given to the enrollee); *see also* André Hampton, *Markets, Myths, and a Man on the Moon: Aiding and Abetting America's Flight from Health Insurance*, 52 RUTGERS L. REV. 987, 1016 (2000) (pointing out that monthly capitation payment is given despite the possibility that service may not be rendered for that month).

55. *See* Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STAN. L. & POL'Y REV. 433, 434 (1998) (explaining a capitated fee system in which the HMO assumes the risk of providing more service than premiums collected); Kenneth J. Pippen, *Increasing Consumer Power in the Grievance and Appeal Process for Medicare HMO Enrollees*, 330 U. MICH. J.L. REFORM 133, 134 (1999) (discussing the risk involved with a cost-based HMO); Travis E. Poling, *HMO's Rate Increase Has Schools Scrambling; Contracts Prove Useless As Districts See Costs Rise As Much As 72%*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2001, at 1A, *available at* 2001 WL 28783567 (advancing that a delegated group would realize profits when care is minimized, but it would lose money if too many enrollees became sick at once).

56. Richard Kronick, *Valuing Charity*, 26 J. HEALTH POL. POL'Y & L. 993, 995 (2001); *see also* Robert I. Field, *Holding Health Care Accountable: Law and the New Medical Marketplace*, 23 J. LEGAL MED. 289, 291 (2002) (reviewing E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE (2001)) (emphasizing that physicians are being forced to consider whether each treatment is truly worth the cost); Travis E. Poling, *HMO's Rate Increase Has Schools Scrambling; Contracts Prove Useless As Districts See Costs Rise As Much As 72%*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2001, at 1A, *available at* 2001 WL 28783567 (suggesting that the delegated group would have to manage the capitated fee to realize a profit).

57. Meredith B. Rosenthal & Joseph P. Newhouse, *Managed Care and Efficient Rationing*, 28 J. HEALTH CARE FIN. 1, 3 (2002), *available at* 2002 WL 22457421; *see also* Robert I. Field, *Holding Health Care Accountable: Law and the New Medical Marketplace*, 23 J. LEGAL MED. 289, 291 (2002) (reviewing E. HAAVI MORREIM, HOLDING HEALTH

to afford care that is in the enrollee's best interest.[58] The full risk capitated model agreed to by PacifiCare and Quantum is increasingly being recognized as a failed health care delivery system.[59] Creditors in the Quantum bankruptcy cited the capitation system as one of the factors that led the delegated entity to collapse.[60]

3. Development of Delegated Networks

A delegated network is an entity authorized to provide or arrange medical care for HMO enrollees in return for a predetermined payment (capitated fee).[61] The network is designated contractually to perform various duties assigned by the HMO.[62] These services include medical care, hospital or other institutional services, or prescription drugs.[63] Sharing of risk with an HMO for any of these services does not qualify an entity as a delegated network. Texas consumer law requires an HMO to give an accurate description of terms and conditions of the health care plan.[64] This

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CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE (2001)) (stressing that, under the capitation plan, physicians must make both financial and clinical decisions).

58. Jayne E. Zanglein, *Cutting Employee Benefit Costs*, 32 TEX. TECH L. REV. 747, 759 (2001); *see also* Robert I. Field, *Holding Health Care Accountable: Law and the New Medical Marketplace*, 23 J. LEGAL MED. 289, 291 (2002) (reviewing E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE (2001)) (explaining that capitation has forced doctors to think about the cost of care being rendered rather than just simply providing whatever care seems helpful).

59. Letter from Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex., Attorney for the Official Committee of Unsecured Creditors of Quantum Southwest Medical Associates, to the Honorable Ronald B. King, United States Bankruptcy Judge (Nov. 5, 2001) (on file with the *St. Mary's Law Journal*).

60. *Id.*

61. STEPHEN G. COCHRAN, TEXAS CONSUMER LAW HANDBOOK § 5B (2003 ed.). Prior to being recodified in 2001, Article 20A.02(ff) described a delegated network as any entity that assumes full financial risk for health care services. Acts 1975, 64th Leg., 1975 Tex. Gen. Laws 514, *repealed by* Acts 2001, 77th Leg., R.S., ch. 1419, § 1, 2001 Tex. Gen. Laws 3761. The HMO Act is now located in Section 843 of the Texas Insurance Code. TEX. INS. CODE ANN. §§ 843.001-.364 (Vernon 2003). Although Section 843 does not use the term "delegated network," Articles 20A.18D-G continue to use the terms "delegated network" and "delegated entity." In 2003, the legislature repealed Articles 20A.18D-G as well. Act of June 21, 2003, 78th Leg., R.S., ch. 1274, § 26, 2003 Tex. Sess. Law Serv. 4138 (Vernon). The repeal does not go into effect until April 1, 2005. *Id.* § 28, 2003 Tex. Sess. Law Serv. 4139 (Vernon). In addition, although these articles have been repealed, the legislature has clearly stated that the repeal was "a recodification only, and [that] no substantive change in law [was] intended by this Act." *Id.* § 27, 2003 Tex. Sess. Law Serv. 4139 (Vernon). The fact that the recodification was not substantive indicates that there will be no change in the definitions of "delegated network" and "delegated entity."

62. STEPHEN G. COCHRAN, TEXAS CONSUMER LAW HANDBOOK § 5B (2003 ed.).

63. TEX. INS. CODE ANN. § 843.002(13) (Vernon 2003) (formerly Article 20A.02 of the Texas Insurance Code).

64. STEPHEN G. COCHRAN, TEXAS CONSUMER LAW HANDBOOK § 5B (2003 ed.).

allows any current or prospective group contract holder and current or prospective enrollee eligible for enrollment in a health care plan to make knowledgeable decisions before selecting among health care plans. Section 5.01(a) of the Texas Medical Practices Act enables an HMO to create delegated networks to assist in the servicing of its enrollees and reduce rising health care costs.[65] Quantum's relationship with PacifiCare began with this purpose.[66] In the agreement, PacifiCare required Quantum to process medical claims submitted by health care providers for care rendered to PacifiCare enrollees in return for a fixed capitation fee.[67] The agreement between PacifiCare and Quantum is a standard relationship between an HMO and its delegated network.

B. *History of PacifiCare and Quantum*

PacifiCare is a health maintenance organization that offers health insurance to its enrolled members.[68] The insurance company is one of the nation's largest MCOs, generating approximately $11 billion in yearly revenues.[69] The HMO serves eight states and over three million enrollees.[70] PacifiCare is listed as both a group/IPA model HMO and network HMO.[71] Established in Texas in 1986, the HMO has the largest share of the San Antonio market, where Quantum is based.[72]

Quantum Southwest Medical Association, created in 1986, served as a delegated network for PacifiCare.[73] Quantum was a special purpose, non-profit corporation.[74] Quantum assumed a portion of the monetary risk, in addition to administrative responsibilities such as claims process-

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65. Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 17, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC).

66. *Id.*

67. *Id.* at 18.

68. Letter from Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex., Attorney for the Official Committee of Unsecured Creditors of Quantum Southwest Medical Associates, to the Honorable Ronald B. King, United States Bankruptcy Judge (Nov. 5, 2001) (on file with the *St. Mary's Law Journal*).

69. PACIFICARE.COM, *About PacifiCare*, *at* http://www.pacificare.com/region/home/0,2654,1109673,00.html (last visited May 10, 2003) (on file with the *St. Mary's Law Journal*).

70. *Id.*

71. PACIFICARE.COM, *For PacifiCare of Texas*, *at* http://www.pacificare.com/region/home/0,2654,7816_20731,00.html (last visited May 9, 2003) (on file with the *St. Mary's Law Journal*).

72. *Id.*

73. Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 9, 17, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC).

74. *Id.* at 10.

ing, claims adjudicating, and network maintenance of medical providers from PacifiCare.[75] In exchange, PacifiCare sent capitation payments every month to the delegated network.[76] Quantum had no independent staff, but instead paid Quantum Southwest Medical Management for overseeing the administrative duties.[77]

C. *Increasing Trend of Financial Instability Among PacifiCare's Delegated Networks*

Three of PacifiCare's delegated networks in Texas have filed for bankruptcy. The networks include Heritage Southwest Medical Group, Medical Select Management, and Quantum.[78] The three insolvencies led many to blame PacifiCare.[79] The reasons for the financial turmoil of the three groups are further discussed below.

1. Heritage Southwest Medical Group

Heritage Southwest Medical Group (Heritage) was an 800-physician IPA in Dallas.[80] PacifiCare contracted with Heritage to provide care for 50,000 enrollees.[81] In March 2000, PacifiCare sought a corrective action plan from Heritage,[82] which was having financial difficulties,[83] but no plan was ever received.[84] In April 2000, PacifiCare approved the contin-

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75. *Id.* at 9-10.

76. *Id.* at 9.

77. *Id.* at 9-10. Quantum Southwest Medical Management (QSMM) has served as a physician practice management company since 1995. *Id.* at 17. QSMM assists Quantum (delegated network) in managing the capitation payments received from PacifiCare by providing the facilities and staff necessary to fulfill its contractual obligations. *Id.* QSMM received a portion of these payments as management fees in return. *Id.*

78. Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5; Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

79. *See* Plaintiffs' Original Petition at 18, State v. PacifiCare (250th Dist. Ct., Travis County, Tex. 2002) (No. GV-200718) (alleging that many delegated networks under PacifiCare that are both in and out of the state have failed).

80. *PacifiCare Drops Heritage Contract in Texas*, AM. MED. NEWS, July 23, 2001, at 20.

81. Plaintiffs' Original Petition at 15, State v. PacifiCare (250th Dist. Ct., Travis County, Tex. 2002) (No. GV-200718); J.C. Conklin, *Medical Group Suit Is Going to Arbitration in Dallas Area*, KNIGHT-RIDDER TRIB. BUS. NEWS, Apr. 19, 2001, *available at* 2001 WL 18881799.

82. Plaintiffs' Original Petition at 16, State v. PacifiCare (250th Dist., Ct., Travis County, Tex. 2002) (No. GV-200718).

83. *Id.* at 15-16.

84. *Id.* at 16.

uation of duties to Heritage.[85] In January 2001, Heritage's financial problems led to lawsuits by an HMO, several medical groups, and numerous physicians, primarily for not paying claims properly.[86] Shortly thereafter, PacifiCare sent a statement regarding the matter to its providers stating:

> PacifiCare has taken appropriate steps to assure payment of all eligible services rendered by participating providers to our members. We have placed PacifiCare staff onsight [sic] to ensure that Heritage is functioning effectively and has appropriate resources to operate under our agreement. We appreciate your cooperation and request that you continue to service your PacifiCare patients, our members[,] so we may continue to provide appropriate and quality care.[87]

Despite these promises, PacifiCare terminated its agreement with Heritage in June 2001.[88]

2. Medical Select Management

The agreement between PacifiCare and Medical Select Management (MSM), formerly Harris Methodist Select, made the network responsible for payment of claims, utilization review, and credentialing.[89] On July 24, 2001, MSM filed for bankruptcy, leaving many providers with unpaid claims worth millions of dollars.[90] PacifiCare refused to pay for all or some of the claims owed to providers.[91]

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85. *Id.*

86. *Id.*; Julie A. Jacob, *Physicians, Southwest Texas HMO Sue to Force Texas IPA into Bankruptcy*, AM. MED. NEWS, Feb. 5, 2001, at 19; *see also* J.C. Conklin, *Medical Group Suit Is Going to Arbitration in Dallas Area*, KNIGHT-RIDDER TRIB. BUS. NEWS, Apr. 19, 2001, *available at* 2001 WL 18881799 (stating the allegations of physicians and insurer).

87. Plaintiffs' Original Petition at 16, State v. PacifiCare (250th Dist. Ct., Travis County, Tex. 2002) (No. GV-200718) (quoting "fast facts" statement issued by PacifiCare).

88. *Id.* at 17; *PacifiCare Drops Heritage Contract in Texas*, AM. MED. NEWS, July 23, 2001, at 20.

89. Plaintiffs' Original Petition at 17, State v. PacifiCare (250th Dist. Ct., Travis County, Tex. 2002) (No. GV-200718).

90. *Id.*; Julie A. Jacob, *Don't Get Caught Unaware If Your IPA Fails: The Bankruptcies of Four IPAs in Texas Highlight the Importance of Being Alert to the Warning Signs That an IPA May Be in Financial Trouble*, AM. MED. NEWS, (Dec. 17, 2001), http://www.ama-assn.org/sci-pubs/amnews/pick_01/bil21217.htm.

91. Plaintiffs' Original Petition at 17, State v. PacifiCare (250th Dist. Ct., Travis County, Tex. 2002) (No. GV-200718).

3. Quantum Southwest Management Associates

PacifiCare contracted with Quantum to perform claims processing, utilization review, and various other delegated functions.[92] PacifiCare received notice from providers that Quantum was not properly paying claims.[93] In particular, payment checks were being prepared but were not timely mailed to health care providers.[94] Quantum filed for bankruptcy on July 18, 2001, leaving millions of dollars worth of claims unpaid.[95]

D. *How Problem Manifested*

The alleged reason for Quantum's demise was PacifiCare's failure to make complete capitation payments in due time.[96] The insufficient payment, in turn, left Quantum unable to compensate its providers.[97] As such, Quantum filed for Chapter 11 bankruptcy protection in 2001.[98] PacifiCare, however, refutes such fault, stating that the HMO withheld capitation payments because of Quantum's failure to pay previous claims to certain providers, thereby creating exposure to liability for PacifiCare.[99] In addition to the failure of receiving capitation fees, Quantum had some structural defects in its business model.[100] Quantum believes that the main structural problem lies within PacifiCare's actuarial analysis because the HMO did not charge enough of a premium to cover the rap-

92. *Id.* at 20.

93. *Id.*

94. *Id.*

95. *Id.*; *see also* Steve McDermott & Melody Newsom, *Quantum Bankruptcy Updates*, BEXAR COUNTY MED. SOC'Y, (Oct. 8, 2001), *at* http://www.bcms.org/Current%20News/Quantum%20Filings/Quantum_Updates.htm (announcing the latest transactions that have occurred in the Quantum bankruptcy proceeding since its voluntary filing on July 18, 2001) (on file with the *St. Mary's Law Journal*).

96. Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC); Interview with Carol Jendrzey, Attorney, Cox & Smith Incorporated, in San Antonio, Tex. (Sept. 12, 2002) (on file with the *St. Mary's Law Journal*).

97. Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC); Interview with Carol Jendrzey, Attorney, Cox & Smith Incorporated, in San Antonio, Tex. (Sept. 12, 2002) (on file with the *St. Mary's Law Journal*).

98. Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC).

99. *Id.*

100. *Id.*

idly increasing medical costs.[101] Quantum further asserts that PacifiCare knowingly set capitation payments at a level that was below the cost it takes to provide health care coverage for an individual enrollee.[102]

E. *Ramifications of Problems*

When a delegated entity such as Quantum becomes insolvent, both health care providers and their patients are adversely affected. Providers do not receive payment for the services rendered to their HMO-enrolled patients because the entity responsible for compensating the providers' claims is ruined.[103] Since no money is available to distribute, providers are left with the notion that they are risking a possibility of no payment for the treatment of enrolled patients.[104] Thus, providers are forced out of business.[105]

The domino effect of an IPA bankruptcy will eventually harm enrollees of the health plan.[106] Patients will be cheated out of their agreements with the HMO since the obligation to provide quality service and availability of certain providers has not been met. Financial turmoil within such entities will prevent the enrollees from obtaining the care that was guar-

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101. *Id.*

102. *See* Interview with Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 24, 2001) (discussing that the cost structure of the health care system is not well-organized and the capitation payment is not solving the problem) (on file with the *St. Mary's Law Journal*).

103. *See* Brad Bollinger, *If Not HPR, Then What?*, THE PRESS DEMOCRAT, June 16, 2002, at E1(noting that surgeons participating in Health Plan of the Redwoods HMO were dissatisfied with the insurer when left unpaid); *see also* Michael Perrault, *Health-Care Conundrum Cigna's Boss Says There Are Problems, but He's Optimistic*, DEN. ROCKY MOUNTAIN NEWS, Feb. 4, 2001, at 4G (discussing why physicians have gone from a willingness to take risks for the costs of health care to not wanting to have anything to do with it).

104. *See* Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036 (noting that Quantum owed millions to doctors for unpaid claims, which put patients in danger of not receiving care); *see also* Travis E. Poling, *Medical Firm Goes Bankrupt*, SAN ANTONIO EXPRESS-NEWS, July 20, 2001, at 1E, *available at* 2001 WL 24769513 (reporting that some hospitals had stopped taking Quantum patients because of money still owed to them).

105. *See* Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036 (reporting that providers will cease to operate their business if they do not get paid). *But see* Brendan Doherty, *Blue Cross Pulls Out of Napa in Wake of Local IPA Bankruptcy*, SAN FRANCISCO BUS. TIMES, July 13, 2001, at 17 (reporting that Blue Cross HMO was forced to relocate its business due to an IPA failure).

106. Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

anteed to them in their agreements with the HMO.[107] In turn, the bankruptcy will put health care providers at a terminal loss and, ultimately, put many patients that have paid for health care at harmful risk.

F. *Texas Attorney General Files Suit Against PacifiCare*

On February 11, 2002, Texas Attorney General John Cornyn filed suit against PacifiCare for alleged violations of law that left many claims unpaid and disrupted patient care.[108] The State contends that these violations hurt patient care.[109] The suit specifically addresses allegations that the HMO is not properly monitoring its delegated networks.[110] Further, the State claims that because delegated networks failed to promptly pay their providers, PacifiCare should be responsible for any violation of the Prompt Pay Act.[111] The State also asserts that PacifiCare should be stat-

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107. *Id.*

108. Bob Richter, *PacifiCare Vows to Defend Itself; HMO Says It Has Already Paid Millions in Claims Directly or to Its Providers*, SAN ANTONIO EXPRESS-NEWS, Feb 13, 2002, at 1C, *available at* 2002 WL 13903149; Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036; Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5; Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

109. Bob Richter, *PacifiCare Vows to Defend Itself; HMO Says It Has Already Paid Millions in Claims Directly or to Its Providers*, SAN ANTONIO EXPRESS-NEWS, Feb 13, 2002, at 1C, *available at* 2002 WL 13903149; Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036; Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5; Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

110. Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036; Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5; Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

111. Bob Richter, *PacifiCare Vows to Defend Itself; HMO Says It Has Already Paid Millions in Claims Directly or to Its Providers*, SAN ANTONIO EXPRESS-NEWS, Feb. 13,

utorily prohibited from contractually indemnifying itself of accountability of these functions performed by the delegated entities.[112] The Attorney General estimated that the unpaid claims total several tens of millions of dollars.[113] Additionally, Attorney General Cornyn emphasized that HMOs are the overseers of the delegated functions: "HMOs are obligated to ensure that covered health care services are provided to members and that doctors and hospitals are paid for those services."[114] After PacifiCare failed to fulfill the promise that it would improve its oversight, the Texas Department of Insurance informed the Office of the Attorney General (OAG) of the problem.[115] In 2002, Attorney General Cornyn

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2002, at 1C, *available at* 2002 WL 13903149; Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*); *see also* TEX. INS. CODE ANN. § 843.338 (Vernon 2003) (formerly Article 20A.18B of the Texas Insurance Code) (affirming the HMO's obligation to pay clean claims within forty-five days); Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036 (alleging that PacifiCare was given notice of check-hiding by Quantum).

112. Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*); *see also* Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036 (accusing PacifiCare of failing to monitor its delegated network).

113. Julie A. Jacob, *PacifiCare Faces Lawsuit over Bankrupt IPAs: The Insurer Claims the Suit Brought by the Texas Attorney General Has No Merit*, AM. MED. NEWS, Mar. 4, 2002, at 24; Bob Richter, *PacifiCare Vows to Defend Itself; HMO Says It Has Already Paid Millions in Claims Directly or to Its Providers*, SAN ANTONIO EXPRESS-NEWS, Feb. 13, 2002, at 1C, *available at* 2002 WL 13903149; Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036; Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

114. Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (quoting Attorney General Cornyn) (on file with the *St. Mary's Law Journal*).

115. Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*); *see also* Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of*

filed this suit as a result of investigations of nine HMOs.[116] Instead of cooperating with the investigation, PacifiCare filed suit against the OAG, challenging its power to investigate suspected violations of state laws.[117] The State is seeking restitution for the unpaid health care providers, actual damages, and civil penalties.[118]

III. ANALYSIS

A. *Relevant Arguments from the Primary Parties Involved*

Recognizing that all participants of managed care are disadvantaged, all relevant points of view are discussed below. A delegated network's financial problems mainly affect the HMO, the IPA, the health care providers, and the enrollees. This section discusses how the problem affects these participants.

An HMO that contractually delegates responsibility to an IPA may expect a transition of liability as well.[119] In turn, when the HMO distributes

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Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036 (stating that Attorney General Cornyn filed lawsuit on behalf of insurance commissioner).

116. Armando Villafranca & Susan Kreimer, *Attorney General Sues PacifiCare/Alleges Insurer Too Slow to Pay*, HOUS. CHRON., Feb. 12, 2002, at 1, *available at* 2002 WL 3241118; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*); *see also* Julie A. Jacob, *PacifiCare Faces Lawsuit over Bankrupt IPAs: The Insurer Claims the Suit Brought by the Texas Attorney General Has No Merit*, AM. MED. NEWS, Mar. 4, 2002, at 24 (mentioning that PacifiCare refused to comply with the Attorney General's investigation).

117. Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*); *see also* Bob Richter, *PacifiCare Vows to Defend Itself; HMO Says It Has Already Paid Millions in Claims Directly or to Its Providers*, SAN ANTONIO EXPRESS-NEWS, Feb. 13, 2002, at 1C, *available at* 2002 WL 13903149 (reporting that PacifiCare plans to defend itself from the Attorney General's accusations).

118. Plaintiffs' Original Petition at 27-31, State v. PacifiCare (250th Dist. Ct., Travis County, Tex. 2002) (No. GV-200718); Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

119. Prior to being recodified in 2001, Article 20A.02(ff) of the Texas Insurance Code held that a delegated network assumes total financial risk. Acts 1975, 64th Leg., 1975 Tex. Gen. Laws 514, *repealed by* Acts 2001, 77th Leg., R.S., ch. 1419, § 1, 2001 Tex. Gen. Laws 3761. The HMO Act is now located in Section 843 of the Texas Insurance Code. TEX. INS. CODE ANN. §§ 843.001-848.364 (Vernon 2003). Although Section 843 does not use the term "delegated network," Articles 20A.18D-G continue to use the terms "delegated net-

capitation payments to the delegated network, and the entity does not make proper payment to the health care providers, accountability should point to the network.[120] The HMO would "double pay" for services if accountability was placed on it.[121] Furthermore, placing further demand on the HMO would also only increase the cost of health care.[122] As a result, HMOs believe that the delegated network is the one that should be liable under laws requiring prompt payment of claims, since it willingly accepts the delegated responsibilities and risks.[123]

Many of these delegated networks are caught in the middle of a health care plan originated by the HMO and agreed upon by the enrollee. As a result, the so-called "middle man" is forced to oblige both parties' expectations. If there is any delay by the HMO to pay set capitation fees, the delegated network is unable to make payment claims.[124] In turn, the del-

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work" and "delegated entity." In 2003, the legislature repealed Articles 20A.18D-G as well. Act of June 21, 2003, 78th Leg., R.S., ch. 1274, § 26, 2003 Tex. Sess. Law Serv. 4138 (Vernon). The repeal does not go into effect until April 1, 2005. *Id.* § 28, 2003 Tex. Sess. Law Serv. 4139 (Vernon). In addition, although these articles have been repealed, the legislature has clearly stated that the repeal was "a recodification only, and [that] no substantive change in law [was] intended by this Act." *Id.* § 27, 2003 Tex. Sess. Law Serv. 4130 (Vernon). The fact that the recodification was not substantive indicates that there will be no change in the definitions of "delegated network" and "delegated entity." *See also* 46 TEX. JUR. 3D *Insurance Contracts and Coverages* § 734 (Supp. 2002) (discussing liability issues under the Texas Insurance Code).

120. *See* Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC) (stating that PacifiCare's withholding of fees was proper because of Quantum's alleged failure to pay Baptist Health Systems).

121. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40; Bob Richter, *PacifiCare Vows to Defend Itself; HMO Says It Has Already Paid Millions in Claims Directly or to Its Providers*, SAN ANTONIO EXPRESS-NEWS, Feb. 13, 2002, at 1C, *available at* 2002 WL 13903149. PacifiCare contends that it has intervened to ensure that its enrollees receive continued benefits by paying $43 million in claims which were obligations of the contacted networks. *Id.*

122. Laura B. Benko, *The Week in Healthcare*, MODERN HEALTHCARE, Feb. 18, 2002, at 34, *available at* 2002 WL 9524625. Professor Clark Havighurst of Duke University Law School worries that bringing frequent action against HMOs could have a paralyzing effect on the health care industry. *Id.*

123. Prior to being repealed in 2001, Article 20A.02(ff) of the Texas Insurance Code detailed the risk that delegated networks are to assume. Acts 1975, 64th Leg., 1975 Tex. Gen. Laws 514, *repealed by* Acts 2001, 77th Leg., R.S., ch. 1419, § 1, 2001 Tex. Gen. Laws 3761. *See also* 46 TEX. JUR. 3D *Insurance Contracts and Coverages* § 734 (Supp. 2002) (illustrating the risk incurred by the delegated network).

124. *See* Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs.

egated entity is liable for violating the prompt pay laws.[125] Furthermore, the fixed capitation payments do not adjust quickly enough to the swift rise in health care costs.[126] Thus, delegated networks feel the impact from both the provider and enrollee, who expect more from managed care, and the reluctance of the HMO to pay outside its fixed capitation rates.

The financial turmoil of delegated networks directly affects physicians and other health care providers.[127] Providers have trouble continuing to operate when claims are paid untimely.[128] In addition, providers that are at odds with a particular HMO or delegated network are forced to turn away enrollees since payment is unlikely.[129] Even with a delegated network filing bankruptcy, the provider will never see the actual amount of the claims filed and must settle for the best possible payout.[130]

Enrollees of the health care plan feel the results of a chain reaction when dealing with financial problems of the delegated network. A member is the last one to feel the effects when a provider does not receive claims. A provider must determine if treatment to the enrollee is a necessity, with the possibility that services rendered will not be compen-

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(Bankr. W.D. Tex. 2002) (No. 01-53321-LMC) (claiming that PacifiCare's withholding of capitation fees is causing financial instability for Quantum).

125. *See* TEX. INS. CODE ANN. § 843.338 (Vernon 2003) (formerly Article 20A.18B of the Texas Insurance Code) (explaining the prompt pay law); *see also* Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC) (urging that delay of payments is causing Quantum to violate the prompt pay law).

126. Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC); *see also* Julie A. Jacob, *Physicians, Southwest Texas HMO Sue to Force Texas IPA into Bankruptcy*, AM. MED. NEWS, Feb. 5, 2001, at 19 (recognizing Heritage's contention that capitation rates were too low to operate).

127. Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036; Press Release, Office of the Attorney General-State of Texas, Attorney General John Cornyn Sues Texas HMO (Feb. 11, 2002) (on file with the *St. Mary's Law Journal*).

128. Bob Richter, *State Sues HMO, Says Bills Not Paid; Suit Claims the Network of Providers for PacifiCare of Texas Failed to Pay Claims Promptly, Which Could Have Endangered Patients*, SAN ANTONIO EXPRESS-NEWS, Feb. 12, 2002, at 1D, *available at* 2002 WL 13903036.

129. *See* Cheryl Jackson, *IPA Law Comes Too Late for Some Doctors: Two Texas IPAs File for Bankruptcy Protection Before a New State Law Protecting Doctors in Such Groups Takes Effect*, AM. MED. NEWS, Aug. 13, 2001, at 15 (discussing that many patients will be left without their primary doctors because of refusal to enter into bad contracts).

130. *Id.*

sated.[131] Enrollees assert a breach of contractual duty when faced with such dilemmas.[132] Until a resolution is accomplished, the enrollee may have to seek care from a doctor outside of the network and pay some of the expenses out-of-pocket.[133]

B. *Assessment of Current Laws Regulating Managed Care*

The Texas Insurance Code and the Texas Administrative Code specifically deal with the regulation of managed care.[134] Since the Quantum bankruptcy, the Texas Legislature has made significant changes to some of these laws in hopes of preventing such insolvencies.[135] Both the amendments and existing statutes are further analyzed to determine whether they are sufficiently designed to prevent delegated network insolvencies.

1. Texas Insurance Code: Health Maintenance Organization Act

The Texas Insurance Code has specifically codified the regulations adhered to by HMOs. The Health Maintenance Organization Act (HMO Act)[136] gives a description of an HMO as an entity that "arranges for or

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131. *See generally* Julie A. Jacob, *PacifiCare Faces Lawsuit over Bankrupt IPAs: The Insurer Claims the Suit Brought by the Texas Attorney General Has No Merit*, AM. MED. NEWS, Mar. 4, 2002, at 24 (mentioning that physicians' practices are hurting because they have not been paid by Quantum).

132. *See* Frank N. Darras & David T. Bamberger, *Standards and Timeliness in Medical Insurance Actions: The Insured's Perspective*, 23 WHITTIER L. REV. 679, 691-92 (2002) (identifying various causes of action that the insured can potentially bring against insurer and its representatives).

133. *See generally* Philip J. Goldberg, *Legal Aspects of an IPA's Insolvency Are Complex*, SMCMA, *at* http://www.smcma.org/documents/insolvency.htm (last visited Oct. 7, 2003) (stressing that maintaining patient relationships during insolvency is in the best interest of the doctor) (on file with the *St. Mary's Law Journal*).

134. *See* TEX. INS. CODE ANN. § 843.001 (Vernon 2003) (formerly Article 20A.01 of the Texas Insurance Code) (referring to the Texas HMO Act); *see also* 28 Tex. Reg. 7032-40 (2003) (to be codified as an amendment to 28 TEX. ADMIN. CODE §§ 21.2801-.2816) (concerning submission of clean claims).

135. Interview with Kathleen Quiroz, Attorney, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 31, 2002) (on file with the *St. Mary's Law Journal*).

136. In 2001 and 2003, the Texas Legislature made both substantive and nonsubstantive changes to the Texas Insurance Code. The original Health Maintenance Organization Act was located in Article 20A of the Texas Insurance Code. Acts 1975, 64th Leg., 1975 Tex. Gen. Laws 514, *repealed by* Acts 2001, 77th Leg., R.S., ch. 1419, § 1, 2001 Tex. Gen. Laws 3761. In 2001, the legislature placed the new HMO Act in Section 843 of the Texas Insurance Code. TEX. INS. CODE ANN. §§ 843.001-.364 (Vernon 2003). It was not until 2003, however, that Articles 20A.18D-G of the Texas Insurance Code were repealed. *See* Act of June 21, 2003, 78th Leg., R.S., ch. 1274, § 26, 2003 Tex. Sess. Law Serv. 4138 (Vernon) (detailing the repeal). The repeal of Articles 20A.18D-G does not go into effect until April 1, 2005. *Id.* § 28, 2003 Tex. Sess. Law Serv. 4139 (Vernon). In addition, al-

provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan."[137] PacifiCare's type of business in Texas satisfies this definition of a Health Maintenance Organization, and therefore it must follow the requirements of the HMO Act.[138]

a. Protection Against Insolvency

The original HMO Act was created during the rise of managed care in Texas. The Act focused on regulating HMOs without giving much attention to other MCOs, such as delegated entities.[139] Section 843.405 of the new HMO Act exemplifies the legislature's neglect in regulating delegated entities, since the statute addresses prevention of insolvencies of HMOs and no other MCO.[140] Amendments to the HMO Act have been

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though these articles have been repealed, the legislature has clearly stated that the repeal was "a recodification only, and [that] no substantive change in law [was] intended by this Act." *Id.* § 27, 2003 Tex. Sess. Law Serv. 4139 (Vernon). Articles 20A.18-D-G will therefore be cited in the pre-repeal format, with a notation that they have been repealed.

137. TEX. INS. CODE ANN. § 843.002(14) (Vernon 2003). A historical note to Section 20A.01 of the former HMO Act contained a much more detailed description of the types of organizations affected by the Act. It stated that the HMO act was

> [a]n Act relating to the establishment, certification, organization, and regulation of health maintenance organizations as defined in the Act; providing a plan of operation; providing for the organization, management, duties, responsibilities, limitation on, and prohibited practices of health maintenance organizations and their personnel; providing for regulation of agents; providing for rights of enrollees and for a system of complaints; prohibiting discrimination against a physician or health provider associated with a health maintenance organization; providing standards for certification and operation; providing the power, duties, and responsibility of the Commissioner of Insurance and the State Board of Health; prohibiting certain practices and defining certain offenses as misdemeanors; providing enforcement procedures; stating the relationship of this Act to existing laws and persons or corporations operating pursuant to other laws; authorizing certain insurance companies to organize and operate health maintenance organizations; designating the law governing rehabilitation, liquidation, or conservation of an organization; providing for certain fees and authorizing certain taxes and establishing a Health Maintenance Organization Fund; providing procedures for administrative and judicial appeals; providing for confidentiality of medical information; and providing an effective date.

Acts 1975, 64th Leg., 1975 Tex. Gen. Laws 514 (repealed 2001).

138. TEX. INS. CODE ANN. § 843.002(14) (Vernon 2003).

139. *See id.* § 843.405 (formerly Article 20A.13 of the Texas Insurance Code) (limiting the regulation of managed care toward HMOs); *see also* TEX. INS. CODE ANN. art. 20A.18G (Vernon Supp. 2003) (repealed 2003) (including delegated networks among the entities that must comply with the regulatory requirements).

140. *See* TEX. INS. CODE ANN. § 843.405 (Vernon 2003) (formerly Article 20A.13 of the Texas Insurance Code) (focusing on what HMOs must do to protect themselves against financial insolvency).

enacted in wake of the recent bankruptcies.[141] In particular, Article 20A.18G of the Act requires delegated entities to comply with all statutory requirements regarding any function assumed from the HMO.[142] In essence, the legislature is anticipating that the delegated entities will adhere to the rules that are directed toward HMOs without explicitly detailing the regulations to be followed. As a result, the amended statute is vague and confusing. The Texas Legislature must go a step further to lay out regulation guidelines for delegated networks as well, specifically stating the ramifications that will occur if both the network does not comply with the requirements and its HMO fails to promptly oversee the network. In other words, legislation similar to Section 843.405 must be passed, but directed toward the delegated entity.[143]

b. Prompt Pay Law

Section 843.338 of the Texas Insurance Code explains that an HMO must act on a clean claim no later than the forty-fifth day of it being received.[144] An HMO that violates this statute is liable to the provider for the amount in addition to the penalty/rate agreed upon.[145] Section 843.344 states that this section "applies to a person with whom a health maintenance organization contracts to: (1) process . . . claims; or (2) obtain the services of physicians and providers to provide health care services to enrollees."[146] A delegated entity satisfies the "person" being referred to because of its contractual obligation with the HMO.[147] Accordingly, this statute places the responsibility on PacifiCare for Quan-

141. *See* TEX. INS. CODE ANN. art. 20A.18C (Vernon Supp. 2003) (repealed 2003) (amending the limited focus of HMOs to include that of delegated networks).

142. *See* TEX. INS. CODE ANN. art. 20A.18C(b) (Vernon Supp. 2003) (repealed 2003) (detailing the information regarding a delegated entity that the HMO is required to report to the state); TEX. INS. CODE ANN. art. 20A.18G (Vernon Supp. 2003) (repealed 2003) (amending the limited focus of HMOs to include that of delegated networks).

143. *See* TEX. INS. CODE ANN. § 843.405 (Vernon 2003) (formerly Article 20A.13 of the Texas Insurance Code) (promulgating specific requirements HMOs must follow to avoid insolvency).

144. *Id.* § 843.338 (Vernon 2003) (formerly Article 20A.18B of the Texas Insurance Code); *see also* Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5 (challenging the constitutionality of Texas's "clean claims" law).

145. TEX. INS. CODE ANN. § 843.342 (Vernon 2003) (formerly Article 20A.18B(f), (h) of the Texas Insurance Code); *see also* Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5 (contending that Texas's "clean claims" law is unconstitutional).

146. TEX. INS. CODE ANN. § 843.344 (Vernon 2003) (formerly Article 20A.18B(n) of the Texas Insurance Code).

147. *See id.* § 843.344 (Vernon 2003) (formerly Article 20A.13 of the Texas Insurance Code) (applying the statute to entities contracting with HMOs).

tum's failure to pay some of its providers, making the HMO liable for damages sustained.[148]

c. Delegation of Certain Functions

Article 20A.18 of the HMO Act states the criteria that must be contained in the written agreement between an HMO and its delegated network.[149] Some of the requirements in the agreement are a monitoring plan, a termination provision, a clause prohibiting providers and the delegated entity from directly billing enrollees, and acknowledgment by the delegated network that the HMO is directly accountable for the entity's compliance with this section.[150] This section was specifically amended, as a result of the recent bankruptcies, to enforce stricter oversight by HMOs.[151]

d. Reserve Requirements for Delegated Networks

A delegated network that assumes liabilities and risk from an HMO must establish financial reserves equal to the greater of eighty percent of the risk and liabilities that must be reserved under this section, or two months of premium amount assumed by the network for services reserved under this section.[152] The statute stops short of explaining what actions will be taken if the network fails to achieve the reserve requirement.[153] In addition, the statute does not mention whether the HMO is accountable for failing to supervise whether the network is properly providing the reserve requirements. Thus, the Texas Legislature must fur-

148. *Id.* § 843.405 (Vernon 2003) (formerly Article 20A.13 of the Texas Insurance Code); *see also* Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 5 (refuting the validity of Texas's "clean claims" law).

149. TEX. INS. CODE ANN. art. 20A.18C (Vernon Supp. 2003) (repealed 2003).

150. *Id.*

151. Tex. H.B. 2828, 77th Leg., R.S., 2001 Tex. Gen. Laws 1041; Interview with Kathleen Quiroz, Attorney, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 31, 2002) (on file with the *St. Mary's Law Journal*). H.B. 2828 distinguishes between delegated entities and delegated networks. Delegated networks accept complete financial risk for more than one form of health services. Vinson & Elkins Health Policy Group, *The 77th Texas Legislature: What a Difference a Biennium Makes*, 64 TEX. B.J. 770, 772-73 (Sept. 2001).

152. TEX. INS. CODE ANN. art. 20A.18D (Vernon Supp. 2003) (repealed 2003); *see also* Vinson & Elkins Health Policy Group, *The 77th Texas Legislature: What a Difference a Biennium Makes*, 64 TEX. B.J. 770, 773 (Sept. 2001) (echoing that the new law requires delegated networks to keep significant reserve requirements).

153. *See* TEX. INS. CODE ANN. art. 20A.18C (Vernon Supp. 2003) (repealed 2003) (explaining the amount of reserves the delegated network must have when assuming certain risks and responsibilities).

ther act to endorse a comprehensive plan to eliminate insolvencies of delegated networks.

e. Officer and Employees Bond

The HMO Act requires an HMO to maintain a fidelity bond that obliges the insurer to pay for any loss sustained through fraudulent or dishonest acts of any officer or employee of the HMO.[154] The law does not include officers or employees of the HMO's delegated networks.[155] Since the functions of the delegated network are directly passed on from the HMO, an amendment including fraudulent activities of network representatives must be added to this section.

2. Texas Administrative Code

Section 11.1604 of the Texas Administrative Code requires an HMO to "take prompt action to correct any failure by the [approved nonprofit health corporation (ANHC)] to comply with regulatory requirements of the Texas Department of Insurance relating to any matters delegated by the primary HMO to the ANHC and necessary to ensure the primary HMO's compliance with the regulatory requirements."[156] The OAG, in its pending lawsuit with PacifiCare, claims the HMO failed to "promptly" act to remedy financial problems with Quantum.[157] Although PacifiCare allegedly failed to take any corrective action,[158] the use of "prompt" in the statute does not give an HMO specific time guidelines to follow, thereby leaving room for confusion as to what constitutes "prompt" action. A specific amount of days must be recognized in the statute to provide concise guidelines for HMOs to follow.

C. *Trend of Concern: Recent Enactments by Other States' Legislatures*

The recent collapse of PacifiCare's delegated networks is not only a major problem in Texas, but a growing trend across the country.[159] Hun-

154. *Id.* § 843.402 (Vernon 2003) (formerly Article 20A.30 of the Texas Insurance Code).

155. *Id.*

156. 28 TEX. ADMIN. CODE § 11.1604 (2002).

157. *See* Plaintiffs' Original Petition at 10, State v. PacifiCare (250th Dist. Ct., Travis County, Tex. 2002) (No. GV-200718) (alleging that PacifiCare failed to provide a complaint system for adequate relief when claims were not paid promptly).

158. *See id.* at 18 (accusing PacifiCare of planning to spend $20 million on advertising and marketing rather than rectifying existing problems).

159. *See* Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40 (discussing the nationwide HMO financial situation).

dreds of medical groups have gone bankrupt from coast to coast within the last few years.[160] The growing concern adversely affects all parties involved, including enrollees, providers, insurers, and regulators.[161] What used to be a focus on preventing HMO insolvency through state legislation is now a shift to find ways to avert delegated networks from being vulnerable to financial failure.[162] Below is a discussion of what a few states are doing to put a stop to financial instability of delegated networks.

1. Maryland

Major failure of delegated networks in Maryland began to occur in 1998.[163] Dimension Health Network, a physician hospital organization, was one of the handful of groups to fail during this period.[164] Over 400 physicians were associated with Dimension at the time of its crash.[165] The five-year-old organization found itself without sufficient funds to pay for a sudden barrage of unexpected claims.[166] Since no reserves were established to pay off the claims when needed, Dimension closed its doors expeditiously.[167]

In efforts to respond to the problem, the Maryland Legislature passed a law requiring that such medical groups establish an emergency fund to provide working capital that can be disbursed to unpaid providers during a time of financial turmoil.[168] The fund will force delegated networks to maintain assets within the group.[169] The amount of the "failure fund" is approved by the state insurance commissioner and varies depending on the amount of risk involved.[170]

In addition to the requirement mandating delegated networks to set aside a "failure fund," Maryland lawmakers adopted the "double pay"

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160. *See id.* (estimating that 150 medical groups have gone bankrupt in the past 5 years).

161. *See id.* (analyzing the impact of the HMO demise on all parties involved).

162. *See id.* (recognizing the changing focus of state HMO legislation).

163. *Id.*

164. *See* Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40 (explaining the demise of Dimension Health Network).

165. *See id.* (illustrating the extent of the Dimension Health Network collapse).

166. *Id.*

167. *Id.*

168. *Id.*

169. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

170. *Id.*

law to ensure all claims were covered.[171] The Maryland law holds the HMO accountable for any inability to pay providers for claims filed.[172] The "double pay" act has been implemented in many states despite strong opposition by HMOs.[173]

2. California

California relies heavily on large medical groups and has the highest managed care penetration in the country.[174] The California Medical Association has identified that more than one in three delegated entities has folded since keeping track of such bankruptcies in 1996.[175] In addition to insolvencies, California has recently experienced the closure of many entities, even though they are not bankrupt.[176] The reason for such closures is that no new IPAs are being created.[177] At the same time, some insurers are retreating from group contracting and returning to individual contracting as a means to ensure enrollees will not be put at risk if medical groups go bankrupt.[178] Some HMOs have taken back responsibilities formerly delegated to IPAs, such as paying claims and reviewing treatments.[179]

Tension between health plans and provider groups arises over "hold-harmless clauses."[180] These clauses prohibit a group's doctors from billing patients directly for any unreimbursed services if the provider group goes bankrupt.[181] California also created a state agency unique to the problems of the health care industry.[182] The Department of Managed

171. *Id.*

172. *Id.*

173. *See* Mary Alice Robbins, *Cornyn Sues HMO Under "Delegated Networks" Law*, TEX. LAW., Feb. 18, 2002, at 6 (contending that forcing HMOs and delegated networks to pay twice is a violation of the United States and Texas Constitutions); *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (arguing that forcing HMOs to pay twice will hurt their low margins and defeats the purpose of a capitation system).

174. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

180. *Id.*

181. *Id.*

182. Charles Downey, *The Department of Managed Care*, MANAGED CARE MAG., Mar. 2002, at 35.

Health Care supervises managed care in California and works to resolve any problems facing insurers, providers, and enrollees in the state.[183]

3. Colorado

States like Colorado have clearly answered the insolvency problem by holding the HMO accountable for all delegated network insolvencies.[184] The HMO contracting with the failed practice group must pay twice—once when it initially sends payments to the IPA administrators, and another time when the delegated network fails to pay the provider.[185] Insurers say the "double pay" law gives physicians leeway to be careless in their practices, realizing health plans have to cover the costs.[186] When a delegated network agrees to a capitation plan with an HMO, responsibility for managing and providing care should transition from the insurer to that group.[187] Randi Reichel, executive director of state affairs for the American Association of Health Plans, has noted that "[i]t seems unfair that if a medical group mismanages or steals the money, the insurer has to pay."[188] "Double-pay rules hold the health plan responsible for con-

183. *See id.* (stating that 23 million members comprise California's HMO market). Health care disputes are a major concern in California, particularly the issue of arbitration for certain disputes. Charles Ornstein, *Health Care Disputes at Issue Policy: Arbitration Provider Breaks with HMOs, Saying It Will No Longer Handle Such Cases Unless Both Sides Agree to the Out-of-Court Process*, L.A. TIMES, Mar. 11, 2002, at B1, *available at* 2002 WL 2460285. American Arbitration Association, the nation's largest arbitration provider, told California lawmakers that it will disallow its arbitrators to try health care disputes without mutual consent by both parties. *Id.* Such a move forces insurers to pressure patients into arbitration, which may have been a provision agreed to in the health plan. *Id.* The move comes after the Department of Managed Health Care director, Daniel Zingale, requested insurers to provide arbitration verdict information to investigate whether changes are needed. *Id.*

184. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40; *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (stating that Colorado has a similar ruling to "double pay" with Maryland).

185. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

186. *Id.*; *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (commenting that physicians would escape any risk, thus encouraging them to use resources less efficiently).

187. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

188. *Id.*

tractual obligations between the physician and the IPA."[189] Ultimately, the goal of careful monitoring will exist if HMOs are forced to pay twice, thus satisfying their supervisory role.

D. *Resolutions to Delegated Network Insolvency*

Although an HMO is primarily accountable for the financial instabilities of its delegated networks no matter the cause, there are many solutions that will not deter an HMO from neglecting its entities, but rather assist the insurer in providing solid health care to its paid members. Possible resolutions include: (1) eliminating the capitation fee system; (2) abolishing the delegated network structure; (3) implementing a "double pay" law; and (4) establishing a managed care state agency to assist HMOs. These improvements are key to preventing financial insolvencies of delegated networks and strengthening the managed care system in America.

1. Eliminating the Capitation Fee System

Some experts maintain that the ultimate root of failure is capitation.[190] The use of a capitation system in a fluctuating industry such as health care is an unworkable business structure.[191] Undercapitalized doctors have no such resources or cushions.[192] Medical groups, eager for business and seduced by the idea of wresting medical decisions from HMOs, sometimes take on more risk than they can handle.[193] The risk system unavoidably creates incentives for providers to withhold care.[194] In

189. *Id.*; *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (quoting Al Holloway, IPA Association of America's CFO, saying that "[w]hen IPAs sign a contract to take on risk, they should be held accountable").

190. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

191. Michael D. Dalzell, *Has Capitation Weathered the Storm?*, MANAGED CARE MAG., July 2002, at 18; *see also* Julie A. Jacob, *Physicians, Southwest Texas HMO Sue to Force Texas IPA into Bankruptcy*, AM. MED. NEWS, Feb. 5, 2001, at 19 (stressing that health plans' capitation rates were too low).

192. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

193. *Id.*

194. Michael D. Dalzell, *Has Capitation Weathered the Storm?*, MANAGED CARE MAG., July 2002, at 40 (discussing how physician practice management refuses to contract for care unless risk is provided).

contrast, under a fee-for-service system, providers are not forced to take risks, and are able to render the care needed.[195]

In all, capitation is declining.[196] Many plan providers are concerned about being responsible for failures, so they are avoiding group capitation.[197] For instance, since the passage of Maryland's pay-twice legislation, Blue Cross Blue Shield has ceased entering into risk-sharing agreements with downstream groups in that state.[198] Moreover, health care will always be unstable because treatment options will never stay the same.[199] Thus, a fixed system like capitation can never timely adjust to a changing system like health care.[200]

2. Eliminating the Delegated Network Structure

Currently, the Texas Department of Insurance allows an HMO to delegate its risk and duties to entities willing to assume the responsibility.[201] In turn, these "middle men" hope to generate revenue through the care given by their primary care physicians.[202] Realistically, the delegated network is not capable of prospering in a system with less than enough capital to begin.[203] In other words, the capitation payments controlled by the HMOs are insufficient amounts of money to distribute to providers while

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195. *Id.* But some providers feel that the capitation system will never retreat because of the business mentality of budgeting costs. *Id.* Stephen George, a Miami reinsurance broker, states that "[t]here's nothing more attractive to any business than a budget where you can predict costs—that's capitation. Like it or hate it, it's a budget. That's all it is." *Id.*

196. *See id.* (stating that Texas, Colorado, and New England are moving away from professional capitation).

197. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

198. *Id.*

199. Michael D. Dalzell, *Has Capitation Weathered the Storm?*, MANAGED CARE MAG., July 2002, at 40.

200. *See id.* (mentioning the conflicting problem with a capitation being used in a fluctuating environment as opposed to a steady state).

201. TEX. INS. CODE ANN. art. 20A.18C (Vernon Supp. 2003) (repealed 2003).

202. *See* Travis E. Poling, *HMO's Rate Increase Has Schools Scrambling; Contracts Prove Useless As Districts See Costs Rise As Much As 72%*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2001, at 1A, *available at* 2001 WL 28783567 (stressing that the physician group would have to manage the money received in hopes of generating a profit, but also risks losing money if too many enrollees seek treatment).

203. Interview with Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 24, 2001) (on file with the *St. Mary's Law Journal*); *see also* Travis E. Poling, *HMO's Rate Increase Has Schools Scrambling; Contracts Prove Useless As Districts See Costs Rise As Much As 72%*, SAN ANTONIO EXPRESS-NEWS, Oct. 11, 2001, at 1A, *available at* 2001 WL 28783567 (discussing the risks that medical groups take on with capitation if too many enrollees are seeking treatment).

trying to reserve enough for revenue.[204] The entity is not in the best position to agree to a capitation payment uncertain of satisfying the costs of health care.[205] Cost satisfaction is left to the HMOs because they are in the best position to determine what each member of their plan is spending on health care.[206] Thus, it is in the best interest of the enrollee, the health care provider, and the HMO, to eliminate the "middle man" and have a direct contractual relationship between individual providers and the HMO.[207] In essence, the direct system will keep everyone honest.

3. Implementing a "Double Pay" Law

Probably the harshest solution to eradicating the insolvencies, in terms of its effect on HMOs, is to implement a "double pay" law similar to the ones enforced in Maryland and Colorado.[208] The law forces the HMO to pay a second time if its delegated network fails to pay the providers from the first payment.[209] The "double pay" law gives HMOs great incentive to strictly monitor the delegated networks and to ensure they are manag-

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204. Interview with Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 24, 2001) (on file with the *St. Mary's Law Journal*). *But see* Karen L. Trespacz, *League of Their Own: What Makes a Winning IPA?*, MANAGED CARE MAG., Apr. 2000, at 18 (advancing the notion that an IPA is successful when it meets the needs of both the health plans and the physicians).

205. Interview with Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 24, 2001) (on file with the *St. Mary's Law Journal*); *see also* Julie A. Jacob, *Physicians, Southwest Texas HMO Sue to Force Texas IPA into Bankruptcy*, AM. MED. NEWS, Feb. 5, 2001, at 19 (indicating that Heritage had problems agreeing with NYLCare on capitation rates).

206. Interview with Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 24, 2001) (on file with the *St. Mary's Law Journal*); *see also* Julie A. Jacob, *Physicians, Southwest Texas HMO Sue to Force Texas IPA into Bankruptcy*, AM. MED. NEWS, Feb. 5, 2001, at 19 (requesting a restraining order to stop Heritage from filing lawsuit over capitation rate disputes).

207. *See* Claudia Morain, *How Much Risk Can Physicians Take?*, BETWEEN ROUNDS (Feb.-Mar. 2000), *at* http://www.betweenrounds.com/volume4/issue1/dialogue/ (predicting that delegated models will no longer be used because entities do not have the ability to manage financial risk) (on file with the *St. Mary's Law Journal*).

208. *See* Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40 (referring to state laws in Maryland and Colorado that force HMOs who contract with failed groups to pay twice for services rendered); *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (proclaiming that HMOs in Maryland are responsible for paying physicians even if the payments were made to intermediaries).

209. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40; *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (voicing HMO's complaint to paying twice for services rendered only once).

ing the payments correctly.[210] Insurers sense that this law would allow providers to become greedy and squeeze out more money through claims than needed, thus overlooking whether the delegated network is mismanaging the money.[211] In response, provider advocates believe that HMOs will realize that sufficient funds must be distributed the first time and will entice adequate monitoring of their networks.[212]

4. Establishing a Managed Care State Agency to Assist HMOs

Although Texas currently has an HMO Division in the Department of Insurance,[213] improvements can be made to bring more focus to assisting HMOs and their delegated networks with managed care.[214] Similar to California's Department of Managed Care, an agency that focuses on managed care activities is essential to the ever-growing importance health care has in people's lives.[215] The agency will serve as an arbitrator to complaints between providers and HMOs.[216] The agency would have the authority to take over a troubled delegated network and arrange for immediate assistance to the enrollees through another network of the HMO or through another health plan.[217] Most importantly, the agency will be a

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210. *See* Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40 (implying that the responsibility for managing care does not completely shift from the insurer to the delegated network); *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (affirming that HMOs shall be primarily responsible for all compensation of health care services).

211. *See* Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40 (arguing that doctors know that insurers will have to bail them out if they bungle their practice); *see also* Leigh Page, *Should HMOs Have to Pay Debts Owed Doctors?*, AM. MED. NEWS, Jan. 31, 2000, at 13 (reiterating that a "double pay" law relieves IPAs from accountability).

212. Maureen Glabman, *Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up with Strategies That Sometimes Shift Accountability to HMOs*, MANAGED CARE MAG., Dec. 2000, at 40.

213. *See* TEX. DEP'T OF INS., *TDI's Key Telephone Listing* (Dec. 2, 2002), *at* http://www/tdi/state/tx/us/general/keytel.html listing the contact information for the HMO Division of the Texas Department of Insurance) (on file with the *St. Mary's Law Journal*).

214. *See* Charles Downey, *The Department of Managed Care*, MANAGED CARE MAG., Mar. 2002, at 35 (proclaiming that California's Department of Managed Care efficiently helps managed care members solve problems).

215. *See id.* (demonstrating a glimpse of how health care rights are being addressed).

216. *See id.* (comparing a recent program that allows an agency worker to be in a three-way conversation with a complaining party and an HMO member).

217. *See id.* (discussing how an agency worker would operate the plan of a troubled HMO until another plan is arranged).

help center[218] for the HMO in time of crisis. The intent is to develop a positive relationship with the HMO and focus the attention on improving care.[219] In turn, when an independent party is monitoring the transactions between HMOs, delegated networks, health care providers, and enrollees, there is a very minimal chance that mismanagement or deceptive practices will continue to the point of bankruptcy.

IV. CONCLUSION

Health care in America is increasingly being interpreted as a basic right.[220] Managed care, the primary way of distributing health care services to paid members, is at a crossroad when dealing with the delivery of health care to millions of people. Problems exist within the delegation-of-risk structure that is predominantly being used today. While HMOs are passing off risk to their delegated networks, their responsibility as overseers continues to exist.

Since the responsibility of the HMO should never diminish in a delegated structure, the ability of the HMO to provide accurate payments based on the cost of each enrolled member is critical for the capitation system to survive. When the HMO underpays the actual values of its members, then the process of the managed care system is doomed.[221] Therefore, any assertive effort to not provide sufficient payments is a violation of the law.[222]

The notion of not distributing sufficient funds to delegated networks is comparable to that of a frequent taxi customer who uses a taxi, without enough money to pay for the ride.[223] The customer has taken many trips to the destination, enough to know the exact cost for the ride.[224] Yet, the

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218. *See id.* (supporting Daniel Zingale's idea of naming the agency "State HMO Help Center").

219. *See* Charles Downey, *The Department of Managed Care*, MANAGED CARE MAG., Mar. 2002, at 35 (discussing how HMOs are working to include the department in their discussions of improving care).

220. NAT'L COMM. FOR QUALITY ASSURANCE, *The State of Managed Care Quality, 2001, Managed Care and the U.S. Health Care Industry*, *at* http://www.ncqa.org/somc2001/INTRO/SOMC_2001_INDUSTRY.htm (last visited Oct. 7, 2003) (on file with the *St. Mary's Law Journal*).

221. *See* Debtors' Disclosure Statement in Support of Their Joint Plan of Reorganization at 19, *In re* Quantum Southwest Med. Mgmt., Inc., Quantum Southwest Med. Assocs. (Bankr. W.D. Tex. 2002) (No. 01-53321-LMC) (noting that flaws in the actuarial analysis led to the Quantum demise).

222. *See* TEX. BUS. & COM. CODE ANN. § 17.46(a) (Vernon 2002) (declaring any act of trade or commerce which is false, misleading, or deceptive to be unlawful).

223. Interview with Raymond W. Battaglia, Partner, Oppenheimer, Blend, Harrison & Tate Inc., in San Antonio, Tex. (Oct. 24, 2001) (on file with the *St. Mary's Law Journal*).

224. *Id.*

customer knowingly has less than the required amount needed to pay the taxi cab driver.[225] So, when the customer reaches the destination by taxi, he immediately takes the insufficient amount of money from his pocket, throws it at the taxi driver, and runs off.[226] The customer's actions took advantage of a service for which he knew the driver would not be compensated.[227] This idea relates similarly to an HMO that contracts with health care providers to render service to its enrollees for a capitation fee. The HMO knows or is unable to keep up with the changing costs of providing services for an individual enrollee, but continues to contract with the providers. The HMO has agreed to benefit from the services of the providers, but it is not certain if the payments are sufficient to compensate the provider for services performed. This is the corrupt state of managed care using the capitation system. Capitation is a fundamental flaw in the unstable industry of health care.[228] It must be re-evaluated because it produces more harm than good in an industry where financial motives take over the motivation to improve and preserve care.

Eliminating the "middle man" from the managed care structure could also eliminate the likelihood that providers will receive no payment, since there is clear and direct liability between the HMO and the provider. In the alternative, maintaining a delegated network structure while implementing the strict "double pay" law will send HMOs a serious message of the state's intent to preserve exceptional health care services in Texas. Quality service can only be preserved if the provider is not at risk.

Finally, establishing an agency specifically geared toward assisting HMOs and their delegated networks in times of crisis gives assurance to HMOs that they are not being preyed upon by the state or health care providers looking for a way to collect as much money as possible. The agency will serve as a third party regulator with any financial problems that arise. The HMO Help Center can be a positive step toward erasing the negative image HMOs have portrayed both in Texas and across the country.

The capitation fee system, disorganization among delegated networks, lack of sound oversight by HMOs, and even unexpected rises in health care costs are significant factors to the disarray plaguing the managed care system. Health care is an essential component to an individual's life. Many other states have progressed to alleviate the loss providers feel and

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225. *Id.*

226. *Id.*

227. *Id.*

228. *See* Travis E. Poling, *Demand for HMO Care Is Fading Away; Medical Care Plans Moving Toward Increased Choice*, SAN ANTONIO EXPRESS-NEWS, Oct. 21, 2001, at 1K (supporting that capitation is being replaced by fee-for-service plans).

the risks enrollees face because of the delegated network insolvencies. It is time for Texas to step forward and put a stop to these bankruptcies, making sure no provider goes uncompensated and no patient goes without health care.