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COMMENTARIES

MANAGED CARE AND THE MEDICAL PROFESSION: OLD ISSUES AND OLD TENSIONS
THE BUILDING BLOCKS OF TOMORROW'S HEALTH CARE DELIVERY AND FINANCING SYSTEM

*By John G. Day**

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INTRODUCTION

Upon this point, a page of history is worth a volume of logic.

– Oliver Wendell Holmes, Jr. (1921)[1]

The United States health care delivery and financing system – representing approximately one-seventh of the national economy[2] – is in the midst of a fundamental and often confusing restructuring. Individual health care providers and delivery and financing institutions, which had clearly defined and stable roles for years, are being forced to redefine themselves or go out of business.[3]

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* A.B. Oberlin College, 1958, J.D. Case-Western Reserve University, 1961. Mr. Day is Senior Vice President and Chief Counsel for CIGNA HealthCare. The views expressed in this article are the personal views of the author and do not necessarily represent the views of CIGNA HealthCare or CIGNA Corporation.

1. New York Trust Co. v. Eisner, 256 U.S. 345, 349 (1921).

2. In 1995, National Health Expenditures were projected to reach $1 trillion and account for 14.2% of the Gross Domestic Product. Sally T. Burner & Daniel R. Waldo, National Health Expenditure Projections, 1994-2005, HEALTH CARE FIN. REV. (Summer 1995) at 221. For one of the more recent and better descriptions of the industry restructuring, see Sylvia Fubini, M.P.H., Ph.D. & Vincent Antonelli, *Restructuring the American Health Market–Separating Myth from Reality*, HEALTH TRENDS ISSUE BRIEF (Health Trends, Inc. 1996).

3. For example, public and private cost containment and new technology that permits treatment in less costly settings have created excess beds at hospitals, forcing many hospitals to consolidate or close. Even venerated teaching hospitals appear to be at risk, or at a minimum are de-emphasizing their traditional mission of teaching, research and charity care. Hospitals and doctors are combining to expand their range of services (vertical integration) and are entering into new relationships with other health care providers (horizontal integration) to strengthen their market positions. Traditional insurers are consolidating or getting out of the business for the same reasons. Other insurers are becoming providers of health care through the acquisition or the creation of various types of managed care organizations, such as health maintenance organizations (HMOs). Existing managed care organizations also are consolidating or forming alliances with larger entities. Conversely, both institutional and individual medical providers are moving into risk-assumption roles, where the providers take on the financing responsibilities traditionally assumed by insurers. In addition, traditional not-for-profit institutions are transforming themselves into for-profit institutions. For more information regarding medical delivery restructuring, see Thomas Bodenheimer, M.D., M.P.H. & Kevin Grambach, M.D., *The Reconfiguration of U.S. Medicine*, 274 JAMA 85 (1995); David Blumenthal & Greg S. Myer, *Academic Health Centers In a Changing Environment*, HEALTH AFF., Summer 1996, at 200; and Barbara Weiss, *Managed Care: There is No Stopping It Now*, MED. ECON., Mar. 13, 1995, at 26. For a general description of changes in the insurance industry, see Harris Meyer, *Indemnity Insurance: Down But Not Out*, BUSINESS

One major reason for this restructuring is that over the last 40 years, health care expenditures have grown five times faster than the gross domestic product.[4] This "out of sync" phenomenon,[5] especially since the 1970s, has created significant economic and political pressure to reduce health care expenditures.[6] As a result, both the government and the private

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& HEALTH, May 1996, at 31. With respect to providers assuming risk assumption roles and the trend from not-for-profit entities to for-profit institutions, see James J. Unland, *The Emergence of Providers as Health Insurers*, J. HEALTH CARE FIN., Fall 1996, at 57; and Stephen Finlay, *When Not-for-Profits Decide to Make a Buck*, BUSINESS & HEALTH, Mar. 1996, at 38.

4. Between 1950 and 1992, the rate of growth of national health expenditures in the U.S. – with the exception of three years – increased faster than the GNP. The difference was usually 2.3% and on occasion was as high as 6%. HIAA (HEALTH INSURANCE ASSOCIATION OF AMERICA), SOURCE BOOK OF HEALTH INSURANCE DATA 97, tbl. 4.3 (1995), (based on data from the U.S. Department of Health and Human Services, HealthCare Financing Administration, U.S. Department of Commerce). While it appears that the rate of growth may be moderating since 1990, it appears that the traditional disparity between health care costs and general cost of living increases will continue. Burner & Waldo, *supra* note 2, at 224.

5. Common reasons given for increasing medical expenditures include: 1) health care is a service that usually grows faster than the rest of the economy; 2) technology advances, which create new health products and opportunities for treatment; 3) an aging population, in which people over 65 consume four times more health services than those below 65; and 4) prepayment of most health care through insurance, which insulates the spending decision and, therefore, the level of spending from general economic conditions. Burner & Waldo, *supra* note 2, at 224-225. In addition, many believe that "defensive medicine" is an importance influence on increased utilization. Martin Hatkie, *Professional Liability: The Case for Federal Reform*, 263 JAMA 584 (1990). Others also believe the United States, compared to other developed countries, has a disproportionate share of behavioral risk factors that influence the need for health care, e.g. drugs, homicide, auto accidents. Leroy L. Schwartz, M.D., *The Medicalization of Social Problems: America's Special Health Care Dilemma*, Am. H.S. Inst. (Public Policy Center for American Healthcare Systems, Washington, D.C.), Apr., 1994, at 3-5. At the same time, some caution that the mere fact that amounts spent on medical care are increasing faster than the GDP, is not conclusive evidence of excessive spending when viewed from a social, rather than political perspective, e.g. CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH CARE REFORM 89-96 (1995).

6. For example, employers that provide health coverage to their employees are finding it harder to compete in a global economy and are under pressure to make their employees pay an increasing share of the cost of coverage. Cathy A. Cowan & Patricia A. McDonald, *Business, Households and Governments: Health Spending 1991*, HEALTH CARE FIN. REV., Spring 1993, at 227. Employers that do not provide coverage are reluctant to do so. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION (PROPAC), MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO CONGRESS (1991). Individuals that buy their own coverage or shoulder a portion of the cost are finding it harder to afford coverage. Paul Fronstin, *Health Insurance Portability: Access and Affordability*, EBRI ISSUE BRIEF, no. 173 (Employee Benefit Research Institute, Washington, D.C., May 1996). In addition, the fastest growing component of federal and state budgets is the cost of government health care programs and, if the trend continues, absent tax increases, diminishing government revenue will be available for other functions, such as

sector have encouraged and developed new ways to deliver and pay for health care. These new delivery and financing systems are rapidly evolving and growing in market share.

It is difficult, if not impossible, to understand what is happening today without understanding the past. This difficulty is especially true with regard to America's health care delivery system because of its complexity and because the interested players that are impacted by the changes tend to over-simplify or camouflage their real concerns. For example, many physicians label their legislative, regulatory and judicial efforts as solely "protecting patients' choice" or the preservation of traditional medical ethics. Many in the payor community (i.e. employers, insurers and the federal and state governments) often impugn doctors' motives by saying that physicians are only concerned with their own economic self-interest. These oversimplified characterizations only confuse the ongoing debate and the fact that all of the participants have legitimate concerns and interests that need to be clearly stated, discussed and evaluated.

The importance of an historical perspective to one's understanding of what the health care restructuring is all about and why people take the positions they do became apparent while preparing a short time-line history of health care delivery and financing in the United States (Appendix A). It also became evident that one could gain considerable insight into the underlying dynamics of the restructuring – even at the risk of some over-simplification – by focusing on the medical community's concerns about managed care. This focus is appropriate for several reasons. First, managed care has become the symbol, if not the actual driver of the changes that are occurring. Second, one of the most pervasive influences on the past and present structure of the health care system is what Clark Havighurst called the "professional paradigm of medicine."[7] This paradigm is the profession's view (and one shared by many outside of medicine) of its mission and how it should do its work. Third, like many other professions, a key component of the paradigm is the medical profession's strongly-felt need for professional autonomy over both the clinical and economic

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education and infrastructure. Cowan & McDonald, *supra*; BIPARTISAN COMM. ON ENTITLEMENT AND TAX REFORM, FINAL REPORT TO THE PRESIDENT (1995).

7. HAVIGHURST, *supra* note 5, at 112-113. For a general summary of the many areas where the paradigm has influenced public and private structures and procedures, see Clark C. Havighurst, *The Changing Locus of Decision-making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697 (1986) and PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

aspects of its work.[8] Many of the profession's concerns about managed care have their roots in this historical and current desire for professional autonomy and, if the past is any index of the future, these autonomy concerns will continue to have a major influence on the structure and regulation of the emerging health care system.

The first part of the article will show how the profession's need for autonomy has both defined the existing structure and many of the profession's public policy positions regarding the structural changes that are occurring today. The article then discusses some new developments that may force both the medical profession and managed care administrators to change some of their traditional views toward one another, and in particular, their views toward professional autonomy. The article concludes with some observations about the future and a list of questions – the answers to which may determine how many of us, and all of our children, will receive and pay for health care.

8. *See generally* ELIOT FRIEDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE (1970) 23-46, 137-57, 359-82 (a seminal analysis of the cultural components of the medical profession and how autonomy over one's work plays an integral role in that culture).

I. MANAGED CARE AND THE MEDICAL PROFESSION: OLD ISSUES AND OLD TENSIONS

> *Managed care has somewhat compromised physicians' powers, leaving some senior physicians despairing about the loss of the golden age of medicine, and younger physicians feeling duped by an unfilled vision of autonomous medical practice.*
>
> *– Charles W. Plows, M.D., Chair of the American Medical Association's Council on Ethics and Judicial Affairs and Rosemary Quigley, Senior Associate in the AMA's Division of Ethics Standards.*[9]

"Managed care" comes in many shapes and flavors.[10] This variety and resulting ambiguity arise because the term is a catch-all phrase for a continuum of the many structural variations possible in the piecemeal transition from one complicated health care delivery and financing system to another. More often than not, the emerging structural variations involve groups of affiliated providers and financing mechanisms. These affiliated delivery and financing mechanisms are often referred to as "networks."

Reduced to essentials, the existing delivery system is moving *away* from a system dominated by relatively autonomous, entrepreneurial individual medical providers or small groups of providers, who treat or focus on episodes of illness and charge a separate fee for each treatment, i.e. on a fee-for-service basis. This traditional system is transaction-based, where the physician determines what services will be provided and at what cost. The institutional centerpiece of this old system is the hospital which provides for both acute and much sub-acute care.

Under the traditional system, there is a strict separation between the delivery of care and the payment for the care. Medical bills are paid by private or public third-party payors. These financial entities "indemnify"

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9. Charles W. Plows, M.D. & Rosemary Quigley, *Managing Care Ethically: A Professional Priority*, THE INTERNIST (April, 1996).

10. For a general description of the many possible networks, structures and the acronyms associated with managed care, see John P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL., POL'Y & L. 75 (1993); Eric R. Wagner, *Types of Managed Care Operations*, *in* THE MANAGED CARE HANDBOOK (2d ed. 1993); John K. Inglehart, *Managed Care* 327 NEW ENG. J. MED. 742 (1992).

the patient for all or part of what the patient owes the provider for care received. The decision of which doctor to go to, how much care one receives and the amount charged for each service is between the patient and the doctor – although many believe that the existence (or non-existence) of insurance often influenced and still influences the behavior of the doctor, hospital or patient regarding whether to give or receive care.[11] This separation between the delivery and financing of health care often was memorialized in the insurance laws.[12]

The traditional system is moving *toward* an integrated system where the delivery of care is provided on a more systematic basis (not just when one is ill) through networks of providers. These networks manage utilization and use reimbursement methodologies designed to encourage cost-effective care that "keeps people well." Here the hospital plays an important role, but it is just one of many options for the delivery of acute and other complicated care.[13]

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11. For example, many believe public and third-party coverage encourages utilization since patients and providers are insulated from the costs of care. *See* note 5. In addition, providers have often and still do provide charity care where no funds are available. Some providers have been known to withhold care because of the absence or inadequacy of coverage. Because of alleged hospital denial of emergency care to indigents, Congress enacted the Emergency Medical Treatment and Labor Act, 42 U.S.C.A. § 1395dd(e) (West Supp. 1996) (also known as "anti-dumping" legislation), which requires hospitals that participate in Medicare and have an emergency room to stabilize emergency cases. For a general discussion, see BARRY FURROW ET AL., HEALTH LAW § 12.2 (1995). Similar issues have arisen regarding physicians who will or will not participate in Medicare. In the early 1980s, it was alleged that physicians would not participate in Medicare without being able to "balance bill" (e.g., charge the patient for amounts due over what Medicaid paid). Over the years, Congress has tried a number of "carrots and sticks" to encourage participation. Some states even outlaw Medicare balance billing. *Id.* §§ 13-26. For a general discussion of Medicaid reimbursement levels and physician refusals to treat, see John Holohan, *Paying for Physician Services in State Medicaid Programs*, HEALTH CARE FIN. REV., Spring 1984, at 99-110.

12. Approximately two-thirds of the states have so-called "freedom of choice" laws, which provide that *indemnity* insurers should not influence a patient's choice or provider. In addition, many group insurance contracts expressly provided that the insurer would not interfere with one's choice of provider. In the 1970s, insurance regulators began to encourage insurers to exercise cost containment oversight through Department bulletins, regulation and even legislation. For example, the Preferred Provider Organization (PPO) and federal and state Health Maintenance Organization (HMO) laws were enacted in part to clarify that directing or encouraging beneficiaries to use certain providers was allowed. *See* Edward Potanka, *Alternative Health Care Delivery Systems: A Legal Overview*, ASSOC. OF LIFE INS. COUNCIL PROC. 124-27 (1989); S. BRIAN BARGER ET AL., THE PPO HANDBOOK (1985).

13. Stephen Shortell et al., *The New World of Managed Care: Creating Organized Delivery Systems*, HEALTH AFF., Winter 1994, at 48; *see also* Gordon K. MacLeod, *An Overview of Managed Health Care*, *in* THE MANAGED HEALTH CARE HANDBOOK, (Peter R. Kongstvedt ed., 2d ed. 1993); Paul Fronstin, *Physician Practice in a Dynamic Environment:*

The new system is accompanied by a major change in how insurance and other financing mechanisms pay for care. Instead of indemnifying patients for what the patient owes the provider, payors deal directly with providers regarding what will be paid and how much. In addition, the old system is in transition from the fee-for-service indemnity system *to* one where the reimbursement mechanism is partially or totally integrated with the doctors, hospitals and other care givers.[14] The goal of network integration is to: (1) provide high quality care while avoiding or minimizing the fee-for-service incentive to "over-utilize;"[15] and (2) optimize marketplace forces, such as volume and discounting arrangements, with providers and hospitals.[16]

Although "managed care" involves a wide variety of delivery and payment structures at varying points on the transition continuum, it exhibits a number of common characteristics that create concerns for many in the medical community. Some major characteristics of "managed care" that cause concern are:

- the delivery of care through a network of providers, i.e., delivery by a *finite* group of providers to a *defined* group of patients that either have access only to, or are encouraged through financial incentives to use network providers, rather than providers outside the network;

- the creation of utilization review and reimbursement methodologies designed to reduce or eliminate the fee-for-service system's incentives to over-treat; and

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Implications for the Health Care System, EBRI ISSUE BRIEF NO. 162 (Employee Benefit Research Institute, Washington, D.C., June, 1995).

14. MacLeod, *supra* note 13, at 3-11.

15. One common approach includes capitation, where the payor prepays for one's care irrespective of how much treatment is received. This puts the provider "at risk" for all or part of unanticipated utilization. If one likes managed care, capitation is characterized as incentivizing the provider to keep someone well and avoid unneeded or marginally beneficial care. If one does not like managed care, capitation is characterized as incentivizing under-treatment. For a general overview of various managed care utilization strategies, see Paul Fronstin, *The Effectiveness of Health Care Cost Management Strategies: A Review of the Evidence*, EBRI ISSUE BRIEF No. 154 (Employee Benefit Research Institute, Washington, D.C., October 1994).

16. *See, e..g.,* H. E. Frech, *Preferred Provider Organizations and Health Care Competition, in* HEALTH CARE IN AMERICA (1988); Kongstvedt, *supra* note 13 at 78-101, 153-154.

- the trend, especially in recent years, to build the new networks within a "corporate" structure and to operate them on a "for-profit" basis.

These characteristics and resulting concerns raise a number of common interrelated economic and cultural themes that impact professional autonomy. For example, is too much control for patient care being shifted from the provider to those that pay the bills? How does the medical profession and society respond to real or perceived resource availability? Is medicine a science, an art or both? Is medical professionalism compatible with "profit"? How does technology influence not just cost and utilization, but also the system's structure and internal power relationships? None of these are new issues, although there are important differences between today and yesterday.

A. Network-Based Delivery of Care

> *The development of modern medicine, and especially of scientific laboratory diagnosis, may make necessary some such cooperative plan, as these groups are intended to provide. But what of the outcome of this new development? What of the physician outside the group? Some evidently are seeing the advantages and are forming other groups – perhaps in some instances to do so in self-defense!*
>
> *– American Medical Association Editorial (1921).*[17]

Organized medicine has always been uneasy and often hostile to any public or private institution that threatened professional autonomy. These concerns have had, and continue to have, both clinical and economic motivations.[18] At the same time, these concerns have been and continue to be articulated in terms of professional ethics that eschew competition, commercialism and the practice of medicine by or through "lay" entities, i.e., the corporation.[19]

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17. *"Group Practice" – A Menace or a Blessing*, 76 JAMA 452-453 (February 21, 1921).

18. For a general history of the medical profession and how it evolved in the United States and organized medicine's concern with corporate and related types of practice, see PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE ch. 6 (1982).

19. STARR, *supra* note 18, at 200-215; Mark Hall & Justin Vaughn, *The Corporate Practice of Medicine, in* HEALTH CARE CORPORATE LAW §§ 3.2-5.51 (1993).

Originally, this professional concern was focused on railroad and mining companies that were providing health services to their employees through salaried doctors and "for-profit" corporations that arranged for the delivery of care.[20] Resistance to these early "networks" was the genesis of the legal prohibition against the corporate practice of medicine.[21] This aversion also extended to group practices controlled by physicians, and especially so if the form of physician payment differed from the traditional fee-for-service system.[22] Here, the profession was concerned about the loss of autonomy and potential competitive disadvantage because a network or group was by definition exclusionary.[23] On occasion, over the last fifty years, certain tactics used by organized medicine in its opposition to networks of various types has prompted federal and state intervention under the antitrust laws.[24]

During the same period, certain networks – such as hospitals and Blue Cross and Blue Shield – were embraced by organized medicine with varying degrees of enthusiasm. Acceptable networks were those that "accommodated"[25] the medical profession's desire to preserve professional autonomy and avoid placing a middleman between the patient and doctor. Acceptance of a network also was influenced by the network's importance

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20. STARR, *supra* note 18, at 204-205.

21. HALL & VAUGHN, *supra* note 19, §§ 3.3-3.27. The doctrine has been criticized for "inhibiting the use of profit-seeking business forms, discouraging innovation in health care organization and cost control and solidifying professional sovereignty over consumers." FURROW, *supra* note 11, §§ 5-10.

22. For a history of organized medicine's opposition to pre-paid medicine, see STARR, *supra* note 18 at 301, 319-27; *see also* David R. Hyde et al., *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, 63 YALE L. J. 938, 969 (1954).

23. Hyde et al., *supra* note 22; MacLeod, *supra* note 13, at 3-11.

24. *See, e.g.*, American Med. Assoc. v. United States, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943) (where the AMA was convicted of a criminal violation of the Sherman Act for conspiring to prevent a health maintenance organization from attracting and retaining doctors). In 1979, the FTC enjoined the AMA from enforcing ethical prohibitions against the corporate practice of medicine. American Med. Assoc. v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd* by an equally divided court, 455 U.S. 676 (1982). *See* Clark C. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303; JOHN MILES, HEALTH CARE AND ANTITRUST LAW § 1:6 (1996). Also see the discussion infra at 25-28.

25. Paul Starr uses the term "accommodation" and one is hard pressed to find a better one. STARR, *supra* note 18. Chapter Two in his seminal work is entitled "The Triumph of Accommodation" and provides a broad overview of the many areas where society "accommodated" the medical profession's view of the world. *See also* HAVIGHURST, *supra* note 5, at 110-115.

to the physician's practice and the physician's need and ability to control the network.

This section will focus on how and why: (1) the profession influenced the hospital "networks" governing structure in order to meet the profession's autonomy requirements; (2) the hospitals have been less accomodating to professional autonomy in recent years; (3) the hospital's central role in the delivery system has declined; and (4) new networks have come into ascendancy that have not "accommodated" providers to the same degree that the hospital network did. The section will close by examining how the medical profession has responded to these changes. The Blue Cross and Blue Shield "networks" will be discussed in the next section of the article in the context of reimbursement options.

1. The Traditional Hospital Network and Professional Autonomy

During the late nineteenth and early twentieth century, modern science transformed the hospital from a custodial institution into a place of healing.[26] Hospitals also provided the structure and capital accumulation necessary to supply the participating medical staff with new diagnostic tools, such as labs and x-rays. In addition, the hospital's governing structure gave the medical staff considerable power over clinical decisions, such as who was admitted or discharged and when and what treatment to give. This autonomy enabled the individual practitioner to make full use of the hospital's organization and facilities without becoming an employee, incurring hospital overhead costs or requiring the initial capital necessary to build the hospital. This autonomy also minimized interference with the doctor-patient relationship.[27]

Until the early 1980s, the economic incentives of hospitals and physicians were aligned. Hospitals charged on a "cost-plus" basis, which complemented the physician fee-for-service system.[28] The public and private insurance system paid on this basis. More volume meant more

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26. Peter Temin, *An Economic History of American Hospitals*, *in* HEALTH CARE IN AMERICA (H.E. Frech III ed., 1988); HOWARD ZUCKERMAN ET AL., HEALTH CARE CORPORATE LAW (1993).

27. ZUCKERMAN ET AL., *supra* note 26.

28. Steven Renn, *The Structure and Financing of the Health Care Delivery System of the 1980s*, *in* HEALTH CARE AND ITS COSTS 8, 41-45 (Carl J. Schramm ed., 1987); *see also* Stephen Ebert, *The Changing Role of the Physician*, *in* HEALTH CARE AND ITS COSTS 145, 168-69 (Carl Schramm ed., 1987).

"profit" or revenues for both physicians and hospitals. To be sure, there were tensions between the medical staff and the hospital administration and governing board, but these tensions were a price worth paying in order to work in a hospital "network."[29]

Physicians were able to preserve their autonomy in the hospitals by the effective use of what Paul Starr has called medicine's "cultural authority, economic power and political influence."[30] Since medicine was a science, only those trained in its nuances could make decisions regarding its practice. Physicians, by training and law, were the only ones allowed to make a medical diagnosis and to prescribe treatment.[31] Accordingly, hospitals depended on doctors for patients – who in turn generated hospital revenue. Not surprisingly, hospitals went to great lengths to assure physician satisfaction, not only with the hospital's physical facility, but also with its day-to-day operations.[32]

The physician's cultural and economic dominance was supplemented by professional self-regulation within the hospital.[33] While hospitals were licensed by the states, state regulation relied heavily and often entirely on "voluntary"[34] private accreditation – both for administrative convenience

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29. *See* BRADFORD GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS ch. 9 (1991).

30. STARR, *supra* note 18, at 5. For a general discussion of the early and evolving attitudes of physicians toward hospitals and the need to exert professional control within hospitals, see STARR, *supra* note 18, at 164-69.

31. FURROW ET AL., *supra* note 11, at 58-71. The usual definition of what constitutes the "practice of medicine" has been and still is very broad. For example, the Indiana Code defines the "practice of medicine" as "holding oneself out to the public as being engaged in diagnosis, treatment . . . of any disease, ailment, defect, injury . . . or other condition of human beings. . . ." IND. CODE § 25-22.5-1-1.1(a) (1996). Enforcing this standard is usually done through boards composed of practitioners. The decisions of the review boards are subject to deferential judicial review. This "self-regulatory system" has been subject to much criticism, both on the ground that it constitutes ineffective oversight and unduly protects the profession from competition. *See* Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6 (1976).

32. Temin, *supra* note 26, at 85-86; MICHAEL MCDONALD ET AL., HEALTH CARE LAW: A PRACTICAL GUIDE § 6.04[2] (1995); ZUCKERMAN ET AL., *supra* note 26, § 2.2.2.

33. For a general overview of the evolving organization structure of hospitals and their relationship to physicians, see MILTON ROEMER & JAY W. FRIEDMAN, DOCTORS IN HOSPITALS: MEDICAL STAFF ORGANIZATION AND HOSPITAL PERFORMANCE (1971).

34. More than 40 states and the federal government rely on the Joint Commission of Accreditation of Health Care Organizations (JCAHO) accreditation as a way to meet the state and federal licensing and regulatory requirements. Accordingly, many view the "voluntary" Joint Commission accreditation as being a mandatory requirement. *See* Timothy Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public*

and because of society's deference to professional norms.[35] The accrediting agency for hospitals was and still is the Joint Commission on Accreditation of Hospitals (JCAH) – which in 1987 changed its name to the Joint Commission on Accreditation of Health Care Organizations (JCAHO) (hereinafter referred to as "Joint Commission") to reflect its expanding accreditation role beyond hospitals.[36]

The Joint Commission was created and controlled by individual and institutional medical providers.[37] While the Board has been expanded to include six public members, the medical profession continues to have a dominant and influential position[38] – which over the years has not been without its critics.[39]

Interest, 24 B.C. L. REV. 835 (1983); FURROW ET AL., *supra* note 11, §§ 1-4; MCDONALD ET AL., *supra* note 32, § 5.03[2].

35. Major benefits of accreditation include: 1) evidence of quality; 2) delineation of standards where compliance with the standards provide evidence of appropriate conduct by a hospital board as it fulfills its corporate duty to assure the competence of the hospital's medical staff and to provide appropriate procedural requirements for staff privileges; 3) a way to meet state regulatory requirements; 4) attracting better quality medical personnel; 5) providing a hospital with "deemed status," i.e., complying with minimum Medicare participation requirements; and 6) meeting a condition often included in private insurance policies, i.e., covered services must be done within or by an accredited entity. MCDONALD ET AL., *supra* note 32, § 50.3[2]; FURROW ET AL., *supra* note 11, at 7-9, 128-129.

36. MCDONALD ET AL., *supra*, note 32, § 5.03[1]. Because this article discusses the Joint Commission's activities both before and after 1987, the term "Joint Commission" will be used to facilitate clarity. Citations in the footnotes use the acronyms JCAH and JCAHO.

37. In 1913 the American College of Surgeons (ACS) was established. The College set minimum hospital standards in 1917 and began on-site inspections in 1918. By 1950 more than 3200 hospitals received ACS accreditation. In 1951, the American Medical Association (AMA), the American Hospital Association, the American College of Physicians and the Canadian Medical Association joined the ASC on the governing board. In 1987, the Joint Commission was governed by a twenty-two member Board: seven members were appointed by the American Medical Association; seven by the American Hospital Association; three by the American College of Surgeons; three by the American College of Physicians; one by the American Dental Association and one private citizen appointed by the rest of the Board. JCAHO, FACTS ABOUT THE BOARD OF COMMISIONERS (Joint Commission on Accreditation, July 1996); James Roberts et al., *A History of the Joint Commission on Accreditation of Hospitals*, 258 JAMA 936 (1987); Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 529-532 (1988); MCDONALD ET AL., *supra* note 32, § 5.03[1]; Jost, *supra* note 34; *see also* Roemer & Friedman, *supra* note 33, at 39-43.

38. Between 1987 and the present, the Joint Commission expanded public and allied professional participation by adding to the twenty-two member Board five new public members and one at-large nursing representative. JCAHO, *supra* note 37.

39. In July of 1996, the Public Citizen's Health Research Group issued a report that concluded, among other things, that because JCAHO is dominated by the industry it accredits, "it cannot serve as the rigorous advocate for safety and quality that the public deserves."

The Joint Commission's main function is to assure an organized system to facilitate and monitor quality. One important way the Joint Commission tries to assure quality is through the use of accreditation standards dealing with the structure and responsibilities of the medical staff within the hospital. While the Joint Commission standards stress the ultimate accountability of a hospital's board of governors (especially since the 1970s),[40] the standards make it clear that the internal structure of the hospital should be designed so the "medical staff members can act with a reasonable degree of freedom and confidence."[41] In this regard, Joint Commission standards require the medical staff (i.e., primarily doctors with privileges) to develop and adopt by-laws and rules and regulations "to establish a framework for *self-governance* of medical staff activities" (emphasis supplied).[42] Appropriate medical staff activities include the creation of credentialing standards and review procedures, the monitoring of the medical staff and the oversight of policies and procedures relating to the quality of care within the hospital.[43] Once the staff by-laws are approved, neither the Board nor medical staff can "unilaterally amend the medical staff by-laws."[44]

Because of the medical profession's "cultural authority, economic and political influence" and the hospital's legally sanctioned self-regulatory structure, physicians with staff privileges in hospitals were reasonably comfortable with the hospital network.[45] The hospital network provided

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PUBLIC CITIZEN HEALTH RESEARCH GROUP, THE FAILURE OF PRIVATE HOSPITAL REGULATIONS (Washington, DC, 1996); Alison Bass, *Agency Criticized over Accreditation Given Hospitals*, BOSTON GLOBE, July 11, 1996 at 19; *Group Sees Conflict of Interest in JCAHO Role*, CCH PULSE, July 15, 1996, at 6.

40. JCAHO (Joint Comm. on Accreditation of Healthcare Organizations), 1995 COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS §§ GO.2, GO.2.1, MS.1. Increased focus on Board accountability during the late 1960s and 1970s was driven in part by the doctrine of corporate negligence, which imposed upon the hospital administration and Board a duty to take reasonable steps directly and through the hospitals' staff to take reasonable steps to insure the competence of those having privileges in the hospital and the adequacy of hospitals' physical and personnel resources. MCDONALD ET AL., *supra* note 32, § 11.01[2][c]; FURROW ET AL., *supra* note 11, §§ 7-4.

41. JCAHO, *supra* note 40, § MS.3.2.

42. JCAHO, *supra* note 40, § MS.3.1.

43. JCAHO, *supra* note 40, at 463, 462-79.

44. JCAHO, *supra* note 40, § MS 3.1. As late as 1988, the standards also provided that the Board could not "unreasonably withhold its approval of the by-laws." CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 550 (1988). This language has been deleted in later versions of the hospital manual. *See* JCAHO 1995, *supra* note 40, at 451-56 (sections entitled "Governance" and "Medical Staff Organizations, Bylaws, Rules and Regulations").

45. *See* ZUCKERMAN ET AL., *supra* note 26, §§ 2.3.2, 2.3.4. For a critical analysis of the Joint Commission self-governance standards, see Hall, *supra* note 37, at 532.

both the economic infrastructure and the autonomy that physicians wanted for their practice of medicine, both within and outside the hospital.

2. Resource Limits, the Declining Importance of the Hospital Network and the Growth of New Networks with Diminished Physician Control

a. Resource Availability and Its Impact on Medical Expenditures

Between the 1930s and 1970s, the health care delivery and financing structure and government policy reflected society's accommodation of the medical profession's view of how medicine should be practiced. Hospitals were viewed and operated as an extension of the doctor's office.[46] Licensing and accreditation agencies deferred to the profession.[47] During this period, government policy also encouraged access to care and treatment through hospital construction loans and grants,[48] medical education subsidies[49] and tax support for employer-based health insurance.[50] And in 1965, the federal government approved two major

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46. *See* Robert Ebert, *The Changing Role of the Physician, in* HEALTH CARE AND ITS COSTS 145, 168-69 (Carl J. Schramm ed., 1987). *See also* STARR, *supra* note 7, at 290-378.

47. FURROW ET AL., *supra* note 11, § 3-3. *See supra* p. 13.

48. For example, the Hill-Burton Act of 1946, 42 U.S.C. §§ 291-99 provided federal funds for the construction and modernization of hospitals. In addition, Medicare early reimbursement formulas provided for capital costs *irrespective* of whether a facility was approved pursuant to state planning requirements, when such requirements existed. ARTHUR F. SOUTHWICK & DEBORA A. SLEE, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 103-54 (2d ed. 1988). *See infra* pp. 46-53.

49. Because of a perceived serious shortage of physicians, Congress enacted health manpower laws in the early 1960's. These laws, along with other government support, increased the number of medical schools from 88 to 127 between 1967 and 1984. During the same period, the annual graduating class doubled, i.e. from 7,400 to 15,900. For a general review of the government's support, the growth of providers and the growth of the academic health center, see Robert H. Ebert & Eli Ginzberg, *The Reform of Medical Education*, HEALTH AFF., Supplement 1988, at 5, 11-19. *See infra* pp. 46-53. Medicare reimbursement also supported medical educators. C. Ross Anthony, *Medical Support of Medical Education*, HEALTH AFF., Supplement 1988, at 158.

50. Federal tax laws were changed to allow an employer's contributions to an employee's health coverage to be excluded from the employee's taxable income. IRC §§ 105-106 (1954). This tax change coupled with the Supreme Court's clarification that employee benefits were appropriate subjects for collective bargaining, Inland Steel Co. v. NLRB, 170 F.2d 247 (7th Cir.), *cert. denied*, 336 U.S. 960 (1949), stimulated the growth of third-party group coverage. *See generally* RAYMOND MUNTS, BARGAINING AND HEALTH:

public health insurance programs: Medicare, which provides care for the elderly, and Medicaid, which provides care for the poor.[51]

One of the more important reasons for the increased use and cost of medical services was the dramatic growth of private and government third-party health insurance coverage after World War II. The population of the United States between 1940 and 1970 grew from 132 million to 205 million people.[52] During the same period, the number of people covered by private insurance increased from 12 to 158.8 million people.[53] Claims paid by private carriers increased from $1.3 billion in 1950 to $17.2 billion in 1970.[54] In 1972 – five years after Medicare and Medicaid became operational – these government programs covered a total of 40.9 million people and paid out over $14.7 billion annually.[55] The infusion of money, fee-for-service reimbursement and the highly judgmental nature of what was medically necessary or appropriate incentivized providers to increase the use of medical procedures. At the same time, technology created new kinds of treatment at an increasing rate. The combination of these forces lead to unparalleled increases in medical care costs. Between 1950 and 1970, national health expenditures[56] increased 586% (from $12.7 billion to $74.4 billion), while the gross national product increased by only 347% ($288 billion to $1 trillion).[57]

Government and private sector efforts to contain increasing medical costs began to gather momentum in the late 1960s and early 1970s and continue to this day. A number of strategies have been tried with mixed results. These include direct hospital rate and facility construction

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LABOR UNIONS, HEALTH INSURANCE AND MEDICAL CARE (1967). *See also* Thomas Bodenheimer, M.D, M.P.H. & Kevin Grumbach, *Paying for Health Care*, 272 JAMA 634, 636-38 (1994).

51. For a general description of these programs, see Paul B. Ginsburg, *Public Insurance Programs: Medicare and Medicaid, in* HEALTH CARE IN AMERICA 179 (H.E. French III ed., 1988). For a general review of the legislative history and political background that influenced the structure of the Medicare/Medicaid programs, see THEODORE R. MARMOR, THE POLITICS OF MEDICARE (1972).

52. U.S. Bureau of Census, Current Population Reports, Series 5, at 25-1045, 25-1176 (1971).

53. HIAA, *supra* note 4, at 40.

54. *Id.* at 41.

55. *Id.* at 67, 72.

56. National health expenditures represent total private and public spending for personal care, research, construction of medical facilities, insurance and administration. *Id.* at 79.

57. *Id.* at 97.

regulation,[58] utilization review,[59] changes in benefit design to promote desired behavior,[60] prospective payment for hospitals and, in recent years, "at-risk" payments and rate schedules for physicians[61] and the encouragement of alternative delivery systems, such as Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO).[62]

Two of these cost-containment efforts warrant special attention because of their impact on professional autonomy in the hospital, the demise of the hospital's central role in the delivery system and the growth of new networks. One is the change in how public and private insurers pay hospitals. The other is the legislative and regulatory efforts to encourage the growth of alternative delivery systems, such as HMOs and PPOs. Both of these developments took place over a period of 10-15 years, starting in the early 1970s.

b. Growing Autonomy Tensions in the Hospital and the Decline of the Hospital's Central Role in Health Care Delivery

After World War II, the complexity and information needs of modern medicine increased dramatically.[63] Hospitals, which now played a central role in treatment, needed to manage this complexity.[64] In addition, during the 1960s, the courts began to make hospitals accountable not only for the

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58. The National Health Resources Planning and Development Act of 1974, which replaced earlier federal efforts at health planning, local health systems agencies and conditioned receipt of federal monies on the creation of state certificate of need (CON) regulation. While the federal law was repealed in 1986, CON laws continue in place in many states. *See generally* FURROW ET AL., *supra* note 11, §§ 1-20.

59. *See generally* INSTITUTE OF MEDICINE, CONTROLLING COST AND CHANGING PATIENT CARE?: THE ROLE OF UTILIZATION MANAGEMENT (Bradford H. Gray & Marilyn J. Field eds., 1989).

60. BURTON T. BEAM, GROUP BENEFITS: BASIC CONCEPTS AND ALTERNATIVES 324-26 (4th ed. 1991).

61. *See* discussion of hospital prospective payments *infra*; discussion of physician at-risk payments *infra* pp. 38-43. Rate schedules have been imposed primarily under government programs such as Medicare and Medicaid. These efforts culminated with the phase-in of Medicare's Resource-Based Relative Value Scale (RBRVS) fee schedule, which is designed to incentivize care migration from surgical specialties and towards primary care and to facilitate access in rural areas. *See generally* FURROW ET AL., *supra* note 11, §§ 13-22.

62. *See infra* p. 22-25.

63. Ebert, *supra* note 46, at 168-169.

64. Ebert, *supra* note 46, at 169.

quality of their physical plant, but also for the quality of the medical personnel that worked in the hospitals, including doctors.[65] As a result of the hospital's growing management and accountability needs, the hospital administration's power was slowly, but inevitably increasing relative to that of the medical staff.[66]

Another important influence on the hospital management structure was the unanticipated growth of Medicare and Medicaid programs.[67] In 1965, the Medicare and Medicaid programs adopted traditional methods of payment for medical services by providing for "cost-plus" reimbursement for hospitals and fee-for-service reimbursement for doctors.[68] However, over time the increasing cost of these government programs forced a retreat by federal and state governments from these reimbursement methods, especially with respect to hospitals.[69] In 1977, the federal government imposed new limits on Medicare fee-for-service hospital and physician reimbursements.[70] In the early 1980s, hospital prospective payment reimbursement was instituted for Medicare and in a number of states for Medicaid.[71] Medicare/Medicaid prospective payment reimbursement began the process of dismantling the economic alignment between hospitals and physicians. Hospitals were now forced to become more cost conscious and

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65. Originally, hospitals were not liable for the negligence of doctors within the hospital, primarily because of charitable immunity and the independent contract status of the physician. During the late 1950s and 1960s, the courts imposed greater accountability on hospitals through the doctrines of ostensible agency and eventually, corporate negligence. For a general overview of this emerging liability, see FURROW ET AL., *supra* note 11, §§ 7-1 - 7-6.

66. For a general discussion of the evolving organizational structure and the need for more integration of physicians into the hospital structure, see Hall & Vaughn, *supra* note 21, at 504-32. *See also*, ROEMER & FRIEDMAN, *supra* note 33, at 25-26, 277-82, 298-9; Ebert, *supra* note 46, at 169.

67. Ginsburg, *supra* note 51, at 187-191; *see also* Senate Fin. Comm. REP. NO. 1230, 92d Cong., 2d Sess. 254-69 (1972).

68. *See infra* 37.

69. The focus on hospitals was because: 1) hospitals were the site where the most expensive care was rendered; and 2) hospitals were in the best position to manage the costs of expensive technology and over-utilization. *See* Hall & Vaughn, *supra* note 21, at 439-40 & n.32.

70. The 1972 Amendments to the Social Security Act authorized the Secretary of HHS to establish reasonable limits on hospital costs and limiting the increases in physician URC charges to an index of the physicians' practice expenses. *See generally* Ginsburg, *supra* note 51, at 192-195.

71. Ginsburg, *supra* note 51, at 196-199; Shortell, *supra* note 13, at 135. The prospective payment methodology also ended the pass through of costs for expensive new equipment. Ebert, *supra* note 46, at 173.

eliminate unnecessary hospital stays.[72] Physicians, on the other hand, retained much of their traditional autonomy over medical diagnosis and treatment, and this autonomy, coupled with the powerful fee-for-service reimbursement incentives, pushed in the opposite direction.[73]

A number of states began to regulate hospital rates.[74] In addition, as the new managed care networks gained market share, they were able to negotiate favorable hospital per-diem rates. As a result, both state regulation and managed care networks limited the hospital's ability to recoup government reimbursment shortfalls from private payors.[75]

Because hospitals were forced to become more efficient and were being held accountable for quality within the hospital, they had to increase their oversight of clinical matters, including physician utilization patterns.[76] This environment created subtle and not so subtle redistributions of power from the individual practitioner to the hospital administration and organizations in which hospitals had significant influence, such as the Joint Commission.

This redistribution of power manifested itself in several ways. Institutions and accreditation agencies began to re-think the traditional staff self-governance structure and develop more integrated models.[77] Peer

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72. ZUCKERMAN ET AL., *supra* note 26, § 2.4.2-2.4.3.

73. Gerald L. Glandon & Michael A. Morrisey, *Redefining the Hospital/Physician Relationship Under Prospective Payment*, 23 INQUIRY 166, 167-168 (1986). *See generally* Ginsberg, *supra* note 51, at 196-199; ZUCKERMAN ET AL., *supra* note 26, § 2.4.3.

74. PAUL J. JOSHOW, CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION 100, 100 (1981).

75. While managed care and state regulation have helped reduce the cost shift, many believe it continues to be a significant issue. *See* DONALD MORAN & JOHN SHEILS, THE NAT'L ASS'N OF MANUFACTURERS EMPLOYER COST-SHIFTING EXPENDITURES: FINAL REPORT (1991).

76. Glandon & Morrisey, *supra* note 73. *See also* INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 106 (Bradford Gray & Marilyn J. Field, eds., 1989); HALL & VAUGHN, *supra* note 19.

77. ZUCKERMAN ET AL., *supra* note 26; Temin, *supra* note 26, at 101. One manifestation of this need for hospital administrators to manage more aggressively was the American College of Hospital Administrators (ACHA) request to the Joint Commission to change the medical staff self-governance standard and to provide for a direct line of accountability between the medical staff and the hospital chief administrative officer through a full-time medical director. This request was opposed by the AMA, and the Joint Commission self-governance standard remains in place today. Because Joint Commission accreditation is not dependent upon compliance with each and every Joint Commission standard, the trend – albeit a slow one – has moved toward ACHA's preferred structure. In addition, most for-profit hospitals embrace the direct line of accountability approach. KIRT DARR & JONATHAN S. RAKICH, EDS., HOSPITAL ORGANIZATION AND MANAGEMENT 25-29 (3d ed. 1993). For a somewhat dated but useful general survey of the literature regarding organizational change in medicine, see Burchell et al., *Physicians and the Organizational Evolution of Medicine*, 260 JAMA 826 (1988).

review was institutionalized.[78] In addition, hospitals made increasing use of physician profiling and economic credentialing.[79]

As hospital bed-days dropped because of government and private cost-containment efforts, hospitals began to consolidate through alliances, mergers and acquisitions to reduce excess capacity, achieve economies of scale and to strengthen their bargaining power with the new managed care organizations. Consolidation often resulted in *central* management being located further away from the local hospital and medical staff, further diluting local physician influence in the local hospital.[80]

The diverging physician and hospital economic incentives and increased hospital oversight of quality and utilization, together with new technological advances, accelerated the movement of much diagnosis and treatment away from the hospital and into affiliated or free-standing clinics or centers and even into physician offices.[81] Hospitals increasingly found that medical staff doctors were becoming competitors rather than sources of patient referral.[82] This patient migration was often to specialty doctors, which further undermined the commonality of interest between specialists, hospitals and the rest of the medical community.[83] As a result of these influences, the hospital's role in the system, while still important, was no longer as fundamental as it was in the past.

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78. Amendments to the Medicare program mandated peer review by hospitals. While the focus was both quality and cost, early efforts focused on cost. More recent efforts are stressing quality. *See* SOUTHWICK & SLEE, *supra* note 48, at 623-626. Historically, the Joint Commission focused on governance and the quality of support services. During the last decade, the Joint Commission has expanded its focus to the actual delivery and quality of care provided in the hospital, e.g. JCAHO (THE JOINT COMM. ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS) AGENDA FOR CHANGE (1986). *See* MCDONALD ET AL., *supra* note 32, § 5.03(1). Recent Joint Commission standards now provide minimum requirements for patients rights and responsibilities, including procedures to make patients aware of informed-consent procedures and the decision process for withholding resuscitation measures. *Id.*

79. *See* ZUCKERMAN ET AL., *supra* note 26; MCDONALD ET AL., *supra* note 32, § 15.04(2); John D. Blum, *Evaluation of Medical Staff Using Fiscal Factors: Economic Credentialing*, 26 J. HEALTH & HOSP. L. 65 (1993).

80. Gray, *supra* note 29. A reflection of this trend is a relatively new Joint Commission standard that requires "multi-hospital systems to provide local physician leaders and other local leaders with mechanisms...to participate in overall system corporate policy decisions affecting their local organizations." JCAHO, *supra* note 40, § 1.1.2.

81. *See* John D. Stoeckle, *The Citadel Cannot Hold: Technologies go Outside the Hospital, Patients and Doctors Too*, 73 MILLBANK Q. 1 (1995); *see also* FURROW ET AL., *supra* note 11, at 401-402.

82. ZUCKERMAN ET AL., *supra* note 26. For a good general overview on why the hospital is ceasing to be the "hub" of medical care delivery, see Stephen Shortell et al., *Reinventing the American Hospital*, 73 MILBANK Q. 131 (1995) at 132-135.

83. ZUCKERMAN ET AL., *supra* note 26; Ebert, *supra* note 46, at 163-164.

c. The Growth of New Networks

Prepaid group practices, which were the forerunners of the HMO, have been around for many years.[84] However, widespread growth of HMOs was stymied by several factors. Start-up capital was hard to come by. Many hospitals and physicians refused to participate and often discouraged other providers (both hospitals and physicians) from participating in the new networks. Restrictive state laws and judicial doctrines, such as the prohibition of the "corporate practice of medicine," laws requiring medical society approval or oversight of HMOs, and state insurance solvency requirements also restricted HMO growth.[85] Government policy makers, however, saw the prepaid-group practice as a way to realize both cost containment and quality by: (1) injecting competition into the system; (2) avoiding fee-for-service incentives to over-utilize; (3) emphasizing preventive care in a systematic way; and (4) providing a structure that permitted outcomes evaluation and continuous treatment monitoring.

In 1973-1974, both the state and federal governments passed laws to encourage HMO growth and to preempt or repeal earlier laws that had been an impediment to the creation of HMOs. In 1973 Congress enacted the Federal Health Maintenance Act of 1973, which among other things, provided start-up grants and loans for new HMOs, and created new market opportunities by requiring employers to offer an HMO option if the employer provided traditional indemnity coverage to its employees.[86] The federal law also pre-empted state laws and policies that inhibited HMO formation.[87] In order for an HMO to get federal benefits, it had to become

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84. STARR, *supra* note 18, at 320-327.

85. *See* Institute of Medicine, *Health Maintenance Organizations: Toward a Fair Market Test*, *in* HEALTH CARE LAW AND POLICY, READINGS, NOTES AND QUESTIONS 1065-1086 (Clark C. Havighurst ed., 1988); Congressional Research Service, Library of Congress, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS (Government Printing Office, 1988) at 16-17.

86. Health Maintenance Organization Act of 1973, 42 U.S.C.A. §§ 300e-300e-17 (1973).

87. Section 3000e-10 of the law preempted any state law that prevented an HMO from becoming federally qualified. *Id.* For a general discussion, see Edward Potanka, *Alternative Health Care Delivery Systems: A Legal Overview*, ASSOCIATION OF LIFE INSURANCE COUNSEL PROCEEDINGS 114-5 (1989). NHLA (NATIONAL HEALTH LAWYERS ASSOCIATION), THE INSIDERS GUIDE TO MANAGED CARE 38-41 (1990); HAVIGHURST, *supra* note 5, at 1098; BARRY FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 380-381 (1987); LAWRENCE D. BROWN, POLITICS AND HEALTH CARE ORGANIZATIONS: HMOS AS FEDERAL POLICY (1983).

"federally qualified" by meeting certain benefit, solvency and consumer protection standards.[88] Federal qualification became a "Good Housekeeping Seal of Approval" and facilitated acceptance of the "new" health care option by employers and the public.

In 1973, the National Association of Insurance Commissioners promulgated a model HMO Act, which when enacted by a state into law, made it clear that HMOs were permitted to operate in that state.[89]

After the enactment of these laws, the HMO market share grew steadily. In 1970, HMOs had roughly 3 million members. By 1980, HMO membership had increased to 9 million; by 1990, to 34 million[90] and 1995 projections placed the number at somewhere between 53 and 58 million.[91]

As HMOs gained market share, another type of network began to emerge: The Preferred Provider Organization (PPO) – which in its *purest* form is a network of providers that agree to be paid or indemnified at a discount to their usual fee-for-service rate in exchange for patient referrals.[92] Most PPO networks have been established by institutional providers, payors or other third-parties that specialize in setting up and managing PPO networks.[93] Payors that offer PPOs use deductibles and co-

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88. FURROW ET AL., *supra* note 11, at 529-30. In 1988, the HMO act was amended to provide greater flexibility for federally-qualified HMOs, so that HMOs would continue to seek federal qualification. The amendment included major changes, including greater flexibility regarding use of the HMO network, out-of-network services and prospective experience rating. *See generally* Potanka, *supra* note 87, at 210-221 (giving an overview of the 1988 amendment).

89. NAIC (NATIONAL ASS'N OF INS. COMMISSIONERS), MODEL HEALTH MAINTENANCE ACT (1973). In order to strengthen the quality and solvency provision, the model was amended in 1988 and 1989. Section 3 of the model law provides that "[n]otwithstanding any other state law," an entity licensed under the state HMO law can operate as an HMO. Authorizing legislation now exists in every state, except Hawaii. Approximately half of the state laws are modeled on the NAIC model.

90. INTERSTUDY CTR. FOR MANAGED CARE RESEARCH, INTERSTUDY COMPETITIVE EDGE: INDUSTRY REPORT 6.1, 2 (1996).

91. Interstudy's 1995 estimate places the number at 53 million. *Id.* at 1. The American Association of Health Plans, places the number at 58 million and projects HMO membership to increase to 70 million in 1996. AMERICAN ASSOCIATION OF HEALTH PLANS, 1995 HMO & PPO TRENDS REPORT, 1 (1995). The most recent Interstudy estimates indicate that as of January 1, 1996, 59 million Americans were in HMOs and 6 million of these were in point-of-service plans. *Growing Pains for HMOs,* BUSINESS AND HEALTH, Dec. 1996, at 9; *HMO Enrollment Surpasses 59 Million, Reports Interstudy*, CCH MONITOR, Nov. 15, 1996, at 3.

92. For a general description, see HIAA (HEALTH INSURANCE ASSOCIATION OF AMERICA), MANAGED CARE: INTEGRATING THE DELIVERY AND FINANCING OF HEALTH CARE 40-44 (1995). *See also* Potanka, *supra* note 87, at 114-5; NHLA, *supra* note 87, at 19-20.

93. Individual providers can also set up PPO networks, but run the risk of antitrust exposure unless they establish a structure that permits each doctor to make an individual

pays to encourage employees or plan participants to use the PPO networks.[94] The PPO often was more attractive than an HMO to employers and employees because it provided more flexibility regarding provider choice, product pricing (e.g. experience rating) and realized cost savings through volume discounts. In the early years, the medical profession did not pay much attention to PPOs, probably because the PPO still embraced fee-for-service reimbursement (though on a discounted basis) and did not have sufficient market share to significantly change existing patient-doctor relationships. However, as the PPO market share grew, the medical profession and insurance regulators began to question whether these new networks violated the old "freedom of choice" laws and insurance "anti-discrimination" statutes.[95] Because of the cost-containment potential of PPOs and employer demand, The National Association of Insurance Commissioners (NAIC) in 1986 adopted a model PPO law that clarified the legitimacy of PPO networks.[96] In response to the medical profession's concerns, the law placed some limits on the degree to which financial incentives could be used to channel patients to participating doctors. Today over 33 states have legislation or regulations authorizing PPOs.[97]

Because the PPO product is built on an indemnity chassis, it can combine various gradations of HMO-type utilization management components along with experience rating and funding on a self-insured

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rather than a concerted, decision on price and participation. These are the so-called "messenger models." For a general review of these issues, see GERALD R. PETERS, HEALTH CARE INTEGRATION: A LEGAL MANUAL FOR CONTRACTING INTEGRATED ORGANIZATIONS (1995); HEALTH CARE COMMITTEE, SECTION OF ANTITRUST LAW, AMERICAN BAR ASS'N, MANAGED CARE AND ANTITRUST: THE PPO EXPERIENCE (1990).

94. If one uses the PPO network, the deductibles and co-pays are less than if one uses a non-network provider. BEAM, *supra* note 60, at 142.

95. *See* ELIZABETH ROLPH ET AL., STATE LAWS AND REGULATIONS GOVERNING PREFERRED PROVIDER ORGANIZATIONS, *in* HEALTH CARE LAW AND POLICY, READINGS, NOTES AND QUESTIONS, 1188 (Clark C. Havighurst ed., 1988); FURROW ET AL., *supra* note 11, at 532-535; Potanka, *supra* note 87, at 222-233.

96. NAIC (NATIONAL ASS'N OF INS. COMMISSIONERS) PREFERRED PROVIDER ARRANGEMENTS MODEL LAW (1986). This law was promulgated fifteen years after the NAIC's model HMO law, in response to the proliferation of PPOs and their increase in market share. Section 4 of the model PPO law states that "[n]otwithstanding any other state law," an entity licensed in accordance with the PPO law can operate as a PPO. For a general discussion, see EDWARD POTANKA, *Regulation of HMOs, PPOs and Managed Care in the United States,* GROUP INSURANCE ch. 12 (1992); FURROW ET AL., *supra* note 11, at 529-535; Elizabeth Rolph et al., *The Regulation of Preferred Provider Arrangements*, HEALTH AFF., Fall 1987, at 32.

97. Potanka, *supra* note 87; NAIC (NATIONAL ASS'N OF INS. COMMISSIONERS), NAIC MODEL LAWS, REGULATIONS AND GUIDELINES 65-68 (1996).

basis.[98] In addition, PPOs often offer a broader choice of providers. Over the last decade, PPO networks have grown in market share largely because of this flexibility. For example, PPO enrollments increased from 12.2 million to 111 million people between 1987 and 1994.[99] When PPO and HMO numbers are combined, network-delivered care surpasses traditional fee-for-service indemnity coverage as the dominant delivery and financing mechanism in the United States. One recent study indicates that between 1988 and 1993, traditional indemnity (non-network-based financing) has decreased from 72% to 33% of the market.[100] Also, it is estimated that approximately 95% of these "pure" indemnity plans presently have some form of utilization review.[101]

d. The Physicians' Ability to Act Collectively to Influence Existing and New Networks

For the first three-quarters of this century, all professions, including the medical profession, operated in the belief that they were not subject to the antitrust laws.[102] This exemption from the antitrust laws was important to the professions because many professional objectives, including self-regulation, were often realized through collective action.[103] The anti-trust laws, on the other hand, outlawed concerted activity among competitors that could stabilize prices or resource allocation. The profession's belief that it was exempt from the antitrust laws was premised on (1) the "learned-profession" exemption that assumed professions had a higher calling than mere business and therefore, were not part of "trade or

98. For a general overview of how managed care attributes can be grafted on a PPO and the responses of HMO regulators when these managed care PPO products look and operate like an HMO, see Potanka, *supra* note 87, at 106-118, 142-155.

99. AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS, PPO GROWTH (1984-1992) (supplemented by unpublished updates); *see also* Meyer, *supra* note 3.

100. Meyer, *supra* note 3.

101. *Id.* For a summary of the types of utilization review usually associated with indemnity (e.g., Pre-admission Certification, Continued-Stay Review, Mandatory Outpatient Surgery, Second-Opinion Surgery, Case Management and Employee Assistance Programs), see Potanka, *supra* note 87, at 112-16.

102. *See* Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071.

103. For a general overview of physician collective activity and its potential economic impact, see STARR, *supra* note 7, and Thomas Greaney & Jody Sindelar, *Physician-Sponsored Joint Ventures: An Antitrust Analysis of Preferred Provider Organizations*, 18 RUTGERS L.J. 513, 531-7 (1987).

commerce," or did not operate "for profit;" and (2) the view that medical care was a "local business" and not within interstate commerce.[104]

Starting in 1975, in a series of decisions,[105] the United States Supreme Court rejected these assumptions. The Court made it clear that medicine was involved in interstate commerce and that a professional practice had a strong commercial component that was subject to the antitrust laws. These decisions had a significant psychological and legal impact, both on antitrust enforcement agencies and physicians.[106]

Prior to 1975, organized medicine was able to collectively control both the clinical aspects of its work and much of its economic activity through professional codes of conduct and ethics.[107] Antitrust enforcement agencies were reticent to enforce the antitrust laws against the medical profession because of the early legal ambiguities regarding the reach of the antitrust laws and the political power of the medical profession.[108] After 1975, the Federal Trade Commission (FTC) and Department of Justice (DOJ) became more aggressive in their antitrust enforcement regarding the medical profession in a number of areas, such as the American Medical Association's (AMA) ethical ban on solicitation and advertising,[109] and the

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104. For a general discussion, see FURROW ET AL., *supra* note 11, § 10-6. *See also* MILES, *supra* note 24, §§ 1:5, 1:6.

105. *See* Goldfarb v. Virginia State Bar, 423 U.S. 886 (1975); National Soc'y of Prof. Eng'rs, 435 U.S. 679 (1978); Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982); FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

106. Indiana Fed'n of Dentists, 476 U.S. 447 (1986). At the same time, there have been indications that the Court considers professions to be different than traditional commerce and has indicated some deference may be shown to professional collective activity that furthers the clinical and ethical goals of the profession. See *Goldfarb*, 423 U.S. at 788-789, where the Court opined in fn. 17: "It would be unrealistic to view the practice of the professions as interchangeable with other business activities, and automatically to apply to the profession's antitrust concepts which originated in other areas. The public service aspect, and other features of the profession, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." *See also* United States v. Oregon State Med. Soc'y, 343 U.S. 326, 336 (1952).

107. Areas commonly cited are the power to limit physician supply through accreditation standards, medical specialty board certification, limits on professional advertising, the denial of hospital privileges to allied professionals and jurisdictional treatment limitations imposed by medical professional licensing. *See* Clark C. Havighurst, *The Changing Focus of Decision-making in the Health Care Sectors*, 11 J. HEALTH POL. 697 (1986). *See also* Greaney & Sindelar, *supra* note 103, at 531-7.

108. *See* Clark C. Havighurst, *The Antitrust Challenge to the Professional Paradigm of Medical Care*, The Michael M. Davis Lecture, The Center for Health Administration Studies, Univ. of Chicago (May 4, 1990).

109. *See e.g.*, *In re* American Medical Association, 94 F.T.C. 701 (1979).

ethical opposition to alternative ways of providing care.[110] And in 1982, the Supreme Court decided *Arizona v. Maricopa County Medical Society*,[111] and upheld a *per se* violation against doctors that set up their own network and fee schedules through a Foundation controlled by the local medical society. This decision created its own paradigm[112] regarding what doctors could and could not do when forming their own networks.[113]

As a result of the changed antitrust environment, doctors could no longer count on the courts and enforcement agencies deferring to the profession with respect to economic matters. In addition, the economic and clinical aspects of medicine were and are often closely interrelated and difficult to separate.[114] This ambiguity, coupled with the physician's traditional preference for independent, rather than collaborative action, often inhibited the physician's ability to collectively deal with the changing hospital networks and the emerging managed care organizations.[115] In 1993, the FTC and the DOJ, issued the first of a series

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110. *See e.g.*, Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476 (4th Cir. 1980). *See* Janet L. McDavid, *Antitrust Issues in Health Care Reform*, 43 DEPAUL L. REV. 1045 (1994).

111. Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

112. *Maricopa* has been viewed by many as requiring "capital contribution and risk sharing" in order to avoid a *per se* characterization. Others, however, believe this conclusion may not have been required by the *Maricopa* majority. *E.g.*, Greaney & Sindelar, *supra* note 103, at 553 and *infra* note 148.

113. For a general discussion of these issues, see Richard Raskin, *Antitrust Issues for Independent Health Care Providers: "Integration" and the Per Se Rule*, *in* ANTITRUST AND EVOLVING HEALTH CARE MARKETS: A SYMPOSIUM FOR HEALTH CARE INDUSTRY PARTICIPANTS, COUNSEL AND POLICYMAKERS (DePaul College of Law and Loyola University Chicago School of Law, 1995).

114. For example, there are a number of activities, such as peer credentialing, peer review or the development of practice standards, that can further both clinical quality and the profession's economic self-interest. Careful scrutiny of such collective activity is required to make sure the benefits outweigh the anti-competitive impact. *E.g.* Wilk v. American Med. Ass'n, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 496 U.S. 927 (1990). For a general discussion, see FURROW ET AL., *supra* note 11, §§ 10-7, 10-9, 10-12 and 10-13.

115. For a general description of the changing healthcare marketplace and the perceived need for a high level of provider cooperation and collaboration, see Edward B. Hirshfield, *The Health Care Industry's Transformation and the Anti-trust Laws*, *in* ANTITRUST AND EVOLVING HEALTH CARE MARKETS: A SYMPOSIUM FOR HEALTH CARE INDUSTRY PARTICIPANTS, COUNSEL AND POLICYMAKERS (DePaul College of Law and Loyola University Chicago School of Law, 1995), particularly at 39-42. Even when individual providers from "joint ventures" or integrated arrangements with institutional providers (e.g. hospitals), the legal and administrative issues are extremely complicated. For an excellent overview of the issues and how to deal with them, see Douglas A. Hastings, *Physician - Hospital Integration: Beyond Contracting Models*, *in* HEALTH LAW HANDBOOK 3 (Alice G.

of guidelines designed to clarify areas of permissible collective activity and to afford physicians somewhat more flexibility than had been allowed in the past.[116]

In summary, over the last several decades, physicians have found their traditional hospital "network" power-base less hospitable and less essential to their practice as it once was. They also saw more patients moving to new networks established and controlled by others. Decisions about which providers would be available to patients were increasingly influenced by HMOs, insurers and employers. For both perceived legal and attitudinal reasons, individual providers felt that they were at an economic disadvantage in dealing with these organizations.

3. Provider Response to the New Network Environment

Over the years, physicians have been incrementally consolidating through group practices in order to achieve economic efficiencies and to strengthen their bargaining power with payers. Additionally, physicians are joining networks – even those controlled by non-providers – in order to assure continued patient volume.[117] In recent years, more providers are focusing on affiliating with provider-owned and managed networks, e.g., hospital-based networks (PHOs) and physician-owned, independent practice associations (IPAs), or in selling their practices to publicly-traded physician management companies (PMCs) or to PHOs.[118] In addition to horizontal arrangements with one another, hospitals have begun setting up networks with their medical staffs to retain the referrals needed to avoid losing acute and ambulatory revenues to other networks and to build truly

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Gosfield ed., 1995); Douglas A. Hastings, *Developing Integrated Delivery Systems: An Era of Change in Health Care Delivery and Financing, in* HEALTH LAW HANDBOOK 3 (Alice G. Gosfield ed., 1994).

116. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, ANTITRUST GUIDELINES, 1993, 1994 AND 1995. For a general review of antitrust enforcement and the guidelines and concerns of organized medicine, see Clark C. Havighurst, *Are the Antitrust Agencies Overregulating Physician Networks?*, 8 LOY. CONSUMER L. REP. 78 (1996).

117. Dennis Murray, *The Four Market Stages and Where You Fit In*, MED. ECON., Mar. 1995, at 57 (quoting Jeff Goldsmith: Doctors have "panicked and thrown away a lot of their leverage, either by selling their practices or agreeing to unfavorable arrangements with insurers . . . all the talk about how private practice is doomed and that physicians have no choices is driving doctors to make bad decisions.")

118. *Id.* at 44-57; Jeffrey A. Alexander et al., *Organizational Approaches to Integrated Health Care Delivery: A Taxonomic Analysis of Physician-Organization Arrangements*, 53 MED. CARE RES. & REV. 88 (1996).

integrated health care systems.[119] These provider networks – while still in their infancy – seem to be aimed at building the capacity to contract directly with public and private payers and to by-pass the traditional insurance or HMO "middleman."[120] Teaching hospitals have also turned to the network model to maintain insurer/patient referral patterns – even though this approach may dilute their historic teaching and research missions.[121]

Viewed in this perspective, recent initiatives by organized medicine to stop or slow down various hospital oversight efforts, to blunt the exclusionary nature of networks and to enhance the medical profession's bargaining position, are understandable. To manage utilization within the hospital, many hospitals have instituted "economic credentialing," which compares an individual doctor's utilization profile to the hospital's collective experience or national experience.[122] In 1993, the American Medical Association (AMA) condemned the use of economic credentialing and asked the Joint Commission to amend its credentialing standards to reflect this position.[123] Many hospitals are doing it anyway.[124] Similarly, the medical community continued to push for any willing provider (AWP) laws – just as they did in 1934, with Blue Cross and Blue Shield[125] These AWP laws would allow any doctor agreeing to abide by the network's terms to be admitted to the network. Because such laws effectively preclude network formation and the network's ability to reduce utilization and costs, these laws have been opposed by business, the managed care community, the National Governor's Association and the Federal Trade

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119. For one of the better descriptions of the consolidation of the health care delivery and financing sectors, see FUBINI & ANTONELLI, *supra* note 2, at 33-44.

120. *Id.*; James Unland, *The Emergence of Providers as Health Insurers*, 23 J. HEALTH CARE FIN. 57 (1996).

121. *See, e.g.*, Blumenthal & Myer, *supra* note 3; Paulette V. Walker, *Government Cuts and Rise in Managed Care Force a Medical Center to Shift Gears,* CHRON. OF HIGHER EDUC., Dec. 13, 1996, at A30.

122. For a general description see MCDONALD ET AL., *supra* note 32, § 15.04[2]; Blum, *supra* note 79.

123. American Medical Association Resolution 832 provides that the AMA work to amend the Joint Commission Standard MS 2.4.1.3 to add "that economic credentialing shall not be part of the appointment/reappointment process to the medical staff." FURROW ET AL., *supra* note 11, § 4-7, n. 4.

124. Brian McCormick, *Is Economic Credentialing Really Thriving?*, 35 AM. MED. NEWS 1, 1 (1992); *Compromise Economic Credentialing Bill Supported by Medical Society, Hospitals*, HEALTH CARE DAILY (BNA) (April 20, 1994).

125. Michael Pretzer, *Do Any-Willing Provider Laws Really Help Doctors?*, MED. ECON., Mar. 1995, at 108.

Commission, among others.[126] Although the AMA initially supported these laws, the AMA has revised its stance, since many AMA members either had already joined or were forming their own networks.[127] A refined AMA position emerged in the form of the Patient Protection Act.[128] The Patient Protection Act[129] does not require a network to admit "any-willing" providers. Instead, it relies heavily on informed consent (historically not always embraced with enthusiasm by the medical profession)[130] and due process concepts.[131] For many of the same reasons, the AMA is advocating changes in the antitrust laws to make it easier for physicians in less than fully integrated (i.e., fully "at-risk") networks to engage in joint activity.[132]

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126. *Id.* at 118. For a general overview of the role of networks, selectivity and quality, see Karen A. Jordan, Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians 27 ARIZ. ST. L. J. 875 (1995).

127. AMA, REPORT OF THE BOARD OF TRUSTEES, I-93-25 (1993); Pretzer, *supra* note 125, at 118.

128. AMA, PATIENT PROTECTION ACT OF 1995, (February, 1995).

129. The original version was limited to managed care plans; the new version applies to all third-party payors. Key provisions include: 1) disclosure to subscribers of coverage limits, managed care procedures, financial incentives; 2) disclosure of provider panel selection criteria; elimination of the "without cause" contract provisions and appeal rights similar to the health Care Quality Improvement Act of 1986; 3) limits on utilization review (UR), including a same specialty denial requirement and minimum response time requirement for authorization requests; 4) treatment appeal procedures; and 5) a mandatory point of service option (which would allow recourse to fee for service at the patient's option) for any health plan.

130. *See, e.g.*, E. G. Laforet, *The Friction of Informed Consent*, 235 JAMA 1579, 1585 (1976). Because of the medical profession's paternalistic and professional concerns regarding patient participation in medical decision-making, state statutory and case law governing informed consent usually defer to professional standards in determining whether enough information has been provided to patients to make an "informed" decision. For a general discussion of professional concerns and the relationship of these concerns to economic and quality consideration, see Randall Bovbjerg et al., *Provider-Patient Relations and Treatment Choice on the Era of Fiscal Incentives: The Case of the End-Stage Renal Disease Program*, 65 MILBANK Q. 177 (1987); David Blumenthal, M.D., M.P.P., *Quality of Care – What Is It?*, 355 NEW ENG. J. MED. 891, 892 (1996).

131. *See, e.g.*, California Medical Association, *Provider Terminations 'Without Cause'* (Oct. 22, 1996) (a letter to various HMOs and networks arguing that hospital decisions regarding physician privileges at a hospital control "important economic interests" and, therefore, are subject to common law "due process" and fairness principles).

132. *See* OFFICE OF GENERAL COUNSEL, AMA, ANTITRUST REFORM (Jan. 1995). This report summarizes the AMA view of the issues and problems raised by the antitrust laws with respect to physician joint activity and advocates state regulation of less than fully integrated ventures structure that would hopefully qualify under the "state action" exemption to the antitrust laws. In addition, over the last several years the AMA has lobbied for a change in the antitrust laws to permit less than fully integrated doctor affiliations to be subject to the rule of reason, rather than *per se* standard. *E.g.*, Antitrust

And some physicians are openly talking about forming unions, even though their independent contractor status is an obstacle.[133] In 1994, the AMA developed a model bill[134] for state and federal lawmakers that encourages the development of physician-sponsored health plans and networks through grants, tax relief and special regulatory oversight, especially with respect to solvency.[135] Another objective of the model law is to encourage "participation of physicians in the governance of non-physician sponsored health plans." This last objective would be realized in part by mandating a medical staff self-governance provision (similar to the Joint Commission hospital self-governance standard) in non-physician-owned networks.[136] At the 1996 AMA annual meeting, the AMA House of Delegates approved a resolution calling for the AMA to "establish as a

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Health Care Advancement Act of 1996, H.R. 2925, 104th Cong., 2d Sess. (1996); and HOUSE COMM. ON THE JUDICIARY, 104TH CONG., 2D SESS., REPORT ON ANTITRUST HEALTH CARE ADVANCEMENT OF 1996 (Comm. Print 1996). In response to provider concerns and their political clout in Congress, the Department of Justice and Federal Trade have issued Joint Guidelines that will hopefully dilute pressures for legislative changes in the antitrust laws. For a general discussion, see James Sneed & Matthew Rosser, *Provider Network Formation and Operation: Antitrust Guidance in Light of Recent Enforcement Activities*, *in* HEALTH LAW HANDBOOK 281-311 (Alice G. Gosfield ed., 1996); Bruce Stewart & John Steren, *Will New Guidelines Clarify Role of Antitrust Law in Health Care?*, LEGAL BACKGROUNDS NO. 23 (Washington Legal Foundation, June 1996). On August 28, 1996, the DOJ and the FTC issued amended guidelines that explicitly recognize that networks can avoid a *per se* violation without using "capitation" or "withhold" arrangements. *See* FEDERAL TRADE COMM. & U.S. DEPT. OF JUSTICE, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (August 28, 1996). *See also Amended Health Care Guidelines to Address 'Rule of Reason' Treatment*, HEALTH L. REP. (BNA) (July 4, 1996) at 1158-9.

133. *See, e.g.*, Peter T. Kilborne, *Feeling Devalued by Change, Doctors Seek Union Banner*, N.Y. TIMES, May 30, 1996, at A5. Professional autonomy concerns *may* explain why formalized "collective" initiatives *may* focus on allied medical professionals. For example, the Office and Professional Employees International Union (OPEIU) recently announced that the OPEIU has joined with representatives of professional podiatry organizations to form an AFL-CIO union, Local 45, the First National Guild for Health Care Providers of the Lower Extremities. Union organizers have indicated that they will not seek to engage in formal collective bargaining in the near future but will focus on lobbying and public education. *See Podiatry Groups Form Union to Address Strains Tied to Managed Care*, HEALTH L. REP. (BNA & OPEIU) (Oct. 31, 1996) at 1598.

134. PHYSICIAN HEALTH PLANS AND NETWORKS ACT OF 1994 (AMA, 1994).

135. Among other things, the federal and state versions provide exemptions from "certain restrictive" antitrust laws, securities laws, fraud and abuse laws, laws impacting equity partners, insurance laws and provided tax assistance and a government-sponsored Physician Network and Health Plan Loan Pool. *See id.* tits. V, VI, VII (state and federal versions).

136. *Id.* tit. IV. The formalized medical staff structure in managed care networks was also endorsed. *See* AMA Council on Ethics and Judicial Affairs, *Ethics in Managed Care*, 273 JAMA 330 (1995).

very high priority, the inclusion of an organized medical staff as a requirement for accreditation in *all* managed care organizations."[137] The AMA has also set up a program to advise providers on managed care developments and how to set up provider-owned networks.[138]

All of these efforts are in one way or another designed to re-establish or maintain in whole or in part the profession's autonomy over its clinical, professional and economic activities.

B. Third-Party Payers, Financing and Cost Containment

> *There is no known method of physician reward that dissolves conflict of interest. The trick is to tilt that conflict toward the patient, and most physicians do.* [139]
>
> *– James S. Todd, Executive Vice President, American Medical Association (1992)*

"Managed care" uses a number of techniques to reach its twin objectives of delivering cost-effective and quality care.[140] Some of the more important techniques include quality control,[141] utilization review[142]

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137. *AMA's Annual Meeting Focuses on Managed Care Plan Quality*, Managed Care Rep. (BNA) at 669-670 (July 10, 1996) (emphasis added). In addition, the AMA and Joint Commission have just announced a joint effort to work more closely together on managed care issues. *See e.g., AMA-AHA: Team Up to Help JCAHO's Accreditation Process*, HEALTH LINE (June 10, 1996).

138. The AMA Medicine in Transition Program is described as a "Multi-faceted initiative designed to provide physicians with practical assistance in responding to the emerging new health care environment." This program includes a Doctors Advisory Service, a network of physicians, attorneys and business consultants, Strategies for Change Workshops and the Doctors Resource Service. *See* AMA Marketing Materials (October, 1994).

139. James S. Todd, *Must the Law Assure Ethical Behavior?*, 278 JAMA 98 (1992).

140. *See* Peter R. Kongstvedt, *Primary Care in Closed Panels*, *in* THE MANAGED CARE Handbook (Peter R. Kongstvedt ed., 1993)

141. Quality control programs vary greatly. Key common components are credentialing and recertification of participating physicians, monitoring of adverse events, establishment of practice guidelines and periodic updates of these guidelines, and the monitoring of outcomes and use of patient satisfaction surveys. Quality assurance is required by state and federal HMO regulations and private accreditation. *See* Michael Pine & Peter Kongstvedt, *Quality Management*, *in* THE MANAGED CARE HEALTH CARE HANDBOOK 161 (Peter R. Kongstvedt, ed., 1993); Margaret E. O'Kane, *Outside Accreditation of Managed Care Plans*, *in* THE MANAGED CARE HEALTH CARE HANDBOOK 231 (Peter R. Kongstvedt ed., 1993).

142. For a general description of common pre-authorizations and concurrent utilization provisions (e.g. pre-admission certification, continued stay review, second-opinion surgery and case management), see Potanka, *supra* note 87, at 231.

and various "at risk" arrangements designed to avoid or minimize the fee-for-service system's incentive to over-utilize care.[143] To managed care advocates, utilization review and appropriate economic incentives are particularly important because of modern science's ability to produce a never-ending stream of new treatment opportunities – which often have marginal benefits relative to cost.[144]

As managed care plans have proliferated, many in the medical community, as well as payers and the ultimate consumers of care – the patient – have raised concerns about utilization management and "at-risk" arrangements.[145] Their expressed concern is that utilization management and "at-risk" arrangements can result in "under-serving" the patient by making the doctor a "double agent" serving two masters: the patient and the payer.[146] At the same time, there are indications that the medical community's concerns are equally related to professional autonomy. This is not unexpected. Professional autonomy concerns have always been present regarding any third-party payment system, whether fee-for-service or "at risk." Any payer, other than the patient, creates the potential for a

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143. While there are many variations of "at risk" reimbursement, there are three basic approaches that are often used either singularly or in combination: 1) capitation where a provider is paid a fixed-fee in advance for whatever care a patient needs during the coverage period – as a result, the doctor shares the risk of a patient becoming very sick, but also benefits if the patient stays well; 2) bonus arrangements that reward providers that meet certain desired objectives, e.g. patient satisfaction or utilization targets (some would argue this is technically not a provider "at-risk" arrangement); and 3) withholds where a portion of what is paid to a doctor is withheld and then paid in whole or in part if the provider's utilization experience justified it. *See* Wendy L. Krasner & Thomas J. Walsh, *The Regulation of Physician Incentives*, *IN* HEALTH LAW HANDBOOK 179, 181-183 (Alice G. Gosflied ed., 1995); Kongstvedt, *Primary Care in Closed Panels*, *supra* note 140, at 31; Joan B. Trauner & Sibyl Tilson, *Utilization Management and Quality Assurance in Health Maintenance Organizations: An Operational Assessment*, *in* CONTROLLING COSTS AND CHANGING PATIENT CARE?: THE ROLE OF UTILIZATION MANAGEMENT 205 (Bradford H. Gray & Marilyn J. Field, eds., 1989).

144. *See e.g.*, Fred J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence*, 53 MED. CARE RES. & REV. 294 (Sept. 1996).

145. *See, e.g.*, AMA, COUNCIL OF ETHICAL AND JUDICIAL AFFAIRS, FINANCIAL IMPLICATIONS OF HMOS AND IPAS (1990); AMA, Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995). For a general summary of recent articles involving ethical considerations of managed care, see MARTINA DARRAH & PAT MILMOW MCCARRICK, NATIONAL REFERENCE CENTER FOR BIOETHICS LITERATURE, KENNEDY INSTITUTE OF ETHICS, *Managed Health Care: New Ethical Issues for All*, Scope Note 31 (Georgetown University, 1996).

146. *See, e.g.*, AMA, Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care*, *supra* note 145; Marcia Angell, *The Doctor as Double Agent*, KENNEDY INST. ETHICS J. (1993), at 279-86. *But see* H. Trishram Engelhardt, *Morality for the Medical-Industrial Complex*, 319 NEW ENG. J. MED. 1086 (1988).

"middleman" coming between the doctor and patient and, therefore, dilutes professional autonomy over treatment decisions and fees.

1. Professional Autonomy and Third-Party Payers

Before the 1930s, virtually all medical treatments and payment decisions were between the provider and the patient. Treatment decisions and fees were not questioned by a third-party. Providers usually charged on a fee-for-service basis and, therefore, assumed only the credit risk that the patient would not be able to pay. Providers, especially individual practitioners, often adjusted their fees to reflect the patient's ability to pay.[147] This system worked reasonably well until the 1930s and the Great Depression. In the early thirties, institutional providers worried about cash flow, developed the concept of a not-for-profit company that would provide services for a premium.[148] These were the first Blue Cross plans.[149] The original Blue Cross plans were established and controlled by the hospitals. Under these plans, a hospital agreed to provide a service (i.e., usually a certain number of hospital days) in exchange for a set premium that was paid in advance.

Many doctors viewed these developments with alarm, despite the economic advantages of an insurance system, especially during the depression years. The doctors were concerned that insurance would become a third-party intermediary between the doctor and the patient, and that Blue Cross might be engaged in the "corporate practice of medicine."[150]

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147. For a doctor's view and justifications of this "Robin Hood" pricing practice, see Max Seham, *Who Pays the Doctor?*, 135 NEW REP. 10 (1956). For an economic analysis of this pricing practice and why such a practice can be viewed as a natural extension of the "discriminating monopoly" model, see Ruben A. Kessel, *Price Discrimination in Medicine*, 1 J. L. & ECON. 20 (1958).

148. STARR, *supra* note 18, at 295-8. *See also* Susan Feigenbaum, *Risk Bearing in Health Care Finance*, *in* HEALTH CARE AND ITS COSTS 111-117 (Carl J. Schramm, ed., 1987).

149. Feigenbaum, *supra* note 148.

150. STARR, *supra* note 18, at 295-6. For a general description of the doctrine and its underlying rationale, see Hall & Vaughn, *supra* note 19; Comment, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 U. CHI. L. REV. 445 (1987). In addition to legal arguments, the profession justified the doctrine on ethical grounds of injecting competition into the profession. *See* STARR, *supra* note 18, at 299-300; *supra* note 20.

Paul Starr illustrated the strength of the medical profession's concerns by pointing to the AMA's ten principles[151] regarding health insurance that were adopted by the AMA House of Delegates in 1934.[152] The first principle set the tone: "*All features of medical service in any method of medical practice* should be under the control of the medical profession. No other body or individual is *legally or educationally equipped* to exercise such control."[153] The fifth and sixth principles built on this foundation. Since "*all medical phases of all institutions* involved in medical service should be under professional control" *all* medical institutions, including hospitals and, by inference, insurance, "are but expansions of the equipment of the physician. Accordingly, only the medical profession "can determine the adequacy and character of such institutions. . .according to medical standards."[154]

Medical or physician services, as opposed to hospital services, were subject to several additional safeguards under the ten principles: (1) patients must have the "absolute freedom to choose *a legally qualified doctor of medicine* who will serve them from among all those qualified to practice and who are willing to give service";[155] (2) any form of medical service should "include within its scope *all* qualified physicians of the locality covered by its operations who wish to give service under the conditions established;"[156] (3) there should be "no restriction on treatment or prescribing not formulated and enforced by the medical profession";[157] and (4) no third party can "come between the patient and his physician in any medical relation."[158]

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151. The ten principles were set forth in a pamphlet prepared by the AMA's Bureau of Medical Economics and entitled, "Sickness Insurance Problems in the United States." These principles were developed in response to the growing support for "state systems of medical care" and support for health insurance. The ten principles were approved by the AMA House of Delegates in Executive Session. *See Executive Session, Report of the Special Committee to the House of Delegates*, 102 JAMA 2199 (1934).

152. Much of the historical analysis regarding the attitude and activities of the AMA toward indemnity insurance and Blue Shield during the 1930's draws heavily from STARR, *supra* note 18, at 299-306 (sections entitled "Holding the Line" and "The Physicians Shield").

153. *See supra* note 151, at 2200 (emphasis added).

154. Fifth Principle. *Id.*

155. Third Principle. *Id.* When the House of Delegates approved the committee report, which included the ten principles, it also approved an amendment substituting the words "legally qualified Doctor of Medicine" for the word "physician." *Id.*

156. Eighth Principle (emphasis added). *Id.*

157. Tenth Principle (emphasis added). *Id.*

158. Second Principle. *Id.*

One way to conceptually maintain the integrity of professional autonomy and still obtain the economic advantages of pooled financing was to make sure the financing did not interfere with the patient-doctor relationship. This separation could be realized by making sure: (1) the financing system did not favor one doctor over another; and (2) the insurance payments were made directly to the patient and that the patient was still responsible for paying the physician's fees.[159]

Blue Cross and Blue Shield "accommodated" these requirements. Blue Cross limited its service agreements to "hospital services;" it did not cover "medical services." Therefore, service agreements, as opposed to cash payments to doctors, were permissible. Blue Cross carefully avoided favoring one provider over another by extending its coverage to *all* hospitals within a geographic area. Blue Shield (which covered physician services) and commercial insurers "indemnified" the patient for all or part of the physician expenses incurred by the patient – which supposedly ameliorated the risk of a "middleman." Both Blue Cross and Blue Shield boards of directors were also controlled by providers. In addition, Blue Cross, Blue Shield and commercial insurers limited coverage to those treatments provided by "licensed practitioners."[160] Finally, many early insurance contracts did not contain the "medically necessary" limitation or other utilization review requirements that are so common today. Efficacy of treatment was simply assumed, if ordered by a physician.[161] Even state legislatures and regulators often deferred to professional medicine's autonomy concerns by prohibiting insurance carriers from influencing the patient's choice of a provider.[162]

Medicare and Medicaid also were influenced by the medical professional paradigm. The enactment of these government programs was in part dependent upon the dilution or muting of organized medicine's opposition to the program and to ensure that physicians would accept

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159. Implied by the Seventh Principle. *Id.* Since the language of the original principles did not make this crystal clear, the AMA passed a reworded principle in 1934 to make it absolutely clear that indemnification would pass muster. *Report of Reference Comm. on Medical Economics*, 104 JAMA 2364 (June 1935) (minutes of the AMA Board of Trustees, Executive Session).

160. Clark C. Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, *in* HEALTH CARE IN AMERICA 248-54 (H.E. Frech III ed., 1988).

161. Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1644-1651 (1992); JOSHOW, *supra* note 74, at 40.

162. Hall & Anderson, *supra* note 161; Potanka, *supra* note 12. Some, however, question whether these legal restraints were as formidable as the industry asserts. Some argue that the insurance industry merely pursued the path of least resistance. *E.g.*, Havighurst, *supra* note 160, at 248-54.

Medicare patients. For example, the preamble to the Medicare legislation explicitly provided that none of its provisions would result in "supervision or control over the practice of medicine or the manner in which medical services are provided" and further stated that "any individual entitled to insurance . . . may obtain health services from any institution, agency or person qualified to participate . . . if such institution, agency or person undertakes to provide him with such services."[163] As a result, Medicare and Medicaid coverage reflected some of the basic principles embodied in the prevailing Blue Cross/Blue Shield and commercial coverages: (1) cost-plus payments for hospitals and fee-for-service payments for physicians; (2) indemnity payments only; and (3) reimbursement only for treatment by licensed practitioners.[164]

2. Third-Party Payers, Utilization Review and "At-Risk" Arrangements

As a result of several conceptual and economic developments, the 1970s and 1980s saw a "sea-change" in third-party payor attitudes towards the medical profession and cost containment. First, small area variation studies by John Wennberg,[165] the conclusions of which have been repeatedly vindicated,[166] demonstrated that physician practice patterns

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163. 42 U.S.C.A. 1395, 1395(a) (West Supp. 1996). For a general discussion, see Ebert, *supra* note 28, at 169-72.

164. Ebert, *supra* note 28, at 170; Ginsberg, *supra* note 51. This deference to organized medicine may also explain why hospital funding was treated differently by physicians. Some of the differences include: (1) the hospital program (Part A) was compulsory and funded through payroll taxes; (2) physician coverage (Part B) was *voluntary* and paid in part through *personal premiums* subsidized through general revenues; and (3) both hospitals and physicians were subject to "reasonable" reimbursement levels, but physicians could balance bills, while hospitals could not. *See* Hall, *supra* note 37, at 438-39.

165. *See, e.g.*, John E. Wennberg & A. Gittlesohn, *Small Practice Variations in Health Care Delivery*, 182 SCI. 1102 (1973); John E. Wennberg & A. Gittlesohn, *Variations in Medical Care Among Small Areas*, 246 SCI. AM. 120, 134 (1982).

166. *See, e.g.*, John E. Wennberg, Dealing with Medical Practice Variations: A Proposal for Action, 3 HEALTH AFFAIRS 6 (1984); Mark R. Chassin et al., *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 NEW ENG. J. MED. 285 (1986). In January 1996, the Center for Evaluative Clinical Services at the Dartmouth Medical School released a study that extended the small area analysis model to the whole country and was based on several years of Medicare data. THE CENTER FOR THE EVALUATIVE CLINICAL SCIENCES, THE DARTMOUTH ATLAS OF HEALTH CARE (Dartmouth Medical School ed., 1996). For a good general summary of this new study and some of the practice variation studies, see Megan McAndrew Cooper, *The Dartmouth Atlas of Health Care:*

differ greatly from area to area for the same malady for no apparent reason other than different medical philosophies ("practice style") of what is appropriate and without dramatically different outcomes. These different treatments also resulted in substantially different costs, even when adjusted for regional differences. Still, other studies showed that a significant amount of unnecessary care was being delivered.[167]

Further conceptual insight was provided by research documenting that practice decisions often were influenced by economic considerations, e.g., treatments and tests under fee-for-service often appeared to be greater than those under prepaid care without any apparent difference in outcomes.[168]

The results of these studies reinforced one another and gave rise to a growing consensus: Since there appeared to be a broad range of acceptable medical treatment for many conditions and at varying costs and if practice decisions were influenced by how one was paid, maybe the cost of medical care could be "managed" without sacrificing quality through utilization controls and economic incentives.[169]

The changing third-party payor system and the continuing increase in health care costs strengthened both the ability and resolve of third-party payors to do something about escalating medical costs. Between 1970 and 1993, individuals under private coverage, including indemnity insurance, HMOs, PPOs and self-insurance increased from 158 million to 180 million individuals.[170] Claim payments increased from $7.5 billion to $87 billion.[171] Health benefit cost concerns became more focused for many employers, resulting in a dramatic shift from traditional group insurance to self-insurance and minimum premium plans.[172] This shift was aided and

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What is it Telling Us?, HEALTH SYS. REV. 45-47 (May-Jun. 1996) and Gina Kotata, *Sharp Regional Incongruity Found in Medical Costs and Treatments*, N.Y. TIMES, Jan. 30, 1996 at C3.

167. *See, e.g.*, Stephen A. Schroeder et al., *Use of Laboratory Test and Pharmaceutical Variations Among Physicians and Effect of Cost Audit on Subsequent Use*, 225 JAMA 969 (1973) (finding that the lab use varied as much as 17 times for different internists); Kathi J. Kemper, *Medically Inappropriate Hospital Use in a Pediatric Population*, 318 NEW ENG. J. MED. 1033 (1988) (concluding that 21% of pediatric use was inappropriate); Mark R. Chassin et al., *How Coronary Angiography Is Used*, 258 JAMA 2543 (1988) (concluding that carotid enterectomies were appropriate in only 38% of surveyed cases).

168. GRAY, *supra* note 29, at 251-60.

169. *Id.* Gray uses the term "mutability" rather than "manage."

170. HIAA, *supra* note 4, at 40 tbl. 2.5.

171. *Id.* at 41, tbl. 2.6.

172. Between 1980 and 1993, self-insurance and minimum premium plan claims increased from $7.8 billion to $54 billion. HIAA, *supra* note 4, at 43 tbl. 2.8. "Self-insurance" or "ASO" coverage is really not insurance in the traditional sense. Instead, self-insured employers retain the risk and pay benefits out of operating revenues. A minimum

abetted by the 1974 enactment of the Employee Income Security Act (ERISA), which freed employers from many state benefit requirements if employers used funding mechanisms other than insurance.[173] In addition to reducing employer costs, these new arrangements permitted many employers to better see what the health care costs were for their employee populations because the cost impact of health benefits was not camouflaged by risk spreading or community rating.[174] Between 1970 and 1993, Medicare and Medicaid enrollments increased from 40 million to 70 million. Claim payments from these programs increased between 1972 and 1994 from $13.7 billion to $244 billion.[175] Not surprisingly, medical costs had become the fastest growing component of private labor costs and the fastest growing component of both the federal and state budgets.[176]

The response from private and government payors was not long in coming. During the 1970s, state regulators and legislators, who previously had deferred to the medical community and in many instances prohibited fiscal intermediaries from influencing physician choice, now advocated that payors get actively involved in "cost containment."[177] By the 1970s, virtually all benefit plans included "medical necessity" and "experimental" limits, which by definition defer to and incorporate the norms of the medical profession.[178] Medicare and Medicaid used the general "medical necessity" limits for covered care from the inception of both programs.[179]

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premium plan looks like self-insurance in that the employers wire money for claims to the insurer as claims are paid. However, a minimum premium plan is really insurance, since the employer is liable up to a fixed sum, and the insurance company retains the risk after the fixed sum. *See* BEAM, *supra* note 60, at 281-82.

173. For a general history of ERISA and its impact on health insurance financing and policy, see Daniel Fox & Daniel Schaeffer, *Health Policy and ERISA: Interest Groups and Semipreemption*, 14 J. OF HEALTH POL., POL'Y & L. 239 (1989).

174. GRAY, *supra* note 29, at 250-51. This observation is not meant to convey that risk spreading and community rating do not have their advantages.

175. HIAA, *supra* note 4, at 67-68, 72 tbls. 3.1, 3.3.

176. Cowan & McDonald, *supra* note 6.

177. Hall & Anderson, *supra* note 161; Potanka, *supra* note 12; Havighurst, *supra* note 160.

178. The inclusion of these limits started in the 1940s and became common practice over the next several decades. *See* Havighurst, *supra* note 160, at 115-37 (discussing the difficulties of enforcing professional standards embodies in insurance contracts, e.g., "medically necessary" and "experimental" limits); *see also* ALAIN ENTOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF HEALTH CARE 12 (1980).

179. Medicare will not pay for any service "not reasonably necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part." 42 U.S.C.A. § 1395y(a)(1) (West Supp. 1996); Under Medicaid a state may limit a service based on medical necessity or utilization control criteria, 42 U.S.C.A. § 1396(a)(30) (West Supp. 1996) requires states to assure that medical services are neither "unnecessary or excessive" and

Enforcement of these general standards was a logical next step and gave birth to structured utilization review programs that evolved during the 1970s and 1980s.[180]

For example, the original Medicare law required hospitals to set up utilization review committees staffed by the hospital medical staff, but with no real sanctions.[181] Over time, Congress strengthened the peer review requirements program[182] and relied more on *independent* physician review organizations. Congress also began to shift the emphasis from cost to quality and from case specific review to the examination of practice patterns using large data sets.[183] The last shift that focused on practice patterns – known as the "Fourth Scope of Work" – was becoming possible as Medicare data and improved information management technology became available.[184]

Private utilization review proceeded somewhat along the same lines, with the private sector being more aggressive regarding pre-treatment and concurrent review. By definition, pre-treatment and concurrent utilization review introduce a party other than the treating physician and patient into the medical decision-making process[185] which has been a source of tension in the medical community.[186]

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the regulations implementing the statute includes limits based "on such criteria as medical necessity," 42 C.F.R. § 440.230(d)(1997).

180. For an in-depth analysis of the growth of the utilization review industry and the underlying reasons for this growth, see INSTITUTE OF MEDICINE, *supra* note 59.

181. FURROW ET AL., *supra*, note 11, at 86-90. For a general overview of peer review, see Timothy Jost, *Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review Organizations (PRO) Program: Analysis and Recommendations*, 50 OHIO ST. L. J. 1 (1989).

182. In 1972, Congress attempted to strengthen utilization review through the creation of the Professional Standards Review Organization (PSRO), which relied on regional non-profit physician groups which had the power to deny payment for inappropriate care. This review function was often delegated to hospitals. In part because of deference to the medical community, the review focus was on care in hospitals and a case-by-case review after treatment. The vagaries of what constituted appropriate care and due-process requirements associated with government action made enforcement difficult, at best. In 1982, Congress eliminated PSROs and substituted in their place a supposedly focused and effective utilization review program known as PROs. Here, review responsibilities could not be delegated to the hospitals, and the PRO was subject to greater FFS oversight. *See* FURROW ET AL., *supra* note 11, at 86-90; Jost, *supra*, note 181.

183. FURROW ET AL., *supra* note 11.

184. *Id.*

185. GRAY, *supra* note 29, at 282-4

186. INSTITUTE OF MEDICINE, *supra* note 59, at 36-38.

The growth of utilization review also was very much related to changes in provider reimbursement.[187] In 1982, the strengthened PRO program was part of Medicare's new hospital "at-risk" prospective payment program, under which hospitals were given incentives to use cost effective rather than more care. The potential of Medicare economic incentives to "under-serve" and the practice variation studies were major reasons that PRO utilization review also started to look at quality, as well as cost containment.[188]

In addition, the integration of the delivery and financing of care through HMO and evolving "managed care" PPO structures was and still is designed to achieve cost-effective care through the use of *both* utilization review and economic incentives. Here, the HMO or the managed care PPO entity assumes responsibility for coordinating both for the delivery of care and payment of providers. The HMO network takes the "risk" that it will be able to provide the quality of care required for the population it serves within a "budget." The HMO then makes arrangements with providers to deliver the care. The provider arrangements can be structured any number of ways from full "capitation," where the provider is "at risk," to salaries (staff model HMOs) or even negotiated fee-for-service rates.[189]

Recently, there has been a trend to shift the financial risk from the network entity to the medical providers through the use of provider capitation and withhold arrangements. Recent estimates indicate that 33% of physicians are compensated, at least in part, through capitated arrangements. The use of "at-risk" arrangements varies geographically depending on where a network and market is on the managed care continuum.[190] "At-risk" arrangements are heavily used in the Western United States and to a much lesser degree in the South.[191]

In summary, managed care organizations use a combination of medical quality and cost-management tools, i.e., selective contracting, pre and concurrent treatment review, case management, the use of primary care physicians as "gatekeepers," outcomes review and financial incentives. In addition, Medicare and Medicaid are now encouraging or mandating managed care delivery, so that both utilization management and economic

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187. *See, e.g.*, GRAY, *supra* note 29, at 260-62; Alan Hillman, *Managing the Physician: Rules versus Incentives*, HEALTH AFF., Winter 1991, at 139.

188. GRAY, *supra* note 29, at 245-257.

189. *See* Krasner & Walsh, *supra* note 143; Potanka, *supra* note 87, at 109.

190. Fubini & Antonelli, *supra* note 2, at 16-19; Stephen Findlay, *Can Capitation Save the World?*, BUSINESS & HEALTH, June 1996, at 45-46.

191. Findlay, *supra* note 190.

incentives are extended to the Medicare[192] and Medicaid[193] population. A number of commentators believe that "at-risk" reimbursement is "gaining prominence as a dominant model" for reimbursing doctors in managed care networks.[194]

3. Provider Response to the New Utilization Review and Reimbursement Environment

Not surprisingly, the medical community has expressed concern regarding the growth of utilization review and "at-risk" arrangements. These concerns are long-standing. They focus on the reduction of provider autonomy over the patient-doctor relationship (e.g., "second guessing" provider decisions) and the potential conflict created for the provider, when making a diagnosis and prescribing treatment (i.e., to be the patient's advocate). The provider community also has concerns about the transaction costs associated with utilization review (e.g., paper work and difficulty in getting timely approval), especially for pre-authorized and concurrent review.[195]

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192. Medicare capitation options were available as early as 1972, but the conditions for participating were unattractive for HMOs. In 1982, participation was made more attractive. *See* Ginsberg, *supra* note 51. In the last year, it was made even more attractive by allowing more flexible product offerings. In addition, FASB 106, which requires employers to accrue future liability for all health benefits, including those for retirees, has created a large new market for the Medicare managed care product. The proposed 1995 Medicare reform legislation incentivized the use of managed care options, especially for provider plans. *See* Michael Langan & Joseph Martingale, *Medicare Risk-Based HMOs: The Growing Market and Implications for Employers*, 8 BENEFITS L. J. 25 (1995). In 1981, the states were given more discretion via waivers with respect to alternative delivery approaches. Use of this discretion was stimulated by budget constraints, both at the state and federal level, on Medicaid reimbursement.

193. In recent years, the states have placed increasing emphasis on managed care to improve access and to reduce costs. By mid-1995, Medicare managed care was estimated that 44 states and the District of Columbia enroll 25% of Medicaid beneficiaries in managed care. Kaye Horvath, *Medicaid Managed Care: A Guide for the States* (Nat. Academy for State Health Policy, 1995). For a general discussion of the evolution of Medicaid and the increasing use of managed care, see Trish Riley, *Medicaid, The Role of the States*, 274 JAMA 267 (June, 1995); Drane Rowland, *Medicaid at 30: New Challenges for the Nation's Health Safety Net*, 275 JAMA 271 (June, 1995). For recent developments associated with the implementation of managed care in various state Medicaid programs, see David Nather, *Some Lessons Emerge on Managed Care, But Impact on Quality Still Uncertain*, HEALTH L. REP (BNA) (Dec. 12, 1996) at 1812-15.

194. *See, e.g.*, Fubini & Antonelli, *supra* note 2 at 16.

195. GRAY, *supra* note 29, at 305-307.

In response to these concerns in the late 1980s, many states began to license and regulate utilization review organizations. By 1993, over 35 states had some regulation in place.[196] The AMA supports heavy involvement of physicians in the development of utilization review criteria, as well as for the disclosure of such criteria in advance of treatment decisions.[197] The utilization review industry supports physician involvement and disclosure, although not to the extent advocated by the AMA because of transaction costs and the potential for the provider to "game-the-system."[198] State regulation, for the most part, has taken a "middle road."

In 1986, Congress enacted amendments to the Social Security Act prohibiting any prepaid health care organization (including an HMO) or hospital with a Medicare or Medicaid risk contract from knowingly making incentive payments to a physician to limit or reduce service to Medicare and Medicaid patients.[199] Because these broad prohibitions have the potential to inhibit legitimate and useful managed care activity, Congress repeatedly delayed the law's effective date. In 1990, Congress enacted legislation giving the federal government authority to promulgate provider "at-risk" incentive guidelines.[200] The government would then regulate rather than prohibit incentive plans in prepaid healthcare organizations. In

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196. For a general review of state utilization review, see Richard Hinden & Marguerite Snyder, *State-Level Utilization Review War: Who Reviews the Reviewers?*, 4 BENEFITS L.J., 345, 346-359 (1991). Most utilization review regulation provided for confidentiality, clear disclosure of internal processes and appeal procedures, time limits on utilization review determinations (with expedited consideration for emergency situations) and often provided for a role of physicians in the development criteria and their implementation in specific cases. One good specific example of how states approach the issue, see CONN. GEN. STAT. ANN. § 38a-226 (West Supp. 1996).

197. *Id.*

198. For example, if providers have an indication of what the maximum amount of care that will be covered, payors fear that providers will gravitate to the maximum. FURROW ET AL., *supra* note 11, at 527-8.

199. Omnibus Budget Reconciliation Act of 1986, § 9313(c), 42 U.S.C.A. §§ 1320(a)-7a-(c) (West Supp. 1991).

200. The Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS) was given authority by the Omnibus Budget Reconciliation Act of 1990, § 4204(a), 42 U.S.C.A. §§ 13966 and 1395mm. In 1992, HCFA proposed regulations prohibiting "specific payments" to induce limits or reduction in care and limits on the extent to which physicians can assume risk and insurance stop-loss when they do. 57 Fed. Reg. 59,024 (1992) (codified at 42 C.F.R. § 417.479(a)(1) (1997)) (proposed Dec. 14, 1992). The rules were delayed because of their potential impact on managed care and the physician "at risk" arrangements. *See also HCFA To Delay May 28 Effective Date of Physician Incentive Regulation*, HEALTH L. REP. (BNA) at 791 (May 23, 1996).

addition, the AMA has issued several analyses and recommendations dealing with potentially perverse "at-risk" incentives.[201]

Despite the concerns of organized medicine, an increasing number of physicians have willingly embraced "at-risk" arrangements. They see "capitation" as a way to regain control of their professional autonomy, especially when the HMO delegates utilization management to the "at-risk" provider group. They reason that under capitation, they are "at risk" and responsible for allocating available resources through their own clinical decisions. In addition, many doctors believe that by assuming risk, they can: (1) satisfy customer demand for cost-consciousness; and (2) deal directly with the customer without the HMO or payer-middleman who will take "a piece of the action."[202] This "liberating" aspect of at-risk arrangements may be a partial explanation for the AMA's endorsement of Medicare Plus Plans in the recent Medicare reform legislation – though the AMA also used its endorsement to advocate less stringent regulatory standards in provider at-risk arrangements than would be applicable to non-physician-owned networks.[203] In many respects, the wheel has come full circle. The profession's original aversion to "at-risk" arrangements had economic and professional autonomy roots. Today, many providers view "at-risk" arrangements as a way to provide economic stability and to preserve autonomy.

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201. AMERICAN MED. ASS'N ET AL., GUIDELINES FOR HEALTH BENEFITS ADMINISTRATION (1990); COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MED. ASS'N, FINANCIAL INCENTIVES TO LIMIT CARE: FINANCIAL IMPLICATIONS FOR HMOS AND IPAS (June, 1990); COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MED. ASS'N, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995).

202. Nancy Bell, *The Trend Towards Capitation: Pros and Cons,* MEDICAL INTERFACE, Jan. 1995, at 61; Interview with Paul Ellwood, Chief Executive, InterStudy and Jackson Hole Group, *How Doctors Can Regain Control of Health Care,* MED. ECON., May 13, 1996, at 178; FINDLAY, *supra* note 190, at 51-55.

203. In the Fall of 1995, the United States House of Representatives considered Medicare reform under the Medicare Preservation Act of 1995, H.R. 2424, 104th Cong., 1st Sess. (1995). This proposed legislation established special federal oversight for physician-sponsored networks (PSNs) that would, among other things, provide antitrust relief and reduce solvency standards of PSNs, relative to other networks. That same year, the United States Senate, while declining to provide antitrust relief, provided oversight by the U. S. Department of Health and Human Services to ensure that PSNs were not unduly burdened by state regulation. *See Insurers Restate Opposition to RSNs as Negotiations on Regulation Continue,* HEALTH CARE POLICY REPORT (BNA) at 1563 (Oct. 2, 1995). For a general discussion of what the medical profession wants with Medicare reform, see Marilyn Serafini, *Not your Father's HMO*, NAT'L J., Oct. 1995, at 2582.

C. Professionalism Versus Commercialism and "For-Profit" Medical Care

> *A key to using resources efficiently is understanding that whereas the professional model advocates providing the best possible care at any price, the competitive model advocates good care at the best price. Moreover, quality of care is measured in terms of procedures or outcome. It will not be long before organized consumers and enterprising physicians will challenge the fixed boundaries established by medical licenses and rules of certification so they can match training with task in the most cost effective way.*
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> *The next few years may see enterprising physicians and health administrators shift from the professional model with its hallowed tradition and monopolistic tendencies to one of professionally regulated competition.*
>
> *– Donald Light (1983)*[204]

For many years, the medical profession, like other professions, has downplayed the entrepreneurial and commercial aspects of the profession. Commerce and "profit" have been frowned upon because the profession is perceived to have a higher calling: that the profession's ethical and public service motivations transcend material or business considerations.[205] In addition, many medical professionals think that the focus on economics and "profit" only enhances the potential for a doctor's conflict of interest vis-a-vis the patient. They think "profit" dilutes the ability of professional ethics to counter-balance real world economic influences that may be perverse to the patient's best interest.[206]

This professional culture, which purports to eschew the "economics" and "profit" aspect of medicine, has had a significant influence both on the structure and regulation of medicine. For example, the maintenance of the not-for-profit hospital (the centerpiece of the medical delivery system in

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204. Donald Light, *Is Competition Bad?*, 309 NEW. ENG. J. MED. 1315, 1317-18 (1983).

205. GRAY, *supra* note 29, at 172-73; *see also* STARR, *supra* note 7, at 23. For a general overview, see INSTITUTE OF MEDICINE, THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT (Bradford H. Gray ed., 1983).

206. *See* ROBERT M. VEATCH, INSTITUTE OF MEDICINE, ETHICAL DILEMMAS OF FOR-PROFIT-ENTERPRISE IN HEALTH CARE, at 125, 125-52 (Bradford H. Gray ed., 1983).

many communities) and the creation of the indemnity insurance and fee-for-service system were justified in large part by professional and ethical concerns regarding "corporatization."[207] Similarly, restrictions on advertising and fee-splitting and opposition to contract prepaid group practice (e.g. HMOs) were justified because these activities would "commercialize" the profession and create "unfair competition."[208] Also, the now defunct "learned-profession" exemption to the antitrust laws existed to serve the same "noble" purposes. However, many have asserted that the profession's aversion to commerce also played a major role in enhancing the profession's economic well-being by assuring and perpetuating professional control and monopoly over the delivery of medicine and how it was paid for.[209] Irrespective of the relative merits of the profession's motivation, it is clear that the profession's concerns are strongly felt.

Despite the medical profession's traditional bias against commercialism and "for profit" medicine, an increasing number of institutional and individual providers are providing care on a "for profit" basis. The following section briefly describes some of the forces that have encouraged "for profit" medicine and the profession's response to this development.

1. The Growth of "For Profit" Medical Care

This article has discussed a number of the cultural and economic forces that, over the last twenty to thirty years, have profoundly changed the delivery and financing system and the medical profession's concerns

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207. STARR, *supra* note 7, at 215-20, 299-306, 332.

208. HAVIGHURST, *supra* note 5, at 257-60; STARR, *supra* note 7, at 209-18.

209. For example, some have argued that the local not-for-profit hospital facilitated physician control of the institution and was directly related to maximizing a physician's economic rewards. STARR, *supra* note 7, at 215-20. Others have equated these local hospitals to "shelters," within which physicians operate profitable businesses, such as laboratories. Mark Pauly & Michael Redisch, *The Not-for-Profit Hospital as a Physician's Cooperative,* 63 AM. ECON. REV. 87, 87-89 (1973); Carson Bays, *Why Most Private Hospitals are Non-Profit,* 2 J. POL'Y, ANAL. & MGMT. 366 (1983). Still others have argued that the profession's opposition to "corporate enterprise" was based on keeping "for itself the profits potentially available in the practice of medicine" and preventing anyone else, "such as an investor, from making a return on the physician's labor." STARR, *supra* note 7, at 216. This last statement was in reference to a portion of the AMA's 1934 Code of Ethics, which characterized a "direct profit" by physicians as being "unprofessional," a form of "unfair competition," and "against sound public policy." *Id.*

regarding these changes. There are two changes which have been described earlier in a different context, but warrant further discussion in the context of "for profit" medicine. The first relates to the large number of practicing physicians in the United States. The second relates to Medicare reimbursement.

As previously described, government policy during the 1960s focused on access to health care. In the early 1960s, the federal government instituted a program of grants and financial aid for the education of new physicians, which was significantly expanded in 1971.[210] Although the program was phased out in the late 1970s, the number of medical school graduates nearly doubled between 1963 and 1986, from 239,000 to 430,000.[211] During the same period, foreign doctors in the United States increased from 37,000 to 131,000.[212] This large increase in the physician population set the stage for intense competition between physicians themselves and between physicians and hospitals during the 1970s and 1980s. In turn, the increased competition helped foster an entrepreneurial climate in medicine as physicians utilized new technology and their referral power to create new sources of income.[213] These competitive pressures also made physicians more receptive to changing how they traditionally organized their practice and to joining the new emerging networks,[214] which were and are an increasingly important source of patient referrals.[215]

Another important influence encouraging medical entrepreneurism after 1965 was Medicare and Medicaid – not only because of the vast sums of money these programs infused into a system already flush with money from growing group coverages, but also because of the hospital

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210. *See, e.g.* Health Professions Educational Assistance Act of 1963, 42 U.S.C. §§ 292-292(i).

211. *See* SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH & HEALTH CARE, 536-44 (1993) (Table 20.3 of the accompanying text is based on statistics developed by the U. S. Department of Health and Human Services).

212. *Id.*

213. Many believe that the increasing number of physicians was not necessarily related to need, but "actively induced consumer demand for more health care services." Stuart Altman & Stanley Walluck, *Health Care Spending: Can the United States Control It?*, *in* STRATEGIC CHOICES FOR A CHANGING HEALTH CARE SYSTEM 13 (Stuart H. Altman & Uwe E. Reinhardt, eds., Health Administration Press, 1996).

214. GRAY, *supra* note 29, at 213-14; *see also* Alvin Tarlov, *HMO Enrollment Growth and Physicians: The Third Compartment,* 5 HEALTH AFF., Spring 1986, at 23, 24. Some also argue that a physician surplus will increase utilization due to physician-induced demand. Thomas H. Rice & Roberta J. Labelle, *Do Physicians Induce Demand for Medical Services,* 14 J. HEALTH POL., POL'Y & L. 587 (1989).

215. GRAY, *supra* note 29, at 218-219.

reimbursement formula. The original Medicare hospital reimbursement formula, which remained in place for 18 years, provided for not only direct care costs, but also reimbursed hospitals for depreciation expenses, interest on borrowed money and with respect to profit institutions, paid an amount for a return on equity.[216] As a result, hospitals often were more valuable to buyers rather than sellers, since the amount of depreciation that was available to the buyer was based on the purchase price rather than the original cost.[217] In addition, the reimbursement formula facilitated the borrowing of capital for acquisitions by paying for interest on debt capital and tended to favor for-profit institutions by the reimbursement component for a return on equity.[218] Not surprisingly, investor-owned hospital organizations or "chains" grew rapidly through acquisitions. The investment returns were dramatic, which attracted additional investment capital, further expansion and eventually public and regulatory concern.

Congress responded to these concerns in 1983 by changing the reimbursement formula in a way that decreased the depreciation and return-on-equity incentives.[219] Even so, the basic message was clear: health care was a "commercial" enterprise involving large amounts of money and was a business where individual and institutional entrepreneurs could do very well under the right circumstances.

Entrepreneurial attitudes were also encouraged by another 1983 change in the reimbursement formula. As previously discussed,[220] Congress transformed the basic Medicare reimbursement formula from a cost-plus basis to a prospective payment system. At the same time, private payors, through the growing PPO and HMO networks, aggressively implemented hospital utilization review and negotiated lower hospital per-

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216. In chapter 3 of his book, Bradford Gray provides a general discssion of the impact of Medicare and Medicaid on medical entrepreneurism. *See* GRAY, *supra* note 29, at 31, 31-60.

217. GRAY, *supra* note 29, at 33.

218. *Id.*

219. After 1983, Medicare would pay for depreciation only once; it did not restart the process after each sale. In addition, the depreciation base was the original cost, rather than the sale price. Congress also reduced the amount available for return on equity to the same rate of return earned by the Medicare Hospital Insurance Trust Fund. Previously, it had been at 1.5 times the Trust Fund return. For a general and detailed description of the Medicare reimbursement formula, how it fueled the growth of investor-owned hospital systems and how these systems responded to the changes, see GRAY, *supra* note 29, at 32-41.

220. *See infra* p. 19.

diem rates. It became increasingly difficult for hospitals to make up Medicare revenue shortfalls from the private payors.[221]

In response to these economic pressures, *all* hospitals (both for-profit and not-for-profit) began to operate on a more cost-efficient basis and to seek out new sources of revenue. These efforts, among other entrepreneurial efforts, focused on buying, creating or engaging in joint ventures often with for-profit specialized facilities, such as those dedicated to psychiatric care, alcohol and substance abuse, primary care centers and urgent care centers.[222] Hospitals also started to buy physician practices or create joint ventures or affiliate with physician groups (often those physicians having staff privileges at the hospital) in order to maintain patient referral patterns.[223] The new focus on managed care also required investment in new information and monitoring technologies. All of these initiatives required significant capital.

For-profit entities -- hospitals, HMOs and insurers -- had and continue to have greater flexibility than their non-profit counterparts in adjusting to the new market realities and in obtaining needed capital.[224] Not-for-profit entities were less flexible in this environment because of the restrictions imposed by their not-for-profit tax exempt status.[225] Despite these constraints, not-for-profit entities embraced many of the entrepreneurial attitudes, practices and diversification strategies that characterized for-profit institutions. These strategies were realized through consolidations, mergers, alliances, joint ventures and marketing, which often use a complicated holding company structure with for-profit subsidiaries.[226] Many not-for-profit hospitals and Blue Cross/Blue Shield plans are going one step further by converting to for-profit operations. Many others are seriously thinking about giving up their not-for-profit tax exemption.[227] This "commercial" or "for-profit" transformation by not-for-profit health

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221. *See infra* p. 19-22.

222. For a general description of how hospitals, and in particular, not-for-profit hospitals, have responded to the increasing competitive health care market, see GRAY, *supra* note 29, at 61-89.

223. GRAY, *supra* note 29, at 207-215.

224. *Id.* at 41-48; GRAY, *supra* note 29, at 31-60; J. GOLDSMITH, CAN HOSPITALS SURVIVE: THE NEW COMPETITIVE HEALTH CARE MARKET (1981).

225. GRAY, *supra* note 29, at 31-60

226. *Id.*

227. Sylvia Fubini, Ph.D., *The Perils of Wall Street*, HEALTHCARE TRENDS REPORT (October, 1996) at 1, 1-2; and Taharski, *A New Rhythm for the Blues*, HOSPITALS AND HEALTH NETWORKS (March, 1995). For a summary of the recent for-profit Columbia/HCA and Blue Cross merger, see Ken Terry, *Why Columbia Will be Part of Your Life*, MEDICAL ECONOMICS , May 13, 1996, at 116-129.

care institutions, and the increasing need for tax revenues, has prompted many scholars, regulators and government officials to re-evaluate the continued efficacy of health care's traditional "not-for-profit" tax exempt status.[228]

For the same reasons, many of the hospital, HMO and provider consolidations over the last several years have been driven by for-profit entities. For example, publicly-traded organizations purchased 45% of the hospital beds for sale in 1994-1995. During the same period, a publicly-traded company was the acquirer in 54 out of the 69 HMO merger and acquisition transactions. Of the 174 physician practice transactions, publicly-traded companies were the acquirers in three-quarters of the transactions.[229] In addition, an increasing number of for-profit entities are acquiring or affiliating with Blue Cross and Blue Shield plans.[230]

2. Physician Response to the New Environment

As old power structures and revenue streams change, many in the medical profession view the trend to "for-profit" as another manifestation of the de-professionalization of medicine.[231] However, many in the profession are active participants in the "new" commercialism,[232] which

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228. For example, a 1988 Department of Treasury and Department of Tax Policy study concluded that tax exemptions to private non-profit hospitals cost federal, state and local governments $8.5 billion. A 1990 GAO study concluded that the revenue loss of the tax exemption exceeded the value of uncompensated care delivered by non-profit health institutions. In addition, numerous states are re-evaluating their present policy. For a general overview of the competing legal, policy and economic issues, see NATIONAL HEALTH LAWYERS ASSOCIATION, COLLOQUIUM REPORT ON LEGAL ISSUES RELATED TO TAX EXEMPTION AND COMMUNITY BENEFIT (1996). *See also* Steven Furdlay, *When Not-For-Profits Decide to Make a Buck*, BUSINESS AND HEALTH (March, 1996) at 38-46.

229. Fubini & Antonelli, *supra* note 2; Fubini, *supra* note 227, at 1.

230. *Id.*

231. In 1988, The Milbank Quarterly published a supplementary edition devoted to the real or perceived "de-professionalization" of medicine and the external economic and institutional changes causing it, both in the United Stated and abroad. *The Changing Character of the Medical Profession*, 66 THE MILBANK Q. 2 (Supp. 2 1988).

232. For example, individual providers began to participate in "for-profit" activities that stressed self-referral to facilities owned by providers, e.g., labs and radiology. The resulting self-referral conflicts eventually prompted Congressional legislation that severely limited this activity. *See, e.g.*, in 1989 and 1993 – the so-called Stark I and II Amendments (42 U.S.C. §§ 1395 et seq. (1993)). For a general discussion of healthcare fraud and federal laws, see FURROW ET AL., *supra* note 11, §§ 15-2 to 15-15, and for a general review of the Stark Amendments, see FURROW ET AL., *supra* note 11, § 15-18. *See also supra* note 228 and accompanying text.

reinforces the fragmentation associated with the increasing specialization of medicine.[233] This fragmentation has influenced a number of the AMA's public policy pronouncements. For example, AMA pronouncements regarding physician secondary income and health facilities ownership emphasize disclosure and case-by-case evaluation, rather than outright prohibition.[234] In the late 1980s and before the 1989-1995 expansion of physician enterprises and the tightening up of prohibitions against physician "self-referrals,"[235] the AMA Council on Ethics and Judicial Affairs concluded that "physician-ownership interest in a commercial venture with the potential for abuse is not in itself unethical."[236] The opinion further said it would be unethical to exploit the patient through either "inappropriate or unnecessary utilization" and imposed an affirmative disclosure requirement before utilization.[237] The most recent AMA Council opinion has strengthened the requirements. While physicians are "free" to have ownership interests, they should not "in general" refer patients to such facilities outside their office practice and where they do not directly provide services."[238]

The AMA position on any-willing provider also has been somewhat equivocal because many in the profession have joined networks or were

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233. This fragmentation is one reason for declining membership in the traditional state medical societies and the AMA. However, membership levels appear to have stabilized and the managed care debate may have enhanced their continued relevance. Chuck Appleby, *S.O.S Save Our Societies*, HOSP. & HEALTH NETWORKS J., October 5, 1996, at 58.

234. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMA, CODE OF MEDICAL ETHICS § 8.032 (1994). Some of the specialty professional organizations and commentators also have urged a more stringent prohibition.

235. In 1972, the Social Security Act was amended to make it a felony for anyone to knowingly and willfully solicit or receive or to offer or pay any remuneration (e.g., kickback) directly or indirectly in return for a referral for items or services paid for by Medicare and Medicaid. This amendment was the so-called "anti-kickback" law. Because of ambiguities surrounding what constitutes remuneration and intent and because there are often economies and benefits, as well as potential conflicts associated with various financial inter-relationships, a number of "safe-harbors" have been developed by HHS with varying degrees of success. In 1989, 1993, and 1995, Congress enacted a number of laws that banned certain types of self-referrals (irrespective of intent) and set forth exceptions. These are commonly known as the Stark Amendments, *see supra* note 232. For a general overview of federal efforts to curb health care fraud, see Mark Joffe & Edwin Ing, *Curbing Health Care Abuses Under Federal Laws*, 8 BENEFITS L. J. 95 (Winter 95/96). *See also* Stuart M. Gerson, *New Managed Care Safe Harbor Regulation: Safety or Lee Shore?*, in CONTEMP. LEGAL NOTES 1996 (Legal Studies Division, Washington Legal Foundation, Series No. 19).

236. GRAY, *supra* note 29, at 199-201 n. 103.

237. *Id.*

238. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 234, § 8.032.

forming them, and networks by definition are exclusionary.[239] On the other hand, a number of local medical societies where networks have not flourished (e.g. in rural areas) are more militant and have lobbied successfully for any-willing provider legislation.[240]

Because of this fragmentation, restructuring and an open recognition that medicine has both economic and professional attributes, the medical profession's historical policy positions designed to preserve autonomy have had to adjust to the new political and economic realities. Today, organized medicine's policy positions fall into several categories: (1) the perceived need to change the federal and state antitrust laws in order to permit the horizontal organization of physicians for bargaining purposes without requiring the physicians to become fully integrated "at risk" practice groups;[241] (2) proposals that exempt providers from quality and solvency requirements that are applied to non-physician-owned networks;[242] (3) efforts to provide procedural safeguards for physicians denied access to networks or primary care status, similar to those safeguards imposed on hospitals regarding the denial of staff privileges;[243] (4) proposals to formalize physician clinical input into network policies and to establish appeal procedures regarding coverage decisions by physicians and patients;[244] and (5) proposals to require for-profit organizations to disclose medical-loss ratios for the purpose of showing how much of a plan's premiums are devoted to administrative costs and return to shareholders.[245]

Underlying all of the AMA proposals are the assumptions that professional autonomy is better than non-professional control, especially with respect to clinical matters, and that the payment of monies to physicians (i.e., usually phrased as providing patient care) is preferable to paying money to others (i.e., shareholders or administrators). Again, these are essentially the same assumptions underlying past arguments for

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239. *See supra* note 127.

240. For example, the Arkansas Insurance Code which provides, among other things, that a plan cannot directly or indirectly deny a provider "that is qualified . . . and is willing to accept the health benefit plan's operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in that plan." ARK. CODE ANN. § 23-99-204(a)(3) (Michie 1995).

241. *See supra* note 116, pt. I.A.2(d), at 25-28; FEDERAL TRADE COMM. & U.S. DEPT. OF JUSTICE, *supra* note 132.

242. FEDERAL TRADE COMM. & U.S. DEPT. OF JUSTICE, *supra* note 132.

243. *See, e.g.*, PATIENT PROTECTION ACT, tit. IV, § 1(c)(1)(I) (AMA 1994).

244. *Id.* § 1(c)(1)(E).

245. *See, e.g., id.* § 1(c)(1)(A)(v); PHYSICIAN HEALTH PLANS AND NETWORKS ACT, tit. I, § 103(c) (AMA, 1994).

professional autonomy and the profession's control over both the clinical and economic aspects of the profession.

Once again, old arguments are being resurrected in somewhat different forms in order to maintain long-standing objectives in the face of massive structural changes in the health care delivery system.

II. DIFFERENCES BETWEEN TODAY AND YESTERDAY THAT MAY IMPACT THE OLD ISSUES AND TENSIONS.

> *It is the year 2025, and social historians and astute health policy analysts look back on the Nineties as the turning point in American health policy and delivery. They point to this decade as the time in which a new paradigm based on new principles took shape. The old principles focusing on acute care, provider dominance, and individuals were called the 'illness' model. The new principles called for health status prediction and management, provider-patient partnerships, and collective population-based focus. These principles came to be called the "wellness" model.*
>
> *– Steven Shortell, David Anderson, Robin Gillis, Mitchell & Karen Morgan (1995)*[246]

As we have seen, the medical profession's view of how medicine should be practiced and in particular, professional autonomy has had a profound impact on the structure and regulation of the health care delivery and financing system. For the most part, society's legal and organizational structure and processes have "accommodated" the profession's views. And, there is every reason to believe that the medical profession will continue to exert considerable influence on the structure of the system, including managed care.

However, in the last several decades, a number of things have changed that have caused and will continue to require some refinements in the profession's traditional view regarding professional autonomy.

First, there appears to be a changing societal view of resource availability, i.e. from one of abundance to one of limits. Second, there is a growing focus on systematic, continuous process management and

246. Steven Shortell et al., *The Holographic Organization*, HEALTH CARE F.J., March/April 1995, at 20.

feedback (e.g., Total Quality Management or Continuous Quality Improvement)[247] as the best way to realize quality – this focus in the medical context has been reinforced by the small variation practice studies that have created an "intellectual crisis"[248] both within and outside medicine regarding the efficacy of current clinical decision-making. Fortunately, information technological advances now permit the collection and analysis of immense amounts of clinical and financial data and make outcome evaluation and real-time clinical analysis possible. Finally, various types of network delivery systems have emerged that offer both the potential for delivering systematic rather than episodic medical care and the infrastructure for the data collection and feedback mechanisms necessary to actually link clinical and financial decision making.

A. Real or Perceived Resource Limits

The first trend of real or perceived economic[249] limits may be the most influential. Interestingly, it is the flip-side of the perceived resource availability during the 1950s and 1960s when policy makers embarked on expensive government programs that laid the foundation for much of today's medical cost inflation. For example, after World War II, the United States expanded its medical delivery capabilities on all fronts: bricks and mortar, personnel and financing.[250] This expansion was reinforced by society's post-World War II economic expectations and growing civil rights focus that stressed open and equal access to all citizens. Continued long term economic expansion appeared sustainable. New wealth creation (productivity) had been proceeding at an impressive and reasonably consistent rate for 100 years, and policy makers had every reason to believe this good fortune would continue. Consequently, it was thought

247. For a general review, see W. Edwards Deming, OUT OF THE CRISIS (1986). For a more useful description of these concepts to medical care, see J.WILLIAMSON ET AL., ASS'N OF MEDICAL COLLEGE SERIES IN ACADEMIC MEDICINE, TEACHING QUALITY ASSURANCE AND COST CONTAINMENT IN HEALTH CARE (John A.D. Cooper ed., 1982); Peter Boland, *The Role of Reengineering in Health Care Delivery*, 4 Managed Care Q. 1 (Autumn, 1996).

248. J.E. Wennburg, *Better Policy to Promote the Evaluative Clinical Sciences*, 2 J. OF THE INT'L SOC'Y FOR QUALITY ASSURANCE IN HEALTH CARE 21 (1990).

249. The word "perceived" is a necessary qualification especially in view of recent questions that have been raised about how economic growth, inflation and productivity have been and should be measured. *See, e.g.*, ADVISORY COMMISSION TO STUDY THE CONSUMER PRICE INDEX, TOWARD A MORE ACCURATE MEASURE OF THE COST OF LIVING (Michael Boskin, Chairman, December, 1996) (Final Report); *see also* Max Frankel, *Word and Image: Margins of Error*, N.Y. TIMES, June 15, 1990, § 6, at 34.

250. *See infra* appendix, p. 65.

that future costs of these programs could be paid for out of future revenue growth. This view of the world heavily influenced government policy in many areas (e.g., highways, Medicare, Medicaid) after World War II.[251]

It now appears (although disputed by some)[252] that the historical productivity rate has declined dramatically since the early 1970s. This slowing of new wealth creation coupled with the sobering experience of Vietnam and global market competition have imposed a real or perceived[253] sense of limited economic resources for the foreseeable future. It now appears that resource limitations will *require* society to set priorities. The establishment of these priorities will force an "accommodation" by everyone, including those that work in the health care sector, that they would not otherwise make.

B. Quality Concerns and How to Measure Quality

The second trend is the growing consensus on how best to measure and monitor the quality of medical care. Conceptually, quality measurement has progressed through three steps, each having its advantages and disadvantages: structure, process and outcomes.[254] Structure focuses on relatively objective matters, such as equipment, adequacy of records, credentialing and licensing of providers. While one is likely to have better results with adequate resources and structure, there is no guaranteed correlation. Process focuses on whether medical treatment and procedures are done in accordance with current medical practice. This approach defers to professional norms and depends heavily on medical judgment. This approach's handicap is that treatment norms are constantly changing and that even widely accepted protocols have been proven inadequate or even harmful. The third and most recent evolution is outcomes validation, which attempts to link actual treatment results to valid clinical indicators. This approach has widespread conceptual appeal (one respected commentator

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251. *See generally* JEFFREY MADRICK, THE END OF AFFLUENCE (1995).

252. *See, e.g.*, Floyd Harris, *Sorry, Wrong Numbers: So Maybe It Wasn't the Economy*, N.Y. TIMES, December 1, 1996, § 4, at 1.

253. For an example of how economic growth is measured and how our present approach may understate the health of the economy and resource growth, see Harris, *supra* note 252.

254. AVEDIR DONABEDIAN, EXPLORATIONS IN QUALITY ASSESSMENT AND MONITORING: THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT (1980); ZUCKERMAN ET AL., *supra* note 26, § 2.13; Robert H. Brook et al., *Measuring Quality of Care*, 335 NEW ENGLAND J. OF MEDICINE 966 (Sept. 1996).

has called it the "Third Revolution of Medicine").[255] While conceptually appealing, it will not be an easy task. It requires the accurate selection of valid clinical indicators and their application to patients appropriately adjusted for risk. Once this is done, actual outcomes are compared, taking into account random bad results.

Almost contemporaneous with this thinking, John Wennberg embarked upon his small practice variation studies – which demonstrated that practice norms vary widely, and that most have not been clinically validated.[256] The need for validation and for outcomes data reinforce one another. In addition, modern risk management focuses on improving the quality outcome of institutional processes rather than looking at specific wrong-doing after the fact.[257] Accordingly, outcomes research and systematic quality management are a natural fit. Because of these technological and conceptual developments, a consensus appears to be emerging on how best to measure and assure medical quality. These concepts also mesh with the increasing insistence of health care purchasers to engage in "value purchasing, that is the increasing focus of payors on quality (good outcomes), as well as cost."[258] For the same reasons, report cards – which attempt to compare providers and networks – are being demanded by both purchasers and patients[259] and appear to be a permanent feature of the new system.[260]

C. Information Technology and Infrastructure

The fourth and fifth trends – the major advances in information management technology and the growth of all kinds of networks – are related to the growing quest for "accountability" and will play an important role in the development of meaningful outcomes research. Networks will provide the capital, administrative infrastructure and defined populations necessary to collect, configure and analyze clinical and financial

255. Arnold S. Relman, M.D., *Assessment and Accountability: The Third Revolution in Medical Care*, 319 NEW ENG. J. MED. 1220 (1988).

256. Wennberg, *supra* note 248.

257. *Id.* at 21-22.

258. *See generally Employers: Digging for Value*, BUS. & HEALTH SPECIAL REPORT: THE QUEST FOR ACCOUNTABILITY, 1995, at 19; *see also* David Blumenthal, M.D., M.P.P. & Arnold Epstein, M.D., *The Role of Physicians in the Future of Quality Management*, 335 NEW ENG. J. MED. 1328 (1996).

259. Blumenthal & Epstein, *supra* note 258.

260. *See* Louis Diamond, *Report Cards: What Physicians Should Know – And Can Do*, INTERNIST, October, 1996, at 10.

information. Networks also have the capability of giving providers meaningful profiling information on a systematic basis. This information, when coupled with appropriate financial incentives, appears to be a more effective influence on practice patterns than government or rule-based regulation.[261] The literature also indicates that an increasing number of doctors recognize that independent accountability is rapidly replacing the profession's traditional self-regulation through peer review. As a result, practice guidelines, practice profiles and benchmarking (as educational tools rather than prescriptive regulatory mandates) will become the rule rather than the exception.[262]

Networks are also related to the development of workable *regulatory* initiatives regarding quality. Since all delivery and reimbursement approaches create potential economic conflicts, the real question is how best to moderate or regulate the potential for undesirable results. Here, one needs to ask what type of delivery and regulatory structure is best suited to efficiently *monitor* the process on a *continuing basis* in order to identify distortions or abuses caused either by ignorance or greed that are not checked by professional ethics. In this regard, "networks" of some kind provide the infrastructure for systematic data collection and feed-back capabilities necessary for a credible and continuous monitoring of treatment patterns. Networks and valid outcome data for defined populations will also permit meaningful comparisons and informed consumer choice. In this environment, competition also should be a formidable regulator.

If these are the major forces that will be at work over the next several decades, then practicing in a network environment will enhance rather than hinder the medical professional's ability to provide quality care. In this environment, however, professional autonomy must make some "accommodation" to enable collaboration, not just with patients, but also with colleagues, information and system personnel and network administrators. In the past, physicians have behaved as independent small

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261. Alan L. Hillman, *Managing the Physician: Rules Versus Incentives*, HEALTH AFF., Winter 1991, at 138, 142-3; ZUCKERMAN ET AL., *supra* note 26, § 2.7.7; ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 9-12 (1980).

262. *See, e.g.*, Gerald Burke, *Health Care in the 21st Century*, HEALTH SYSTEMS REVIEW, March/April, 1995, at 36; Robert S. Epstein & Louis M. Sherwood, *From Outcomes Research to Disease Management: A Guide for the Perplexed*, 124 ANNALS INTERNAL MED. 832 (1990); American College of Physicians, *The Oversight of Medical Care: A Proposal for Reform*, 120 ANNALS INTERNAL MED. 423 (1994); David M. Eddy, *Rationing Resources While Improving Quality: How to Get More for Less*, 272 JAMA 817 (1994).

business owners. Tomorrow, networks will make physicians more interdependent. Networks will link individual physicians and their peers and specialty groups in a way that has the potential to improve quality and cost through continuity of care, the dissemination of best practices and other efficiencies. In the past, what constituted quality was in the exclusive domain of professional medicine. Tomorrow, report cards will allow consumers to evaluate the medical outcomes of different networks and providers and, thereby, force providers to be more responsive to patient expectations.[263]

At the same time, the medical profession must play an important role in the development of the new system.[264] Consumers respect the role of the physician and look to the physician to guide them through the health care system. Consumers are also looking for accountability. If providers are to be held accountable, they must have real input and influence in setting standards and processes regarding how care is delivered. Doctors must be "willing participants" rather than "disgruntled victims," as the United States health care system continues the search for the appropriate mix and balance.

III. CONCLUSION: SOME OBSERVATIONS ABOUT THE FUTURE AND SOME UNANSWERED QUESTIONS

> *The organization of medicine is not a thing apart which can be subjected to study in isolation. It is an aspect of culture whose arrangements are inseparable from the general organization of society.*
>
> *– Walton Hamilton (1932)*[265]

Predicting the future is always risky. However, one is fairly safe in concluding that the medical profession's view of autonomy will heavily influence the structure and regulation of the emerging system. First,

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263. ZUCKERMAN ET AL., *supra* note 26, § 2.13.

264. Blumenthal & Epstein, supra note 258, at 1330-1; R. Clay Burchell, M.D. et al., Physicians and the Organizational Evolution of Medicine, 260 JAMA 826 (1988); Linda L. Emanuel, Professional Standards in Health Care: Calling All Parties to Account, HEALTH AFF., January/February, 1997, at 52.

265. WALTON HAMILTON, *Personal Statement, in* MEDICAL CARE FOR THE AMERICAN PEOPLE 189, 190 (1932); *see also* Victor R. Fuchs, *Economics, Values, and Health Care Reform*, 86 AM. ECON. REV. 1, 2 (1996) (quoting from Walton Hamilton in his Presidential Address at the 108th meeting of the American Economic Association on January 6, 1996).

physicians have been conditioned to operate independently.[266] Second, physicians also have the knowledge and expertise to diagnose and to treat. In addition, autonomy enhances the trust between doctor and patient and permits physicians to maintain their primary loyalty to the patient.[267]

While autonomy is essential for quality care, it is important to understand that autonomy is not synonymous with quality care. Autonomy is not an end in itself. It is an important means to make the best use of accurate patient information and up-to-date clinical protocols. As a result, the emerging network systems, with their information and systematic delivery capabilities, can support rather than work against professional objectives. Accordingly, medical professionals must become more collaborative and view the new networks and their information infrastructures as integral to their fundamental mission of "making people well." At the same time, the emerging network structures and administrators must also collaborate with the profession and allow the profession to have meaningful input in the development and implementation of network strategies, resource allocations and ethical standards.

The emerging structure and professional autonomy also will be influenced by larger, on-going cultural and economic developments. Medicine, as Walton Hamilton noted, cannot be considered in a vacuum separate and distinct from the rest of society. Some of these broader influences can be best described in the form of some unanswered questions:

First, how will society ultimately balance the competing fundamental values that determine social structure? Identification of these fundamental values and their appropriate balance will not be easy. Nor will everyone agree. Trade-offs will be the rule rather than exception. Yet, such decisions will be very important. As Tristram Englehardt pointed out, if one were to assume that the four key goals of societal organization are "liberty, equality, prosperity and security," one could be living in either North Korea or in Texas, depending on how one ranks these values.[268]

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266. For a good general description of medical education and its socialization attributes, which are now changing, see Ebert, *supra* note 28, at 155-9. While the socialization process helps inculcate professional ethical standards, the process can also encourage and perpetuate practice styles that are influenced more by regional norms and supply, rather than science.

267. *See, e.g.*, Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, HEALTH AFF., January/February, 1997, at 34; AMA, *supra* note 145.

268. H. Tristram Engelhardt, Jr., *Why a Two-Tier System of Health Care Delivery is Morally Unavoidable*, *in* RATIONING AMERICA'S MEDICAL CARE: THE OREGON PLAN AND

Second, Victor Fuchs and others raise the question of whether a market-driven system will plant the seeds of its own destruction by exacerbating the problem of the uninsured, thereby forcing massive government intervention.[269] Will this happen? Can the market properly address these issues? If government safety-nets are necessary, can the intervention be done in a way to preserve the benefits of a market economy? Or will a government system, rather than a pluralistic structure, be the end result?

Third, outcomes research, including clinical guidelines and professional autonomy in the application of such guidelines, appears to hold real promise for enhancing quality. Will workable outcomes analysis be technically achievable? Even if possible, will it create an inflexibility that inhibits innovation? Will it enhance and improve quality, or will it drive quality of care to an "average" level?

Fourth, will technological advances continue to be a major driver of medical inflation? Or, can we harness these advances to be our savior? Technology breakthroughs, at least for the near term, appear to favor biotechnology and genetics rather than hardware. This direction, coupled with the changing demographics of disease and the aging of the population, may lend itself to cost-effective treatment of chronic diseases and the maladies of the aging population.

Last but not least are society's attitudes toward limits – not just regarding economic resources, but also of the finite quality of life itself. Are we capable of accepting these limits in a realistic and graceful way? Maybe the answer to this question, more than any of the others, will have the greatest influence on the emerging health care system.

BEYOND 196, 197-198 (Martin A. Strosberg et al. eds., 1992). Victor Fuch's values are: "efficiency, justice, freedom and security." Fuchs, *supra* note 265, at 20. How one balances these values would also yield diverse results.

269. Fuchs, *supra* note 265, at 20.

APPENDIX

TIME LINE HISTORY OUTLINE OF HEALTH CARE DELIVERY AND FINANCING IN THE UNITED STATES[270]

- 1700 - 1840s: The Beginning

The original hospital has two functions: (1) isolation; and (2) maintenance (not cure). It is financed through: (1) taxes (public hospitals); and (2) charity (private hospitals, often with religious sponsorship). Since care is generally done in the home, the hospital is a substitute home for the indigent that are sick. The hospital also is a custodian for the mentally ill.

Anyone can practice "medicine." The prevailing disease theory is premised on the belief that sickness is caused by moral turpitude or

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270. This distillation of major trends, which by necessity only skims the surface, relied heavily on the following sources: An obvious basic source was the seminal work, PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982). Additional sources regarding the structure of medical institutions, the role of providers and the law include: CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY (1988); HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION (Mark A. Hall ed., 1994 & Supp. 1995); MICHAEL G. MACDONALD ET AL., HEALTH CARE LAW: A PRACTICAL GUIDE (1995); BARRY R. FURROW ET AL., HEALTH LAW (1995); ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION (2d ed. 1988); BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS (1991); HEALTH CARE AND ITS COSTS: CAN THE U.S. AFFORD ADEQUATE HEALTH CARE? (Carl J. Schramm ed., 1987); INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE?: THE ROLE OF UTILIZATION MANAGEMENT (Bradford H. Gray & Marilyn J. Field eds., 1989); and Nancy DeLew et al., *A Layman's Guide to the U.S. Health Care System*, 14 HEALTH CARE FINANCING REV.151 (1992).

Important sources, in addition to my own background in the industry and as an insurance regulator, for health insurance history, concepts and regulation include: BURTON T. BEAM, JR., GROUP BENEFITS: BASIC CONCEPTS AND ALTERNATIVES (4th ed., Gary K. Stone ed., 1991); JOHN G. DAY, ECONOMIC REGULATION OF INSURANCE IN THE UNITED STATES (1970); CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS (Comm. Print. 1988); HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITALS AND HEALTH INSURANCE (H.E. Frech III ed., 1988).

one's imbalance with nature. Accordingly, the cure stresses regimentation, convalescence and a caring environment – factors that ostensibly bring one back into balance with nature or facilitate one's moral rehabilitation. Treatment also is heavily based on folklore that relies on drugs (of questionable value), bleeding and blistering.

Other than the poor and homeless that are treated in hospitals, people are treated at home and pay physicians out of their own pocket. Physicians often treat patients in hospitals on a "pro-bono" basis.

• 1840 - 1860s: The Industrial Revolution, Specialization of Labor and Rise of the Middle Class

Urbanization creates a new "homeless" with financial means. These individuals often live in rented quarters in cities far from their original home. When they are sick, they need a facility for recuperation, which gives rise to a new form of hospital: the voluntary hospital. The function of this hospital is still maintenance, but the hospital and physician are paid for by the individual.

By 1850 most major cities have: (1) isolation or "pest" facilities for the mentally ill; (2) "alms" houses for the poor (the forerunner of the public hospital); and (3) voluntary hospitals where middle class individuals can elect to be treated and pay for their care.

There is no pooled or structured financing for individuals. Care for the poor are paid through taxes or charity. Individuals, who can pay, do so. Many medical practitioners perform a "Robin Hood" role or socialize their fees by charging the affluent more so the practitioners can afford to treat the poor. Barter is also common.

Around the middle of the century, practitioners begin to get organized. Practitioners also recognize the utility of a structured education and training program for new physicians. The American Medical Association (AMA) is founded in 1847. Clinical "internships" begin at this time. Despite these developments, the

public is still not ready to give physicians an exclusive franchise: anyone can still practice medicine.

• 1860's - early 1900's: The Transformation of the Hospital from a Place of Maintenance to a Place of Healing; the Transformation of Medicine to a Science

The Crimea and US civil wars provide clinical experience – which enhance surgical techniques and also validate the role and importance of nurses and ancillary providers. This experience is incorporated into medical practice during this period.

Pasteur develops the germ theory of disease. This new science requires clinical laboratories to aid in diagnosis. X-Rays, anesthetics and technical advances expand treatment opportunities. All of these activities require centralized facilities and specialists, which enhance the treatment role of hospitals and the importance of hospitals to physicians.

Voluntary hospitals rely on paying patients and, therefore, have a common economic interest with physicians who care for these patients. Public hospitals also want to care for fee generating patients. As a result, some public hospitals set up affiliated but separate facilities for fee-paying patients in order to avoid the stigma often attached to indigent facilities.

In Germany, Bismarck provides a government insurance "safety-net" to workers to enhance political stability. In the United States, Congress enacts the Sherman Act – which mandates competition as the preferred means for allocating resources – though this law is not applied to the medical profession until the 1950s. In addition, up until the late 1970s, the antitrust enforcement was differential to the "learned professions."

• 1900 - 1920: The Hospital Consolidates its Position as a Place of Healing; Physicians Consolidate Their Professional Status; and the Allopathic School Achieves Dominance

The Flexner Report of 1910 sets the model for medical education, which influences foundation giving, medical school curriculum

and how physicians are trained. As a result, practitioners become more homogeneous in their outlook and their socialization. Internal feuding is reduced. Where differences exist, there is a tendency to debate these differences outside of public view. Physicians and surgeons are well along in consolidating their position as a true profession and their new unity permits them to influence government/regulatory control over entry (e.g., state physician licensing laws and self-regulation). *Peer* evaluation becomes the standard.

Allopathic medicine becomes the dominant and the most respected and influential school of medicine.

The potent combination of a discipline built on "science," the need for extensive training to understand the science, the reliance of large institutions (hospitals) on physicians to generate fee-paying patients and the legally protected personal relationship between doctors and the patient give the medical profession widespread "cultural authority, economic and political influence." The way medicine was practiced (i.e. the general family doctor) also provided considerable "grass-roots" influence.

Private accreditation of hospitals begins. In the second decade of the twentieth century, the American College of Surgeons establish detailed hospital standards for accreditation to remedy the lack of hospital records necessary for the College to decide which practitioners should become new members. This effort to require records (charting) is expanded to include others items necessary for the new physician work place (the hospital), i.e. structural standards and certain technical capabilities, such as X-Ray machines and clinical labs. It takes several decades before accreditation is viewed as a necessity by most hospitals (e.g. in 1918 only 13% of surveyed hospitals were approved; twenty-seven years later 94% are approved).

Voluntary hospitals tend to rely more on fees (generated by patients referred by physicians with privileges at the hospital) to meet the hospital's operating expenses. These same hospitals rely on charity and public funds for capital projects and improvements. This trend is reinforced by the workers' compensation laws

(Massachusetts enacts the first such law in 1911) which pay for the hospitalization and treatment of work related injuries. Some hospitals view this new legally-sanctioned fee schedule as an indication of appropriate fee levels. As a result, hospitals raise their fees significantly (e.g., in Massachusetts the hospital per diem rate went from $1 to $15) for all paying patients – not just those with work related injuries.

The medical profession's economic and cultural clout shift the balance of power in the hospital from the Board of Trustees to the "staff" physicians (i.e., physicians having privileges at a hospital). This shift is reflected in hospital's organizational structure and accreditation protocols, i.e. staff physicians must have their own mini-government within the hospital, control over peer review and control over who gets and keeps hospitals privileges. This power shift is reflected in tort law which views the physician in the operating room as the "captain of the ship." As captain, he or she controls hospital support employees and, therefore, insulates the hospital from vicarious liability for the negligent acts of its employees in the operating room. Clearly, the medical professional paradigm has come of age.

• 1920 - 1930s: The Depression Forces the Creation of a Predictable and Stable Income Stream to Pay for the Medical Health Care

The Depression creates grave cash flow problems for everyone – including hospitals and surgeons and, to a lesser degree, general practitioners.

Hospitals create the first structured pooled financing mechanism: Blue Cross. This insurance policy is a "service" contract where a certain number of hospital days are covered for a set premium. Since the contract paid a per-diem rate for all services other than physician care that is provided in the hospital, these policies represent the first integration of financing and delivery. These service contracts are sold on an individual basis and are limited to hospital services only. Physicians reluctantly follow shortly thereafter with Blue Shield, which is originally limited to surgical procedures performed in the hospital. Blue Shield plans were more akin to a traditional indemnity coverage because insurance

payments directly to the patient had less potential for interfering with the doctor and patient relationship. These coverages were later expanded to office visits and evolved into major medical coverage.

The Blues view themselves as an extension of the traditional not-for-profit public service hospitals with a unique blend of social and economic missions. In exchange for tax and regulatory advantages, the Blues provide for: (1) open-enrollment periods; and (2) community rating. Only participating providers can sit on the Blues' Boards of Directors.

Progressive employers begin to provide health benefits to their workers. This new employee benefit is accompanied by the development of group insurance – a very cost efficient way to deliver coverage to large amounts of people, while minimizing anti-selection.

A few employers rely on and some even create group practices (e.g. Kaiser, Ross-Loos), which are the early health maintenance organizations (HMOs). The medical profession has real concerns about these new ways of sponsoring and delivering care and push for anti-alternative care legislation and regulation, including the prohibition against the corporate practice of medicine.

Commercial insurers enter the market and are able to compete with the Blues through: 1) different benefit designs; 2) the use of experience rating; and 3) the ability to better handle multi-state employee populations. The Blues are essentially "local" operations operated for and by the local medical community. For example, in the 1970s, there were 17 different Blue Cross and 17 different Blue Shield plans in New York alone.

• World War II and the Late 1940s: The Dramatic Growth of Employment-Based Group Coverage

The World War II wage and price freeze encourages employers to look at employee benefits as a way to improve employee morale.

Tax law changes reinforces this trend by: (1) making employer expenditures for employee benefits deductible as a business expense; and (2) not taxing as income the health benefits received by an individual employee.

At the end of World War II, the Supreme Court concludes that the term "wages" includes health care and pension benefits; and, therefore, these benefits become legitimate items for collective bargaining under the federal labor laws.

As a result, group employer-based health care coverages grow dramatically. Even the Blues aggressively market group coverages to employers. In 1940, only 12 million people had health insurance. Blue Cross/Blue Shield covered more than half of the covered population and commercial group insurers covered 2.5 million people. By 1960, more than 122 million individuals have coverage and more than 100 million are covered through group commercial (55 million) and Blue Cross/Blue Shield (58 million).

Immediately after World War II, Congress embarks upon a program of hospital expansion. One major piece of legislation is the Hill-Burton Act where federal aid in various forms is made available to update and expand hospital facilities. This aid is conditioned upon (1) compliance with minimum structural standards (which give rise to state hospital licensing laws as the enforcing vehicle); and (2) the provision of some "uncompensated care" and "community service." State and federal not-for-profit tax status for hospitals are usually accompanied by obligations to pursue certain charitable, scientific or educational purposes, which often requires the providing of charitable care to indigents.

In 1944 the Supreme Court reverses a 100-year precedent and holds that insurance is interstate commerce. In response Congress enacts the McCarran-Ferguson Act, which permits the states to continue to regulate and tax insurance. Thirty years later Congress enacts the Employee Retirement Income Security Act (ERISA), which sets federal standards for certain employee benefits (including health care benefits). When drafting ERISA Congress maintains its historic policy of letting states regulate insurance. Thirty years later these two laws are creating a great deal of

confusion, litigation and limiting the ability of the states to deal with health care reform.

With the exception of the Blues' modest integration between delivery and financing and a few HMOs (e.g., GHC of Puget Sound, HIP of New York and GHA in Washington), there is a clear separation between the delivery of care and insurance financing. In fact the original wording of insurance indemnity policies and the regulation of such policies make it clear that the purpose of indemnity coverage is to provide passive financing; indemnity financing entities are not to interfere with the doctor and patient relationship or one's choice of doctor.

Antibiotics and vaccines are widely used during World War II, both for the military and civilian population. Communicable diseases decrease significantly. When these diseases do occur, they are quite manageable.

President Roosevelt and President Truman develop proposals for a broad-based government health care system, but nothing happens because other issues are more pressing. In addition, the political support for such proposals is thin and fragmented, while the opposition is focused and formidable.

- 1950s: The Eisenhower Years

This is a period of unprecedented and widespread economic growth.

There is a dramatic increase in hospital facilities, physicians' technology and the ability to pay for it through widespread group insurance and various government programs that encourage hospital expansion and the education of new doctors.

The economic interests of physicians and hospitals are in alignment. Hospitals are paid on a per diem (cost plus) basis and physicians are paid on a fee-for-service (FFS) basis. Increased utilization by both hospitals and doctors increases the revenues for both. Since physicians are now the dominate source of hospital

patient revenue (whether or not paid for by insurance), the doctor, not so much the patient, becomes the hospital's primary customer.

• Early 1960s: Pressures Build for a Government Insurance System

Employer-based insurance continues to grow dramatically. In the early 1960s, both public and private insurance payments account for roughly 50% of the total spent on health care services to patients.

The coverage limitations of an employer-based system become apparent with increasing unemployment, an increase in low-wage employees and a growing number of retired employees because these individuals cannot, or are unable to obtain coverage through employer-sponsored plans. In addition, individual coverage is not subsidized by an employer.

Pressures begin to build for insurance programs for these populations. However, government intervention is resisted by organized medicine, insurers and portions of the employer community who see such programs as the first step towards a government-run health care system.

• 1965 - 1970: The Johnson Years – Government Insurance Becomes a Reality

Congress enacts Medicare (for those over 65) and the joint federal and state-funded Medicaid programs (for the economically disadvantaged) with a 1967 start date.

By late 1969, a substantial majority of Americans are covered by some form of public or private coverage. Government policy-makers are becoming aware that actual Medicare and Medicaid spending is exceeding the original projections by a fair margin.

The medical profession's concerns with the new government programs are ameliorated by the fact that payment under these programs originally mirrors what is paid through private insurance and individuals without insurance, i.e. hospitals are paid on a per-diem basis set by the hospitals and physicians on a FFS basis.

Choice by patients is not restricted. Physicians do not have to participate and can "balance bill" if their charges are higher than what is paid by Medicare and Medicaid.

- 1966: The Calm Before the Coming Storm

Federal programs and state and federal planning build upon the nation's focus on civil rights by encouraging the expansion of care through medical education grants and new services to under-served areas.

Congress enacts the Comprehensive Health Planning Act and Public Service Act Amendments which establish a federal framework and funding for health care planning by the states. This program is not very effective at containing costs in part because the public policy focus is still on the adequacy of coverage rather than cost containment.

The economic interests of physicians and hospitals are still in alignment. Technology is king and a technological "arms race" develops between hospitals as the hospitals do everything they can to attract doctors – the source of fee-paying patients.

Tort law begins to recognize the importance of hospitals and their role in quality control by making hospitals: (1) vicariously liable for the negligence of core hospital employee practitioners (e.g., radiologists, anesthesiologists); and (2) liable for negligence when the hospital does not have or does not correctly implement a reasonable credentialing program, i.e., procedures designed to assure that doctors having privileges at the hospital are properly licensed and monitored by their peers.

- 1970s: The Realization of Real or Perceived Limits

The Vietnam war, rampant inflation, foreign cartels and national scandals blunt American confidence and underscore the possibility that there may be limits on what we can do as a country. In addition, people begin to realize that we may be living in a world of finite health care resources.

By the end of the decade, 80% of the population is covered by third-party public and private insurance. Forty-two percent of those individuals are covered by federal government programs, i.e. Medicare, Medicaid and CHAMPUS.

Technological advances continue to proliferate in part because of the space program and breakthroughs in electronics, biology and chemistry.

Enough time has elapsed (aided by demographics and a less than robust economy) for the Medicare and Medicaid programs to demonstrate their awesome growth and cost potential. By 1979, Medicare and Medicaid enrollments have climbed to 28 million and 21.5 million, respectively. Total Medicare benefits approximate $28 billion annually. Medicaid benefits approximate $20 billion annually.

States enact many mandated insurance benefit laws requiring private insurance policies to cover certain procedures and providers. These mandated expansions of coverage often are driven by providers who want new procedures covered (e.g., newborn coverage) or who feel their services should be covered (e.g., mental health, physical therapy and occupational therapy). These mandates increase the cost of insurance on an incremental basis. It is only by the end of the decade that policy-makers really begin to understand the cost impact and require some cost/benefit analysis. Some estimate that the 700+ mandates account for 15-20% of the premium for health care insurance.

During the 1970s, public policy-makers begin to focus on health care cost containment rather than access.

A number of initiatives occur at the federal and state level that deal with health care cost increases. For example, the 1972 Social Security amendments require that hospitals eligible for Medicare receive approval from state planning authorities for hospital expansions. The 1974 National Planning Act conditions federal funding for health care on the existence of state review and approval of new hospital construction. As a result, all states develop some form of certificate of need (CON) legislation.

Similarly, state insurance regulators begin to urge insurers to take a more active role in cost containment through indemnity benefit design, such as greater use of deductibles, second surgery opinions and hospital pre-certification. Some commissioners require these provisions by regulation.

In 1973, Congress enacts the federal HMO Act in order to facilitate the growth of health care delivery systems other than the traditional physician FFS indemnity system. In addition to grants and loans for start-up capital, the federal law requires that any employer with 20+ employees that offers health benefits to its employees also to offer HMO coverage, when a federally qualified HMO exists where the employer is located. Another section of the federal law preempts any state law that inhibits or blocks the formation of HMOs. The states follow suit with their own HMO laws to encourage this alternative way of providing and paying for health care.

The Employment Retirement Income Security Act of 1974 (ERISA) is enacted to remedy retirement-plan abuses. However, Congress also extends the law, without much thought, to employer health plans. While the law does not mandate employer coverage, it does limit the states' ability to regulate employee benefit plans. Within ten years, there will be considerable confusion and litigation regarding how far a state can go in enacting laws that "relate" to or impact employer-sponsored health plans. As a result, the ability of the states to realize reforms that apply to *all* private payers and in particular – self-insured employers or employers that refuse to provide employee coverage – is limited.

Group insurers (including the Blues) develop various new forms of "experience rating" to reduce the incentives of employers to move to self-insurance. As a result, insurers begin to move away from broad-based premiums, such as community rating. Risk selection also becomes increasingly important. Even so, the new minimum premium plans (while functioning like self-insurance, is really insurance) and self-insurance grow dramatically as the Carter inflation years underscore the importance of cash management and "float" (i.e., who has the possession of the "reserves" and interest while claims are being incurred and processed). In 1960, total self-

insured claims payments approximated $2.4 billion. By 1991, self-insured and minimum premium payments total approximately $88 billion.

This restructuring creates major distortions in the health care delivery and financing system. In fact, these pressures cause the development of a number of different systems – what I refer to as the "Balkinization" of the health care delivery system. For example, hospital rate regulation begins to break up the traditional alignment of the economic self-interest between doctors and hospitals, where hospitals are given incentives to decrease utilization (i.e., prospective reimbursement). Less-than-cost government reimbursement schedules and the growing Preferred Provider Organization (PPO) concept that pays providers discounted FFS rates in exchange for volume results in "cost shifting." Here, hospitals and physicians make up shortfalls by charging other payers more (generally employers providing health care benefits through traditional insurance and self-insurance). Employers seek to reduce costs by (1) using the ERISA preemption protection and self-insuring to avoid state imposed burdens, such as the premium tax and state mandated benefits; (2) taking advantage of their "at work" population by experience rating, i.e., basing the premium on the actual employee experience which by definition is usually better than that of the population at large; and (3) introducing benefit design changes (e.g., pre-certification) and alternative delivery systems (HMO's).

• Late 1970s - 1980s: A Brave New World

There is a growing realization that direct regulation is having little or no impact on increasing medical costs and utilization. President Carter tries to impose direct hospital rate regulation but is rebuffed by the Congress. Public policy begins to move away from direct regulation to market competition and economic incentives as a way of containing health care costs.

In 1978, the Supreme Court severely restricts the "learned profession" exemption of the antitrust laws. In doing so the Court recognizes the growing commercialization of both the legal and medical professions. These decisions, as well as other Supreme

Court decisions, "commercialize" the professions and enhance the role of markets and competition in the rationalization of the medical care industry.

In 1985, the Supreme Court holds that ERISA breaks the health care financing system into two discrete pieces (insured and self-insured) and that the self-insured employer population is not subject to state mandated benefit laws. As a result, two federal enactments – ERISA and the McCarran-Ferguson Act – help drive employers out of insurance-funded plans to self-insurance and beyond state regulation.

The federal Department of Health and Human Services (HHS) and some states develop a new hospital reimbursement approach: prospective payment where hospitals are placed "at risk" for the delivery of hospital services. This reimbursement approach creates incentives for hospitals to look for the more cost efficient ways to deliver care, which accelerates the diverging economic self-interest of hospitals and its staff physicians. Hospitals now have incentives to reduce care, while many physicians continue to be paid under the FFS system. Technology re-enforces this divergence of economic interest by permitting hospitals and physicians to become competitors rather than collaborators, e.g., competing outpatient treatment facilities.

Hospital bed days start to drop for the first time as a result of (1) the de-institutionalization of mental health patients; (2) the growth of alternative outpatient acute care facilities; (3) the growth of alternate maintenance facilities for the old, e.g., nursing homes, (this in turn has been stimulated by the generous long-term care provisions of Medicaid and creative estate planning lawyers); and (4) strong reimbursement incentives for in-hospital utilization review.

Staff physicians, hospital administrators and trustees begin to reevaluate their relationship. As traditional hospital care moves to a less costly setting (encouraged by the new reimbursement approaches and made possible by technology), the doctors and hospital administrators began to wonder if they are allies or competitors. It is also becoming apparent that the physicians'

traditional "grass-roots" support is being eroded by medical specialization, the emphasis on technology and the growing depersonalization of the doctor and patient relationship. However, the doctor and patient relationship and America's preference for freedom of choice remain potent forces.

In 1987 the federal Planning Act is repealed. A number of states follow suit and repeal their CON laws because of a growing anti-regulatory bias and some empirical research that casts doubt on the efficacy of the CON approach, i.e., there is some evidence that hospitals may have "gamed" the system by reducing resources subject to CON regulation and diverted these resources to non-regulated activities, such as adding nurses. Despite doubts and conflicting arguments, most states retain some vestige of this form of direct regulation. Even so, it is becoming clear that there is growing dissatisfaction with direct regulation at both the state and federal levels.

HMOs and "network" based care increase dramatically as employers began to look for alternatives to the traditional FFS system. "Managed care" and private "utilization review" come into their own and grow in market share. By 1991, the number of covered individuals had increased to 41 million and by 1996, 56 million.

The Joint Commission on Hospital Accreditation (JCHA) shifts its focus to internal systems and processes (not just structural specifications) for assuring quality. The Joint Commission also changes its name to the Joint Commission on Health Care Organizations (JCHCO), to reflect the growing proliferation of alternative health care facilities and delivery systems, and the Commission's intent to extend accreditation to these new entities.

Cost shifting is exacerbated by "managed care," in that providers do what they can to make up lost revenues from "managed care" savings. This cost shift is in addition to the cost shift caused by government program reimbursement shortfalls.

The federal government continues to use its purchasing power to force compliance with minimum standards to fill in gaps on a

piecemeal basis, e.g., anti-dumping and emergency care requirements of the Emergency Medical Treatment and Active Labor Act of 1986.

The Federal government starts to impose its own direct employer mandates – again filling in gaps on a piecemeal basis, e.g., COBRA's continuation of coverage provisions and the Medicare primary/secondary rules.

Last but not least, a number of states begin to experiment with varying degrees of success with different ways to make small group and individual coverage affordable and available. Usually, these efforts center on broadening rating classifications (risk spreading) and requiring insurers, or special quasi-government agencies (e.g., reinsurance facilities), to offer coverage. Mandated employer coverage is not permitted because of ERISA.

- 1990s: A Braver, but More Uncertain New World

The early 1990's economic slow down – which appears to be part and parcel of a fundamental restructuring of the economy rather than a traditional cyclical downturn – creates a heightened insecurity in the middle class about the loss of coverage that one normally gets through their employment. This concern extends to all uncovered or underinsured individuals – not just the disadvantaged. Proposed solutions are stymied by real or perceived resource limitations. This conflict forces a public debate about how we deliver and finance care. President Clinton does a great job raising the issues and public consciousness, but does not manage the issue adroitly. Major reform flounders and many believe that far reaching government-based reforms are not realistic for at least another decade, if ever.

Medicare and Medicaid expenditures are now the fastest growing segment of federal and state budgets. The Bipartisan Commission on Entitlement and Tax Reform chaired by Senators Kerry and Danforth) concludes that without changes, virtually all tax revenue will go for entitlement by the year 2010. If taxes are not increased or spending is not decreased, little or no monies will be available for other purposes, such as education and infrastructure.

In 1994, the Republicans capture both houses of the Congress. This shift in Congressional power appears to be based on growing public bias towards less government and, in particular, less federal government. There is also evidence that the public is increasingly willing to reexamine entitlement – which many legislators felt was political suicide. The Republican Congress pushes the issue, but "backtracks" somewhat during the 1996 Presidental campaign as the issue gets caught up in partisan politics. As a result of the 1996 Presidential campaign and President Clinton's reelection, many feel vindicated in their belief that entitlement reform is the "third-rail" of domestic politics.

Managed Care continues to gain acceptance and is now starting to be extended to the government programs at the state and federal level. In addition, the development of Medicare's relative value scale reimbursement methodology reinforces the movement toward primary care physicians.

"Rationing" is no longer a taboo word. The public appears to understand (though not without reservations) that any system must have limits. Oregon forthrightly comes to grips with the issue by debating and setting limits in the open – unlike the Clinton plan and other proposals that consciously camouflage these difficult decisions in layers of bureaucracy.

- 1995 - The Present: A Glimpse of the Future?

The demise of the Health Security Act of 1993 and the resulting 1994 Congressional elections signaled that the public is not ready for wholesale change even though the public continues to have general concerns regarding the health care system. This perception is confirmed by the successful enactment of the Kassebaum-Kennedy legislation, which focused on *specific targeted concerns*, such as portability and access to health care coverage. In addition, the new law applies to *all* coverage: group and individual insurance and self-insurance. The law also encourages the states to establish "safety-net" facilities to provide coverage when it is not available elsewhere.

"Managed care" comes under increasing scrutiny because of restrictive practices used by some managed care operations to manage utilization, e.g., limits on various types of hospital stays that get characterized as "drive-through" treatment. Organized medicine, while still very fragmented, is unified in the need for: (1) more professional control over practice guidelines; and (2) the need for legally sanctioned collective professional activity regarding the new networks. Providers also want to be able to form provider-owned networks subject to less stringent regulation than other networks, especially with respect to solvency. The President, who made managed care the cornerstone of his 1993 Health Security Act, now openly criticizes managed care and establishes a commission to develop appropriate regulation. All of these developments reflect a growing concern with the quality of health care and not just its cost. Others also observe that future reform will at least at the federal level, emulate Kassebaum-Kenndy's focused incremental approach.

The potential for greater state involvement also appears likely. A 1995 Supreme Court decision narrows the ERISA's preemption in a way that appears to permit states to raise revenues from provider taxes that will be charged to everyone, including the self-insured population. Some form of comprehensive reform for uncompensated care at the state level now may be possible. In addition, the Kassebaum-Kennedy model stresses *minimum* focused federal mandates for *all* payors and permits the states to implement and expand upon the minimum standards.

Both institutional and individual providers are going through a major restructuring that is breathtaking. Hospitals are consolidating and forming their own networks. Corporations and insurers are also expanding their already sizable multi-state networks. Individual providers finally realize that network care is here to stay and try and either (1) catch-up by joining networks or form their own; or (2) fight back via any-willing provider laws and "patient-protection" acts.

Regulators, especially at the federal level (e.g., DOJ, the IRS and HHS), feel great pressure to revamp or refine the traditional rules regarding antitrust, provider fraud/kickback laws and not-for-profit

rules, because these rules inhibit the development of provider-owned networks – at least on the terms that providers deem acceptable. Providers and regulators begin to argue over how provider-owned networks should be regulated – if at all.

The medical profession continues to be fragmented over what it wants or needs. Some physicians are for a government-run system. Others are against a single-payer system. Some like networks. Others do not. Some are retiring. Some wish they could retire. Others who are retiring wonder if they will get the same quality of medicine they provided to others before they retired. Where we go from here is anyone's guess, even though the ultimate destination will dramatically impact everyone in the country and generations to come.

"BEST PRICE" CLAUSES IN HEALTH CARE PROVIDER CONTRACTS: AN ANTITRUST CRITIQUE*

*by Anthony J. Dennis***

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* The author would like to dedicate this article to his mentor and former supervisor, James Edward Bowers, who served for over a decade as Aetna's senior antitrust counsel. It was under Jim Bowers' watchful gaze that the author spent his critical early years of formation as a practising lawyer. I wish to extend my thanks also to those who furnished helpful comments or otherwise rendered assistance in the production of this article. It should be noted that the views expressed herein are solely those of the author and should not be attributed to Aetna, Inc. or any other person or party.

** Counsel, Aetna Inc., headquartered in Hartford, CT. Anthony J. Dennis is the author of 21 law review and other legal articles and is contributing author of HEALTH CARE ANTITRUST: A MANUAL FOR CHANGING PROVIDER ORGANIZATIONS (Thompson Publishing Group, 1994). He received his J.D. from Northwestern University School of Law in 1988 where he served as an executive editor of the criminal law journal and a member of the international moot court team. He holds a B.A., *cum laude*, from Tufts University.

I. INTRODUCTION

The substantial increase in health care costs throughout the 1980s and into the 1990s,[2] and the amount of our nation's total wealth which is spent on health care,[3] are two major factors that have caused the United States and its citizens to focus on this rapidly expanding sector of the economy and to attempt to insure the affordability of health care for all Americans. By the early 1990s, health care had clearly become a major political issue. The election, in a special race held in Pennsylvania in 1991, of former Senator Harris Wofford to fill the vacant U.S. Senate seat that had been occupied by the late Senator John Heinz demonstrated that fact.[4] Mr. Wofford was widely viewed as the underdog in that contest which pitted him, a political unknown, against the widely known and generally popular Richard Thornburgh, who had served previously as Governor of Pennsylvania and more recently as United States Attorney General under President Bush.[5] The issue that made all the difference in that particular U.S. Senate race was health care. Wofford pounded mercilessly on many citizens' fears that health insurance was becoming too expensive and perhaps, under certain conditions such as temporary unemployment, even unavailable.[6]

The rapid rise in health care costs and the publicity that such a development generated caused the nation to focus its attention and energies on ways to slow this potentially disturbing trend.[7] The issue took on further

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2. "[F]rom 1981 to 1991, medical prices rose more than twice as fast as the Consumer Price Index for all items." Robert Pear, *States Are Moving To Re-Regulation Of Health Costs*, N.Y. TIMES, May 11, 1992, at A1.

3. "Total national spending on health care soared to $738 billion last year, from $290 billion in 1981." *Id.* Health care has accounted for "a growing proportion of the gross national product (GNP). In 1950, national health expenditures represented 4.4 percent of GNP. Today they represent over 10 percent and are rising to an estimated 12 percent of GNP by 1990. Even in constant dollar terms, per capita personal health expenditures rose at a rate of 4.8 percent per year between 1950 and 1980." Geraldine Alpert & Thomas R. McCarthy, *Beyond Goldfarb: Applying Traditional Antitrust Analysis to Changing Health Markets*, 29 ANTITRUST BULL. 165, 166 (1984).

4. *See Health, the Lose-Lose Issue*, ECONOMIST, Nov. 16, 1991, at 27.

5. *Id.*

6. *Id.*

7. "The escalating costs of health care have placed health care issues firmly on the national political agenda." Anthony J. Dennis, *Hospitals, Physicians, and Health Insurers: Guarding Against Implied Agreements in the Health Care Context*, 71 WASH. U. L. Q. 115, 115 (1993).

national importance when President Clinton attempted forcibly to restructure the entire health care sector of the economy mid-way through his first term as President. That effort ultimately failed. However, all of these factors (i.e., increasing costs, negative publicity regarding the same, health care as a campaign issue) nonetheless caused the health care industry to take stock of itself and to reflect on ways in which health care could be made more affordable for, and readily available to, Americans.

Broadly speaking, the rise in health care costs and the attention from the media and from politicians that this development promoted gave rise to two discernible trends within the health care industry. First, new forms of financing and delivering health care rapidly took root in the marketplace. These newer health care delivery systems were introduced, by and large, by traditional health insurance companies interested in offering consumers low cost alternatives to traditional indemnity forms of health insurance. The new or, in health care parlance, "alternative" form of health insurance[8] eventually became known as "managed care," and the organizations that offered such forms of health insurance became known as "managed care organizations" or MCOs.

The second trend that spiraling health care costs promoted was a battle between MCOs and providers of various kinds (e.g., physicians, hospitals) to reduce or at least to hold the line on the amount of compensation that MCOs were paying to providers to render care to consumers. This hard fought battle continues to this day and is summarized in Part B below and is discussed in further detail throughout the rest of this article.

A. The Growth of Managed Care

Managed care is a term which denotes several forms of health insurance, all of which rely on a limited panel of medical providers (physicians, allied health practitioners, hospitals, surgery centers) to provide all of the care required by the individual enrollees who subscribe to the managed care plan in question.[9] This limited panel or "provider

8. A federal district court in Kansas characterized managed care as an "emerging alternative delivery system" that "radically alter[s] traditional notions about delivering and financing [of] health care." Reazin v. Blue Cross & Blue Shield, Inc. of Kansas, 663 F.Supp. 1360, 1371 (D. Kan. 1987), *aff'd*, 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1990).

9. MCOs or "[m]anaged care plans offer pre-paid health insurance in which customers pay an up-front fee or premium in return for nearly unlimited access to a network of medical providers at little or no additional cost. Such plans include . . . HMOs, . . . PPOs and

network" delivers care on a more cost-effective basis than would otherwise be provided under an old-style indemnity plan because the providers in the network agree with the MCO to render all care necessary for a favorably low price.[10] This low price is then passed on to the consumer in the form of lower health insurance premiums.[11]

In contrast, indemnity insurance provides that the health care insurer will reimburse the provider rendering care at a fixed rate no matter what the form of medical treatment or whether the provider has a preexisting contractual relationship with the insurer or not.[12] Generally, the indemnity insurer will pay the lion's share of the bill, often 80% of it, while the individual covered by the indemnity plan is left to pay the remaining 20%.[13] Indemnity insurance is not thought to be particularly effective in holding down health care costs because there is no incentive for providers to prescribe the cheapest, medically appropriate care available since the providers will be reimbursed no matter what the cost of the treatment or tests they prescribe.[14] Similarly, patients don't normally ask about the cheapest care available in an indemnity plan since their health insurer will be paying for most of the tab.[15] And health insurers, until recently, have felt capable of recovering their own costs in reimbursing providers for the expensive tests and treatments they have prescribed for their patients by simply raising premiums over time.[16] The political and economic environments no longer allow for such a passive approach to health care financing and delivery.

As can be seen, technical terms quickly proliferate in the health care arena. Two additional terms that one should be aware of in this field are: health care financing and health care services. Medical providers provide health care services to patients who are enrollees (i.e., covered individuals) under various health insurance plans.[17] Health care services consist merely of medical services and nothing more. In contrast, health care financing is

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several variations on these two basic managed care entities." Dennis, *supra* note 7, at 117-18 (footnotes omitted).

10. See discussion of capitation payments, *infra* notes 19-22 and accompanying text.

11. "In an HMO or PPO, the member typically pays less for health care coverage than under a traditional indemnity insurance plan, but is limited in his or her choice of medical care providers." Reazin v. Blue Cross & Blue Shield, Inc. of Kansas, 899 F.2d 951, 956-57 n.5 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1990).

12. *See generally* Dennis, *supra* note 7 at 116-17.

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.* at 123, n.27.

a term that includes not only the health care services offered to enrollees but also the insurance or financing component that makes purchase of such services a reality.[18] In the indemnity as well as the managed care context, health care financing consists of the health insurance purchased by enrollees.[19] The insurance companies set a price for health care financing which allows them to recoup the cost of serious illnesses on the part of a certain percentage of the enrollee population and a profit besides. Actuaries are the insurance professionals who help set accurate premiums which allow health insurance companies and MCOs to stay in business without going bankrupt paying for expensive medical treatments.

1. Capitation Contracts

From the providers' perspective in the managed care setting, providers trade patient volume for lower individual fees. They sign contracts with MCOs, known as capitation contracts, which entitle them to receive an upfront fee per patient as their sole compensation for treating that patient, regardless of how sick or healthy that patient turns out to be.[20] The payment that providers receive at the outset is called a "capitation payment," meaning "per head." Capitation is a form of compensation purposely designed to influence provider behavior by getting them to provide the minimum amount of care that is medically appropriate under the circumstances.[21] Since providers will not be able to receive reimbursement for the medical care they provide, so the reasoning behind managed care goes, they will not be as quick to order expensive medical tests or treatments since the cost of such tests or treatment will quite literally come out of their pocket.[22] Hence, managed care forces providers to be more cost conscious in their treatment decisions since the capitation

18. *Id.* at 123 and 123, n.27.

19. *Id.*

20. *See* Gerald L. Coe & Jeffrey M. Sconyers, *Contracting (Risk-Provider Oriented) in* THE INSIDER'S GUIDE TO MANAGED CARE 78, 82-83 (Susan K. Chambers, ed. 1990); Gary S. Davis, *Introduction: Managed Health Care Primer, in* THE INSIDER'S GUIDE TO MANAGED CARE, 27 (Susan K. Chambers, ed. 1990); Edward P. Potanka, *Alternative Health Care Delivery Systems: A Legal Overview,* 1, 9 (May 22, 1989) (paper presented to the Association of Life Insurance Counsel, on file with author).

21. Potanka, *supra* note 20.

22. *Id.*

payment is the only form of compensation they will receive for treating patients covered by the MCO.[23]

2. Forms of Managed Care

There are currently several forms of managed care. One of the oldest and most established forms of managed care is a health plan known as a health maintenance organization or "HMO."[24] Individual enrollees belonging to an HMO are directed to use only those health care providers who are members of the HMO's provider network. If they do so, virtually all of the cost of their medical care is covered and paid for by the HMO. At most, the enrollee might have to pay a small deductible, with $5.00 per office visit not being uncommon. If, on the other hand, enrollees receive treatment outside the HMO's provider network then they must pay for 100% of the cost of that treatment themselves. The HMO will not pay for such "out-of-network" office visits. As a result of this coverage mechanism, HMOs are said to "strongly steer" their patients toward using "in-network" providers. Another common description of HMOs is that they are a "strong form" of managed care because of the incentives they create for enrollees to seek treatment solely from providers who are members of the HMO's provider network.

Preferred provider organizations, or "PPOs,"[25] also have a limited panel of network providers which enrollees are directed to use. However, the incentives for seeking care solely from providers within the provider network are not quite as strong as an HMO's incentives for seeking such care. If the enrollee uses "in-network" providers then, like an HMO, the PPO will pay for virtually all of the care but for a small deductible. In contrast, if the enrollee seeks care "out-of-network" then the PPO, unlike an HMO, will pay for some portion of that care. Thus, in managed care parlance, providers who are members of a PPO provider network are said

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23. "Since medical providers receive only . . . capitated . . . fees for services rendered, they attempt to reduce their operating costs so that the capitation payment they receive yields some net profit." Dennis, *supra* note 7, at 118.

24. *See generally* Harold S. Luft, *How Do Health-Maintenance Organizations Achieve Their Savings?*, 298 NEW ENG. J. MED. 1336, 1336 (1978); Linda E. Demkovich, *"PPO" - Three Letters That May Form One Answer to Runaway Health Costs*, 15 NAT'L J. 1176 (1983) (explaining similarities and differences between HMOs, PPOs, and fee-for-service arrangements).

25. *See* Luft, *supra* note 24, at 1337; Demkovich, *supra* note 24, at 1176; *see generally* Robert E. Youle & Paul C. Daw, *Preferred Provider Organizations: An Antitrust Perspective*, 29 ANTITRUST BULL. 301, 303-04 (Summer 1984).

to be "preferred" in this context. Given the financial incentives summarized above, one can also see that patients are not as strongly influenced in making decisions about which provider to use as they are in an HMO. PPOs are not a particularly "strong form" of managed care.

In recent days, managed care has spawned several new hybrids on the above two models. These hybrid forms of managed care have some attributes of both an HMO and a PPO and are known by a wide array of names which are tied to the trade name of the company offering them. (In other words they are usually known by the particular name under which each company markets them, not a generic, descriptive name such as "HMO" or "PPO.")

Managed care organizations, or MCOs, have also been known to "unbundle" their services and offer one component piece of their operation for "rental" to other MCOs or directly to employers. For example, MCOs can rent just their claim processing services or other "back room" portions of their operation. When an MCO is merely handling the paperwork or claims for another company or companies, it is functioning as a third party administrator or "TPA." To cite another example, MCOs can rent their provider networks on a stand alone basis to other MCOs. The other MCO renting the provider network would actually provide the health insurance contract to consumers. The first MCO, the one renting out its provider network, would simply be functioning as a vendor and would be paid an "access fee" for allowing others to utilize the provider network it has created and continues to maintain.

To sum up, managed care essentially came of age due to spiraling health care costs and the widely perceived need to inject more price competition into the health care industry.[26] The concern over health care costs prompted health insurers and others to invent new forms of health care delivery which would be more cost effective and less expensive for consumers.

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26. *See* Robert J. Enders, *Alternative Delivery Systems*, *in* ANTITRUST HEALTH CARE ENFORCEMENT AND ANALYSIS 195, 195-96 (M. Elizabeth Gee ed., 1992); Potanka, *supra* note 20, at 5, 9-17; Peter D. Fox, *Forward: Overview of Managed Care Trends*, *in* THE INSIDER'S GUIDE TO MANAGED CARE, *supra* note 20, at 1-5; Hal Belodoff, *HMOs - New Challenges - New Products*, *in* THE INSIDER'S GUIDE TO MANAGED CARE, *supra* note 20, at 241-42.

B. Provider Contracting: Another Battleground for Holding Down Costs

The second trend prompted by rising health care costs involves provider contracting and the amount of compensation paid (also called "reimbursement" due to the fact that health insurers in the old, indemnity universe were said to "reimburse" providers for the cost of treatment rendered and tests prescribed) by MCOs to providers for care delivered to enrollees covered by the health insurance plan in question. As costs have escalated and public attention has increasingly focused on this issue, negotiations between MCOs and providers have grown increasingly strenuous as MCOs have become more determined to obtain the most favorable prices from providers in order to pass on those favorably low prices in the form of lower health insurance premiums to consumers.

Given the competitive nature of the health care industry, it is virtually certain that MCOs and providers will continue to look for ways to reduce expenses and achieve greater efficiencies with respect to their own operations. One of the principal battlegrounds in the managed care field, and a key point of competition between MCOs, has been the level of reimbursement paid by managed care plans to providers (be they hospitals, physicians or some other kind of provider). In light of the fact that medical expenses (i.e., reimbursement paid to providers for care rendered to individual health plan enrollees) are a large component of a health plan's overall operating costs, managed care plans are constantly on the lookout for ways they can reduce overhead by obtaining more favorable rates from providers. One of the more popular methods that some managed care companies have used to help achieve this objective is known as "most favored nation" ("MFN") pricing.[27] Pursuant to an MFN contract clause which is inserted as part of a provider contract between a managed care plan and a provider, the provider promises to charge a managed care plan as favorable a rate as that provider is charging any other managed care

27. *See* Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 ANNALS OF HEALTH L. 71 (1995) ("Most favored nation . . . contract clauses have been widely used in the health care industry by managed care organizations and health insurers in contracts with medical providers."). *See also* Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N. C. L. REV. 863, 869-70, n.44 (1991) (it is "not uncommon" for Blue Cross and Blue Shield plans to use MFN provisions).

plan.[28] MFN provisions are promises by sellers to buyers. These buyers are typically large managed care plans with sufficient market power to extract such favorable price guarantees from providers.[29] Blue Cross plans have been known to use MFN provisions in their provider contracts,[30] as well as at least one dental plan known as Delta Dental and a managed care plan involving vision care services known as Vision Care.[31] Each of these entities has significant market power. For example, Delta Dental is generally acknowledged to dominate the markets in which it operates, and Vision Care Service Plan is the largest vision care plan in the nation.

C. MFN Contract Clauses

MFN contract clauses have been increasingly challenged in recent years by state and, especially, federal antitrust authorities.[32] These governmental challenges come on the heels of approximately fifteen years of litigation during which a variety of plaintiffs have unsuccessfully challenged MFN provisions under numerous state and federal antitrust theories of liability. Although no court has yet concluded that MFN clauses violate state or federal antitrust laws, there is a general sense among some members of the private antitrust bar that it is perhaps just a matter of time before some court somewhere in the nation does just that.

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28. *See* Dennis, *supra* note 27, at 71-72. *See, e.g.,* Ocean State Physicians Health Plan v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101, 1103-04 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990) (pursuant to Blue Cross's MFN clause, it would not pay "a physician more for any service or procedure than that physician was accepting from any other health care cost provider"), *cert. denied*, 494 U.S. 1027 (1990).

29. *See* Anthony J. Dennis, Presentation before the National Health Lawyers Association, Antitrust in the Healthcare Field Conference (February 21-23, 1996) (Copy of presentation available from National Health Lawyers Association, Washington, D.C.) ("[MFN clauses] are typically used by health plans with significant market share that are capable of extracting such promises from providers.") *Id.* at 33-34.

30. *See* Celnicker, *supra* note 27.

31. *See* Dennis, *supra* note 27, at n.3.

32. For a discussion of MFN case law and consent decrees to date, an extensive analysis of the potential anticompetitive effects of MFN contract clauses and recommendations for reducing the legal risks associated with the use of MFN provisions in provider contracts, see Dennis, *supra* note 27; Anthony J. Dennis, *Most Favored Nation Contract Clauses Under the Antitrust Laws*, 20 U. DAYTON L. REV. 821 (1995). *See also* Celnicker, *supra* note 26 (analyzing MFN clauses by bringing to bear against such provisions the extensive academic criticism of the Robinson-Patman Price Discrimination Act).

MFN provisions may be accurately thought of as "price parity" clauses because, pursuant to an MFN provision, a favored buyer will get "as good a price" as some other buyer is getting from the seller in question.[33] Thus, pursuant to an MFN provision, there will be at least two buyers both reaping the "most favored" price or rate from the seller.

In contrast, a "best price" clause in a contract means that the buyer will reap a price that is "unique and lower than" the price which any other buyer is paying to the seller in question. This is not price parity. Rather, the price truly is a "best price," meaning that pursuant to contract no one else can achieve the same favorable rate from that seller. From a purely economic standpoint, "best price" clauses would appear to be more desirable than MFN clauses because the buyer who has extracted the "best price" guarantee is able to secure a better price than anyone else in the marketplace, including the buyer's competitors.

"Best price" provisions do not appear to be as common as MFN provisions in provider contracts. In fact, within the author's knowledge and experience of the health care industry, they appear to be extremely rare.[34] However, in light of the unfavorable amount of legal scrutiny that MFN provisions have recently received,[35] there may be renewed interest in "best price" clauses as a possible safe alternative to MFN provisions. What are the antitrust risks associated with using "best price" clauses in provider contracts? Are "best price" provisions a superior alternative to MFNs or does one merely substitute one set of legal risks for another in moving from an MFN price protection provision to a "best price" price protection provision? These are the questions that this article will attempt to answer.

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33. For example, the MFN clause at issue in *Ocean State Physicians Health Plan* which was used by Blue Cross in the state of Rhode Island, provided that Blue Cross would not pay "a physician more for any service or procedure than that physician was accepting from any other health care cost provider."

34. The terms and provisions of provider contracts are often a mystery to outside parties because they are usually subject to a confidentiality clause that prevents either party to the agreement (MCO and provider) from disclosing to non-parties the terms and conditions upon which they do business. Thus, it is difficult to point to quantitative data proving or disproving the prevalence of "best price" clauses within the health care industry. One only knows of the existence of MFN clauses through the many cases that have been litigated concerning their legality. Since we have not yet seen any lawsuits in the health care arena concerning the use of "best price" clauses we can only draw one of two conclusions: either they are very rarely used in the industry or no one has seen fit to challenge them yet. I suspect the former although that situation will probably change over time as health care clients and their lawyers seek alternatives to MFN clauses since such clauses have been under such frequent legal attack of late.

35. *See* consent decrees mentioned in notes 41 and 43, *infra*.

D. Antitrust and Insurance: Does the McCarran-Ferguson Act Exemption Apply?

One threshhold question that must be faced is whether the antitrust laws apply at all to MCOs or the health insurance industry generally. The McCarran-Ferguson Act is the insurance industry's traditional form of protection from the strictures of the federal antitrust laws.[36] Many people outside the industry, and even some of those who work within it, incorrectly assume that the McCarran-Ferguson Act provides insurance companies with a wholesale exemption from the antitrust laws. At best, however, that statute provides insurance companies with only limited immunity from antitrust. And with regard to the kinds of provider contracts at issue here, the McCarran-Ferguson Act probably provides MCOs with no protection at all from the reach of the antitrust laws.

The McCarran-Ferguson Act exempts from the antitrust laws those activities which constitute the "business of insurance," which are regulated by state law and which do not constitute "boycott, coercion or intimidation."[37] The Act was passed by Congress in 1945 and has been interpreted in an increasingly narrow fashion over the years so that today, the statute provides the industry with only limited protection. For example, judicial opinions over the years clearly indicate that the phrase "business of insurance" is not synonymous with the "insurance business."[38] In other words, not every activity an insurance company, including a health insurer, undertakes is protected by this statute merely because it has been undertaken by such a company. Only those arrangements that involve the transfer or spreading of risk or implicate the relationship between the insurer and the policyholder qualify for protection from the antitrust laws under the Mccarran-Ferguson Act.[39]

In light of the foregoing, one can see that interactions between providers and MCOs are probably not protected by McCarran because provider contracts are essentially service contracts, not insurance contracts.[40] The insurance contract exists between the MCO and the

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36. 15 U.S.C §§ 1011-15 (1996).

37. *Id.*

38. *See* WILLIAM C. HOLMES, 1996 ANTITRUST LAW HANDBOOK § 7.01[2]; 6 JULIAN O. VON KALINOWSKI, ANTITRUST LAWS AND TRADE REGULATION § 47.01-47.02; *see also* Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

39. *See* HOLMES, *supra* note 38, at § 7.01[2]; 6 VON KALINOWSKI, *supra* note 38, at § 47.01-47.02.

40. *See* Dennis, *supra* note 7, at 122.

insureds, not the MCO and the providers. On the other hand, one could make the argument that there is nonetheless a "risk spreading" component to provider contracts in the managed care context because the providers who sign up with MCOs undertake the risk that actual medical costs will exceed the amount of the capitation fee they are paid by the MCO. It is, however, safest from a counseling perspective not to assume McCarran-Ferguson Act protection in the provider contracting context since it is doubtful whether such a defense would hold up in court in light of the increasingly narrow way in which that statute's protections have been interpreted over the years.

Having concluded that the McCarran-Ferguson Act does not in fact provide MCOs with complete and absolute immunity from the antitrust laws when contracting with providers, this article will next turn to an antitrust analysis of "best price" clauses in such provider contracts.

II. ANTITRUST ANALYSIS OF "BEST PRICE" CLAUSES

Broadly speaking, there are two sources to which one can turn in working to assess the antitrust risks raised by the use of "best price" provisions in contracts between providers and managed care organizations ("MCOs"): case law and legal commentary. In contrast to its close cousin the MFN provision,[41] however, existing case law concerning "best price"

41. MFN clauses have been challenged under a variety of antitrust theories and under both state and federal antitrust statutes. To date, MFN contract clauses have been upheld every time under the antitrust laws. *See, e.g.*, Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989) (challenging MFN clauses as illegal monopolization under section 2 of the Sherman Act), *cert. denied*, 494 U.S. 1027 (1990); Kitsap Physician Serv. v. Washington Dental Serv., 671 F. Supp. 1267 (W.D. Wash. 1987) (challenging MFN clauses as unlawful attempted monopolization under section 2 of the Sherman Act); Blue Cross & Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980) (MFNs challenged under both section one of Sherman Act and Michigan state antitrust statutes); *In re Ethyl Corp.*, 729 F.2d 128 (2d Cir. 1984) (challenging defendant's use of MFN clauses as unfair method of competition under section 5 of the Federal Trade Commission Act); Michigan Ass'n of Psychotherapy Clinics v. Blue Cross & Blue Shield of Mich., 325 N.W.2d 471 (Mich. Ct. App. 1982) (challenging MFN clauses as unlawful price fixing under both section 1 of the Sherman Act and Michigan's state antitrust laws); Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic, 65 F.3d 1406, 1415 (7th Cir. 1995) (challenging MFN clause as price fixing under section 1 of the Sherman Act); Willamette Dental Group, P.C. v. Oregon Dental Serv. Corp., 882 P.2d 637 (Or. Ct. App. 1994) (challenging MFN clauses as unlawful monopolization and attempted monopolization under Oregon state antitrust statutes). There have also been a number of consent decrees in which

clauses is extremely sparse. In fact, the only legal challenge on record involved an ocean transportation company which was investigated and sued by the Department of Justice and later signed a consent decree with that agency.[42]

A. Lykes Bros. *Consent Decree*

Because it involved a best price clause which was challenged by the United States Department of Justice under the federal antitrust laws, the *Lykes Bros.* consent decree[43] casts light on the competitive effect of best price clauses and gives one insight into the variables that affect antitrust risk in this area.

1. Terms and Stipulations of the Decree

Defendant Lykes Bros. Steamship Co., Inc. ("Lykes") is a Louisiana corporation that provides ocean transportation services for cargo worldwide. Lykes is known in the business as an "ocean common carrier." Those who contract with carriers for the transportation of goods in this manner are known as "shippers." Shippers who contract as a group for such services are known as "shippers' associations." One particular shippers' association known as Universal was able to extract a best price promise from Lykes for the transportation of its members' cargo. Universal was responsible for "about half of the wine and spirits carried across the

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MFN contract clauses have been challenged by state and federal antitrust authorities. For example, in a legal challenge involving Delta Dental Plan of Arizona, Inc., the United States Justice Department challenged Delta Dental's use of an MFN clause in its provider contracts with dentists as an unlawful vertical restraint while the Arizona Attorney General challenged the same clause as illegal boycott and price fixing activity. *See* United States v. Delta Dental Plan of Arizona, Inc., 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995); Arizona v. Delta Dental Plan of Arizona, Inc., No. CV 94-10142 (Ariz. Super. Ct. Maricopa County, July 1, 1994). *See also,* United States v. Vision Service Plan, Proposed Consent Decree No. 94 CV02693 (D.D.C. Dec. 15, 1994), Vol. 61, No. 47 FED. REG. § 9487 (Friday, March 8, 1996); Oregon Dental Service, 60 FED. REG. § 21218 (May 1, 1995); RxCare of Tennessee, Vol. 61, No. 19 FED. REG. § 2833 (Monday, January 29, 1996); Delta Dental of Rhode Island, CA # 96, 113 (D.R.I., February 29, 1996), 70 Antitrust & Trade Reg. Report 253 (March 7, 1996).

42. *See* U.S. v. Lykes Bros. Steamship Co., Inc,.1996-1 TRADE CAS. (CCH) ¶ 71,272 at 76,193.

43. *Id.*

North Atlantic."[44] One suspects it was because of Universal's significant purchasing power as a shipper that it was able to extract this kind of favorable price guarantee from Lykes.

The best price clause at issue in *Lykes Bros.* was known as an "automatic rate differential clause" in the shipping contract. That clause of the contract stated:

> Carrier [Lykes] guarantees that rates and charges in this Contract shall at all times be at least 5% lower than any other [rate or charge] for similar commodities at a lesser volume and essentially similar transportation service. As necessary, Carrier shall reduce rates/charges in this Contract as necessary to honor this guarantee, promptly informing the Association [Universal] . . .[45]

The United States District Court for the District of Columbia, the federal court in which the consent decree was entered, noted that in order "[t]o comply with the clause, Lykes must either offer these shippers prices that are at least 5% higher than the prices in Universal's service contract, or it must lower Universal's price for all of Universal's service contract shipments in order to maintain the 5% differential."[46] The federal district court also noted that the clause "in effect places a tax on the buyer's competitors" and that this *de facto* "tax" constituted a "barrier to competition" which, along with Universal's "substantial market presence," unreasonably restrained trade.[47] The consent decree prohibits Lykes from using an automatic rate differential clause in its shipping contracts for an initial term of five years, extendable at the government's discretion for up to another five years.[48] Lykes is also required to institute an antitrust compliance program.[49] Because it was a consent decree, not a legal opinion handed down after full adjudication, the settlement order entered by the court did not contain significant discussion of the Department of Justice's antitrust concerns. Nor did the consent decree contain any substantial

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44. *Id.* at 76,196.

45. *Id.*

46. *Id.*

47. *Id.* The district court stated in relevant part: "There is a danger that this tax will protect the buyer [Universal] from competition from firms whose costs may otherwise be lower than its own, thus erecting barriers to competition. It is the raising of these barriers to competition with Universal, which already has a substantial market presence, that constitutes the unreasonable restraint of trade in this case." *Id.*

48. *Id.* at 76,197.

49. *Id.*

antitrust analysis by the court. The parties merely settled their differences by agreement and had that agreement accepted as definitive and legally binding by the court.

2. MFN and Best Price Clauses Compared

a. Causes of Action and Alleged Anti-competitive Effects

The consent decree itself, like most consent decrees, is brief. Therefore, we must coax as many lessons and observations as we productively can from the language approved by the district court in the final decree. Comparing and contrasting best price clauses as illustrated by the *Lykes Bros.* consent decree with the myriad of MFN cases and consent decrees previously cited[50] can help illuminate the law in this area.

The *Lykes Bros.* consent decree illustrates that there are a number of similarities between best price clauses and MFN clauses. Both clauses are apparently used by buyers with significant market power. In the MFN line of cases and consent decrees, the buyers who have been able to extract such favorable price guarantees have invariably possessed significant market strength. Similarly, in *Lykes Bros.* we see that the buyer of ocean transportation services, Universal, possesses "a substantial market presence" and "accounts for about half of the wine and spirits carried across the North Atlantic."[51] Thus, MFN clauses and best price clauses appear to be most frequently used by buyers capable of exploiting their market power and demanding such provisions in their contracts. These large buyers are also the ones who may fare the worst when subject to an antitrust challenge since their large market share will count against them under a rule of reason test.[52]

Both kinds of contract clauses have the potential to cause distortions in the affected market. In the MFN line of cases, time and again plaintiffs have alleged that the use of MFN clauses have the effect of forcing sellers to forego contracting with other, non-favored buyers for fear of activating the MFN rate. MFN clauses can indirectly convince providers, for example, not to contract with other MCOs out of an apprehension that if they do so, they will have to give the MCO with the MFN rate the same favorable rates the providers intend to give to other MCOs. Instead, the

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50. *See supra* note 41.
51. Lykes, *supra* note 42 at 76,196.
52. *See infra* notes 57-63.

providers end up doing business almost exclusively with the MCO that has contracted for the MFN rate. In a sense then, MFNs can function as *de facto* exclusive dealing arrangements which a court might conclude are "unreasonable" under the rule of reason and section 1[53] of the Sherman Act.[54] Plaintiffs also have alleged that MCOs use MFNs as a weapon to unlawfully obtain or maintain monopoly power in violation of section 2[55] of the Sherman Act and the *Grinnell* case[56] interpreting that statute.

One can make some of the same antitrust arguments and allegations against best price clauses. In raising the operating costs of competitors who are not able to reap the benefits of such a clause, a best price clause may be thought of as a tool for unlawfully obtaining or maintaining monopoly power in violation of section 2 of the Sherman Act. If the price differential is substantial enough, then a best price clause over time potentially can

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53. Section 1 of the Sherman Act provides:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding [$10,000,000] if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

15 U.S.C. § 1 (1988 & Supp. 1993).

54. This is a point I develop at length in Anthony J. Dennis, *Most Favored Nation Contract Clauses Under the Antitrust Laws*, 20 U. DAYTON L. REV. 821, 848-850 (1995).

55. Section 2 of the Sherman Act provides:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding [$10,000,000] if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

15 U.S.C. § 2 (1988 & Supp. 1993).

56. United States v. Grinnell Corp., 384 U.S. 563 (1966). The *Grinnell* Court stated that the offense of monopolization contains two elements: "(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident." *Id.* at 570-71.

drive competitors of the favored purchaser off the field of competition. However, the five-percent rate differential at issue in *Lykes Bros.*, for example, may be enough over time to drive Universal's competitors out of business or at least make them noncompetitive in the market if the cost of shipping distilled spirits is a significant enough percentage of a company's total operating costs. A one-percent rate differential may not make much difference, while a ten-percent differential may have a marked impact on a buyer's competitors.

The competitive effect of a best price clause also depends on what cost component the clause operates on and the percentage of total operating costs that this particular cost represents. For example, hospital costs typically represent the largest single line item of an MCO's operating costs. If an MCO has a best price guarantee from a given hospital concerning hospital charges, then this will most likely have a potentially significant effect on other MCOs purchasing services from the same hospital. In contrast, a best price clause for wall paint used by an MCO to paint the halls of its building will not have a substantial competitive impact on competing MCOs using paint from the same manufacturer, since wall paint does not constitute a significant portion of an MCO's total operating expense. The competitive effect of MFN clauses can be analyzed in the same manner by looking at the significance of the affected good or service as compared to an MCO's total "overhead" expense.

In addition, one could always make the generic charge that a contract containing a best price clause constitutes an "unreasonable" restraint of trade under section 1 of the Sherman Act and the rule of reason.[57] The latter theory would necessitate submitting the facts of the case to the rule of reason test, a factually intensive test that requires much work on the part of a plaintiff.[58] Nonetheless, best price clauses might be found to be "unreasonable" in an antitrust sense provided enough of the factors weighed under the rule of reason were found to be present.[59] Depending

57. *See supra* note 54.

58. *See* HOLMES, *supra* note 38, at § 1.04[2] for a description of this rule of judicial review. *See also* Piraino, *Making Sense of the Rule of Reason: A New Standard for Section 1 of the Sherman Act*, 47 VAND.L.REV. 1753 (1994). The rule of reason was born as a rule of judicial review for non-per se antitrust offenses in 1911 in the U.S. Supreme Court's decision in Standard Oil Co. of N.J. v. United States, 221 U.S. 1, 65 (1911). *See also* Nat'l Society of Professional Engineers v. United States, 435 U.S. 679, 690 (1978); Nat'l Collegiate Athletic Ass'n v. Board of Regents of Univ. of Okla., 468 U.S. 85, 103 (1984); Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985).

59. *See* HOLMES, *supra* note 38, at § 1.04[2]. These factors include: the purpose of the competitive restraint, the parties' intent in using a best price clause, the market strength of

upon how "steep" the rate differential was in a given best price provision, one might even find an instance in which a best price clause, like its cousin the MFN clause, functioned as a *de facto* exclusive dealing provision which drove all of the buyer's competitors away.

In *Lykes Bros.*, the Department of Justice in fact used a Section 1 unreasonable restraint of trade theory in attacking the best price clause at issue. The Justice Department's theory was that the automatic rate differential clause constituted an unreasonable vertical restraint of trade.[60] The fact that the government achieved a consent settlement shows that it is indeed possible to attack such clauses under a Section 1 theory of liability using the rule of reason. Factors germane to a Section 1 unreasonable restraint of trade claim include the market power of the party or parties in question, the impact upon competition and the procompetitive justifications or reasons for the use of such a clause, among other factors, all of which would be weighed against anticompetitive effects.[61] No single

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the parties, competitive conditions in the affected industry, whether there are competitive barriers to new entrants, the ability of competitors to respond to and overcome the challenged restraint, the competitive effects of such a restraint on providers and other insurers, the procompetitive business justifications, including efficiency gains, which favor use of the restraint in question, and the existence of anticompetitive effects. *Id.* No single factor is absolutely dispositive of the inquiry. *Id.* The factfinder must weigh all the circumstances to determine whether the restraint in question is unreasonable and thus illegal under Section One of the Sherman Act. *Id.*

60. *See* Lykés, *supra* note 42.

61. One legal commentator recently stated:

> The rule of reason . . . dictates a facts and circumstances-type of analysis which considers numerous factors. These factors include: the purpose of the restraint; the parties' intent in using [the contractual] provision; the market strength of the parties; competitive conditions in the affected industry; whether there are competitive barriers to new entrants; the ability of competitors to respond to and overcome the challenged restraint; the competitive effects of such a restraint on providers and other payors; the procompetitive business justifications, including efficiency gains which favor use of the restraint in question; and the existence of anticompetitive effects. No single factor is dispositive of the inquiry. The factfinder must weigh all the circumstances to determine whether the restraint in question is "unreasonably restrictive of competitive conditions" and, therefore, illegal under section 1 of the Sherman Act.

Dennis, *supra* note 54, at 848-49 (footnotes omitted).

factor is dispositive.[62] Instead, a court will decide whether a given practice or action is competitively unreasonable based on "all the circumstances."[63]

b. The Justice Department Challenges Seller Rather Than Purchaser

Interestingly, the U.S. Justice Department chose to challenge the best price provision found in *Lykes Bros.* by going after the seller, Lykes Bros. Steamship Co., Inc., and not the buyer, Universal, which had extracted the provision from Lykes in the first place. This approach represents a point of departure for the government between its pursuit of abuses in the best price area versus its pursuit of perceived abuses in the MFN field. With regard to MFNs, the government has always challenged the buyer.[64] The buyers have all been large managed care plans of various sorts that possess the market clout to extract MFN provisions from their contracted providers. If it had used the same tactic, the government would have challenged Universal, not Lykes. Why did the government alter its investigatory and prosecutorial approach? It is difficult to tell.

How can an apparent victim (Lykes) of an alleged contracting abuse effectively be held responsible for ending the alleged abuse? Perhaps Lykes was not the innocent victim of Universal's market strength afterall. Perhaps Lykes had a hand in the creation and deployment of the best price guarantee, although it is hard to imagine under what circumstances a seller such as Lykes would wish to lower its price to a buyer and make this kind of promise of its own volition.

The government may have focused on Lykes as the most visible party involved in this kind of contracting behavior and may have intended to "send a signal" to others in the industry, both buyers and sellers. Again, however, an argument can be made that Universal was the most visible party since it is a large shipper responsible for half of the Atlantic freight in distilled spirits. Arguably, Universal, as a large shipper, should have been the party challenged by the government for purposes of "chilling" this kind of anticompetitive behavior. Nonetheless, the result is the same. Prohibiting Lykes from using such a contract clause serves to prohibit Universal from taking advantage of such a clause, at least insofar as

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62. *Id.*

63. Standard Oil Co. of N.J. v. United States, 221 U.S. 1, 65 (1910).

64. *See* MFN cases and consent decrees in which the federal government was a party, *supra* note 41.

Universal's contract with Lykes is concerned. However, Universal would apparently not be prohibited from extracting such a best price guarantee from another ocean carrier besides Lykes.

B. Legal Commentary

Having extracted as many lessons and observations as we possibly could from the recent *Lykes Bros.* consent decree involving best price contract clauses, we must turn to legal commentary for additional sources of legal guidance in this area. While there are no law review or other legal articles that expressly analyze and address the antitrust implications of best price clauses, one law review article does exist which I believe presents a helpful paradigm for thinking about the competitive effects of best price clauses.[65]

1. Krattenmaker and Salop's *Raising Rivals' Costs*

In 1986, Thomas Krattenmaker and Steven Salop co-authored an article entitled "Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price." Despite the passage of time, this article remains a valuable addition to antitrust literature and is extremely helpful in analyzing the antitrust implications of best price clauses.

The term "best price" is never explicitly mentioned in Krattenmaker and Salop's article. Instead, the authors use the term "exclusionary rights contract"[66] ("ERC") to denote a whole host of competitive practices and contracting approaches, all of which have the purpose and/or effect of excluding from the market competitors of the party engaging in the exclusionary contract or practice. A best price provision may be thought of as an ERC because it has the potential to exclude competitors from competition by raising their operating costs to unsustainable levels. Best price clauses, quite literally, "raise rivals' costs" within the meaning of Krattenmaker and Salop's article because they confer a cost advantage on the party that has extracted the "best price" guarantee. Stated another way, they have placed anyone else who does not possess such a guarantee at a cost disadvantage by giving only one party the "best price."

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65. Thomas G. Krattenmaker & Steven C. Salop, *Raising Rivals' Costs To Achieve Power Over Price*, 96 YALE L.J. 209 (1986).

66. *See id.* at 224.

ERCs are those contracts that can have the effect of raising rivals' costs by restraining the supply of "inputs" available to them, thereby giving the purchaser power to raise prices in its output market.[67] "Inputs" are those goods or services (e.g., raw materials, labor, supplies) that ERC purchasers need to buy in order to offer their own product or service in the marketplace.

As noted, Krattenmaker and Salop extensively analyze and discuss a whole host of exclusionary practices.[68] They maintain that competitive harm arises when an ERC gives the ERC-holder the power over the ultimate product price.[69] The fact that a particular competitor's operating costs are increased by virtue of someone else's ERC is not actionable under antitrust law, according to the authors.[70] Instead, the antitrust laws are designed to protect competition, not particular competitors. However, when an ERC gives the ERC-holder the power over price generally in the market, then antitrust authorities should step in and the ERC should be closely analyzed under the antitrust statutes.[71]

Although they do not expressly characterize it as such, the antitrust standard of review that Krattenmaker and Salop propose in their article looks like a rule of reason analysis. The authors state that a court must evaluate and weigh: (1) the costs to the purchaser of judicial intervention; (2) counterstrategies available to rivals for avoiding or overcoming someone else's ERC; and (3) the efficiency benefits or other redeeming procompetitive features of the practice.[72] The ERC must confer upon the ERC-holder power over price for Krattenmaker and Salop to label the ERC as violative of the antitrust laws.[73] To impact overall product price then, the increase in "input" prices caused by the ERC must be significant.

a. Effect on Market Prices

Krattenmaker and Salop are not concerned solely with increases in competitors' operating costs (expressed as the cost of a particular "input"

67. *Id.*

68. *Id.* at 227-30, 234-42.

69. *Id.* at 227-30.

70. *Id.*

71. *Id.* at 292. ("We believe that our two-step test – asking whether a competitor has excluded rivals by raising their costs and, if so whether that competitor thereby gained power over price – would structure the [antitrust] inquiry. . .") *Id.* at 292, n.276.

72. *Id.* at 249-52, 277-82, 291.

73. Krattenmaker & Salop, *supra* note 65, at 291.

by the authors).[74] Rather, they are concerned with those cost increases which lead to higher overall product prices in the ultimate product market caused by an ERC-holder's power over market prices.[75] To affect overall market price (and to have power over price), three factors must be present.[76] First, the ERC-driven increase in the cost of an "input" (the component of the product/service subject to the ERC) must be significant either by virtue of the absolute dollar increase, or in the sense that the affected variable represents a significant percentage of the rival's overall operating costs.[77] Only significant "input" price increases in the cost of an "input" have the potential to make rivals noncompetitive in the marketplace and to confer upon ERC-holders the power over the price of the ultimate product or service.[78]

Second, barriers to entry must be sufficiently high such that other new entrants cannot enter the market and undercut the ERC-holder's attempt to control prices.[79] In addition, the ERC-holder's rivals must not be capable of securing ERC contracts of their own, and if they do, they must secure ERC contracts with more expensive, less efficient suppliers.[80] In sum, one must look at the counterstrategies available to rivals before concluding that an ERC has or has not given an ERC-holder the power over price in the ultimate product market.[81]

b. Krattenmaker and Salop Raise Both Section 1 and Section 2 Concerns

Krattenmaker and Salop's article essentially illustrates ways in which an ERC may violate Section 1's prohibition against unreasonable restraints of trade and/or Section 2's prohibition against the unlawful attempt or possession of monopoly power. The ERCs may be problematic under Section 1 of the Sherman Act (and any analogous state antitrust statutes) because, depending upon the market power of the ERC-holder and other factors such as competitive effects and the ERC-holder's motivations in

74. *Id.* at 227-30.
75. *Id.* at 242.
76. *Id.* at 242-47.
77. Krattenmaker & Salop, *supra* note 65, at 234-38.
78. *Id.* at 243, 246.
79. *Id.* at 246-47.
80. *Id.* at 238-40.
81. Krattenmaker & Salop, *supra* note 65, at 268-77.

seeking an ERC, the ERC may be found to be unreasonable under the rule of reason test.

ERCs may also be problematic under Section 2 of the Sherman Act (and any analogous state statute) because, in raising rivals' costs the ERC-holder may over time force its rivals to increase their product prices to such a level that they become noncompetitive and are forced out of business. Thus, an ERC may be viewed as a strategy (sometimes a long term one) for unlawfully attempting to obtain or maintain monopoly power.

c. Significance of Krattenmaker and Salop's Article for Best Price Clauses

Again, Krattenmaker and Salop do not use the term "best price" nor do they expressly analyze best price clauses. Rather, their article concerns any contract right which gives one party a unique economic advantage over others purchasing from the same source of supply. The article is helpful, however, in shedding light on how best price clauses might be analyzed and treated under the antitrust laws. Best price clauses may be thought of as ERCs because they can raise rivals' costs and they have exclusionary effects. Strictly speaking, best price clauses are not exclusivity clauses because they do not absolutely prohibit sellers subject to a best price restriction from contracting with others. Rather, they merely require those sellers subject to such clauses to contract with other purchasers on less favorable price terms. Nonetheless, depending upon their terms and conditions best price clauses may in fact act as *de facto* exclusivity agreements because sellers may be herded by their terms into not contracting with others. An example may help to illustrate this thought.

If a best price clause requires Seller to give Buyer a price that is "unique and 50% lower than" any price that Seller is giving to any other Buyer, then the best price provision in question may in fact operate as an exclusivity clause. Seller will be loathe to contract with anyone else for fear of having to give Buyer a price 50% lower than whatever price deal Seller strikes with the other nonfavored purchaser. Rather than having to lower its price to Buyer to comply with the best price provision, Seller will simply opt to maintain an exclusive relationship with Buyer since that makes more economic sense. Even a less significant price differential may convince sellers not to do business with other buyers for fear of activating the best price clause. So, like MFN clauses, best price clauses can operate as *de facto* exclusivity agreements which force sellers to avoid doing

business with other nonfavored buyers, especially where the differential between the "best price" and the next most favorable price is significant, as in the above example.[82]

Even in the absence of *de facto* exclusivity, best price clauses still have potentially exclusionary effects, because in raising the operating costs of rivals, best price clauses can eventually undermine the competitiveness of those rivals and force them out of business to the detriment of consumers and the marketplace. Much will depend upon the cost variable mentioned in a given best price clause. For example, if hospital costs are the subject of a best price guarantee between an MCO and the hospitals in its network, then this guarantee will most likely have a powerful and deleterious effect on the operating costs of that MCO's rivals in the market. Since hospital costs are typically the largest single expense item for an MCO,[83] raising the cost of such services for rivals promises to hurt their bottom line and may force these rivals to raise their product prices, thereby making them noncompetitive and eventually forcing them from the market over the longer term. This result would certainly give the favored MCO power over price, which is the source of Krattenmaker and Salop's concern.

III. CONCLUSIONS AND RECOMMENDATIONS

Considered from a purely theoretical standpoint, "best price" provisions appear to be just as vulnerable as MFN provisions to antitrust challenge under both Section 1 and Section 2 theories of antitrust liability. That is to say, these clauses might be found to be both competitively unreasonable vertical restraints of trade (under a section one type claim) and to constitute unlawful monopolization or attempted monopolization (under a section two type claim). "Best price" provisions may also be subject to attack under other antitrust theories such as price fixing or a boycott theory of liability, although these theories seem more far-fetched than either of the two already mentioned. Thus, the legal risks of using one or the other form of price protection clause would appear to be about equal.

However, the risks of investigation and litigation for the use of a "best price" provision appear to be substantially lower than the investigation and

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82. The author analyzed MFN contract clauses as possible *de facto* exclusivity agreements in *MFN Clauses, supra* note 54 at 848-50.

83. *See* Reazin, 663 F.Supp. 1360, 1418 (D. Kan. 1987) ("[T]he price of hospital care is the single largest element of health care financing companies' costs . . .")

litigation risks associated with use of an MFN provision. As the case law indicates,[84] the federal government and even some state governments have been very active in investigating and challenging MFN provisions. There are also a host of cases which demonstrate that private plaintiffs have not hesitated to bring antitrust suits challenging the use of MFNs by MCOs.[85]

In contrast, there is only one consent decree and no cases on record involving the use of "best price" clauses and the status of those clauses under state or federal antitrust laws.[86] To use a colloquialism, it would appear that all of "the action" is on the MFN side of the house. Hence, the investigation and litigation risks associated with using "best price" provisions are substantially less than those associated with the use of MFNs. MFNs simply serve to make an MCO with significant market power more visible to state and federal antitrust authorities and disgruntled providers. The following recommendations follow from the above analysis and observations:

(1) When given a choice, MCOs should use a "best price" provision, not an MFN provision, in their contracts with health care providers.

> Rationale: Best price clauses are a superior alternative from a business standpoint (i.e., why not get the best price?) and they also carry less risk of investigation and suit.

(2) In using a "best price" clause, MCOs should be mindful of the fact that the larger the differential between the "best price" and the next most favorable price, the more competitors may be harmed and the higher the risk that the MCO obtaining the "best price" guarantee might be sued or investigated. Steep price differentials might be interpreted, fairly or unfairly, as attempted monopoly or illegal monopolization.

> Rationale: Significant price differentials for health care services can impact competitors' ability to secure their own favorable pricing and may ultimately harm competition.

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84. *See supra* note 41.

85. *Id.*

86. *See Lykes*, 1996-1 TRADE CAS. at 76,193; *see supra* notes 42-63 and accompanying text.

(3) In using a "best price" clause, MCOs should be mindful of the fact that the litigation and legal risks associated with using such a clause are also affected by the significance (i.e., percentage of item's cost compared to MCO's overall operating costs) of the product or service subject to the "best price" clause.

> Rationale: If a given product or service subject to a "best price" guarantee represents a significant percentage of an MCO's overall operating costs, then fixing the price of that item will indirectly affect the overhead expenses of competing MCOs. Again, this may subject the MCO holding the "best price" guarantee to section 1 and/or section 2 antitrust claims.

In the absence of a more developed body of law on this subject, it is hoped that the above analysis will provide a helpful analytical framework for thinking about the antitrust risks presented by the use of "best price" clauses, and that these recommendations will prove helpful to health care and antitrust lawyers and their clients who may be pondering the use of such price protection guarantees.

PRIORITY BETWEEN INSURER AND INSURED IN SUBROGATION RECOVERIES

*by John Dwight Ingram**

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A fire occurred at Mary Wanna's Drug Store. Mary had hired Hi Wire Electrical Company to install a new electrical system in her store, but due to Hi Wire's negligent work, the new system caused the fire. Mary had previously purchased fire insurance from the Friendly Insurance Company. Unfortunately, Mary had forgotten to increase her insurance coverage

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* A.B., Harvard University 1950; C.L.U., American College of Life Underwriters 1957; J.D., John Marshall Law School 1966. Professor Ingram often serves as a consultant, expert witness and arbitrator in cases involving questions of insurance law.

I gratefully acknowledge the valuable contributions of my very capable Research Assistants, Evelyn Kuck and David Bradford, and former Research Assistants, Brad Berliner and Alyson Ray.

when she remodeled the store with the latest in display counters, indirect lighting displays, and other expensive fixtures.

After the fire, Friendly's adjuster agreed that the amount of the loss was $100,000, but since Mary's policy limit was $50,000, Friendly Insurance Company paid Mary only $50,000. However, the adjuster (remembering the importance Friendly places on subrogation) made a thorough investigation and concluded that Hi Wire Electrical Company was at fault and could be proved liable for the loss. Mary learned of this, and when Friendly decided to file suit against Hi Wire to assert Friendly's subrogation claim of $50,000, Mary became interested and was pleased to learn that Friendly planned to sue in her name.

Meanwhile, Hi Wire learned of this and notified its liability insurer, which provided only $50,000 in liability insurance coverage for Hi Wire. After reviewing the report of Friendly's investigation and interviewing Hi Wire's employees, the liability insurer determined that Hi Wire was legally liable, and therefore notified both Friendly and Mary that it would pay $50,000 to settle the case. However, it appeared that Hi Wire had fallen on hard times and had no other assets, so the $50,000 from the liability insurer was the maximum recovery that, as a practical matter, would ever be had by either Friendly Insurance Company or Mary Wanna.

Not surprisingly, a dispute arose. Mary asserted that she was entitled to the whole $50,000 that was offered, because she had a $100,000 loss for which Friendly compensated her for only half. On the other hand, Friendly asserted that it was entitled to the whole $50,000, because its payment to Mary of that amount entitled Friendly to the same amount by way of subrogation. Friendly had already paid Mary the $50,000 and thus, standing in her shoes as a subrogee, should be able to recover that amount under the theory that the insurance payment was really an advance against the assignment of Mary's claim. The claim was not only a term of the insurance contract but was also expressed in the subrogation receipt Mary signed when she was given Friendly's $50,000 payment.

I. INTRODUCTION

A. What Is Subrogation?

"Subrogation is the right of the insurer to be put in the position of the insured in order to pursue recovery from third parties legally responsible to

the insured for a loss paid by the insurer."[1] A right of subrogation can be created by agreement between insurer and insured[2], by judicial decree[3], or by statute[4], and serves to put the burden of a loss on the wrongdoer who caused the loss.[5] Thus, in an insurance setting, when an insurer has indemnified its insured, and the insured has a right to seek indemnification from another party for this loss, the insurer may be subrogated to the insured's rights. The insurer is substituted for the insured, and stands in the shoes of the insured as to all or some of the insured's rights. The insurer's rights are therefore equal to, but not greater than, the rights of the insured.[6]

An insurer's subrogation right is often expressly provided for by a clause that is included in the applicable insurance policy, or in a settlement agreement with an insured, or both. This type of subrogation right is often referred to as "conventional subrogation," presumably because the insurer's subrogation interest is established by a convention (that is, an understanding, agreement or contract) of the parties. In addition, a right of subrogation can be specifically provided for certain types of insurance in a state's insurance legislation.[7]

When there is no contractual provision or legislative act that expressly sets forth a right of subrogation, an insurer may be able to seek subrogation on the basis of a judicially created right. Such a right of subrogation is often referred to as "legal subrogation" (even though such rights originally resulted from the actions of the courts of equity rather than law and their availability depended on equitable principles).[8]

B. The Purpose of Subrogation

Subrogation, which is based on general principles of equity, was developed to prevent overcompensation of the insured[9] and to assure "that

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1. 16 GEORGE J. COUCH, COUCH ON INSURANCE § 61.1 (Ronald A. Anderson & Mark S. Rhodes eds., rev. ed. 1983).

2. An insurer's subrogation right may be provided for by a clause in the insurance policy, or in a settlement agreement with the insured.

3. This is usually called equitable subrogation.

4. *See, e.g.*, IND. CODE ANN. § 27-7-5-6 (West 1993) (uninsured motorist coverage); 820-ILCS (Smith-Hurd 1996) (workers' compensation).

5. COUCH, *supra* note 1 at § 61.1.

6. ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES §3.10(a) (1988).

7. *Id.*

8. *Id.*

9. Subrogation prevents the insured from recovering from both the insurer and a third party (usually a tortfeasor), which could mean double recovery.

a wrongdoer who is legally responsible for the harm [will] not receive the windfall of being absolved from liability [merely] because the insured" has obtained and paid for insurance for his[10] own benefit. Thus the ultimate payment of the obligation is "by the person who in equity and good conscience ought to pay it."[11]

II. DIVIDING THE "SPOILS"

A. Possible Results

If the recovery from one or more third party tortfeasors is sufficient to provide full indemnification to both subrogor (insured) and subrogee (insurer), there should be no dispute or problem. The insurer will recover the full amount it paid to the insured, and the insured will keep the rest, including any possible excess over the insured's claim. (The underlying claim is, after all, the insured's claim.)

Unfortunately, in most cases "full recovery" is not achieved, or at least there is a dispute as to whether the amount received constitutes "full recovery." If the disputes in such instances were decided by King Solomon of Biblical fame,[12] he might well propose that the "baby" (that is, the actual or potential recovery from third parties) be divided between insured and insurer, either 50-50 or pro rata.[13] While some division of the "spoils" may seem the most equitable approach, it seldom occurs unless it is agreed to by insured and insurer. When there is no agreement, the courts usually grant priority to one party or the other. Thus, the two most common results are:

> (1) The insurer is to be reimbursed first out of the recovery from the third party for the full amount of the insurance benefits paid to the insured, and the insured is then entitled to any remaining balance.

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10. When the gender for a personal pronoun could be either male or female, I use the masculine pronoun generically, due to habit and my masculine personal orientation. By doing so I avoid the rather awkward "he or she" and the grammatically incorrect "they." I trust that female authors will balance the scales on the other side.

11. COUCH, *supra* note 1, at § 61.18.

12. 2 *Kings* 3:16-28 (Revised Standard Version 1952).

13. *See, e.g.,* Aetna Life Ins. Co. v. Martinez, 454 N.E.2d 1338, 1341 (Ohio Ct. App. 1982) (holding that since both insured and insurer agreed to less than full recovery, each should recover pro rata to what they would have received had there been full recovery).

> (2) The insured is to be reimbursed first out of the recovery from the third party for any loss that was not covered by insurance, the insurer is then entitled to be reimbursed fully, and the insured is entitled to anything that remains from the amount paid by the third party so that any "windfall" goes to the insured.[14]

B. Typical Subrogation Provision

Many insurance policies, whether they are automobile, homeowners, health, or other coverages which indemnify the insured for loss or damage, contain a subrogation provision. For example, the standard fire insurance policy provides that the insurer "may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment thereof is made by" the insurer.[15] In addition, at the time of payment by insurer to insured the insurer will ordinarily obtain from the insured a subrogation receipt providing that the insurer will be subrogated "to all of the rights, claim[s] and interest[s] which the [insured] may have against any person or corporation liable for the loss . . . ."[16] Unfortunately, in most cases both the policy and the receipt are silent on the question of how to allocate any subrogation recovery if it is not sufficient to fully indemnify both insured and insurer.

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14. KEETON & WIDISS, *supra* note 6, at § 3.10(b). *See also* Sapiano v. Williamsburg Nat'l. Ins. Co., 33 Cal. Rptr. 2d 659 (Cal. Ct. App. 1994).

15. Garrity v. Rural Mut. Ins. Co., 253 N.W.2d 512, 513 (Wis. 1977). A typical subrogation clause will state:

> If any person or organization to or for whom we make payment under this Coverage Part has rights to recover damages from another, those rights are transferred to us to the extent of our payment. That person or organization must do everything necessary to secure our rights and must do nothing after loss to impair them.

Capitol Indemnity Corp. v. Strike Zone, S.S.B. & B. Corp., 646 N.E.2d 310, 311 (Ill. App. 1995).

16. Garrity v. Rural Mut. Ins. Co., 253 N.W.2d 512, 515 (Wis. 1977).

C. Subrogation Provision Expressly Gives Insurer Priority

In recent years it has become more common for insurers to include in their policies an express provision which gives the insurer first priority in any third party recovery to the full extent of its payment to its insured. A good example can be found in a Blue Cross policy which was at issue in *Powell v. Blue Cross and Blue Shield of Alabama*:[17]

> Separate from and in addition to the Administrator's right of subrogation, if a subscriber or member of his family recovers money from the other person or organization for any injury or condition for which benefits are provided by the administrator, the Member agrees to reimburse the Administrator from the recovered money the amount of benefits the Administrator has paid or provided. That means that the member will pay the Administrator the amount of money recovered by him through judgment or settlement from the third person or organization up to the amount of the benefits paid or provided by the Administrator. The right to reimbursement of the Administrator comes first even if a member is not paid for all of his claim for damages against the other person or organization or if the payment he receives is for, or is described as for, his damages (such as for personal injuries) for other health care expenses or if the member recovering the money is a minor.[18]

Some courts have expressed a willingness to honor and apply an express policy provision giving the insurer priority in a third party recovery. For example, in *Sapiano v. Williamsburg National Insurance Company*,[19] the court held that an insurer would have no subrogation right in a third party recovery unless the insured was "made whole," (that is, recovered from insurer and third party an amount at least equalling the full amount of his claim or loss), unless the insurance contract by which the

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17. 581 So.2d 772 (Ala. 1990).

18. *Id.* at 774. Despite this seemingly clear and unequivocal language, the court denied any recovery to the insurer because the insured had not been "made whole." *Id.* The court said equitable principles still apply even in the face of an express and clear policy provision. *Id.*; *see* discussion *infra* Part III.

19. 33 Cal. Rptr. 2d 659 (Cal. Ct. App. 1994).

subrogation right was created provided otherwise.[20] The court said that the policy could provide for priority of the insurer even though the insured was not "made whole."[21] "[O]rdinarily there is no barrier to the use of explicit subrogation terms that provide either for proration or for a disposition of recoveries from third persons that is even more favorable to the insurer's interests."[22]

After allowing this glimmer of hope to insurers, the Sapiano court went on (as have other courts) to state that any transfer or subrogation to an insurer of a right to recover from a third party, in general terms, will not create a priority for the insurer. It must be clear and specific.[23]

D. Statute Gives Priority to Insurer

State and federal statutes sometimes give the insurer priority in any third party recovery. The coverage where such a provision is most often found is probably Workers' Compensation. Giving priority to the employer and its insurer in any recovery by the injured employee from a third party tortfeasor is part of the *quid pro quo* rationale behind Workers' Compensation legislation. The employer is subjected to strict liability to pay benefits for work-related injuries. In return, the employer is given immunity from a common law suit by the employee, and the employer, and its insurer, are given the possibility of recovering all or part of the benefits paid to the injured employee-worker if the latter recovers from a third party.

A typical statutory provision was involved in *McCarter v. Alaska National Insurance Company*:[24]

> If the employee or the employee's representative recovers damages from the third person, the employee or representative shall promptly pay to the employer the total amounts paid by the employer under . . . this section, insofar as the recovery is sufficient after deducting all litigation costs and expenses. Any excess recovery by the

20. *Id.* at 661.
21. *Id.*
22. *Id.* at 662, n.2 (quoting KEETON & WIDISS, *supra* note 6, at § 3.10).
23. *Id.* at 662.
24. 883 P.2d 986 (Alaska 1994).

> employee or representative shall be credited against any amount payable by the employer thereafter.[25]

The *McCarter* court held that this statutory language was unambiguous, and "when the statutory language is unambiguous, . . . we will not modify or extend the statute."[26] The court added further support for its holding by citing similar recent holdings in three other states.[27]

III. ILLUSTRATIVE CASES: RESULTS AND RATIONALES

A. First Priority to the Insured

Under the equitable principles from which subrogation originated, the insurer was not entitled to any subrogation recovery until the insured had

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25. *Id.* at 988, quoting ALASKA STAT. § 23.30.015(f) (1995). *See also* 820 ILCS 305/5(b) (Smith-Hurd 1996):

> Where the injury or death for which compensation is payable under this Act was caused under circumstances creating a legal liability for damages on the part of some person other than his employer to pay damages, then legal proceedings may be taken against such other person to recover damages notwithstanding such employer's payment of or liability to pay compensation under this Act. In such case, however, if the action against such other person is brought by the injured employee or his personal representative and judgment is obtained and paid, or settlement is made with such other person, either with or without suit, then from the amount received by such employee or personal representative there shall be paid to the employer the amount of compensation paid or to be paid by him to such employee or personal representative. . . .
>
> * * * * *
>
> If the injured employee or his personal representative agrees to receive compensation from the employer or accept from the employer any payment on account of such compensation, or to institute proceedings to recover the same, the employer may have or claim a lien upon any award, judgment or fund out of which such employee might be compensated from such third party.

26. McCarter v. Alaska Nat'l. Ins. Co., 883 P.2d at 990.

27. *Id.* at 990, n.5. The cases were Young v. Industrial Comm'n., 707 P.2d 986, 987 (Ariz. Ct. App. 1985); Laureano v. N.J Transit Bus Operations, Inc., 531 A.2d 1361 (N.J. Super. 1987), *cert denied*, 540 A.2d 174 (1988); Maxay v. Dept. of Labor & Indus., 789 P.2d 75 (Wash. 1990).

been "fully compensated" or "made whole."[28] Many courts have also applied this principle to situations involving "conventional" or "contractual" subrogation where the provision in the insurance policy does not expressly and clearly give the insurer priority in any third party recovery.[29] These courts often justify the application of this rule by pointing out that the insured loss was a risk that the insured paid for the insurer to assume and, had the tortfeasor been judgment-proof and uninsured, the insurer would still have had to bear the loss up to the full amount of the insurance policy.[30]

This rationale was further explained in *Shelter Insurance Companies v. Frohlich*.[31] After citing 12 cases from other states,[32] and the treatises of Couch and the Applemans,[33] which favor the rule that the insurer may exercise a subrogation right only when the insured has obtained an amount from all sources that exceeds the insured's loss, the court pointed out that an insurer accepts premiums for the coverage provided, and is obligated to pay claims regardless of the insured's negligence or the liability of any third party.[34] The court was also influenced by its belief that "there is little empirical substantiation that possible reimbursement through successful subrogation is considered in determining insurance premiums . . . ."[35]

At least one court has gone so far as to hold that an insurer has no right of subrogation until the insured has been fully compensated for his loss, even though the policy expressly provides for priority to the insurer in any third party recovery.[36] In *Powell v. Blue Cross and Blue Shield of Alabama*,[37] Blue Cross paid medical expenses of more than $27,000 under a group health insurance policy. In her complaint against the other driver,

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28. The judicial definitions of these terms will be discussed in Part IV *infra*.

29. *See, e.g.*, Complete Health, Inc. v. White, 638 So.2d 784, 786 (Ala. 1994); Sapiano v. Williamsburg Nat'l Ins. Co., 33 Cal. Rptr. 2d 659, 661-62 (Cal. App. 1994); Skauge v. Mountain States Tel. & Tel. Co., 565 P.2d 628, 632 (Mont. 1977) (purpose of subrogation is to avoid unjust enrichment of insured and to be sure wrongdoer does not go free). *Id.* at 630.

30. Wimberly v. American Casualty Co., 584 S.W.2d 200, 203-04 (Tenn. 1979) (insured's restaurant destroyed by fire; undisputed loss of almost $45,000; fire caused by third party driving car into restaurant; driver's insurer paid liability policy limit of $25,000; insureds had $15,000 fire insurance coverage; court allotted entire $25,000 recovery to insureds, who still had not been "made whole").

31. 498 N.W.2d 74 (Neb. 1993).

32. *Id.* at 80-81.

33. *Id.* at 81.

34. *Id.* at 82.

35. *Id.*

36. Powell v. Blue Cross and Blue Shield of Alabama, 581 So.2d 772 (Ala. 1990).

37. *Id.*

the insured alleged over $7,000,000 as damages. She subsequently settled for the other driver's liability insurance limit of $100,000. Blue Cross intervened in the suit seeking subrogation. The trial court allowed Blue Cross full recovery of its $27,000 plus payments.[38] The court also stated in its judgment that "it is conceded by all concerned that the $100,000 recovery does not make [the insured] whole."[39]

On appeal, the Alabama Supreme Court stated that the insurance policy contained "specific language [giving the insurer] first priority over any money that the insured collected from a third party."[40] In addition to the usual subrogation language requiring the insured to reimburse the insurer from any third party recoveries, the Blue Cross policy expressly stated that "[t]he right to reimbursement of the [insurer] comes first even if [the insured] is not paid for all of his claim for damages against the other person . . . or if the payment he receives is for, or is described as for, his damages . . . for other health care expenses. . ."[41]

Despite this express and very clear contractual language, the majority of the court held that it would apply the same principles that govern equitable subrogation, and therefore deny any subrogation recovery by the insurer because the insured had not been made whole. The court said that when an insured buys insurance, the "very heart of the bargain . . . is that if there is a loss he . . . will be made whole . . . . Where either the insurer or insured must to some extent go unpaid, the loss should be borne by the insurer for that is a risk the insured has paid it to assume."[42]

Not surprisingly, the dissenters stated their disagreement quite strongly. Justice Maddox first observed that the majority was essentially holding that an indemnitor "cannot, by contract, create a right to be reimbursed out of [the] . . . indemnitee's recovery for damages caused by a third party tortfeasor until [the] . . . indemnitee is made whole."[43] Thus, any subrogation provision . . . in [an] . . . insurance policy is void unless the insured has been made whole . . ."[44] As Justice Maddox argued, the holding of the majority was in direct conflict with the settled law of Alabama "that, in the absence of public policy considerations or statutory provisions to the contrary, insurance companies have the right to limit their

38. *Id.* at 773.
39. *Id.*
40. *Id.* at 774.
41. *Id.*
42. *Id.* at 777 (citation omitted).
43. *Id.* at 783 (Maddox, Jr., dissenting).
44. *Id.*

liability or insure against loss as they choose."[45] This view was further reinforced by Justice Houston, who stated in his dissent that "[t]he courts in this state cannot make public policy by judicial fiat or ukase, the power to legislate having been reserved to the Legislature . . ."[46]

B. First Priority to Insurer

Notwithstanding the holding of the majority of the Alabama court in *Powell*,[47] most courts will honor and apply a contractual or statutory provision which expressly and clearly gives the insurer (or its employer-insured, in the case of workers' compensation) first priority in any recovery by the injured insured (or injured worker, in the case of worker's compensation). For example, in *McCarter v. Alaska National Insurance Company*,[48] the applicable provision in the workers' compensation statute stated "If the employee . . . recovers damages from the third person, the employee . . . shall promptly pay to the employer the total amounts paid by the employer under [this statute], insofar as the recovery is sufficient after deducting all litigation costs and expenses."[49]

Based on this, the court granted priority in reimbursement to the employer's insurer for workers' compensation benefits paid, reasoning that "when the statutory language is unambiguous, as it is here, we will not modify or extend the statute."[50]

Even under the standard subrogation provisions which are commonly included in insurance policies and receipts for claim payments,[51] provisions which do not expressly and clearly provide for priority for the insurer in recoveries from third parties, many courts construe the provisions to require priority to the insurer. In so doing, such courts reject the suggestion that equitable principles should apply and the insured should be "made whole" first. Thus, in *Higginbotham v. Arkansas Blue Cross and Blue Shield*,[52] the court held that equitable principles should apply only to subrogation by operation of law, and that there was no reason for equitable principles to "be imbued with dominance over clear and

45. *Id.*
46. *Id.* at 789 (Houston, J., dissenting).
47. 581 So.2d at 772.
48. 883 P.2d 986 (Alaska 1994).
49. *Id.* at 988.
50. *Id.* at 990.
51. *See infra* Part II.B.
52. 849 S.W.2d 464 (Ark. 1993).

specific provisions of a contract agreed to by the parties, at least where public policy considerations are wanting."[53] The court further stated that "courts have the right neither to make contracts for parties, nor to vary their contracts to meet and fulfill some notion of abstract justice . . ."[54]

Even in a state like Wisconsin which applies a strict rule that the insurer has no right of subrogation unless the insured is "made whole",[55] the state's rule may be preempted by federal law. Thus, in *Ramsay County Medical Center, Inc. v. Breault*,[56] the court held that since federal law under ERISA[57] did not restrict subrogation rights of a health insurer until the insured was "made whole", a self-insured employer could provide for priority in any recovery from a third party, and the court will enforce that provision.[58]

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53. *Id.* at 466. Higginbotham was a 4-3 decision. The dissenters urged that there should be no subrogation until the insured was "made whole." *Id.* at 467.

54. *Id. See also*, Fields v. Farmers Ins. Co., Inc., 18 F.2d 831 (10th Cir. 1994). The court, applying Oklahoma law, said that the "unambiguous, clear and consistent. . .[terms of an insurance contract] are to be accepted in their ordinary sense and enforced to carryout the expressed intention of the parties." (citation omitted) *Id.* at 834. "[P]arties are bound by the terms of the contract and courts will not undertake to rewrite the terms thereof." *Id. See generally* Capitol Indemnity Corp. v. Strike Zone, S.S.B. & B. Corp., 646 N.E.2d 310 (Ill. App. Ct. 1995):

> The parties here were free to negotiate the terms of the contract of insurance, including the subrogation provision . . . .We decline to upset the settled expectations of the parties as reflected in the policy of insurance by overlaying inapplicable equitable principles which contravene the contract terms and force a new agreement between the parties.

Id. at 312.

55. Garrity v. Rural Mut. Ins. Co., 253 N.W.2d 512 (Wis. 1977).

56. 525 N.W.2d 321 (Wis. Ct. App. 1994).

57. Employee Retirement Income Security Program, §514(a), 29 U.S.C.A. §1144(a) (West 1996).

58. *Accord,* Medcenters Health Care, Inc. v. Ochs, 854 F.Supp. 589 (D. Minn. 1993) (rule in Minnesota is that insured must be "made whole" first; federal statute provided that provisions of contract providing health insurance for federal employees would supercede and preempt any state or local law relating to health insurance to extent such law was inconsistent with the provisions of the health insurance contract; court said standard subrogation provision in this insurance contract was inconsistent with Minnesota rule that insured be "made whole" first).

C. Recovery Pro-Rated Between Insured and Insurer

Third party recovery is typically pro-rated between insured and insurer, especially where the insurer initiates and prosecutes the action against the third party and the insured's uninsured loss is relatively small (such as the deductible – $50 to $500 – on a collision insurance coverage, where only property damage is involved). However, when a dispute over a division of "the spoils" ends up in court, one party or the other is usually given priority until full recovery is accomplished. Occasionally, however, a court will find that the fairest solution is to pro-rate.

An example can be found in *Aetna Life Insurance Company v. Martinez*.[59] In that case, the insurer sought reimbursement for about $32,000 paid to the insured under a group health insurance policy for medical expenses. Thereafter, the insured, with the insurer also participating in the negotiations, "settled her personal injury claim . . . for $200,000, even though the value of her case was $1,000,000, because of limited insurance coverage by the tortfeasor who apparently had no independent means of paying a judgment."[60] The insurance policy provided that the insurer had a first lien, to the extent of benefits that it paid, on any recovery from a third party if the net amount of the recovery was attributable to medical expenses for which the insurer had paid the insured.[61]

The court held that, since both insured and insurer had agreed to less than full recovery, each should recover "on a pro rata basis proportional to that which they would have received had full recovery been possible . . ."[62] Thus, the court said the insurer could share in the recovery according to this formula, after appropriate deductions for expenses:[63]

$$\frac{\text{paid to insured}}{\text{value of claim}} \times \text{settlement amount} = \text{insurer's share}^{64}$$

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59. 454 N.E.2d 1338 (Ohio Ct. App. 1982).
60. *Id.* at 1340.
61. *Id.* at 1341.
62. *Id.*
63. *See infra* Part V (discussing litigation costs and attorneys' fees).
64. 454 N.E.2d 1338, 1341-42. In this case, the formula would have become:

$$\frac{\$32,000}{\$1,000,000} \times \$200,000 = \$44,000$$

IV. WHAT CONSTITUTES "FULL RECOVERY"

A. Where There Is A Judgment Against The Third Party

When the insured's claim against a tortfeasor results in a judgment against the latter, it is reasonable to hold that the judgment conclusively establishes the amount of the insured's damages, and thus constitutes "full recovery".[65] In that case, "the insurer [should be] entitled to full reimbursement of the payments made to the insured, less its proportionate share of costs and legal fees."[66] An insured's contention that his actual damages were greater than the amount of the judgment is usually rejected.[67] However, it would seem equitable to allow full subrogation recovery to the insurer only in those cases where the insured's judgment against the tortfeasor is actually collected in full.[68]

A good example of the rationale for this approach can be found in *Bartunek v. Geo. A. Hormel & Company*.[69] In that case, an employee received $8,800 from his self-insured employer for medical expenses and disability benefits under a union contract. Thereafter, the employer claimed a subrogation interest in the employee's $45,000 judgment against the tortfeasor. The employee resisted, arguing that he had not had "full recovery."[70]

The court said that collateral estoppel applied.[71] In his tort suit the employee had included in his claim the amount of his medical bills and lost wages, evidence was introduced thereon, the jury was instructed to include these as items of damage, and a verdict in excess of the amount of these items was returned in the employee's favor.[72] There was no special verdict and there were no special interrogatories. So long as the verdict exceeded the amount of the subrogation claims, it conclusively established that the

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65. *See* Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer in a Subrogation Case,* 29 TORT & INS. L.J. 803, 804 (1994) (note cases cited therein).

66. *Id.*

67. *Id.*

68. KEETON & WIDISS, *supra* note 6, at § 3.10(b)(1). "[F]ull recovery of a judgment against a tortfeasor occurs in an extremely small percentage of cases."

69. 513 N.W.2d 545 (Neb. 1994).

70. *Id.* at 549.

71. *Id.* at 552.

72. *Id.* at 553.

employee had obtained "full recovery," and the employer was entitled to reimbursement for the payments it made to the employee.[73] The court said that this was true even though the employee placed a greater value on his damages than the jury did. (He had asserted loss of earnings in excess of $240,000.)[74]

B. Where Claim Against Third Party Is Settled

Where the insured's claim against the tortfeasor is settled, and there has thus been no judicial determination of the insured's total damages, the insured will often resist any recovery by the insurer on the grounds that the settlement did not make the insured "whole". There is a sharp split of authority as to whether a settlement should be conclusively deemed to constitute "full recovery" by the insured.

On one side are cases like *Bell v. Federal Kemper Insurance Company.*[75] in which the insurer had paid $5,274 for physical damage to the insured's automobile and for medical expenses. The relevant policy contained a standard subrogation provision. The insured then settled his personal injury and property damage claims against the other driver for more than $20,000.[76] The court held that the settlement "fully fixed" the insured's damages, so that the insured "was precluded from arguing that she was not fully compensated." Therefore, the insurer could "assert its subrogation claim . . . to the extent of payments previously made."[77]

Similarly, in *Allstate Insurance Company v. Clarke,*[78] the court stated that the rule of the Pennsylvania Supreme Court is that when a subrogor-insured settles his claim against the tortfeasor instead of pressing the suit to verdict, "he cannot defeat [the] subrogee[-insurer]'s claim by asserting that his loss exceeded the settlement recovery." He has "waive[d] his right to a judicial determination of his losses, and conclusively establishe[d] the settlement amount as full compensation for his damages."[79]

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73. *Id.* at 553-54.

74. *Id.* at 554.

75. 693 F.Supp. 446 (S.D. W.Va. 1988).

76. *Id.* at 448.

77. *Id.* at 450. The court went on to indicate that the insurer's recovery would be reduced by its "proportionate share of attorney's fees and expenses." *Id.* at 451.

78. 527 A.2d 1021 (Pa. Super. Ct. 1987).

79. *Id.* at 1023.

After indicating that it was compelled to apply this rule of the state supreme court, the lower court went on to indicate its concern over the application of this rule, stating that:

> [T]he treatment of a settlement as conclusively establishing the value of the subrogor's damage is neither supported in reason, sound policy or equity. There can be no doubt that many claims are settled for far less than the actual value of the damages sustained. This can be attributed to many factors. For example, the liability case may be weak for a number of reasons or there may be a readily ascertainable limit on the plaintiff's ability to collect on a judgment. This is often the case when liability coverage is limited and there exists little or no other assets to satisfy a judgment. Hence . . . there may be many cases in which the subrogor will be well advised to settle for substantially less than his claim. However, the fact that the subrogor settles for less than the full value of his claimed damages does not magically reduce the value of the damages suffered to that sum, the loss remains just as great even though the innocent and often frustrated injured party may not have a real opportunity to collect the full value of that loss. By treating the settlement value as full compensation for the loss the courts are raising the relative value of the insurer's subrogation interest and penalizing the injured insured.[80]

In some cases the settlement agreement itself may lay the groundwork for resolving the controversy as to whether there has been "full recovery" by the insured. For example, in *Sorge v. National Car Rental System, Inc.*,[81] the injured insured settled her claim against the other driver for $23,500. The settlement stipulated that the payment represented an amount "equal to what [the insured] would have received from a jury after a reasonable deduction for . . . her contributory negligence."[82] Despite that, the insured insisted that she had not been "made whole," as required by the rule in Wisconsin, because she had not recovered all of her damages. The court disagreed, holding that:

> [A] negligent insured is made whole in terms of equity when she receives payment for that percentage of her damages for which she

80. *Id.* at 1025, n.4 (emphasis omitted) (quotations omitted).
81. 470 N.W.2d 5 (Wis. App. 1991).
82. *Id.* at 6.

> was not at fault. When an injured party receives all the damages to which she is legally entitled, she would be unjustly enriched if allowed to keep her damage payment and the medical payments from her insurer as well.[83]

Therefore, the insurers were entitled to their subrogation recovery.[84]

In some jurisdictions which adhere to the rule that there can be no subrogation until the insured is fully compensated, the courts further hold that a settlement does *not* necessarily set the amount of the insured's damages for the purpose of determining full compensation. These courts place the burden "on the insurer to prove that the insured has been fully compensated before the insurer can assert its subrogation rights against the insured . . ."[85]

A good example of these cases is *Rimes v. State Farm Mutual Automobile Insurance Company*.[86] In that case, the insured was injured when he was hit by a car, and was paid $9,650 under his medical payments coverage. He then sued the other motorists involved, who had a total of $350,000 liability insurance. During the trial, the insured settled for $125,000, and his insurer claimed a right of subrogation. The trial court then held a "mini-trial" and found that the insured's damages were more than $300,000 and there was no contributory negligence. Therefore, the insured was not "made whole", as required by Wisconsin law, so there could be no subrogation recovery for the insurer.[87] The Wisconsin Supreme Court affirmed, stating that the insured did not indicate in any way that the settlement made him whole. The court further noted that "the very nature of the settlement of personal-injury claims precludes a hypothesis that [it represents] full reimbursement for the wrong done."[88]

In his dissenting opinion, Justice Coffee argued that, at least under the facts of this case the holding of the majority seemed clearly wrong. The insured "voluntarily settled [the] entire claim for an amount less than the total . . . available [liability] insurance" ($350,000). Had they

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83. *Id.* at 7.

84. *Id.* at 6. The insurers had conceded on appeal that their claims should be reduced by the percentage of the insured's negligence.

85. Complete Health, Inc. v. White, 638 So.2d 784, 787 (Ala. 1994). *See also*, Shelter Ins. Cos. v. Frohlich, 498 N.W.2d 74 (Neb. 1993) (insured's medical expenses were over $50,000; she collected $10,000 medical payments coverage limit from insurer; settled with other driver for $212,000; court said it was question of fact whether insured was fully compensated).

86. 316 N.W.2d 348 (Wis. 1982).

87. *Id.* at 352.

88. *Id.* at 354.

"litigated . . . and . . . received a favorable verdict, they [could] have . . . been made whole and the insurer could have collected on its subrogation claim."[89] As Justice Coffee further pointed out, the decision of the majority allowed "the insured to effectively eliminate the insurer's" subrogation right. Yet it should be "obvious that [at least] some portion of the settlement [was] intended to compensate" for damages covered by the insurer's medical payments coverage.[90] "In a personal injury case, both the valuation of compensatory damages and the determination of relative fault are inexact and always open to dispute . . . [so it's] fair and reasonable to assume that a party is made whole by the amount for which he voluntarily settles his claim."[91]

Furthermore, in a separate dissenting opinion, Justice Steinmetz observed that, since a settlement in most cases represents a compromise, the rationale of the majority would mean that the insured-claimant would never be "made whole" by a settlement, unless perhaps the claimant admitted wholeness in the settlement, a most unlikely eventuality.[92]

V. LITIGATION EXPENSES AND ATTORNEYS' FEES

The expenses of litigation (court costs, investigation, experts, etc.) and attorneys' fees create additional problems in allocating any recovery that may be subject to a subrogation right. Let us suppose, for example, that the insurer has paid $15,000 to the insured in satisfaction of the insured's claim on the insurance policy; the insured's total loss is $30,000; and a judgment for $30,000 is collected from a third party tortfeasor. Attorneys' fees and litigation expenses total $12,000. If the insured is to be truly "made whole", the insured should retain $15,000 from the third party recovery, leaving a net recovery to the insurer of only $3,000 ($30,000 minus $15,000 (to insured) minus $12,000 (fees and expenses)).

Most courts, however, do not grant such a favorable result to the insured in these cases where the gross recovery from the tortfeasor equals or exceeds the gross claim of the insured.[93] Under any of the possible

89. *Id.* at 357 (Coffee, J., dissenting).

90. *Id.*

91. *Id.* at 358.

92. *Id.* at 362.

93. Naturally, under the "full recovery to the insured" rule, in cases of a lesser recovery the insured will retain the full gross recovery but will have to pay all fees and expenses. The same result would apply to the insurer in reverse if the insurer was entitled to priority in any recovery and was not fully reimbursed.

rules – priority to insured, priority to insurer, or pro rata sharing[94] – if both insured and insurer will share in the third party recovery, they will also usually share the fees and expenses involved, most often on a pro rata basis according to their shares of the gross recovery.[95] Proration would seem appropriate either where insured and insurer are both represented by one attorney who presses the claims of both against a third party, or where the insured (and his attorney) carry the claim to conclusion without any participation by the attorney of the insurer. Of course, where insured and insurer pursue their claims separately, each with his own attorney and expenses, each would pay his own fees and expenses out of his gross recovery from the third party.[96]

VI. METHODS FOR MINIMIZING SUBROGATION RECOVERIES BY INSURERS

Not surprisingly, sophisticated attorneys representing subrogor-insureds in actions against third party tortfeasors will attempt to reduce or eliminate any subrogation recovery by their clients' insurers. One approach is well illustrated by *Westendorf v. Stasson,*[97] in which an HMO[98] paid its member more than $22,000 for medical and hospital expenses. The enrolled member thereafter settled with the tortfeasors for their $100,000 liability insurance policy limit, though her damages greatly exceeded that. The settlement release stated that the payment was attributable only to pain and suffering, permanent injury, loss of consortium, and other non-economic loss. None of the proceeds were attributable to medical expenses.[99] Since the HMO's "right of reimbursement . . . applie[d] by its

94. *See supra* text accompanying note 14.

95. *See, e.g.,* 820 ILCS 305/5(b) (requiring employer to pay its pro rata share of fees and expenses out of any reimbursement received by employer); Bell v. Federal Kemper Ins. Co., 693 F.Supp. 446 (S.D. W.Va. 1988) (absent agreement to contrary, insured may reduce insurer's recovery by insurer's proportionate share of attorney's fees and expenses); Bartunek v. Geo. A. Hormel & Co., 513 N.W.2d 545 (Neb. App. 1994) (on remand, trial court can consider whether there should be a setoff for attorney's fees and trial costs in tort suit); Aetna Life Ins. Co. v. Martinez, 454 N.E.2d 1338 (Ohio App. 1982) (policy gave insurer first lien, to extent of benefits paid, on recovery from third party to extent net amount was attributable to medical expenses for which insurer paid insured; court said "net amount" must apply apportionment after fees and expenses deducted).

96. *See* KEETON & WIDISS, *supra* note 6, at §3.10(b), N. 14.

97. 330 N.W.2d 699 (Minn. 1983).

98. Health Maintenance Organization.

99. *Westendorf,* 330 N.W.2d at 701.

terms only to payments specifically collected by the enrollee for . . . medical expenses"[100] paid by the HMO, the member argued that the HMO was not entitled to any part of the settlement because no part of that was for medical expense.[101]

It is quite possible that this method could prevail in some cases, though it did not in *Westendorf*. The court noted that had the claim gone to a jury, a special verdict form could have made separate allocation for medical expenses, and this would have been binding on the HMO. But when the claim is settled without a verdict, the HMO's rights should not depend on a settlement bargain to which it wasn't privy. Thus, the court held that the settlement agreement was not determinative of the allocation of the proceeds.[102]

Of course, even in a jurisdiction which would bar subrogation after a settlement like that in *Westendorf*, it may well be that the liability insurers of tortfeasors will not be "cooperative in wording settlement documents to benefit"[103] subrogor-insured plaintiffs. The liability insurers may be concerned about a subsequent claim for the elements of damages not included in the settlement, in further actions by either plaintiff or his insurer. Moreover, knowledgeable liability insurers, and their attorneys, will surely use the plaintiff's possible elimination of a subrogation recovery as a lever to reduce the amount it must pay in settlement.

A better option for the subrogor-insured might be to request a specific allocation of damages by the trial court,[104] either by special verdict or special interrogatories. This is more likely to be binding on the subrogee-insurer, since it is less subject to self-serving manipulation by the insured. And of course, if the insurer is participating in the action against the third party, it might well be the one to initiate a trial court allocation, in the hope of improving its chances for a subrogation recovery.[105]

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100. *Id.* at 702.

101. *Id.*

102. *Id.*

103. Paul R. Thomson III, *A Subrogation Clause in a Health Insurance Policy is Enforcible Even Though the Insured Has Not Been Made Whole*, Higginbotham v. Arkansas Blue Cross & Blue Shield, 312 Ark. 199 (1993), 16 U. ARK. LITTLE ROCK L.J. 475, 490 (1994).

104. *Id.* at 491.

105. *See,* Scales v. Skagit County Med. Bureau, 491 P.2d 1338, 1340 (Wash. Ct. App. 1971) (insurer could have required in contract itself that award against third party be segregated as regards medical expenses).

VII. SUGGESTIONS AND SOLUTIONS

It seems ridiculous that we have had, and continue to have, so much dispute and litigation about the allocation of subrogation recoveries. As the court correctly stated in *Capitol Indemnity Corp. v. Strike Zone, S.S.B. & B. Corp.*,[106] the parties to an insurance contract are free to negotiate its terms, including the subrogation provision.[107] For many insurers, their success or failure in effecting subrogation recoveries has a direct, and sometimes substantial, effect on their premium rates,[108] although some courts do not accept this view.[109] Despite the views of those courts, it is my experience after fifty years in and near the insurance industry that those insurers which maximize their subrogation recoveries usually charge lower premiums and offer better terms and availability of coverage than do those insurers who ignore or do not maximize subrogation opportunities.

Ultimately, of course, it must be a matter of public interest. If the best social policy is for the insured to have priority in third party recoveries until he is "made whole", then insurance policies should expressly provide for that. If this is deemed to be the best answer, such provisions can be mandated by statute, if necessary. If, on the other hand, the public interest favors giving the insurer priority until it is fully reimbursed for all payments made to its insured, that can be expressly provided for in the policy.[110] The primary justification for this approach would be that larger subrogation recoveries would be reflected in lower premium rates, and that this will benefit the public generally. And if some courts will not honor and apply such an express provision,[111] it will be necessary to convince the legislatures that such provisions really are in the public interest, and this will require presenting to the legislatures statistical and financial data to prove the point.

Finally, it may be decided that the most equitable and beneficial result overall is to prorate any subrogation recoveries between insured and insurer.[112] If so, it is critical that all disputable aspects of such proration be

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106. 646 N.E.2d 310 (Ill. App. Ct. 1995).

107. *Id.* at 312.

108. *Id.*

109. Rimes v. State Farm Mut. Auto. Ins. Co., 316 N.W.2d 348, 355 (Wis. 1982) ("there appears to be very little evidence that possible recoveries in subrogation are considered in the determination of insurance premiums").

110. *See, e.g.*, Powell v. Blue Cross & Blue Shield of Ala., 581 So.2d 772 (Ala. 1990).

111. *Id.*

112. *See, e.g.*, the statute involved in Magsipoc v. Larsen, 639 So.2d 1038 (Fla. Dist. Ct. App. 1994).

anticipated and provided for in the insurance policies. To achieve a desirable degree of uniformity it may be helpful to have a model statute drafted.

Whatever may be the best answer, it is imperative that the disputes come to an end. They are incredibly wasteful and totally unnecessary.

REMOVING A ROADBLOCK TO REFORMING HEALTH CARE: *NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS V. TRAVELERS INSURANCE COMPANY*

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I. INTRODUCTION

When the Employees Retirement Income Security Act ("ERISA"),[1] a comprehensive federal statute regulating employee pension and health benefit plans, was enacted, approximately thirty million employees were covered by private pension plans with at least 125 million dollars in assets.[2] A little more than ten years later, three quarters of a million ERISA private pension plans existed, "covering over sixty-five million persons, with assets approaching one trillion dollars."[3] This dramatic growth has continued: self-funded plans are now used by more than sixty-five percent of employers nationwide[4] and pension plans "constitute the largest block of private capital in the United States. . . ."[5]

ERISA regulates these plans and contains a provision which broadly preempts state laws that "relate to" these plans. The federal government's failure to reform health care, the spiraling costs of health care,[6] and the large number of underinsured and uninsured have forced the states to enact measures to increase health care access and reduce costs. ERISA's preemption provision has blocked state efforts to reform health care. Even when a state tries to raise revenues by indirectly taxing ERISA plans and using the money to fund programs designed to increase access to health care, the law may be preempted. Thus, while ERISA plan numbers and financial worth have increased dramatically, there has been a concomitant reduction in the state's role as a regulator and formulator of health care policy as the courts have preempted a variety of state laws.

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1. 29 U.S.C. §§ 1001 *et seq.*

2. SUB COMM. ON LABOR OF THE SENATE COMM. ON LABOR AND PUBLIC WELFARE, INTERIM REPORT OF ACTIVITIES OF THE PRIVATE WELFARE AND PENSION PLAN STUDY, S. REP. NO. 634, 92nd Cong., 1st Sess. 10 (1971).

3. David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV., 427, 435 (1987).

4. Kevin Caster, *The Future of Self-Funded Plans*, 79 IOWA L. REV. 413, 419 (1994) (citing Marybeth Burke, *The Growth of Self-funded Plans Sets Hurdles for State Reform Efforts*, HOSP., June 20, 1992, at 34 (reporting that ERISA is one of the biggest obstacles to state health care reform)).

5. Gregory, *supra* note 3, at 435 (citing W. Michael Kaiser, *Labor's New Weapon: Pension Fund Leverage -- Can Labor Legally Beat Its PlowShares Into Swords?*, 34 RUTGERS L. REV. 409, 409 (1982)).

6. The cost of health care in this country has grown from 5% of G.N.P. in 1960 to 11.6% by 1989. *See* Joseph A. Califano, Jr., *Rationing Health Care: The Unnecessary Solution*, 140 U. PA. L. REV. 1525, 1526 (1992).

This Note discusses a recent case in the field of ERISA preemption, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*,[7] and how it may, and already has, affected the determination of when a law is preempted. The case involved New York's innovative health care legislation designed to increase access to medical services by placing a surcharge on all hospital bills of patients not covered by Blue Cross/Blue Shield. New York used the funds that the surcharge created to pay the hospital costs for the indigent. The lower courts held that this surcharge "related to" an ERISA plan because of its "indirect economic effect." Thus, it was preempted. The U.S. Supreme Court reversed, and held that an "indirect economic effect" on ERISA plans from a state law of general applicability is not sufficient by itself to warrant preemption.

This Note will address the reasons why the Supreme Court's decision was correct and what the effect of *Travelers* may be. Overall, the Supreme Court's reading of the preemption provision in *Travelers* will allow the states greater freedom to design and implement health care legislation. The opinion restores the states to their traditional role as formulators of health care policy and removes the judiciary, to an extent, from blocking needed health care reforms. The opinion is also consistent with the legislative intent and impetus behind the enactment of ERISA. Part II of this Note will address the legislative and legal background of ERISA preemption. This part shows the roadblock ERISA preemption has created for the states' efforts to reform health care. Part III of this Note will discuss the *Travelers* case itself and will delve into the history and purpose of the New York legislation. The lower courts' and Supreme Court's opinions are considered to demonstrate how, after *Travelers*, preemption analysis has changed. Part IV of this Note provides an analysis of what the affect of this shift in preemption analysis may have and the effect it already has had. Overall, the Supreme Court's refusal to strike down a state law that merely has indirect economic effect on ERISA plans allows the states to experiment with health care legislation. This Note concludes that *Travelers* reverses a disturbing trend of broad preemption and allows states to deal with the current health care crisis in a more flexible, innovative manner.

7. 115 S. Ct. 1671 (1995).

II. THE HISTORY OF ERISA: LEGISLATIVE HISTORY, COURT INTERPRETATIONS AND THE STATES

A. Legislative History

ERISA was enacted in 1974[8] to correct abuses in the private pension system. Thousands of workers and retirees had lost their pensions because of mismanagement, or because the rules for receiving a pension were too stringent for many employees to meet.[9] Many employees found themselves terminated "only days before the retirement age [which] usually precluded pension vesting."[10] To compound the problem, many pension plans lacked adequate funding and many employees feared losing their pension benefits.[11] It was estimated that less than half of the national work force received their entitled benefits.[12]

Thus, ERISA was Congress' attempt to protect employees from "administrative and funding abuses while establishing fair vesting requirements for pensions."[13] To these ends, ERISA has reporting,[14]

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8. Several bills covering the regulation of pension and insurance plans were introduced in Congress before ERISA was enacted. *See* H.R. REP. NO. 12906, 93rd Cong., 2nd Sess. (1974); H.R. REP. NO. 12855, 93rd Cong., 2nd Sess. (1974); H.R. REP. NO. 9824, 93rd Cong., 1st Sess. (1973); H.R. REP. NO. 4200, 93rd Cong., 1st Sess. (1973); H.R. REP. NO. 462, 93rd Cong., 1st Sess. (1973); H.R. REP. NO. 2, 93rd Cong., 1st Sess. (1973); S. REP. NO. 1631, 93 Cong., 1st Sess. (1973); S. REP. NO. 1557, 93rd Cong., 1st Sess. (1973); S. REP. NO. 1179, 93rd Cong., 1st Sess. (1973); S. REP. NO. 4, 93rd Cong., 1st Sess. (1973).

9. Vicki Gottlich, *ERISA Preemption: A Stumbling Block to State Health Care Reform*, CLEARINGHOUSE REV., March 1993 at 1469.

10. Gregory, *supra* note 3, at 444.

11. Jolee Ann Hancock, Comment, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 CUMB. L.REV. 383, 384 (1995) (citing Steven R. Snodgrass, *ERISA Preemption of State Law: The Meaning of "Relate To" in Section 514*, 58 WASH. U. L.Q. 143 (1980)).

12. *Hearings on Examination of Private Welfare and Pension Plans Before the Subcomm. on Labor and Public Welfare*, 92d Cong., 1st Sess. 87 (1971).

13. Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L.REV. 355, 358 (1994). Congress codified its purpose in its "findings and declaration of policy," 29 U.S.C. § 100 (1988), in which it stated:

> The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans . . . . [T]hat

eligibility[15] and funding requirements.[16] In addition, ERISA imposes fiduciary duties on plan administrations[17] along with provisions governing plan administration.[18] ERISA also establishes jurisdiction and causes of action[19] and has provisions governing multi-employer plans.[20] Thus, "[ERISA] is a comprehensive framework for the federal government to regulate pension plans and employee welfare benefit plans."[21]

An important part of ERISA's framework is the preemption provision. Congress intended that any benefit from ERISA's preemption was to "inure to the employees and other beneficiaries under an ERISA plan."[22] Congress also enacted the preemption clause of ERISA, in part, to protect employers who were concerned about being subject to differing state laws and multiple and conflicting state regulations.[23] However, the main purpose of the preemption clause is to protect employees' benefits from administrative and funding abuses.[24] The diversity of these goals led to conflicting versions of the preemption provision during the drafting stages.[25]

> [because there is] a lack of adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries . . . that disclosure be made and safeguards be provided with respect to the establishment, operation and administration of such plans . . . it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide the free flow of commerce, that *minimum standards be provided assuring the equitable character of such plans and their financial soundness . . . it is [thus] declared to be the policy of this chapter to protect interstate commerce, the Federal Taxing Power, and the interests of participants in private pension plans and their benficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring termination insurance.* (emphasis added)

14. ERISA 101-11, 29 U.S.C 1021-31 (1988).
15. ERISA 201-11, 29 U.S.C 1051-61 (1988).
16. ERISA 301-06, 29 U.S.C 1081-86 (1988).
17. ERISA 401014, 29 U.S.C 1101-114 (1988).
18. ERISA 501-15, 29 U.S.C 1131-45 (1988).
19. ERISA 3001-42, 29 U.S.C 1201-42 (1988).
20. ERISA 4201-303, 29 U.S.C 1381-1453 (1988).
21. Hancock, *supra* note 11, at 386.
22. Pittman, *supra* note 13, at 359-60 (citing Rep. Dent, a major sponsor of ERISA).
23. Gottlich, *supra* note 9, at 1469.
24. Pittman, *supra* note 13, at 360 (citing Marilyn Klinger & James Diwik, *ERISA Preemption and the Surety,* 29 TORT & INS. L.J. 111, 112-13 (1993)).
25. The House's version can be found in H.R.2, 93d Cong., 2d Sess. (1974). It was enacted on February 28, 1974. 120 CONG. REC. 4742 (1974). The Senate's version is found

The final version of ERISA's preemption provision states that: "the provisions of this subchapter and subchapter III of this Chapter *shall supersede any and all state laws as they may now or hereafter relate to any employee benefit plan*[26] described in section 1003 (a) (4) (a) of this title and not exempt under section 1003 (b) of this title."[27] ERISA goes on to *save* from this preemption "any law of any State which regulates insurance, banking, or securities."[28] However, ERISA also limits the reach of the "savings clause" by not allowing an employee benefit plan to be *deemed* "an insurance company or other insurer, bank, trust company or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."[29] If the employee benefits are not a plan within the meaning of ERISA, preemption is not applicable. Similarly, *if the state law or regulation does not "relate to" an ERISA plan there can be no*

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at 120 CONG. REC. 5002 (1974). The Senate's provision was somewhat broader than the House's version. Ultimately, the final version of ERISA was broader than *either* the House or the Senate version. *See supra* note 4, at 388.

26. An " 'employee benefit plan' or 'plan' means an employee welfare benfit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." 29 U.S.C. § 1002(3) (1994). ERISA also defines "employee welfare benefit plans" and "pension plans" as:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization . . . to the extent that . . . [it is] established or is maintained for the purposes of providing for its participants or their beneficiaries . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death, unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . . [and] the term "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization . . . to the extent that . . . such plan, fund, or program provides retirement income to employees, or results in a deferral of income by employees for periods extending to the termination of covered employment or beyond. . . .

Id. at § 1002 (1), 2 (A) (1982).

27. 29 U.S.C. § 1144 (a) (1988) [hereinafter Preemption Clause] (emphasis added).

28. 29 U.S.C. § 1144 (b) (2) (A) [hereinafter Savings Clause] (emphasis added). The concept of "saving" simply refers to the fact that state laws touching insurance, banking, etc. are unaffected by ERISA.

29. 29 U.S.C. § 1144 (b) (2) (B) [hereinafter Deemer Clause]. "Deemed" refers to the fact that an "employee benefit plan" cannot be "deemed" one of the exceptions to ERISA under the savings clause. *See supra* note 28 and accompanying text.

preemption. Lastly, there is no premption if ERISA specifically allows the state law or regulation.[30]

A final and important point should be made regarding the preemption provision: ERISA does not define when a law or regulation "relates to" an employee welfare benefit plan. Congress evidently intended that the federal courts, in interpreting the statute, would fashion federal common law on the subject.[31] Although there were numerous comments during the enactment of ERISA from influential legislators,[32] none of them are precise enough to define concisely the all-important question of when a law "relates to" an ERISA plan. The problem with defining when a law or regulation "relates to" an ERISA plan is one of scope. If ERISA preempted *all* state law relating to employee benefit plans, a "dangerous vacuum would result . . . [as] . . . [p]rogressive state legislation would be frustrated, and Congress [might] not fill the void with the necessary federal

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30. *See id.* § 1144 (b) (2) (A).

31. Gregory, *supra* note 3, at 453.

32. Senator Jacob Javits (N.Y.) commented that: "[T]he emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required -- but for certain exceptions -- the displacement of State action in the field of private employee benefit programs." 120 CONG. REC. 29, 942 (1974);

Senator Harrison Williams (N.J.) stated that:

> [W]ith narrow exceptions specified in the bill, the substantive and enforcement provisions of [ERISA] are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law."

Id. at 933;

Representative John Dent (Pa.):

> I wish to make note of . . . the crowning achievement of [ERISA], the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption if the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation. . . . [T]his principle [is applied] in its broadest sense to foreclose any non-Federal regulation on employee benefit plans. Thus, [the preemption provision] would reach any rule, regulation, practice or decision of any State. . . . which would affect any 'employee benefit plan'.

Id. at 197.

legislation."[33] On the other hand, a narrow reading of the preemption language "would undermine the federal structure of providing a coherent and comprehensive national solution to address the grave national problems afflicting pension and welfare plans."[34] Thus, deciding whether a law "relates to" an ERISA plan raises federalism questions dealing with the proper relationship between federal and state law. For better or worse, it has been left to the courts to interpret the language of ERISA,[35] and fashion a balance between federal power to preempt and state power to regulate.

B. The Supreme Court's Attempt to Define "Relates To"

The Supreme Court's attempts to interpret the ERISA preemption clause are inconsistent. One commentator has suggested that, "at best, the Court's interpretation of the clause is confusing. At worst . . . the Court . . . [has not] established [a] controlling doctrine that guides its interpretation of ERISA -- a statute that governs the lives of millions of employees and their dependents."[36] The Supreme Court has rejected a general rule on ERISA preemption cases, and this has lead to conflicting decisions in other courts.[37]

In one line of cases, the Supreme Court has adopted a very broad definition of ERISA's "relates to" clause. In *District of Columbia v. Washington Board of Trade*[38], the state law in question required that employers "who provide health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive worker's compensation under this chapter."[39] In finding the state law preempted, the Supreme Court employed an ordinary meaning test and adopted a textualist approach: a "*connection with or reference to*"

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33. Gregory, *supra* note 3, at 457.

34. *Id.*

35. The Second Circuit in *Travelers* referred to ERISA's statutory language as a "veritable Sargasso Sea of obfuscation." New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 14 F.3d 708, 717 (2d Cir. 1994).

36. Pittman, *supra* note 13, at 384.

37. Justice Souter in *Travelers* acknowledged that previous Court opinions failed to shed much light on the proper interpretation of the phrase "relate to." See this Comment, *infra* Part II.

38. 113 S.Ct. 580 (1992).

39. *Id.* at 582 (quoting D.C. CODE ANN. § 36-307(a-1)(1)(Supp. 1992)).

definition of "relates to."[40] Writing for the majority, Justice Thomas stated, "This reading is true to the ordinary meaning of 'relate to' [that] gives effect to the 'deliberately expansive' language chosen by Congress."[41] Thus, the District of Columbia health law was preempted because it referred to employee welfare benefit plans.[42]

This is a broad reading of ERISA's preemption provision.[43] As one author points out, "the only criteria for preemption [is a] simple reference to an ERISA plan, even when no harm will occur to any of the congressional purposes [in enacting ERISA]."[44] Instead of relying on the state's traditional role as a formulator of health policy and experimental legislation, the Court preferred a textualist approach and read the plain language of a statute that they had previously characterized as "not a model of legislative drafting."[45]

The Court, however, has not hewed to a simple textual reading of the statute, although plain meaning has been a significant factor in other cases they have considered. In *Shaw v. Delta Airlines*,[46] the Court considered the New York Human Rights Law[47] and the New York Disability Benefits Law,[48] which together requires employers to pay disability benefits to employees.[49] The Court found that portions of the Human Rights Law were preempted but that the Disability Benefits Law was not.[50] The Court adopted broad, sweeping language in interpreting the ERISA preemption provision, stating that "[a] law relates to an 'employee benefits plan' in the normal sense of the phrase, if it has a connection with or reference to such

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40. *Id.* at 583 (emphasis added).

41. *Id.* (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987)).

42. *Id.*

43. Pittman, *supra* note 13, at 406.

44. *Id.*

45. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985).

46. 103 S. Ct. 2890 (1983).

47. N.Y. EXEC. LAW 290-301 (McKinney 1982 & Supp. 1982-83).

48. N.Y. WORK. COMP. LAW 200-42 (McKinney 1965 & Supp. 1982-83).

49. *Shaw,* 103 S.Ct. at 2893.

50. Portions of the Human Rights Law were saved from preemption by an ERISA preemption exception -- ERISA §514(d), 29 U.S.C. 1144(d) provides that §504(a) (the preemption provision) shall "not be construed to alter, amend, modify, invalidate, impair, or superseded any law of the United States." *Shaw* at 2902. The other law that the Court referred to was Title VII. The Disability Benefits Law was not preempted because of another ERISA preemption exception--ERISA 4(b) (3) exempts from preemption "any employee benefit plan...maintained solely for the purpose of complying with applicable . . . disability benefit insurance law." *Id.* at 2905.

a plan."[51] The Court relied on BLACK'S LAW DICTIONARY to determine the meaning of what "relates to" means.[52]

However, the Court did not end its inquiry with plain meaning. The Court also delved into the history of ERISA and most importantly, limited its own broad definition of "relates to" in dictum:

> Some state actions may affect employee benefit plans *in too tenuous, remote, or peripheral a manner to warrant a finding that the law "relates to" the plan.* The present litigation [in *Shaw*] plainly does not present a borderline question, and we express no views about where it would be appropriate to draw the line.[53]

The Court in *Shaw*, unlike the Court in *District of Columbia*, was not entirely comfortable with a straight forward "plain meaning rule." In the Court's own definition, even a law that was to be interpreted in its "broadest sense" still had some limit -- namely, that which is too tenuous or remote to "warrant a finding that the law 'relates to' ERISA." This inconsistency and underlying tension between state law and ERISA is present in other cases that the Court has considered. In *Metropolitan Life Insurance Co. v. Massachusetts*,[54] the Court found that a state law which mandated a minimum level of mental health protection fell within the broad reach of the preemption provision because it "clearly relate[s] to" welfare plans covered by ERISA [since it impacts] . . . indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the statute. . . ."[55] However, pursuant to the "savings clause," the statute was saved[56] from preemption because it "regulates the terms of certain insurance contracts."[57]

The significance of *Metropolitan Life* and its interpretation of "relates to" is that the Court acknowledged that the preemption clause is "not a model of legislative drafting."[58] This extends *Shaw's* "too remote and

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51. *Shaw* at 2900.

52. *Id.* at n.16. "Relate. To stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with." Black's Law Dictionary 1158 (5th ed. 1979).

53. *Shaw* at n.21 (emphasis added).

54. 471 U.S. 724 (1985).

55. *Id.* at 739.

56. *See supra* note 28 and accompanying text.

57. *Metropolitan Life Ins. Co.*, 471 U.S. at 740.

58. *Id.* at 739.

tenuous limit" to the preemption clause insofar as the courts should use caution before using "badly drafted clauses to preempt state laws, especially those [state laws] of general applicability."[59] Further, other courts, including the U.S. Supreme Court in *Travelers*, were able to point to *Metropolitan Life* as standing for the "assumption that the historic police powers of the States were not to be superseded by the [federal law] unless that was the clear and manifest purpose of Congress."[60] *Metropolitan Life,* then, struck a balance between federal power to preempt and state power to regulate in favor of the state. Since ERISA's preemption provisions were acknowledged by the Court to be vague, and since the Court indicated that it preferred clear intent when striking down state laws, the decision balances federal and state power. Similarly, in *Fort Halifax Packing Co. v. Coyne*,[61] the Court again favored state regulation over preemption. *Fort Halifax* concerned a Maine law that required certain employers to provide their employees with a one-time severance pay.[62] The Court went beyond plain language and examined the history of the preemption clause.[63] The Court held that ERISA's *purpose* of providing uniform regulation[64] was not implicated by the Maine statute because the Maine statute only referred to benefits, not *employee welfare benefits*. Finding that ERISA's goal of uniformity of such plans is frustrated only when employee welfare benefits are involved, the Court stated, "[o]nly . . . [this type of ERISA plan] . . . embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation."[65] A straightforward textualist approach to this case suggests that the law would have been preempted,[66] but the Court looked to the legislative history, purpose and plain meaning of ERISA to interpret the statute. In general, the Supreme Court has interpreted the preemption clause broadly.[67]

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59. Pittman *supra* note 13, at 393 n.224.

60. *Travelers*, 115 S.Ct. at 1676.

61. 482 U.S. 1 (1987).

62. *Id.* at 7-19. The Maine statute in question was ME. REV. STAT. ANN. tit. 26, § 625-B (West Supp. 1986-1987).

63. *Id.* at 9.

64. Pittman, *supra* note 13.

65. *Fort Halifax Packing Co.*, 482 U.S. at 11-12.

66. Pittman, *supra* note 13, at 395.

67. The Court has decided several other cases relating to ERISA preemption. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Court held that an employee's claim that he was wrongfully discharged in order for his employer to avoid making contributions to his pension fund is preempted by ERISA. In *Alessi v. Raybestos-Manhattan Inc.*, 451 U.S. 504 (1981) the Court held that a state law prohibiting pension offsets by amounts awarded in workers' compensation actions was preempted by ERISA. In *Mackey v.*

However, the preemption clause's power to void state laws is not as absolute as the Court's opinion in *Metropolitan Life* demonstrates. *Shaw's* tacit rejection of preempting state laws that have too remote a connection to ERISA plans is another limit that the Court has placed on ERISA's power to preempt. The difficulty in the Supreme Court's formulation of "relates to" is the lack of a general clear standard on both the interpretations of the statute as well as what tools (plain meaning, history, purpose, or a combination thereof) should be employed to discern the meaning of the preemption clause. One commentator has pointed out that, "[a]fter *Shaw*, it was no longer sufficient to ascertain whether the state law intruded upon . . . fields regulated exclusively by ERISA. Instead, courts [must] determine whether the law was generally intended to relate to employee benefit plan . . . [a] . . . broad and difficult [inquiry] not subject to bright-line measurements."[68]

C. ERISA And State Health Care: Blocking Reform

The Supreme Court's formulation of the preemption clause has proved difficult for the lower courts to apply. ERISA has been applied differently by various courts: "[a] state law preempted in one jurisdiction may be similar to that [which is not preempted] in another."[69] This problem has been particularly acute where states attempt to formulate health care legislation. Both federal and state courts have compounded the problem of preemption by "continually expanding the reach of what is already regarded as a very broad preemption provision."[70] As such, the states have had to take a more active role in health care legislation, and courts have found "state laws to be preempted in virtually every area in which states have chosen to regulate."[71]

Lanier Collection Agency & Serv., Inc. 486 U.S. 825 (1988) the Court held that a state law prohibiting garnishment of ERISA plans is preempted because it singled out employee welfare benefit plans for special treatment. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the Court held that a Pennsylvania anti-subrogation statute was preempted because it referred to a self-insurance welfare benefit plan. In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), a state lawsuit asserting improper processing of claim for benefits under ERISA-regulated plan is preempted by ERISA.

68. Gregory, *supra* note 3, at 467.

69. Gottlich, *supra* note 9, at 1470. Gottlich, a staff attorney with the National Senior Citizens Law Center points out that while "[attorneys] worry on behalf of our clients about the effect of reform on Medicaid programs and Medicare, health care providers and employers raise the the issue of preemption of state law by . . . . [ERISA]." *Id.* at 1469.

70. *Id.* at 1470.

71. *Id.* at 1471.

This situation has troubling implications today. Now that the federal government again has backed away from health care reform efforts,[72] the states seem interested in reforming health care and employee benefit plans. Thus, "[t]here is a growing and generally accurate perception that ERISA presents a formidable obstacle to state legislation which affects employee benefit plans."[73] In fact, the states have not only found that ERISA is a barrier to *direct* regulation of ERISA plans, but a significant impediment to *indirect* legislation. Lower courts have wrestled with the Supreme Court's ruling in *Shaw*[74] regarding the "too tenuous or remote a connection" language to find preemption. In this vein, any attempt to solve health care problems through risk spreading or risk pooling in various forms -- "community rating, insurance reforms, surcharges or taxes on hospital payments, premium taxes, employer mandates and other means" can be preempted by ERISA.[75]

The result of broad preemption is detrimental to employees in general, and to the uninsured in particular. For instance, in the case of employees, ERISA preempts benefit protection laws as they apply to self-funded plans.[76] Since ERISA does not require self-funded plans to provide any particular benefits, employers providing such plans enjoy a charmed existence under ERISA -- they can "reduce or eliminate costly benefits after an employee files a claim."[77] Employers are protected in other ways under ERISA. Direct regulation of ERISA plans is usually preempted, but the courts have not been consistent.[78]

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72. *See* this Note, *supra* Section I.

73. 2 No. 4 ERISA LITIG. REP. 27 (August 1993).

74. *See* this Note, *supra* Section II.

75. Lawrence G. Atkins, *ERISA Preemption and the States: A New Look at the Issue*, 23 TAX MGMT. COMP. PLAN. J., Jan. 6, 1995 at 1.

76. Caster, *supra* note 4, at 420. Caster cites Tingley v. Pixley-Richards W., 953 F.2d 1124 (9th Cir. 1992) (holding that a state law which required conversion rights upon termination of employment was preempted as applied to a self-funded plan); St. Louis Children's Hosp. v. Commerce Bancshares, Inc., 799 S.W.2d 87 (Mo.App. 1990) (holding that state law requiring insurance companies to pay for the treatment of prematurely born children was preempted as it applied to a self-funded plan). Caster, *supra* note 4, at n.72.

77. *Id.* at 421. *See* McGann v. H & H Music, 946 F.2d 401 (5th Cir. 1991), *cert denied sub nom*; Greenberg V. H & H Music Co., 113 S. Ct. 482 (1992) (where an employer deprived its employee of AIDS-related health benefits because an employer had an absolute right to terminate or modify its self-funded plan). *Id.* at n.85.

78. St. Paul Elec. Workers Welfare Fund v. Markman, 490 F. Supp. 931 (D. Minn. 1980). The Minnesota Act required self-funded plans to join a reinsurance association for coverage of high risk individuals. MINN. STAT. §§ 62E.035, 62E.16 (1993). The Act also required self-funded plans to provide insurance to former employees six months after termination. MINN. STAT. § 62E.035, 62E.16 (1993). *See also* Wadsworth v. Whaland, 562

Indirect preemption is a barrier to state reform efforts. Progressive statutes that try to raise funds for increased coverage and/or pool risks run into the preemption barrier. Legislation, such as tax and rate setting laws and even state torts, may be preempted if, under ERISA, they are found to "relate to" such a plan.[79] This

> broad sweep of ERISA's preemption incapacitates a wide range of state laws that could be construed to 'relate to employee benefit plans . . . [preemption of] state tax, cost containment, employer mandate and consumer protection laws . . . [have] greatly limited the range of health care reform solutions available to them, which is particularly problematic given the failure of . . . Congress . . . to provide uniform federal health standards and resources.[80]

F. 2d 70 (1st Cir. 1977) (preempting New Hampshire law, N.H. REV. STAT. ANN. §§ 415:18-a; 419: 5a, 420: 5-a (1976), requiring group insurance "issuers" to provide coverage for the treatment of mental illness and emotional disorders); Standard Oil Co. of Cal. v. Agsalud, 442 F. Supp. 695 (N.D. Cal. 1977) (preempting the Hawaii Prepaid Health Care Act, HAW. REV. STAT. §§ 393-1 – 393-51 *amended* to require coverage of the costs of diagnosing and treating alcohol and drug abuse, 1976 HAW. SESS. LAW c. 25, 28 (amending HAW. REV. STAT. 393-7(c)); Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir, 819 F. 2d 408 (3d Cir. 1987) (preempting state laws that regulated contents of employee health benefit plans); Blue Cross and Blue Shield v. Peacock's Apothecary, Inc., 567 F. Supp. 1258 (N.D. Ala. 1983) (preempting state law that regulated reimbursement for prescription drugs); Wayne Chem. Inc. v. Columbus Agency Serv. Corp., 426 F. Supp. 316 (N.D. Ind. 1977), *aff'd* 567 F.2d 692 (7th Cir. 1978) (preempting state insurance law that prohibited the termination of dependent coverage under employee benefit plan); General Split Corp. v. Mitchell, 523 F. Supp. 427 (E.D. Wis. 1981) (preempting state law that mandated conversion benefits and establishes risk sharing plans; United Food & Commercial Workers & Employees v. Pacyga, 801 F.2d 1157 (9th Cir. 1986) (preempting state insurance law that established reimbursement requirements for self-funded plan); Hewlett-Packard Co. v. Barnes, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd* 571 F.2d 502 (9th Cir. 1978), *cert. denied,* 439 U.S. 831 (1978) (preempting state comprehensive health plan that relates to employee benefit plans). *But see* Michigan United Food & Commercial Workers Union v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985) (does not preempt state insurance regulation requiring substance abuse treatment); Maryland v. Metropolitan Life Ins. Co., 463 A.2d 793 (Md. 1983) (does not preempt state insurance regulation that requires reimbursement of social worker service); Blue Cross Hosp. Serv., Inc. v. Frappier, 698 S.W.2d 326 (Mo.banc. 1985) (does not preempt state insurance regulation that mandates chiropractic and psychological services).

79. Atkins, *supra* note 75, at 2. .

80. *Id.* at 3. *See also* Caster, *supra* note 4, at 426. Caster points out that "[s]tates complain that ERISA preemption prevents reform of even the simplest bureaucratic procedures." *Id.* at 426 (citing Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. Davis L. Rev. 255, 301 (1990)).

States have responded to the federal government's failure to reform health care by passing their own legislation, and, consequently, have requested exemptions from the preemptive effect of ERISA.[81] In all cases, save one -- Hawaii's -- the federal government has rejected waivers to ERISA, despite the fact that these waivers are important for the long-term financial viability of significant state reform.[82] Even Hawaii's waiver[83] is a "strong signal to federal courts that congressional allowance of state law waivers is reserved to Congress." Hawaii received a waiver only because it was explicitly granted.[84]

One of the most significant impediments to state health care reforms pre-*Travelers* was the idea that laws or regulations of general applicability, in particular, those that may have an economic effect on ERISA plans, could be preempted. Since it is unlikely that a state can obtain a formal waiver, states are forced to design laws which the "courts are unlikely to interpret . . . in a manner deferential to state health care reform if the interpretation interferes with national policies of uniformity and protection of employee benefit plans."[85] Since most direct regulation is likely to be preempted, states are forced to design innovative legislation that regulates ERISA plans *indirectly.* As with their experience in direct regulation, the courts have not been entirely consistent in this area of ERISA analysis. The rule articulated by the Supreme Court in *Shaw*, i.e., whether a law has "too remote or tenuous a connection" to ERISA plans to be preempted, has been difficult to apply.

Two important cases established the principle that state laws of general application may not be preempted if certain conditions are met. For instance, a law that does not regulate the affairs of ERISA plans, or single out such plans for special treatment, may not be preempted. Also, a law that does not predicate rights on the existence of an ERISA plan, and does not have an effect on how ERISA plans conduct their affairs, or impair the

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81. Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L & SOC. PROBS. 609, 609 (1995). As many as 25 states have requested an ERISA waiver. *Id.* at 652 *citing* Greg Gordon, *Baby Steps; No Giant Strides Expected From Republican Efforts to Reform Health Care System*, STAR TRIB. (Minneapolis-St.Paul) Dec. 18, 1994, at 27A.

82. *Id.* at 612.

83. Hawaii's waiver was written into a 1983 amendment to ERISA. *Id.* at 652

84. *Id.* at 631. The 1983 amendment specifically provided that "[Hawaii's] exemption . . . shall not be considered a precedent with *respect to extending such amendment to any other State law*" (emphasis added). Act of Jan. 14, 1983, Pub. L. No. 97-473, § 301(b), 96 Stat. at 2612 (1983). A factor in Congress's granting a waiver to ERISA was that the Hawaii health plan predated the enactment of ERISA. *Groves, supra* note 81, at 631.

85. *Id.* at 618.

plan's ability to operate in more than state, may not be preempted.

The first of these cases is *Rebaldo v. Cuomo*.[86] In *Rebaldo*, the Second Circuit held that a statute that set hospital rates but did not affect the structure, benefits or administration of an ERISA plan, was not preempted.[87] The case involved a New York statute which prohibited self-insured plans from negotiating the same type of discounts that Blue Cross & Blue Shield was permitted to negotiate. The court declined to find preemption because the law could increase the plan's cost of doing business.[88] Thus, the court refused to find that a statute of general applicability, having an indirect economic effect, was sufficient to warrant preemption: "[An indirect economic effect] that may result from State control over hospital rates does not run counter to ERISA's aim of national uniformity in plan regulation. . . . [T]here is no reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business."[89]

Perhaps the most important aspect of the opinion is the fact that the court recognized the need for the state and federal governments to develop cost control in hospital care.[90] In doing so, the court acknowledged the importance of state health care control, declaring that, "[t]he containment of hospital costs is an exercise of a state's police powers, which should not be superseded by federal regulations unless that was the clear intent of Congress."[91] The court showed deference for "cooperative federalism" – the New York statute was designed to contain costs under Medicaid, a "joint state and federal program to provide medical care to those who otherwise could not afford it."[92] Since New York voluntarily participated in this plan and administered it in compliance with federal statutes, the Court doubted that "Congress intended that ERISA would preempt a project of cooperative federalism."[93]

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86. 749 F.2d 133 (2nd Cir. 1984).

87. *Id.* at 139-40. The statute required each general hospital to establish a charge schedule, and that certain corporations, such as Blue Cross, receive a discount of 12% to 15% below that of other payers. Public Health Law § 2807-a, subd. 6(b). (McKinney 1970).

88. *Id.* at 139-40.

89. *Id.* at 139.

90. *Id.* at 135. The court noted that in 1983 $8 billion was spent on in-patient hospital care in the state of New York. *Id.*

91. *Id.* at 128, citing Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 522.

92. *Id.* at 135, citing Hospital Assoc. of New York v. Toia, 557 F.2d 790, 792 (2d Cir. 1978).

93. *Id.* at 140. The Second Circuit pointed out that it was unlikely that when Congress "gives authority with one hand [for states to administer the Medicaid program] it ordinarily does not take it away with the other [through ERISA premption]." *Id.*

A later, perhaps more important, case is the Third Circuit's decision in *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Hosp.*[94] *United Wire* involved a New Jersey hospital rate setting statute which forced self-insured plans to pay a surcharge in excess of actual hospital charges.[95] The surcharges were intended to raise revenue for hospitals that were required by law to provide treatment for patients who could not pay their bills.[96] The money raised from the surcharges was distributed in proportion to the "uncompensated care" provided by each hospital.[97]

In considering whether the New Jersey law "related to" an ERISA plan, the court refused to read the preemption provision broadly. New Jersey's law was one of general applicability that only established the cost of hospital services; there was no special treatment for such plans because the law could operate without considering their existence.[98] The court rejected the notion that increased costs from the surcharges would deprive ERISA plans of alternative structuring for benefits or conducting internal affairs.[99]

Both the *Rebaldo* and *United Wire* cases allow states to fashion their own health care reform measures. Thus, the uninsured and the underinsured have better access to health care. The *United Wire* court cautioned that if "ERISA is held to invalidate every state action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress."[100] Thus, the two cases indicate that allowing the states the flexibility to legislate and reform health care is not inconsistent with ERISA preemption.[101]

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94. 995 F.2d 1179 (3d Cir. 1993).

95. N.J. STAT. ANN. § 26:2H-1 (West 1987 & Supp. 1994).

96. *United Wire* at 1189.

97. *Id.*

98. *Id.* at 1192. In a dissenting opinion, Justice Nygaard pointed out that ERISA plans *were* considered when enacting the statute because they were one of the principal targets of the statutes. *Id.* at 1198. The dissent also complained that states are free to regulate ERISA plans "so long as . . . [they] . . . exercise a minimum degree of imagination by couching their statutes in 'generally applicable' terms." *Id.* at 1203. *See* Vol. 2 No. 4 ERISA LITIG. REP. 27, August 1993, for a discussion of the majority and dissenting opinions in *United Wire*.

99. *United Wire* at 1193.

100. *Id.* at 1194.

101. Other cases have followed the reasoning in *Rebaldo* and *United Wire* that laws of general applicability should not be preempted merely because they impact ERISA plans in some fashion. *See e.g.*, Boyle v. Anderson, 849 F. Supp 1307 (D. Minn.1994) (holding that ERISA did not preempt Minnesota's health care provider tax); Employee Staffing Serv., Inc. v. Aubry, 20 F.3d 1038, 1042 (9th Cir. 1994) (finding that ERISA did not preempt a

Not all courts have agreed with the logic of the *Rebaldo* and *United Wire* courts. For example, in *NYSA-ILA Medical & Clinical Services Fund v. Axelrod*[102] the Second Circuit held that a 0.6% assessment on hospital gross receipts, including receipts for patient care services, was preempted insofar as it was applied to a medical facility owned by an ERISA plan. The court rejected the claim that the law was one of general applicability, and had a "too tenuous or remote" connection with ERISA plans to find preemption, stating that "the [Act] targets . . . the health care industry . . . [and] [b]ecause this industry is, by definition the realm where ERISA plans must operate, the [Act] was bound to affect them."[103] The state attempted to show that the law was one of general applicability -- taxes that only affected ERISA plans incidentally and merely "raised the cost of doing business in the state."[104] But the court simply said that the tax had an adverse economic impact on plans and "affected the very operations and functions that make the plan what it is."[105]

One final area to briefly examine in the field of ERISA preemption of state laws indirectly affecting ERISA plans is state tort claims. Again, the courts have been inconsistent. Many courts have found that a tort claim stating that an ERISA plan failed to pay a benefit claim, pre-approve a procedure or create adequate rules to guide the conduct of a doctor, directly "relate[s] to" an ERISA plan and is preempted.[106] This seems to

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California law requiring employers to maintain a separately administered worker's compensation program and stating that "the economic effect of independent state requirements . . . should be distinguished from the legal effect of state commands regarding ERISA plans"; Firestone Tire & Rubber Co. v. Neusser, 810 F.2d 550 (6th Cir. 1987) (stating that ordinance imposing a municipal income tax was not preempted); Retirement Fund Trust v. Franchise Tax Board, 909 F.2d 1266 (9th Cir. 1990) (stating that California tax collection procedures were not preempted by ERISA).

102. 27 F.3d 823 (2d Cir. 1994) *vacated, remanded,* 115 S.Ct. 1819 (1995), *and adhered to, on recons.,* 74 F.3d 28 (1996).

103. *Id.* at 827.

104. *Id.*

105. *Id. See also* New England Health Care Emp. v. Mount Sinai Hosp. 846 F. Supp. 190 (D. Conn. 1994), *rev'd,* 65 F.3d 1024 (1995); Connecticut Hospital Assn v. Pogue, 870 F. Supp. 444 (D. Conn. 1994), *rev'd,* 66 F.3d 413 (1995). Both of these cases will be discussed in greater detail in Part III of this note, *infra.*

106. *See* Visconti By Visconti v. U.S. Health Care, 857 F. Supp. 1097, 1101 (E.D. Pa. 1994) (holding that claim that defendant was directly negligent in selecting and employing unqualified personnel and not adopting and enforcing adequate rules and policies to insure quality control for its patients is preempted); Elsesser v. Hospital of Philadelphia College of Osteopathic Medicine, 802 F. Supp. 1286, 1290-1291 (E.D. Pa. 1992) (plaintiff's claim of direct liability of HMO for failure to provide funding for medical advice is preempted by ERISA); Corcoran v. United Health Care, 965 F.2d 1321 (5th Cir. 1992), *cert. denied,* 113 S.Ct. 812 (1992) (claim of medical malpractice under a state common law theory is

suggest that even in the area of tort law, "state laws of general applicability, which impose duties independently of those imposed by ERISA, may be preempted."[107]

A tort claim need not refer directly to an ERISA plan to be preempted. Several cases have held that vicarious liability (i.e., an indirect tort claim) is also preempted by ERISA.[108] In these cases, a member of an ERISA plan sued the plan indirectly, claiming that the plan held a physician out as its *ostensible agent*, and if an ostensible agency relationship between the physician and the plan can be established, then the plan can be held indirectly liable.[109] Courts, as in other forms of indirect regulation through laws of general applicability, have found ostensible agency liability preempted, because it "relates to" an ERISA partly by virtue of the economic impact such liability would have on the plans.[110] But, like other

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preempted). *But see* Anoka Orthopaedic Associates v. Mutschler, 773 F. Supp. 158, 164 (D. Minn. 1991) (claim for malpractice against an attorney and an accountant did not arise under ERISA because it asserted state malpractice claims which are not preempted by ERISA); Greenblatt v. Budd Co., 666 F. Supp. 735, 741 (E.D. Pa. 1987) (claim of misrepresentation of pension benefits employee was to receive is "too tenuous or too remote to warrant preemption.").

107. Pittman, *supra* note 13, at 413.

108. *See, e.g., Elsesser*, 802 F. Supp. at 1290; Independence HMO v. Smith, 733 F. Supp. 983, 988 (E.D. Pa. 1990); Kearney v U.S. HealthCare, Inc., 859 F. Supp. 182 (E.D. Pa. 1994); Stroker v. Rubin, 1994 U.S. Dist. Lexis 18379 (E.D. Pa).

109. An ostensible agency theory of liability can attach when:

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

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

For a fuller development of ostensible agency theory and ERISA preemption, *see* Steven R. Bucholz, *Health Maintenance Organization's Gatekeeper: Opening the Gate to Liability Through Ostensible Agency Theory*, 21 W. ST. U.L. REV. 241 (1993).

110. *Visconti*, 857 F. Supp. at 1104: "[ostensible agency liability] would affect the [ERISA plan] by requiring the health organization to carry additional insurance coverage to protect against claims brought against its doctors. This, ultimately would result in an increase of costs to the end user;" Dukes v. U.S. Health Care Systems of Penn, Inc. 848 F. Supp. 39, 43 (E.D. Pa. 1994), *rev'd*, 57 F.3d 350 (19): "[attaching ostensible agency liability means] higher costs will invariably be passed on to consumers;" Ricci v. Gooberman, 840 F. Supp. 316, 318 (D.N.J. 1993), "such a rule [allowing ostensible agency liability] effectively requires that [the ERISA plan] . . . carry liability insurance . . . [thus] resulting in higher costs that certainly trickle down to plan beneficiaries."

generally applicable state laws affecting ERISA plans, there is dissenting authority. Some courts have allowed tort claims against ERISA plans which used ostensible agency as a theory of liability.[111]

There is little consistency among the lower courts with regard to ERISA preemption as well. Most state attempts to directly regulate ERISA plans have been preempted, and almost all states have been unable to obtain any waiver from Congress to directly regulate ERISA. Even indirect legislation, such as taxes and other cost containment measures, have been preempted. Despite the broad preemption provision, and the legal uncertainty surrounding any regulation, states have little choice but to create innovative health care legislation. However, "because of persistent problems involving health care, and increasing health care costs, effective health care policy remains a priority for many states"[112] It is in this context, a crisis in health care cost and coverage generally, as well as a highly uncertain legal status for any law which regulates health care, that the *Travelers* litigation, the subject of the next section of this Note, first arose.

III. *N.Y. STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS V. TRAVELERS INSURANCE COMPANY*[113]

A. Background

In 1988, the State of New York established a comprehensive scheme of inpatient hospital rates.[114] The new legislation, the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"), altered how hospital inpatient rates were paid.[115] The impetus behind rate setting was

111. *See, e.g., Elsesser*, 802 F. Supp. at 1290; *Independence HMO*, 733 F. Supp. at 988 (E.D. Pa. 1990); Kearney v. U.S. HealthCare, Inc., 859 F. Supp. 182 (E.D. Pa. 1994); Stroker v. Rubin, 1994 U.S. Dist. Lexis 18379 (E.D. Pa).

112. James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call For "Cooperative Federalism" to Preserve the States' Role in Formulating Health Care Policy,* 16 CAMP. L. REV. 405, 415 (1994) *citing* Jerry Geisel & M. Schacher, *States Seize Reins of Health Care Reform*, BUS. INS., June 15, 1993, at 1.

113. 115 S.Ct. 1671 (1995).

114. All references made to the laws of New York are as they stood at the times relevant to this litigation.

115. *See* N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1992) (amended 1993); *see also Travelers,* 115 S.Ct. at 1674. Prior to this "rate setting scheme," New York billed

the legislature's concern that per diem charges were fueling the escalation of health care costs by "giving hospitals an economic incentive to maximize the length of a patient's stay as well as the extent of services."[116]

Accordingly, the new legislation called for patients not to be charged for the cost of their individual treatment, but for the average cost of treating the patient's medical problem, as classified under one of the 794 Diagnostic Related Groups (DRG's).[117] Spiraling health care costs were not the only problem the state addressed under NYPHRM. The legislature also was faced with the financial difficulties that Blue Cross and Blue Shield ("the Blues") were undergoing because of their "open enrollment" policies, a problem that other commercial insurers at the time did not have.[118]

Thus, the Blues were at a serious competitive disadvantage with other insurers. While commercial insurers were able to pick and choose the group health market and control the risks that they would assume, the Blues were left with a subscriber base of higher cost risks and faced mounting losses.[119] Blue Cross could not spread risks like other insurers to attract viable risks at a price competitive with other insurers who could afford to charge less because their risks were so much lower.

Faced with the possible financial insolvency for the Blues, the legislature enacted NYPRHM. Patients with Blue coverage, Medicaid patients and HMO participants were billed at a hospital's DRG rate,[120] while others[121] were billed at the DRG rate plus an additional surcharge of 13%.[122] This surcharge[123] was retained by the hospital.[124] It was hoped that

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most in-patients a simple per diem charge that was comprehensive or coupled with additional charges for particular in-patient services.

116. Robert N. Swidler, *Blue Cross and New York's Hospital Reimbursement System*, N.Y.L.J. (June 27, 1995) at 1.

117. N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993). *See also Travelers,* 115 S.Ct. at 1674. The charges allowable under a particular DRG are further adjusted for a specific hospital to reflect its operating costs, capital investments, bad debts, etc.

118. "Open enrollment" refers to the fact that Blue Cross and Blue Shield are legally required to enroll all applicants, regardless of the risk they pose. *See* Leo T. Crowley, *ERISA and the Rules On Hospital Rates*, 209 N.Y.L.J. 82 (1993).

119. In effect, other commercial insurers were able to "cherry pick" their clients and only accept low risk insured. Blue Cross, with its "open enrollment" was, in effect, left with the pits. *Id.*

120. N.Y. PUB. HEALTH LAW § 2807-c (McKinney 1993).

121. "Others" include "patients served by commercial insurers providing in-patient hospital coverage on an expense-incurred basis, by self-insured funds directly reimbursing hospitals, by certain worker's compensation, volunteer firefighter's benefit [plans], ambulance worker's benefit [plans] and no-fault motor vehicle insurance funds." *Travelers*, 115 S.Ct. at 1674.

122. N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1993). *See also Travelers,*

by increasing the costs of non-Blue patients–thereby making them less price competitive, the Blues would become more price competitive, attract better risks and improve its subscriber base by spreading risks.[125] It was also hoped that the measure would increase the access of hospital services to indigent patients.[126] Since the hospitals retained the funds derived from the surcharge, the funds could be used to finance the health care expenses of those who normally could not afford such services.[127]

However, despite this measure, the Blues continued to lose ground to commercial insurers and HMO's.[128] In 1992, after successful lobbying on the part of the Blues,[129] New York enacted the Omnibus Revenue Act of 1992 (Omnibus Act) that placed two additional surcharges on DRG rates.[130] The first of these surcharges mandated that hospitals bill all commercially insured patients (in addition to the 13% surcharge discussed above) an 11% surcharge which, unlike the previous surcharge, was turned directly over to the state, paid into a state pool, and deposited into the state's general fund.[131] The second of the Omnibus Act's surcharges imposed a surcharge on HMO's. The surcharge amount varied depending on the number of Medicare recipients that an HMO has enrolled, but does not exceed 9% of the aggregate monthly charges paid by an HMO for a member's in-patient hospital care.[132]

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115 S.Ct. at 1674.

123. The surcharge may be appropriately termed a "sick tax." Crowley, *supra* note 118.

124. N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1993).

125. 2 NO. 6 ERISA LITIG. REP. 16 (P-H) (Dec. 1993).

126. Hancock, *supra* note 11, at 407.

127. *Id.* at 403. There was no requirement, however, in the statute that the "sick tax" be used to provide indigent health care.

128. Crowley, *supra* note 118.

129. *Id.*

130. N.Y. PUB. HEALTH LAW 2807-c(11) (i) (McKinney Supp. 1993). An additional motivating factor for the state, beyond the financial crisis that the Blues were facing, was a large budget. The 11% was a solution, albeit temporary, from both problems. Swidler, *supra* note 115.

131. N.Y. PUB. HEALTH LAW § 2807-c(11)(I). *See also Travelers*, 115 S.Ct. at 1674. The 13% surcharge was retained by the hospital. *See supra* notes 12 and 14. The 11% surcharge was only applicable for the years 1992-1993; it ceased after 1993. Leslie J. Gold and Jerry Silverman, *New York Surcharges on Hospital Bills Upheld By Unanimous Supreme Court*, DAILY REPORT FOR EXECUTIVES, April 27, 1995.

132. N.Y. PUB. HEALTH LAW § 2807-c(2-a)(a)-(2-a)(e). *See also Travelers* at 1674. The proceeds from this differential were also paid into the state's pool, but ended up in the state's possession. Travelers Insurance Co. v. Cuomo 14 F.3d 708, 712. The overall purpose of the 9% surcharge was somewhat different than the 13% and 11% differentials which were intended to make the Blues more competitive and provide additional sources of revenue for

Through these regulations, the State of New York attempted to save the Blues fiscally, provide more funds for hospitals treating indigent patients, encourage HMO's to enroll more Medicaid patients, and raise more money for the state's general fund.[133] It remained for the courts to decide whether the law passed muster under ERISA.

B. THE DISTRICT COURT OPINION: *TRAVELERS INSURANCE COMPANY V. CUOMO* [134]

In the summer of 1992, litigation arose challenging the validity of the New York surcharge statutes.[135] The Travelers Insurance Company initiated a declaratory judgment action to invalidate the 13% and 11% surcharges as they applied to commercial insurers based on the ERISA preemption provision.[136] This suit was followed by others from the Health Insurance Association of America and various other insurance trade associations and individual insurance companies, also seeking judgment invalidating the 13% surcharge.[137] The Hospital Association of New York State ("HANYS"), the New York State Conference of Blue Cross and Blue Shield, and Empire Blue Cross and Blue Shield intervened in both actions

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the state. Instead, the 9% surcharge was intended to encourage HMO's to enroll Medicaid patients and lower the cost of the State Medicaid program. Q237 ALI-ABA 1, 5.

133. For further review of the New York statutes and the impetus behind them, see Katherine Hesse, *Travelers Insurance Company v. Cuomo*, BENEFITS QUARTERLY, Vol. 19 No. 1, at 80-81 (First Quarter 1991). *See also* Q 237 ALI-ABA 1, 5-9; Swidler, *supra* note 116.

134. 813 F. Supp. 996 (S.D.N.Y. 1993).

135. The Travelers case involved other issues apart from preemption. The case also considered whether or not the Tax Injunction Act, 28 U.S.C. § 1341 (1996), barred the plaintiff's claim to the 9% and 11% surcharges. *Travelers*, 813 F.Supp at 1000-01; whether the plaintiffs' challenge to the 13% claim was barred by the doctrine of laches. *Travelers*, 813 F. Supp. at 1008-09; whether the Federal Employee Health Benefits Act's preemption provisions, 5 U.S.C. § 8909(f)(1) (1996), preempted the 11% and 13% surcharges. *Travelers*, 813 F. Supp. at 1009-11; and whether an actuarial letter issued by the New York State Department of Insurance, which imposed certain requirements on "stop-loss type policies," was also premepted by ERISA. *Travelers*, 813 F. Supp. at 1011-12. Since none of these issues were considered by the Supreme Court in the appeal that followed, they are outside the scope of this Note.

136. *Travelers*, 813 F. Supp. at 999. *See also* Brief for Petitioner Hospital Association of New York, New York State Conference of Blue Cross and Blue Shield v. Travelers Insurance Co., 115 S.Ct. 1671 (1995) (Nos. 93-1408, 93-1414, 93-1415) (1995). The 13% surcharge was codified in N.Y. PUB. HEALTH LAW § 2807-c (1) (b).

137. *Travelers*, 813 F. Supp. at 999. It should be noted that the leading plaintiffs were insurance carriers. The *Travelers* litigation did not involve self-insured (as distinguished from insured) health plans.

as defendants.[138] The New York State HMO Conference, as well as Health Services Medical Corporation and eleven individual HMO's, then intervened in both actions as plaintiffs to invalidate the 9% surcharge.[139] Since all the parties were broadly attacking the premise of the New York system that compelled them to pay higher rates than the Blues, the District Court consolidated the two actions.

The court invalidated the surcharge statutes, holding that their economic impact "related to" ERISA plans and were within the preemption scope of § 514(a).[140] Further, the court held that the surcharges were not within the "savings clause" of U.S.C. § 1144(b) (2) (A).[141] On a Motion to Stay the ruling pending appeal,[142] the court granted the Motion as to the 13% surcharge, but not as to the 9% and 11% surcharges.[143] Finally, the court ordered the plaintiffs and any other parties subject to the 9% and 11% surcharges to pay -- or continue paying -- the funds into an interest bearing escrow account.[144]

The court found that ERISA's preemption provision should be broadly construed. In holding that the surcharges were preempted, the court noted that Congress' intent is controlling: "If the intent of Congress is clear that is the end of the matter for the court . . . must give effect to the unambiguously express intent of Congress."[145] The court found that the legislative history, which included the Conference Committee's rejection of a much narrower preemption provision in favor of the current broad language, supported a broad reading of § 514(a).[146]

The court also elaborated on a recent series of Supreme Court cases which supported its contention that ERISA's preemption clause should be interpreted broadly, stating that "a law relates to an employee benefit plan in the normal sense of the phrase *if it has a connection with or reference to such a plan.*"[147] Further, "[e]ven if the law is not specifically designed to affect employee benefit plans, or because it does not deal exclusively with

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138. *Id.*

139. *Id.*

140. *Id.* at 1003-1006.

141. *Id.* at 1007-08.

142. The defendants' Motion to Stay was made pursuant to FED.R.CIV.P. 62(c). *Travelers*, 813 F. Supp. at 1013.

143. *Id.*

144. *Id.*

145. *Id.* at 1001, quoting Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984).

146. *Travelers*, 813 F. Supp. at 1002, quoting *Shaw*, 463 U.S. at 98-100.

147. *Travelers*, 813 F. Supp. at 1002, quoting Ingersall-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990) (emphasis added).

subjects covered by ERISA [it may be preempted]."[148] In discussing the Supreme Court cases, the court emphasized the limits to the broad sweep of ERISA's preemption provision on state action, stating that "state action that may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'related to a plan' are not preempted."[149]

Turning its attention to the surcharge statutes, the court found that they clearly had a "connection with ERISA plans" even though they "do not mention such plans."[150] The "connection" in this case was the economic effect that surcharges would have on commercial insurers and HMO's which cover ERISA plans.[151] The court found that the surcharges entire premise was to increase the cost of any insurance that was not obtained through the Blues to a sufficient extent that customers will switch their coverage to the Blues.[152]

The defendants argued that the surcharges did not impact the structure, or administration, or impose requirements on use of plan resources, or impose inconsistent obligations on multistate plans, but they failed to persuade the court.[153] The court pointed out that the economic burden which the surcharges imposed would affect the structure and/or administration of ERISA plans.[154] "The [ERISA] plans," the court said,

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148. *Travelers*, 813 F. Supp. at 1002, quoting FMC Corp. v. Holliday, 498 U.S. 52, 56 (1990). The court also cited Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), as further evidence of the broad scope of ERISA's preemption provision: "a state law may be preempted even if it is consistent with ERISA's substantive requirements." *Id.* at 739-41.

149. *Travelers*, 813 F. Supp. at 1002, quoting *Shaw*, at 100, n.21. *See* this Note, *supra* Part II, Section C for a discussion of Mackey v. Lanier Collection Agency and Service, Inc., 486 U.S. 825, 830-41 (????) (generally applicable wage garnishment law is not preempted). *See also*, *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (????), (one time severance payment not preempted).

150. *Travelers*, 813 F. Supp. at 1003.

151. *Id.* The plaintiffs submitted affadavits stating that if the surcharges were enforced against them, they would pass along those costs to customers, including ERISA plans. *Id.* The plaintiffs claimed that the 11% surcharge brought ERISA plans in New York to raise their premiums from 2% to 5%. *See* Brief for Respondents, The Travelers Insurance Company, et al, New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 115 S.Ct. 1679 (1995). The plaintiffs estimated that the 13% surcharge would result in millions of dollars of added costs to self-insured ERISA plans for which it provided claims administration services. The other commercial insurers and HMO's offered virtually identical experiences. *Travelers*, 813 F. Supp. at 1003.

152. *Id.* at 1003.

153. *Id.* at 1004.

154. *Id.* Here, Judge Freeh was able to cite *United Wire* as precedent for the idea that an economic burden may "affect the structure of the [plans] themselves." *Id.*, quoting

"may reduce the level of benefits or services rather than increase costs to plan participants."[155] Thus, even an indirect increase in plan costs imposes requirements that are related and have a connection to ERISA plans. Finally, the court rejected the defendants' contention that the surcharges would not impose inconsistent obligations upon multistate plans, because "if the plans do opt to change the level of benefits offered rather than pass their [the commercial insurers'] increased costs on to participants, the surcharges will, at least indirectly, impose inconsistent obligations upon multistate plans -- exactly the type of burden ERISA's preemption clause was intended to prevent."[156]

Interestingly, the court declined to follow Second Circuit precedent in *Rebaldo v. Cuomo,*[157] which held that New York's prior hospital rate-setting statute, which granted patients covered by Blue Cross a 12-15% *discount* from the DRG rate, was not preempted by ERISA. *Rebaldo* thus rejected the argument that an economic effect on a plan was sufficient by itself to find a law preempted.[158] But, the court in *Travelers* was not persuaded by *Rebaldo's* reasoning that "a state law must purport . . . to regulate . . . the terms and conditions employee benefit plans to fall within the preemption provisions."[159]

In overturning precedent, the court relied on the recent Supreme Court opinions that interpreted the ERISA preemption provision broadly.[160] The court pointed out that, although the surcharges were indirect, they were likely to be substantial on a plan's costs or benefits, an impact that falls within the preempted sphere of ERISA.[161] Finally, the court rejected the state's argument that a dissimilarity in costs of doing business was not an

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United Wire, 793 F. Supp. at 536.

155. *Travelers*, 813 F. Supp. at 1004.

156. *Id.* at 1004-05. *See* discussion on ERISA's history in this Note, *supra* part II.A.

157. 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1984). The Court in *Rebaldo* found that the statute in question was "[one] of general application [that] does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, *the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.*" *Id.* at 139 (emphasis added).

158. *Id.*

159. *Id.* at 137 (quoted in *Travelers*, 813 F. Supp. at 1005).

160. *Travelers*, 813 F. Supp. at 1005. Judge Freeh emphasized that *Ingersoll Rand* "expressly rejected" the "narrow" interpretation which *Rebaldo* gave to the preemption provision. *Id.*, quoting *Ingersoll Rand*, 498 U.S. at 141.

161. *Id.* at 1006. The Court in Rebaldo, as Judge Freeh pointed out, seems to have assumed that the economic impact of the rate setting statute was insubstantial and indirect. This was not the case in Travelers because the statutes were expressly directed at the cost of medical care and were likely to have a substantial (albeit indirect) impact. *Id.*

impediment to national uniformity,[162] because the surcharges "required . . . calculat[ing] benefit levels in [New York] based on expected . . . conditions. . . . that differ from those in states that [do not impose such costs]."[163] Thus, the NYPRHM "frustrated [an ERISA plan's] . . . obligation to calculate uniform benefit levels nationwide."[164]

Having found that the surcharges had a substantial economic impact on *and thus a connection with ERISA plans*, the court considered whether the surcharges fell within the scope of ERISA's "savings clause."[165] The court found the "surcharges did not regulate insurance."[166] First, the NYPHRM did not regulate insurance because HMO's and self-insured plans do not engage in the business of insurance.[167] Further, the 11% and 13% primary goal of the charges was to regulate hospital rates, not insurance.[168]

Turning to the McCarran-Ferguson's criteria, the court found that the surcharges did spread the risk of insuring high risk individuals.[169] The court relied on the fact that an increase in the premiums would cause at least some individuals to obtain their insurance through the Blues rather than commercial carriers, thus spreading the risk of high risk individuals among a larger pool.[170] But the surcharges failed to satisfy the two other prongs of

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162. *Rebaldo,* 749 F.2d at 139; *Travelers,* 813 F.Supp at 1006. National uniformity was one of the primary goals of the ERISA preemption provision. *See supra* part II.A of this Note.

163. *Travelers,* 813 F.Supp at 1006, quoting *FMC Corp.*, 498 U.S. at 58.

164. *Id.*, quoting *FMC Corp.*, 498 U.S. at 60.

165. *Travelers,* 813 F.Supp at 1006. The Savings Clause is codified in 29 U.S.C. § 1144(b)(2)(A). *See, supra* part II.B. of this Note. The McCarran-Ferguson Act is codified in 15 U.S.C. § 1011.

166. The criteria for whether a law regulates insurance are:

> A. Whether the law regulates insurance; and
> B. Whether the law satisfies the three factors of the McCarran Ferguson Act: (1). "whether the practice has the effect of transferring or spreading a policyholder's risk"; (2). "whether the practice is an integral part of the policy relationship between the insurer and the insured"; (3). "whether the practice is limited to entities within the insurance industry."

Travelers, 813 F.Supp at 1007.

See Pilot Life, 481 U.S. at 48-49. *See also, supra* Part II.B of this Note. (In finding the "savings clause" unavailing, Judge Freeh "gave the clause a reading as narrow as [he] gave the preemption clause broad.") Hesse, *supra* note 133, at 81.

167. *Travelers,* 813 F.Supp at 1007.

168. *Id.*

169. *Id.*

170. *Id.* at 1008.

the McCarran-Ferguson test.

First, the surcharges were (as the court noted earlier) aimed at hospital rates and thus not an integral part of relationship between the insurer and the insured.[171] Second, the surcharges were not limited to the insurance industry as they referred to hospitals, HMO's are entities that are not directly involved in the issuance of insurance.[172]

However, the court did partially grant the Motion to Stay pending appeal. In doing so, the court weighed the relative harms to the applicant, the respondent and the public at large.[173] The court found that the defendants had a substantial possibility of succeeding on appeal, mostly because of the evolving law on ERISA as well as the prior precedent of *Rebaldo*.[174] The court found that the defendants would suffer irreparable harm absent a stay of the 13% surcharge, because it had been in effect for nearly ten years and would cause "an irreparable disruption in the function of and services provided by New York's hospitals" while the respondents would only suffer monetary damages.[175] The court denied the Motion as to the 9% and 11% surcharges because neither party would suffer any harm if the Motion as to these surcharges was denied and it was not in the public's interest to grant a stay. [176]

C. *The Appellate Court Opinion:* Travelers Insurance Company v. Cuomo[177]

The Court of Appeals for the Second Circuit affirmed the district court's holding that the surcharges "relate to" insurers and HMOs and are thus preempted by ERISA.[178] Like the district court, the Second Circuit

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171. *Id.*

172. *Id.*

173. *Id.* at 1013.

174. *Id.*

175. *Id.* at 1014.

176. *Id.* The court pointed out that the plaintiffs would suffer substantial harm if it stayed with respect to the 9% and 11% surcharges because both would be difficult to recover if the court's ruling were stayed and then later upheld. The 9% was collected by the state and could not be recovered through an action in federal court; the 13% surcharge paid to hospitals also would be difficult to recover because they would be required to sue every hospital in order to recover any money improperly paid. *Id.*

177. 14 F.3d 708 (2nd Cir. 1993).

178. The Second Circuit also addressed the issues of whether the Tax Injunction Act, 28 U.S.C. § 1341, barred the plaintiff's claim to the 9% and 11% surcharges, *Travelers,* 14 F.3d at 713-14; whether the plaintiff's claim was barred by the doctrine of laches, *Id.*; whether the Federal Employee Health Benefit Act's preemption provision, 5 U.S.C. § 8909(f)(1), preempted the 11% and 13% surcharges, *Id.* at 715-17; and whether an actuarial

relied primarily on recent Supreme Court opinions which had interpreted the ERISA preemption provision broadly.[179] The court rejected its own precedent set down in *Rebaldo*.[180] The court applied[181] a "less stringent" 'connection with' standard [for finding state laws that "relate to" ERISA covered plans preempted]."[182] The court was able to point to a whole series of other cases that supported this broad interpretation of ERISA preemption.[183]

The Second Circuit agreed with the district court that the indirect economic interference of the surcharges on ERISA plans warranted preemption. The court found the surcharges "purposely interfere with the choices that ERISA plans make for health care coverage [which is] sufficient to constitute 'connection with' ERISA plans [for preemption purposes][184]. . . [because they] . . . 'substantially increase the cost of ERISA plans of providing beneficiaries with a given level of health care benefits.'"[185] Because the three surcharges "relate to" ERISA by this

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letter issued by the New York State Department of Insurance imposing requirements on "stop-loss type policies" was also preempted by ERISA. *Id.* at 723-25.

179. *Id.* at 719. The Second Circuit pointed out that the Supreme Court in *Pilot Life*, 481 U.S. at 718, had interpreted the words "relate to" in ERISA to encompass its "broad common sense meaning." *Id.* at 718. This interpretation gives "effect to the deliberately expansive language chosen by Congress." *Id.* at 719, quoting *Greater Washington Board of Trade*, 113 S. Ct. at 583.

180. 749 F.2d 133 (2d Cir. 1984).

181. The *Travelers* Court rejected a suggestion that ERISA's preemption provision only reached state laws that purported to regulated ERISA plan terms and conditions. *Travelers*, 14 F.3d at 719.

182. *Id.*

183. *Id.* at 719-20. The Court cited National Elevator Indust., Inc. v. Calhoun, 957 F.2d 1555, 1561 (10th Cir. 1992), *cert. denied*, 113 S.Ct. 406 (1992) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"); In Re Michigan Carpenters Council Health & Welfare Fund, 933 F.2d 376, 382-83 (6th Cir. 1991), *cert. denied*, 112 S.Ct. 585 (1991) (ERISA preempts Michigan state corporate reorganization statute that allowed employers to unilaterally alter their obligations to ERISA plans); National Carriers' Conference Comm. v. Heffernan, 440 F. Supp. 1280 (D.Conn 1977) (Connecticut tax on ERISA benefits preempted since it may encourage use of traditional insurance rather than ERISA-covered plans); Morgan Guar. Trust Co. v. Tax Appeals Tribunal of Dep't of Taxation & Finance, 599 N.E.2d 656, 660 (NY 1992) (New York real estate gains tax preempted as applied to sale of ERISA property because tax will influence plans' investiment strategies).

184. *Travelers*, 14 F.3d at 719.

185. *Id.* at 720. The court found persuasive authority in E-Systems, Inc. Authority v. Pogue, 929 F.2d 1100 (5th Cir. 1991), *cert. denied*, 112 S.Ct. 585 (1991). E-Systems, Inc. involved a statute which imposed a 2.5% tax on administrative and service fees because "[t]he cost of the plan must therefore increase for the employer and/or employees or the

"significant economic burden on commercial insurers and HMO's . . . [t]hey therefore have an impermissible impact on ERISA plan structure and administration."[186]

The court then turned its attention to the "savings clause" of ERISA. Judge McLaughlin accepted the district court's analysis and found the "savings clause" unavailing to prevent the preemption of the surcharges. First, the court found that the 13% and 11% surcharges did not "regulate insurance" within the meaning of the savings clause, since they were aimed at hospital rates rather than the insurance industry.[187] Second, the McCarran-Ferguson factors were not all present. While the surcharges did "spread the risk of health care costs," they neither "regulated any practice that was integral to the insurer-insured relationship," nor were they "limited to entities within the insurance industry."[188] Consequently, the savings clause did not preserve the surcharges from preemption.

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benefits must be adjusted downwards to offset the tax bite. This is the type of impact that Congress intended to avoid when it enacted the ERISA legislation." *Id.* at 1103. Further authority was supplied from *Alessi* which preempted a New York labor law governing wage requirements where it required employers to pay certain benefits because "private parties, not the Government, control the level of benefits under ERISA." *Travelers,* 14 F.3d at 720, (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 522 (1981)).

186. *Travelers,* 14 F.3d at 721. By this logic, the court evidently reasoned that there is "some line which must be drawn in order to determine whether a state statute's indirect economic impact is great enough to warrant preemption." See 2 NO. 6 ERISA LITIG. REP. 16.

187. *Travelers,* 14 F.3d at 721-22. The court also expressed concern that reading the words "regulates insurance" too broadly would cut deeply into the preemption provision which would render the scheme of ERISA unworkable. *Id.* at 722. In a footnote the court pointed out that the 9% surcharge also did not fall within the savings clause because "HMO's do not engage in the ' business of insurance' as a matter of law." *Id.* at 723, n.6. Perhaps it was the Court's concern of possible future broad readings of the "savings clause" that led it to rule on an issue that was not before it (i.e., led it to rule on whether an HMO was an insurance entity). None of the petitioners in this case challenged the district court's determination, that, as a matter of law, the 9% surcharge did not fall within the insurance savings clause. Nevertheless, the court of appeals felt compelled to affirm the district court's opinion that since HMO's were not insurers, the 9% surcharge could not be preserved by the savings clause.

188. In finding that the surcharges "spread the risk of health care costs," the court accepted the district court's reasoning that better risk persons would be induced to switch to the Blues because of the higher costs imposed by the surcharges. *Id.* at 722. But the surcharges did not "regulate any practice that was integral to the insurer-insured relationship" because "the essence [of this McCarran-Ferguson factor] is whether the statute dictates any of the terms of the insurance contract itself, the principal embodiment of the insurer-insured relationship." *Id.* at 723 (quoting Howard v. Gleason Corp., 901 F.2d 1154, 1159 (2nd. Cir. 1990)). Finally, the surcharges were not "limited to the entities within the insurance industry" because they involved entities "beyond the insurance industry,

D. The Supreme Court Opinion: N.Y. Conference Of Blue Cross & Blue Shield Plans v. Travelers Insurance Company.[189]

The Supreme Court, in a decision delivered by Justice Souter, unanimously ruled that state-imposed surcharges to hospital bills paid by patients with commercial health insurance were not preempted by ERISA.[190] In resolving the dispute between the Second Circuit's decision in *Travelers* and the Third Circuit's decision in *United Wire*, the Supreme Court unanimously rejected the notion, with a caveat, that an indirect economic influence was insufficient by itself to find a state law preempted by ERISA. In doing so, the Court preserved the role of the state as an innovator and formulator of health care legislation, and reversed a recent trend of broad ERISA preemption of state health care laws in the courts.

The Court began its analysis by stating that there is a "starting presumption that Congress does not intend to supplant state law,[191]. . . [and] . . . [that the Supreme Court] work[s] on the assumption that the historic police powers of the states were not to be superseded by [Federal law] unless that [is] the clear and manifest purpose of Congress."[192] While the Court found that the governing text of ERISA was "clearly expansive,"[193] it was not absolute because "[i]f 'relate to'" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course for "[r]eally, universally, relations stop nowhere."[194] But in attempting to construe the meaning and scope of the phrase "relate to" the court "recognize[d] that its prior attempts to construe the phrase does not give [the Court] much help drawing the line [of ERISA's preemption limits]."[195]

Despite this disclaimer, Justice Souter relied heavily on previous Supreme Court opinions that both interpreted the phrase "relate to" as well

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including the State, hospitals, patients, HMO's, and self-insured funds." *Travelers,* 14 F.3d at 723

189. 115 S. Ct. 1671 (1995).

190. The sole issue before the Court was "whether [ERISA] . . . pre-empts the state provisions for surcharges on bills of patients whose *commercial insurance is purchased by employee health-care plans* governed by ERISA, and for surcharges on HMO's insofar as their membership fees are paid by an ERISA plan." *Id.* at 1673-74 (emphasis added). The Court never addressed the issue of *self-funded plans*. This distinction became relevant in the Second Circuit on remand. *See infra* part III.E. of this Note.

191. *Id.* at 1676.

192. *Id.*, quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947).

193. *Id.* at 1677.

194. *Id.*

195. *Id.*

as the legislative history and impetus behind the ERISA preemption provision. The Court emphasized that § 514 (a) indicates Congressional intent to establish the regulation of employee welfare benefit plans as "exclusively a federal concern . . . [to] eliminate the threat of conflicting and inconsistent regulation . . .[196] [and] to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[197] Souter then pointed to *Shaw* and *FMC Corp* – noting that both gave effect to this stated objective of Congress.[198]

However, the Court was able to distinguish the New York surcharge statutes from the statutes considered in *Shaw* and *FMC. Corp.* by pointing out that "an indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself . . . nor does the indirect influence of the surcharges preclude uniform administration . . . or . . . uniform interstate benefit package[s] if a plan wishes to provide one."[199] The surcharges, the Court continued, "simply bear on the costs of benefits and the relative costs of competing insurance to provide them . . . [I]t [the surcharge law] does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges."[200]

So cost uniformity was *not* an object of the ERISA preemption clause and a "far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans."[201] The Court had two main justifications for finding this result:

> 1. Charge differentials for commercial insurers, even prior to state regulation, always showed variation from region to region, "presumably reflecting the geographically disparate burdens [*hospitals* have] of providing for the

196. *Id.*, quoting Representative Dent, 120 CONG. REC. 29197 (1974). *See supra* note 32.

197. *Id.*, quoting Senator Williams, *supra* note 32.

198. *Shaw* preempted the New York Human Rights Law "which prohibited employers from structuring their *employee benefit plans* in a manner that discriminates against pregnancy . . . and [New York's] Disability Benefits Law, which require[d] employers to pay employees specific benefits." *Id.* at 1678 [emphasis added] (quoting *Shaw*, 103 S.Ct. at 2900). *FMC Corp. v. Holiday Corp.*, "preempted a Pennsylvania law which prohibited plans from . . . requiring reimbursement [from a beneficiary] in the event of a recovery from a third party.") *Id.* at 1678, quoting *FMC Corp.*, 498 U.S. at 408.

199. *Travelers*, 115 S. Ct. at 1679.

200. *Id.*

201. *Id.* at 1680.

uninsured;"[202]

2. Common state regulations have always had indirect economic effects on a plan's costs. The Court cited hospital quality control and workplace regulations as examples of general state action that would "indirectly affect what an ERISA or other plan can afford or get for its money."[203]

For these reasons, to "read the preemption provision as displacing all state laws affecting costs and charges on the theory that they indirectly 'relate' to ERISA plans . . . would effectively read the limiting language in § 514(a) out of the statute."[204] This result would directly counter, Souter wrote, prior precedent which stated that "preemption does not occur . . . if the state law has only a tenuous, remote or peripheral connection with covered plan."[205] Simply, the Court was not willing to displace a general health care legislation, which had "historically been a matter of local [state] concern."[206]

Though the Court clearly shied away from a reading of ERISA's preemption provision so broad that it would bar the state's regulations of hospital costs,[207] it did not hold that ERISA preempts only direct regulation

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202. *Id.* at 1679.

203. *Id.*

204. *Id.*

205. *Id.* at 1679-80 (quoting District of Columbia v. Greater Washington Board of Trade, 113 S.Ct. 580, n.1).

206. *Id.* at 1680. The Court pointed to Mackey v. Lanier Collection Agency, 486 U.S. 825 (1988) as confirmation that it upheld the principle of allowing localities to create general health care legislation. *Mackey* held that preemption "falls short of barring a general state garnishment statute to participants' benefits in the hands of an ERISA welfare plan." *Travelers,* 115 S.Ct. at 1680 (quoting *Mackey*, 486 U.S. at 831). Since this garnishment law "authorizing an indirect source of administrative cost is not preempted, it should follow that a law operating as an indirect source of merely economic influence on administrative decisions as [in the Travelers case], should not suffice to trigger preemption either." *Travelers*, 115 S.Ct. at 1680. In analyzing the case, one author suggested that the Court "evinced concern, even nervousness, that its prior rulings on ERISA preemption could threaten state laws which only remotely affect ERISA plans. The Blue Cross decision is the Court's effort to restore some balance to preemption jurisprudence, and to set reasonable boundaries." Swidler, *supra* note 116.

207. The Court was able to point to numerous state statutes regulating hospital rates after ERISA was enacted as evidence that ERISA was not intended to bar the states from setting hospital rates. *Travelers*, 115 S.Ct. at 1681. In addition, the Court pointed to the National Health Planning and Resources Act (NHPRDA), Pub. L. 93-641, 88 Stat. 2225, §§ 1-3, repealed by Pub.L. 99-660, Title VII, § 701(a) 100 Stat. 3799, which was adopted by

of ERISA plans. An indirect regulation might "produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers [as to] be preempted under ERISA."[208] Though the Court was not specific about what constitutes "an acute indirect economic effect," the New York surcharges only "affected indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation . . ." and were therefore not preempted.[209]

E. The Opinion on Remand[210]

The remanded case is a first look at how the courts may treat a less broadly construed ERISA under the standards articulated by the Supreme Court. On remand, the plaintiffs advanced the theory that surcharges on *self-insured* plans should be preempted because they relate to plans since they "(1) force the plans to buy insurance, rather than self-insure; (2) directly depletes self-insured plans' assets; and (3) 'refers' to ERISA plans [within the meaning of the ERISA preemption statute]."[211] The Court rejected all of these claims and upheld the surcharges in light of the Supreme Court's holding regarding private insurance plans.

The court found no basis for treating self-insured plans any differently than other plans when determining whether a state law "relates to" ERISA. The court rejected the theory that an economic effect, by itself, was enough to warrant preemption. The court answered the plaintiffs first argument by pointing out that the surcharges didn't force any plan to abandon self-insurance since "few, if any, of the plans have decided not to self-insure

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the same Congress that passed ERISA only months earlier. The statute provided certain state agencies would be eligible for federal funding "for the purpose of demonstrating the effectiveness of State Agencies *regulating rates for the provision of health care* . . . within the state" (emphasis added). *Travelers*, 115 S.Ct. at 1680 (quoting NHPRDA at 2249). Congress, then, clearly envisioned the states maintaining their power to regulate hospital rates.

208. *Id.* at 1683.

209. *Id.*

210. 63 F.3d 89 (2nd Cir. 1995).

211. *Id.* at 93. In a footnote the Supreme Court mentioned that it did "not address the [13%] surcharge insofar as it applies to self-insured funds" because the original appellate decision had never "expressly address[ed]" it in their opinion, and because the district court had referred to it only in staying its decision pending appeal. Thus, the issue was left to the appellate court on remand. *Id.* at 92-3 (quoting *Travelers*, 115 S.Ct. at 1675, n.4).

[despite the fact that the plaintiffs had to continue paying the surcharge during the appeal]."[212]

Further, the court, echoing the Supreme Court, broadly pointed out that any economic pressure that the surcharge placed on an ERISA plan's decision to self-insure "is no different from other economic influences on a plan's decisions to purchase insurance . . . and under [the Supreme Court's decision], *states may create rate differentials that influence such decisions*."[213] The court even questioned the utility of distinguishing between laws that "directly deplete ERISA plans' assets and laws that only indirectly do so."[214]

The plaintiff's second argument was dispensed by the court, somewhat awkwardly, by stating that the surcharges don't "directly deplete [a plan's] assets . . . the surcharges raise costs to a third party-the patient who is responsible for the balance of any bill which an ERISA plan or insurance carrier refuses to pay."[215] Finally, the plaintiff's final argument, that the surcharges "related to ERISA plans," was rejected because the surcharges were imposed regardless of whether the commercial coverage was secured by an ERISA plan. The absence or failure of the NYPHRM to single out any "ERISA, pension plans, health insurance coverage" shows that it does not "relate to" an ERISA plan.[216]

IV. ANALYSIS

The Supreme Court's decision in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*[217] will undoubtedly allow states greater freedom to reform health care systems to meet the needs of all persons.[218] The Court's language in *Travelers*, that

212. *Travelers*, 63 F.3d at 94.
213. *Id.* (emphasis added).
214. *Id.*
215. *Id.*
216. *Id.* at 94-95.
217. 115 S.Ct. 1671 (1995).
218. *Supreme Court: Court Vacates Second Circuit Judgment on New York Tax on Medical Centers*, DAILY REPORT FOR EXECUTIVES, April 27, 1995 at 84. New York State Commissioner Barbara A. Debuono said that the decision "maintains New York's flexibility in redesigning [New York's] reimbursement system to achieve [the state's] objective of expanding access to high quality medical services at an affordable costs. *Id.* The chairman of the New York State Conference of Blue Cross and Blue Shield Plans said that the case "was a victory for states because it preserves their ability to set public policies that broaden

areas of "traditional state regulation" are not to be preempted "unless that was the clear and manifest purpose of Congress,"[219] indicates that preemption analysis has undergone a shift. Instead of focusing on whether the statute or regulation imposes "inconsistent and multiple obligations"[220] on an ERISA plan, the Court will *presume* that "traditional state regulation" is *not* preempted unless it is explicitly clear that Congress intended such a result.

Thus, the Supreme Court has yet again added a new standard in its ERISA preemption standard. The Court seems to have rejected its former textualist approach to ERISA preemption.[221] The Court seems more likely today to rely on its dicta in *Shaw*, which expressed the Court's nervousness with preempting state laws that have too "tenuous or remote" an affect on ERISA plans to warrant preemption.[222] The Court's new emphasis on "remoteness" when considering state laws of general applicability is good news to state legislators. Its previous standard of review, which focused on national uniformity, as well as its textualist approach, was used by lower courts to preempt state legislation. The new standard seems much more likely to preserve state laws -- especially those of general applicability.

Travelers preserves the original intent which led to the creation of ERISA. There is no evidence that Congress ever intended to preempt a wide range of state laws that control hospital costs, regulate insurance or increase the availability and affordability of health care, hospital, and medical insurance coverage.[223] *Travelers* thus preserves a wide range of state laws designed to control costs and increase the availability of health and medical coverage. New York relied considerably on its cost shifting legislation. It "was central to the state's efforts to regulate . . . [the health care] . . . industry in a manner which promotes access to affordable health insurance coverage."[224] The Blues, with their open enrollment policies

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access to health care coverage for citizens who are least able to protect themselves . . . [the states] have been given a green light to construct and remodel their systems to remain contemporary with today's world of health care delivery and financing". *Id.*

219. *Travelers*, 115 S. Ct. at 1676.

220. *See supra* part II.A and II.B of this Note.

221. The Supreme Court adopted a textualist approach in *Washington Board of Trade*. *See supra* part II.B of this Note.

222. *Id.*

223. *See supra* part II.A of this Note.

224. Brief for Petitioners, New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield at 40, *New York State Conference of Blue Cross and Blue Shield v. Travelers Insurance Co.*, 115 S.Ct. 1679 (1995).

simply could not compete with other insurers -- their precarious financial situation needed to be addressed.[225]

It is fortunate, then, that the Court found as it did. By bringing ERISA plans back under the ambit of state legislative authority, the Court has allowed the state to assume its traditional role as a formulator of public policy. It has also, to an extent, removed the courts as legislators, an important result especially considering the federal government's failure to address pressing health care issues.[226] States should not have to rely on enlightened courts like those in *United Wire*[227] and *Rebaldo*[228] to formulate health care policy.

By accepting the logic of the *United Wire* and *Rebaldo* courts, the Court served notice that economic effects, standing alone, are not enough to warrant preemption. This is an important limitation on a court's power, as preemption based on economic effect was persuading some courts to void state laws.[229] A simple economic analysis of whether a state law "relates to" an ERISA plan has virtually no practical limit: any state law, even one with a minute or remote financial affect on ERISA, may be preempted. The Court struck a fair balance in *Travelers*. On the one hand, the court refused to find that an economic impact, standing alone, would be enough to warrant preemption. On the other hand, the Court hedged slightly when it acknowledged that an indirect economic effect might be so acute as to warrant preemption.[230] The Court also retained its precedent: *any* law which forces ERISA plans into "inconsistent and multiple obligations" will still be preempted.

It remains to be seen whether and to what extent the lower courts will follow the Supreme Court's lead in *Travelers* and block the reach of ERISA preemption, although the conflict between the Second and Third Circuits has clearly been resolved. The early response of several courts is encouraging. A telling example of *post-Travelers* preemption analysis is the case of Connecticut's foray into innovative health care legislation. In *New England Health Care Employer's Union v. Mount Sinai Hospital*,[231]

225. *See supra* part III of this Note (giving the background of the *Travelers* litigation).

226. *See* Hancock, *supra* note 11. Hancock points out that Republican victories in the 1994 election were "interpreted . . . as a signal by the American public that health care reform was no longer a national priority . . . [b]ecause the federal government has abandoned health care reform many states have attempted to enact reform measures to increase access and contain the costs of health care measures." *Id.* at 383.

227. 995 F.2d 1179 (3rd Cir. 1993), *cert. denied*, 510 U.S. 944 (1993).

228. 749 F.2d 133 (2nd Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

229. *See supra* part II.C. of this Note.

230. *Travelers*, 115 S. Ct. at 1683.

231. 846 F. Supp. 190 (D.Conn. 1994), rev'd, 65 F.3d 1024 (2nd Cir. 1995).

the court considered Connecticut's Uncompensated Health Care Pool Act[232] which "specifically [created a pool of funds] to compensate hospitals for the cost of providing services to those unable to pay for such services -- Connecticut's indigent, uninsured, and underinsured citizens."[233] The statute basically required hospitals to remit the assessment to the state without specifying how it was to be collected.[234] Once the assessment was collected and remitted to the state, it was pooled into an account and from there redistributed to the hospitals in proportion to their level of "uncompensated care."[235]

Thus, Connecticut's legislation was similar to that considered by the *United Wire* and *Travelers* courts. The Court essentially employed an economic argument to find the Act preempted. The Court pointed out that the Act "would not be economically viable without ERISA plans . . . [because] ERISA plans provide as much as 70% of the funding for the Act";[236] thus, "the Act contemplates . . . and depends on [ERISA plan existence, and therefore] it is preempted by ERISA."[237]

The court employed economic analysis in another manner, namely, the substantial financial impact the statutes had on ERISA plans. Like the appellate court in *Travelers,* the court found that ERISA plans would have to "increase costs or reduce benefits."[238] This economic effect, by itself, was enough to trigger preemption, since "such a [substantial] impact,

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232. CONN. GEN. STAT. § 19a-168. The Act underwent numerous amendments. Initially, the Health Care Pool Act was funded by "an assessment on all payers other than Medicare, Medicaid, and CHAMPUS [the Civilian Health and Medical Program of the Uniform Services]." CONN. P.A. 91-2, § 1, as amended by CONN. P.A. 92-16, § 55. The Act was again amended in 1993 by Public Act 93-44, to provide that the pool was to be funded by a 6% sales tax on hospital services plus an "assessment on all hospital charges for patient care services except those rendered to patients whose services are covered by Medicare, medical assistance, and CHAMPUS." CONN. P.A. 93-44. The Act was further amended in 1993 by Public Act 93-229 to provide that the pool is to be funded by a 6% sales tax on all on hospital services plus an assessment on all services, which means that, by the time this litigation arose, the assessment was "a uniform per cent of the hospital revenues for patient care services except those rendered to patients whose services are covered by Medicare, medical assistance and CHAMPUS." CONN. P.A. 93-229, § 10.

233. *New England Health Care Employees Union* at 192.

234. *Id.* at 192.

235. CONN. GEN. STAT. § 19a-168b(d)(1), as amended by CONN.P.A. 93-44, § 10. *See New England Employees Health Care Union* at 193.

236. *New England Employees Health Care Union* at 195.

237. *Id.*

238. *Id.* at 196.

almost by definition, *does* affect the structure and administration of ERISA plans."[239]

In a similar *pre-Travelers* case also involving the Connecticut Uncompensated Health Care Pool Act, *The Connecticut Hospital Association v. Pogue*,[240] the court also found that "statutes that have a substantial economic impact on ERISA plans, causing such plans to either increase costs or reduce benefits, are preempted by ERISA."[241]

Neither case survived a post-*Travelers* preemption analysis. Connecticut's health legislation, on the other hand, did survive. The appeal of *New England Health Care Union*[242] shows how preemption analysis has shifted. The court admitted to this shift in the standard of review.

> Before [the Supreme Court's opinion] in *Travelers*, we [the circuit court] applied the ['relation to'] prong of ERISA preemption differently, depending on whether the law under attack "directly" or "indirectly" affected ERISA plans . . . and reasoned that a tax directly depleted the [ERISA] plan's assets, and thus related to the plan in a very direct manner [because it] substantially increased the cost to ERISA plans of providing beneficiaries with a given level of benefits.[243]

Instead of a straight forward economic analysis, the court emphasized that the surcharge raised the cost to a *third-party* -- i.e., the patient. The self-insured plan are "not directly liable for the surcharge."[244] The court questioned whether it should "continue to distinguish between laws that directly deplete an ERISA plan's assets and laws that only indirectly do so."[245] Courts after *Travelers*, then appear to be more motivated to find that state laws are not preempted. Even a law like Connecticut's "directly" depleting an ERISA fund's assets is not preempted after *Travelers*.

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239. The court pointed that the plaintiffs in the case estimated that the Act increased plan costs by millions of dollars . . . and that benefits had to be reduced in part as a result of the Act. *Id.* at 196-7.

240. 870 F. Supp. 444 (D.Conn. 1994). After *New England Health Care Union*, the Connecticut legislature repealed the original Act and replaced it with essentially similar legislation. See Conn. Pub. Act 94-9. See *Pogue* at 446.

241. *Pogue*, 870 F. Supp. at 446.

242. 65 F. 3d 1024 (2nd Cir. 1995).

243. *Id.* at 1030.

244. *Id.* at 1032 (quoting Travelers v. Pataki, 63 F.3d 89 (2nd Cir. 1995)).

245. *Id.*

The court also evoked a public policy-esque argument for not finding the law preempted -- another change in how preemption analysis has changed. It accepted that "Congress envisioned state experiments with comprehensive hospital reimbursement regulation."[246] This respect for federalism, and the traditional power of states to regulate health care and their need to experiment that was so lacking in other preemption cases, may be an early sign that the courts will be more open to state legislative efforts. In closing, the court suggested that the Connecticut law failed to force plans to "restructure themselves, buy insurance rather than self-insure, or reduce benefits"[247] was not preempted -- a far more permissive analysis than it had employed previously. *Pogue*[248] met a similar fate in *The Connecticut Hospital Association v. Weltman.*[249] The court advanced the same arguments as it did in *New England Health Care Union* to Connecticut's law not preempted.[250]

Other courts are also giving much more leeway to state health care legislation in the wake of *Travelers*. For example, the Seventh Circuit recently found that a Wisconsin statute assessing a fee upon companies selling health insurance in the state was not preempted by ERISA[251] Even this somewhat more direct effect on ERISA plans than that which was present in the *Travelers* case failed to trigger preemption.[252] The funds collected were used to make health insurance available to individuals whose physical or mental condition made it difficult for them to obtain insurance in the private market.[253] Guided by the *Travelers* decision, the court found that Wisconsin's "regulatory scheme . . . attempts to render health insurance and health care more accessible to individuals who find it difficult or impossible to obtain them in the private market."[254] The court accepted the fact that the assessment may "reduce or modify the benefits the employer is able or willing to offer,"[255] but this indirect economic effect was insufficient to cause the law to be preempted.

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246. *Id.* at 1033, (quoting *Travelers*, 115 S. Ct. at 1683, n.6).

247. *Id.* at 1034.

248. 870 F. Supp. 444 (D. Conn. 1994).

249. 66 F.3d 413 (2nd Cir. 1995).

250. *Id.* at 415.

251. Safeco Insurance Co., v. Musser, 65 F.3d 647 (7th Cir. 1995).

252. The effect in *Safeco* is somewhat more of a direct effect on ERISA plans because it charges the ERISA plan directly, not a third party patient like the surcharges in the *Travelers* case.

253. *Id.* at 648.

254. *Id.* at 652.

255. *Id.* at 653.

Thus, the *Safeco* court was willing to view a direct charge on ERISA plan companies as an indirect economic effect. Even in areas outside of state health care legislation, the courts appear much more likely to view ERISA preemption much more narrowly and preserve the state's traditional role as formulators of health care policy. For example, the Third Circuit recently overruled a lower court that had preempted a medical malpractice claim.[256] The court noted that the *Travelers* court had pointed out that while "quality standards . . . in the context of hospital services will indirectly affect the sort of benefits ERISA can afford, they have *traditionally been left to the states*. . . ."[257]

In sum, the cases following Travelers are much more deferential to traditional state authority and more restrained in their use of ERISA's preemption provision to strike down innovative state health care legislation. Perhaps this is what the *Travelers* Court intended. *Travelers* is having a positive effect on the lower courts: states are being given more freedom and flexibility to design their own health care systems as well as use innovative legislation to deal with the problems of the uninsured and increasing costs of health care. *Travelers* has removed the roadblock that ERISA preemption presented to the states and has helped take the courts out of the health care policy making process and returned it where it has traditionally been: in the state legislatures.

V. CONCLUSION

By finding that New York's health care legislation is not preempted by ERISA, the United States Supreme Court has returned the States to their traditional role as a formulator of health care policy. The *Travelers* opinion has reversed what has been a disturbing trend in the lower courts to continually preempt state laws of general applicability that attempted to deal with the health care crisis in this country. Given the federal government's failure to address the problem, *Travelers* offers a potential solution to health care problems: State experimentation. Considering the recent growth of ERISA plans, any law of general applicability dealing with comprehensive health care reform would have, in some fashion, affected ERISA plans. The number and financial worth of these plans makes them an attractive source of revenue for innovative state health care

256. *Dukes v. U.S. HealthCare*, 57 F.3d 350 (1995); see supra note 78.
257. *Id.* at 356 (citing *Travelers*, 115 S. Ct. at 1679) (emphasis added).

legislation. *Travelers* gives the States the freedom and flexibility to deal with assorted health care problems.[258]

258. James M. Saya, J.D. expected May, 1997.

Additional Insured Status In Construction Contracts And Moral Hazard

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I. INTRODUCTION

Suppose a general contractor (GC) wishes to hire a subcontractor (SC) to install an elevator in the building the GC is erecting. In contract negotiations, the inevitable questions surrounding insurance provisions and indemnity arise. The GC has requested that a provision requiring it be named as an "additional insured" be inserted into the contract. The subcontractor, eager to begin installation, succumbs and under the terms of their contract, the SC agrees to indemnify the GC for bodily injury sustained on the premises resulting from the installation work, unless the injury is caused by the GC's sole negligence.[1] The indemnification

1. A common example of such an express indemnity provision might read:

provisions also requires the SC to obtain insurance to this effect and names the GC as an "additional insured."[2] The foregoing arrangement has become an increasingly common risk-shifting technique in construction liability contracts, despite the relative lack of understanding afforded additional insured status. Although the SC has freely consented to this arrangment, the question remains as to what exactly it has consented to, and how the arrangement affects the bound parties. One especially important question is whether the GC, freed from the burden of procuring its own liability insurance and shielded from liability for its own acts will, in the interest of safety, have any incentive to adopt appropriate risk-reducing measures.[3]

This article will explore additional insured status, the reasons why parties desire to be named additional insured, and the policy arguments against allowing such arrangements in their current form, especially given the unfavorable treatment afforded broad form indemnity provisions.

> To the fullest extent permitted by law, the Subcontractor shall indemnify and hold harmless the Owner, Contractor, Architect, Architect's consultants, and agents and employees, of any of them from and against claims, damages, losses and expenses, including but not limited to attorney's fees, arising out of or resulting from the performance of the Subcontractor's Work under this subcontract, provided that such claim, damage, loss or expense is attributable to bodily injury, sickness, disease or death, or to injury or destruction of tangible property (other than the Work itself) including loss of use resulting therefrom, but only to the extent caused in whole or in part by the negligent acts or omissions of the Subcontractor, the Subcontractor's Sub-subcontractor, anyone directly or indirectly employed by them or anyone for whose acts they may be liable, regardless of whether or not such claim, damage, loss or expense is caused in part by a party indemnified hereunder.

THE AMERICAN INSTITUTE OF ARCHITECTS DOCUMENT A401, CONTRACTOR-SUBCONTRACTOR AGREEMENT 239 (12th ed. 1987). (Hereinafter AIA DOCUMENT A401).

2. A common example of contractual provisions imposing additional insured status might read: "If Subcontractor carries a Comprehensive General Liability policy . . . Contractor, his officers, directors, and employees and Owner shall be named as additional insureds under the Comprehensive General Liability insurance policy. . ." Linda R. Beck, *Ethical Issues in Joint Representation Under Subcontract Requirements for Defense and Additional Insured Status*, THE CONSTRUCTION LAWYER, January 1995 at 25.

3. This Comment will assume that an increase in safety precautions requires increased expenditures by the party wishing to reduce the risk of loss.

II. ADDITIONAL INSURED STATUS

For the purposes of this article, "additional insured status" will be used to reflect the practice of adding one party to another party's existing insurance policy[4] in compliance with a contractual provision providing as such, where the two parties are not otherwise related.[5] One party's acquisition of additional insured status on anothers' Commercial General Liability (CGL) policy is a common risk management technique not confined to construction.[6]

The effect of additional insured status is similar to the effect achieved by the more traditional risk transfer via indemnity or "hold harmless" clauses. In contracts, one party utilizes indemnity provisions to secure against future loss or damages. One party (indemnitor) becomes obligated to reimburse the other (indemnitee) for the loss, damages, or liability that the indemnitee incurs while working for or acting at the indemnitor's request or for his benefit.[7] Both attempt to allocate risks "in a manner that would not have occurred under common law in the absence of the contract."[8] Traditional tort common law obligates negligent parties to provide compensation when their conduct violates rules of negligence. In the case of express contractual indemnity and, presumably, additional insured status, this pre-emptive allocation of risk ideally occurs between

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4. *See generally* Thomas M. Hamilton, *Problems Arising From Additional Insured Endorsements*, 62 DEF. COUNS. J. 384 (1995) (noting that the primary insured's certificate of insurance is endorsed as to include insurance for the additional insured and that the endorsement should be performed very carefully as it may substantially affect the liability policy's scope of coverage).

5. This definition is almost identical to the one assumed by other authors when referring to "additional insured status." *See* DONALD S. MALECKI & JACK P. GIBSON, THE ADDITIONAL INSURED BOOK 35-6 (2d ed. 1994). *See also* Beck, *supra* note 2, at 29. The phrase "not otherwise related" in this context means simply that the parties' relationship to each other are governed wholly by the contract entered into.

6. *See generally* Eugene R. Anderson, et al., *A Sword and a Shield; Living at Ease with an Additional Insured Endorsement*, RISK MANAGEMENT, November 1991 at 53.

7. Robert L. Meyers & Debra A. Perlman, *Risk Allocation Through Indemnity Obligations in Construction Contracts*, 40 S.C. L. REV. 898, 990 (1989).

8. *Id.* at 989 ("the underlying principle of indemnity rests on the notion that when one is compelled to pay money another ought to pay, the former may recover the sum so paid from the latter. . .") (citing McLouth Steel Corp. v. AE Anderson Constr. Corp., 210 N.W. 2d 448, 451 (1973)). *See* MALECKI & GIBSON, *supra* note 5, at 44 (the traditional method of allocating risk in the absence of a contract usually involves a court distinguishing between the active and passive fault of the parties).

two parties in an informed, consensual manner,[9] who reside on a "level playing field."[10]

III. ADDITIONAL INSURED VS. ADDITIONAL NAMED INSURED STATUS

A scholarly debate has raged as to whether additional insured status differs in meaning or function from additional "named" insured status. One school of thought holds that additional named insured status has no widely accepted definition,[11] and therefore is open to subjective interpretation.[12] Parties who negotiate whether to enter into an additional insured agreement or additional named insured agreement are either bargaining for unintended coverage[13] or simply wasting their time since there currently exists no meaningful difference between additional insured and additional named insured status.[14] Proponents of this view seem to accept that until additional named insured status can be more clearly and universally defined, all added parties to liability policies should be treated as additional insureds.[15]

Another school of thought, forwarded most clearly by Mark Pomerantz in *Recognizing the Unique Status of Additional Named Insured*,[16] holds that courts have wrongly treated additional named insured status and additional insured status as if they were identical.[17] As a result of this confusion, courts have usually reached decisions contrary to the

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9. *See* Nicholas P. Alexander, *Developments in Indemnity Law: Express, Implied Contractual, Tort-Based, and Statutory*, 79 MASS. L. REV. 50, 51 (1994) (describing this process as commercial parties anticipating their potential liabilities, assessing their exposures and negotiating to accept greater, or less risk than they might otherwise face).

10. *Id.* Alexander non-exhaustively lists factors as affecting a level playing field as "(1) the relative sophistication of the indemnitor, (2) the existence of excessive bargaining power or economic strength of the indemnitee and (3) the extent to which indemnity has historically played a role within the industry." *Id.* at 52.

11. *See* MALECKI & GIBSON, *supra* note 5, at 50 (asserting they searched several law dictionaries and treatises in search of a definition of additional insured status but found none). *But see id.* at 60 (later noting that a publication eventually defined additional named insured status based upon the conclusions Malecki and Gibson drew in their treatise).

12. *Id.* at 52.

13. *Id.* Malecki and Gibson assert that because no universally accepted definition of additional named insured status exists, the result of adding a party as an additional named insured could have results varying from overly broad coverage to excessively narrow coverage. *Id.*

14. *Id.* at 51-2.

15. *Id.* at 52.

16. 53 FORD. L. REV. 117 (1984).

17. *Id.* at 125-26.

contracting parties' intent.[18] He contends that by choosing to specifically designate a party as an additional named insured, parties to the contract intend that the added party be treated more like the named insured, rather than just a third party donee beneficiary (as is the treatment afforded additional insureds).[19] For example, insurers have no obligation to notify those not specifically designated in the policy (such as additional insured) that the policy has been canceled.[20] Since an additional named insured is specifically designated in the policy however, Pomerantz suggests that an insurer should be obligated to notify an additional named insured as to the cancellation.[21] Pomerantz further argues that additional insureds, again by the virtue of their not being specifically designated in the policy, should have a longer time than additional named insureds to notify an insurer of a claim.[22]

As demonstrated by the foregoing, different scholars have asserted their own views on this issue and even forwarded their own definitions of additional named insured status. Hence the debate over whether any meaningful difference exists between the two statuses remains unresolved. For the purpose of this article, additional insured and additional named insured will be afforded treatment similar to that provided by most courts: they will be treated as identical.[23]

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18. *Id.* at 126.

19. *Id.* at 125.

20. *See id.* at nn.105-10 and accompanying text.

21. *Id.*

22. *See id.* at nn.106-114 and accompanying text. Although Pomerantz does not address exactly why additional insureds should be afforded more time to notify an insurer of a claim, one likely reason is that the additional insureds must notify the primary named insured who must then notify the insurer. In contrast, additional named insured, by virtue of actually being named in the policy may notify the insurer directly, obviating the need to notify the primary named insured.

23. For examples of courts' identical treatment of additional and additional named insureds, see Allegheny Airlines, Inc. v. Forth Corp., 663 F.2d 751, 759 (7th Cir. 1981); Landry v. Oceanic Contractors, Inc. 731 F.2d 299, 304 (5th Cir. 1984); Tidewater Equip. Co. v. Reliance Ins. Co., 650 F.2d 503, 506 (4th Cir. 1981); Leventhal v. American Bankers Ins. Co., 283 S.E.2d 3, 6-7 (Ga. Ct. App. 1981); Swift & Co. v. Zurich Ins. Co., 511 S.W.2d 826, 831 (Mo.1972); Waller v. Rocky Mtn. Fire & Casualty Co., 535 P.2d 530, 534 (1975) (en banc); Holthe v. Iskowitz, 197 P.2d 999, 1005 (1948).

IV. REASONS FOR ENTERING INTO AN ADDITIONAL INSURED RELATIONSHIP

No examination of additional insured status would be complete without an understanding of why parties enter into such risk-shifting arrangements at all. Generally, parties buy liability insurance because they are risk averse.[24] In an effort to protect their assets or incomes, parties are willing to trade to insurers the uncertain risk of unlimited legal liability for the certainty of prepaid premiums.[25] Insurers, experts at risk-pooling,[26] assessing the extent and likelihood of actual loss, and the law of large numbers,[27] set their premiums to allow for the absorption of actual loss while preserving some level of profit.[28] Express indemnity functions similarly, with the exception that instead of paying premiums, risk allocation occurs as part of the parties' bargaining activity, and often affects the contract price.[29]

With each party having the option of purchasing its own liability insurance and the availability of express contractual indemnity as an effective risk shifting tool, why do parties enter into additional insured arrangements?

The three[30] major reasons why parties consent to an additional insured relationship are as follow:

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24. *See* Randall R. Bovbjerg, *Liability and Liability Insurance: Chicken and Egg, Destructive Spiral, or Risk and Reaction?*, 72 TEX. L. REV. 1655, 1656 (1994). *See also* KENNETH S. ABRAHAM, DISTRIBUTING RISK 24 (1986) (citing that people are so inherently risk averse that they are willing to pay more than their expected loss for insurance against it, and the very existence of profitable insurance companies serves as proof).

25. *Id.* at 1656.

26. *See* KENNETH J. ARROW, INSURANCE, RISK, AND RESOURCE ALLOCATION: ESSAYS IN THE THEORY OF RISK BEARING, 134-36 (1971).

27. *See* David B. Houston, *Risk, Insurance and Sampling*, 31 J. RISK & INS. 511, 515 (1964) for a good discussion of how insurers eliminate their risk through the application of the law of large numbers.

28. *See* Steven W. Potter & Robert C. Witt, *On the Demand for Liability Insurance: An Insurance Economics Perspective*, 72 TEX. L. REV. 1681 (1994). "Liability insurance premiums are based on expectations of future claim and expense costs, which include amounts paid to third parties as compensation, any insured punitive damages awards, legal defense costs, and other operational expenses." *Id.* at 1685.

29. *See* Blake D. Morant, *Contracts Limiting Liability: A Paradox With Tacit Solutions*, 69 TUL. L. REV. 715, 727 (1995). It should be noted that while an indemnitor accepts the risk of loss through indemnity, it is usually the indemnitor's insurer who ultimately bears the cost associated with the actual loss.

30. There are actually four major reasons for requiring additional insured status. The fourth reason, not discussed in this article, is that additional insured status may provide the indemnitee with personal liability coverage. MALECKI & GIBSON, *supra* note 5, at 46-47.

(1) it may reinforce indemnities and hold harmless provisions otherwise invalidated by courts or statutes;
(2) it may confer upon the additional insured direct rights with respect to defense coverage; or
(3) it may prevent the indemnitor's insurer from subrogating against the indemnitee when the indemnitee has caused or contributed to the loss of damages.[31]

A. As Preventing Subrogation

Subrogation is the right of the insurer, upon paying losses under a policy it has issued, to be put in the position of the insured in order to pursue recovery from third parties legally responsible for the losses.[32] Generally, insurers have no right of subrogation against an insured or a party who has attained additional insured status.[33] For example, in *Baugh-Belarde Constr. Co. v. College Utilities Corp.*[34], a general contractor (Baugh-Belarde) hired a subcontractor (College Utilities) to aid in the construction of college faculty housing. Baugh-Belarde then added College Utilities as an additional insured to its builder's risk policy.[35] In performing

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31. *Id.* at 36.

32. 16 GEORGE J. COUCH, COUCH CYCLOPEDIA OF INSURANCE LAW § 61:1 (Ronald A. Anderson ed., 2d ed. 1984).

33. *Id.* at § 61:137. *See also* U.S. Fire Ins. Co. v. Norlin Industries, Inc., 428 So.2d 325 (Fla. App. 1983); Reliance Ins. Co. v. Morrison, 297 SE.2d 187 (N.C. App. 1982); Transport Indem. Co. v. Carolina Casualty Ins. Co., 652 P.2d 134 (Arizona, 1982); New York Bd. Of Fire Underwriters v. TransUrban Constr. Co., 458 NE 2d 1255 (N.Y. Ct. App. 1983); Frank Briscoe Co. v. Georgia Sprinkler Co., 713 F.2d 1500 (11th Cir. 1983); Miller v. Russell, 674 SW.2d 290 (Tenn. Ct. App. 1983); Reeder v. Reeder, 348 NW.2d 832 (Neb. 1984); Aetna Ins. Co. v. Craftwall of Idaho, Inc., 757 F.2d 1030 (9th Cir. 1985); Safeco Ins. Co. v. Capri, 705 P.2d 659 (Nev. 1989); 1700 Lincoln Ave., Ltd. v. Denver Marble & Tile Co., 741 P.2d 1270 (Col. Ct. App. 1987); Reich v. Tharp, 521 NE.2d 530 (Ill. Ct. App. 1987); Fashion Place Inv. V. Salt Lake County/Salt Lake County Mental Health, 775 P.2d 941 (Utah Ct. App. 1989); Curles v. United States Fidelity & Guaranty Co., 403 SE.2d 458 (Ga. Ct. App. 1991); Marina Del Americana, Inc. v. Miller, 330 So.2d 164 (Fla. Ct. App. 1976); J.F. Shea Co., Inc. v. Hynds Plumbing & Heating Co., 619 P.2d 1207 (Nev. 1980); First Nat. Bank v. Hansen, 268 NW.2d 367 (Wis. 1978); Transamerica Ins. Co. v. Gage Plumbing & Heating Co. (Kan. 1970).

34. 561 P.2d 1211 (Alaska 1977).

35. *Id.* at 1212-13. Baugh-Belarde added College Utilities to its policy pursuant to the terms of a provision in its agreement with its insurer allowing such arrangements. *Id.*

the work College Utilities negligently caused extensive fire damage to the project.[36] Baugh-Belarde's insurer covered most of the loss associated with the accident and promptly brought a subrogated action against the negligent College Utilities.[37] In determining the validity of the insurer's action, the Alaska Supreme Court held, "in subrogated actions, an insurer may not recover its losses from a negligent third party if that party is an additional insured under the applicable policy."[38]

As further evidence of the invalidity of subrogation actions brought by an insurer against an additional insured, courts have treated additional insured as if they were the primary insureds.[39] One court even interpreted additional insured status as being just as effective as an express waiver[40] in preventing subrogation.[41] In *Myers*, an indemnitor's insurer brought a subrogated action against an indemnitee whose negligence had caused death to third parties.[42] The Eighth Circuit Court of Appeals held, "[t]o the extent that a waiver of subrogation rights against ANR would have protected ANR from liability, it served the same function as naming ANR as an additional insured and protected ANR from the consequences of its own negligence."[43]

B. As Affecting Defense Coverage

The party being added as an additional insured may enjoy direct rights in defense coverage it would not otherwise enjoy via contractual indemnity provisions.

A third party entitled to indemnification through contractual provisions must wait until the underlying action is settled, and only then will the

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36. *Id.* at 1213.

37. *Id.* Baugh-Belarde actually brought the claims against College Utilities to recover the amounts its insurer had paid due to College Utilities' negligence, but did so in name only. Both Baugh-Belarde and its insurer admitted that the claims were brought on behalf of the insurer, constituting a subrogated action.

38. *Id.*

39. *See generally* Rosato v. Karl Koch Erecting Co., Inc. v. Thunderbird Constr. Co. v. National Union Fire Ins. Co., 865 F. Supp. 104 (E.D.N.Y. 1994) (applying New York law, an insurer may not subrogate against an additional insured unless a specific exclusion applies); Myers v. ANR Pipeline Co., Allied Signal Corporation v. E-Con, Inc., 959 F.2d 1443 (8th Cir. 1992) (applying North Dakota law).

40. An express waiver is an agreement indicating that the insurer will not, under any circumstances, subrogate against the party obtaining the waiver.

41. *Myers*, 959 F.2d at 1447.

42. *Id.* at 1144-45.

43. *Id.* at 1447.

indemnitor's insurer be obligated to reimburse her.[44] Not coincidentally, the actual timing of the reimbursement is noticeably left out of most indemnity provisions.[45] Hence, the indemnitee must pay for the costs of defense and the eventual judgment or settlement in the hope of future reimbursement by the indemnitor's insurer.

Conversely, a third party who has attained additional insured status has secured certain[46] direct rights in the indemnitor's insurance policy,[47] and is free from relying solely on the rights outlined in the indemnification clause of the underlying business contract.[48] The additional insured indemnitee is therefore entitled to have the insurer pay for the costs of defense/resolution as they are incurred.[49] Such pay-as-you-go relationships may prove especially beneficial to smaller organizations without sufficient resources to defend a costly action.[50]

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44. MALECKI & GIBSON, *supra* note 5, at 45. It should also be noted that the insurer has the option of challenging the validity of the indemnification clause once the underlying action is settled. *Id.*

45. Note, for instance, that the following commonly used indemnity provision does not explicitly specify *when* the indemnitor is obligated to reimburse the indemnitee:

> To the fullest extent permitted by law, the Subcontractor shall indemnify and hold harmless the Owner, Contractor, Architect, Architect's consultants, and agents and employees, or any of them from and against claims, damages, losses, and expenses, including but not limited to attorney's fees arising our of or resulting from the performance of the Subcontractor's Work under this subcontract . . .

AIA Document A401, *supra* note 1, at 239.

46. This does not imply that an additional insured has all the same rights as a primary insured. *See, e.g.*, Thomas H. Hamilton, *Problems Arising From Additional Insured Endorsements*, 62 DEF. COUNS. J. 384, 385 (1995) (citing that unless specifically noted in the additional insured endorsement, an additional insured, unlike the primary insured, generally has no right to be notified by the insurer that the primary insured's general liability insurance policy has been canceled).

47. *See generally* MALECKI & GIBSON, *supra* note 5, at 46 (citing those parties attaining additional insured status are entitled to any of the benefits or limitations imposed upon the primary insured by the policy terms and, by extension, any provision which makes reference to the "insured" is also applicable to the "primary insured," save for a clause providing the contrary in the additional insured endorsement itself).

48. *Id.* at 45.

49. *See id.* at 46. There are some situations, however, in which the additional insured indemnitee may prefer to pay defense costs and then receive reimbursement as a way of avoiding defense conflicts, decreasing the chances of coverage disputes and preventing the loss of defense control. For a good discussion of why organizations (especially large organizations) might want to resist being named an additional insured, see *id.* at 46, 62-4.

50. *Id.* at 63. This benefit, however, comes with a price: the additional insured loses control of the defense. In most liability policies, insurers hold the exclusive right to control the defense of claims they cover, unless otherwise specified. This is why large

Another advantage gleaned by additional insured is that the indemnitor's duty to defend them arises at the time a claim is made. The additionally insured party has the option of joint representation at the outset of the proceeding.[51] By contrast, where an indemnitee is relying solely upon the protection of a contractual indemnification provision, the duty to defend may arise later in the proceeding, for instance upon a finding that the indemnitor was at fault.[52]

C. Reinforcing Contractual Transfer of Risk

Parties may also enter into additional insured agreements to reinforce indemnity principles which, for reasons noted below, are proscribed in most states.

1. Express Indemnity Limitations

Indemnity provisions in contracts do not transfer *liability* from an indemnitee to an indemnitor. Rather, they shift the *financial obligation* of meeting an injured third party's demand from the indemnitee to the indemnitor.[53] Depending on the wording of the indemnity, such financial burdens may include defense costs, judgments, settlements, and any other costs associated with the resolution of an injured third party's claim. In construction contracts, such arrangements usually take the form of a

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organizations, which have the resources to defend a claim as it arises and which desire to take very active roles in defense litigation management, may prefer to resist additional insured status and rely solely on contractual indemnification of defense costs.

51. *See generally* Beck, *supra* note 2, at 25-9 (discussing the various representation and defense complexities resulting from additional insured status).

52. *Id.* at n.16 ("[W]hen the demand for a defense is based on a broad form indemnity clause in which the indemnitor agrees to hold the indemnitee harmless from liabilities, costs, and expenses arising from the indemnitor's performance, but contains no separate express defense obligation . . . the duty to defend does not arise until there is a determination that the indemnitor was at fault.") (discussing Regan Roofing Co., Inc. v. Superior Court (Pacific Scene), 29 Cal. Rptr. 2d 413 (1994)).

53. MALECKI & GIBSON, *supra* note 5, at 36 (citing that if the indemnitor is unable to meet the financial obligation, it is transferred back to the indemnitee and may serve as evidence that the indemnitee retained the liability all along). *See also* NATIONAL UNDERWRITER, THE HOLD HARMLESS AGREEMENT 16 (1987).

contractor indemnifying an owner,[54] or a subcontractor indemnifying a general contractor.[55]

Such contractual indemnities take one of three forms: the limited form indemnity; the intermediate form indemnity; or the broad form indemnity.[56] The limited form indemnity obligates the indemnitor to save and hold harmless the indemnitee only for the indemnitor's own negligence.[57] The intermediate form indemnity obliges the indemnitor to hold harmless the indemnitee for all liability except that which arises out of the indemnitee's sole negligence.[58] The broad form indemnity requires the indemnitor to save and hold harmless the indemnitee from all liabilities arising from the project, regardless of which party's negligence introduces the liability.[59] The first two forms of indemnity have generally been upheld by courts as valid and enforceable transfers of risk[60] as long as they meet the requirements for a valid contract.[61] The third, broad form indemnity, has been deemed unenforceable in construction contracts by many courts applying statutes prohibiting broad indemnities as being void against public policy.[62]

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54. *See* Terry J. Galganski, *Owners and Contractors Protective Liability: An Insurance Tool in Construction*, CONSTRUCTION LAWYER, January 1995 at 12 (citing that owners generally demand contractors to indemnify them for third party liabilities).

55. *See* Beck, *supra* note 2, at 25 (citing that subcontracts often contain risk shifting provisions that require the subcontractor to defend and indemnify the general contractor for claims arising from the subcontractor's work).

56. Galganski, *supra* note 54, at 8.

57. *Id.* at 12. For several examples of limited form indemnity provisions, see NATIONAL UNDERWRITER, *supra* note 53, at 87-8.

58. Galganski, *supra* note 54, at 12. For several examples of intermediate form indemnity provisions, see NATIONAL UNDERWRITER, *supra* note 53, at 73, 74, 86-7.

59. Galganski, *supra* note 54, at 13. For several examples of broad form indemnities, see NATIONAL UNDERWRITER, *supra* note 53, at 78-86.

60. *See* JUSTIN SWEET, LEGAL ASPECTS OF ARCHITECTURE ENGINEERING AND THE CONSTRUCTION PROCESS, 735-37 (1989 ed.) (citing that, although courts have been historically reluctant to recognize any concept of contractual indemnity as not violating public policy, now they do allow such transfers of risk, provided that the indemnitor does not agree to indemnify the indemnitee for the indemnitee's' own negligence). For a good discussion of the courts' historical ambivalence towards the concept of contractual indemnity, see Nicholas Alexander, *Developments in Indemnity Law: Express, Implied Contractual, Tort-Based and Statutory*, 79 MASS. L.REV. 50 (1994).

61. 41 AM. JUR. 2D, *Indemnity* § 5 (1994). For general rules governing the formation, validity, and construction of contracts, *see* 17A AM. JUR. 2D, *Contracts* § 16 (1994).

62. *See* Champagnie v. W.E. O'Neil Constr. Co., 395 NE2d 990 (Ill. 1979); Callahan v. A.J. Welch Equip. Corp. 634 NE2d 134 (1994); Robertson v. Swindell-Dressler Co., 267 N.W.2d 131 (Mich. 1978); Hollmes v. Watson-Forsberg Co., 471 N.W.2d 109 (Minn. 1991); Sierra v. Garcia, 746 P2d 1105 (NM 1987); Estate of Hasset v. Trump Village Constr. Corp., 575 NYS2d 843 (1991); Healey v. J.B. Sheet Metal, 892 P2d 1047 (Utah

Currently, there are 35 states with laws nullifying broad form indemnity provisions in construction contracts as void and unenforceable against public policy.[63] Even in states not bound by such statutes or those states where an indemnitor may indemnify an indemnitee if the indemnitor is concurrently negligent, courts have applied the rules of strict construction and employed the "clear and unequivocal" test.[64] This test

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App. 1995); City of Dillingham v. CH2M Hill N.W., Inc., 873 P.2d 1271 (Alaska 1994); Armco Steel Corp. v. Roy H. Cox Co., Inc., 103 Cal.App.3d 929 (1980); Kole v. Amfac, Inc., 665 F. Supp. 1460 (D. Hawaii 1987); LTV Steel Co. v. Northwest Engineering & Constr., Inc., 845 F. Supp. 1295 (N.D. Ind. 1994), *affirmed*, 41 F.3d 332 (7th Cir. 1994); Heat & Power Corp. v. G.C. Zarnas & Co., 498 A.2d 605 (Md. 1985); Patenaude v. General Elec. Co., 543 N.Y.S.2d 234 (1989); Kendall v. U.S. Dismantling Co., 485 N.E.2d 1047 (Ohio 1985); Consentino v. A.F. Lusi Constr. Co., 485 A.2d 105 (R.I. 1984); Chicago & N.W. Transp. Co. v. V & R Sawmill, Inc., 501 F. Supp. 278 (S.D. 1980); Jacobsen Constr. Co. v. Blaine Constr., 863 P.2d 1329 (Utah Ct. App. 1993); Mountain Fuel Supply Co. v. Emerson, 578 P.2d 1351 (Wyo. 1978).

It should be noted that statutes limiting broad form indemnity are usually confined to the construction context. Accordingly, the statutes listed *infra* Appendix I proscribe the enforceability of broad form indemnity agreements in contracts relating to construction only.

Broad form indemnities in other contracts may or may not be enforceable depending upon the state in which they are sought to be enforced. For example, there is widespread disagreement as to the circumstances under which a lease should be held enforceable where a tenant has agreed to hold harmless and indemnify her landlord for liability arising out of the landlord's own negligence. The general rule in landlord-tenant law is that an indemnity provision whereby the tenant agrees to save and hold harmless a landlord from losses arising from the landlord's negligence is unenforceable unless "such intention is expressed in clear and unequivocal terms." There is considerable disagreement, however, as to what constitutes an expression of this intent in clear and unequivocal terms. Two divergent views have emerged: 1) that the clear and unequivocal requirement is met only by a specific reference in the indemnity clause to the landlord's negligence; or 2) that specific references to the landlord's negligence is not necessary. For a good discussion of these and other issues affecting the validity of broad-form indemnity clauses in landlord-tenant contracts, see Annotation, *Indemnification - Landlord's Negligence*, 4 ALR 4TH 798 (1981). *See also* MILTON R. FRIEDMAN, FRIEDMAN ON LEASES 920-22 (1983).

63. *See* this Comment at Appendix 1.

64. *See, e.g.*, Ocean Accident & Guar. Corp. v. Jansen, 203 F.2d 682 (8th Cir. 1953) (applying Nebraska law); United States Fidelity & Guar. Co. v. Mason & Dulion Co., 145 So.2d 711 (Alab. 1962); Pioneer Roofing Co. v. Mardian Constr. Co., 733 P.2d 652 (Ariz. 1986); Pickens-Bond Constr. Co., North Little Rock Elec. Co., 459 S.W.2d 549, appeal after remand, 495 S.W.2d 197 (Ark. 1972); Laudano v. General Motors Corp., 388 A.2d 842 (Conn. Super. Ct. 1977); Cumberbatch v. Board of Trustees, 382 A.2d 1383 (Del. Super. Ct. 1978); Cone Bros. Contracting Co. v. Ashland-Warren, Inc. 458 So.2d 851 (Fla. Dist. Ct. App. 1984), petition for review denied, 464 So.2d 554 (Fla. 1985); Eastern Air Lines, Inc. v. C.R.A. Transport. Co., 306 S.E.2d 27 (Ga. 1983); Maxon Corp. v. Tyler Pipe Indus., Inc., 497 N.E.2d 570 (Ind. Ct. App. 1986); Wallace v. Slidell Memorial Hosp., 509 So.2d 69 (La. Ct. App. 1987); Parliament Constr. Co. v. Beer Precast Concrete Ltd., 319

generally states that in order to be enforceable, the parties' intent to impose an obligation upon the indemnitor to indemnify an indemnitee must be expressed in clear and unequivocal terms.[65] Both the statutes and the rigorous tests for enforceability imposed by the courts in interpreting broad form indemnity result from strong public policy arguments against allowing an indemnitor to save and hold harmless an indemnitee for the indemnitee's negligence in construction contracts.[66] Yet, most states have decided than an indemnitor may indemnify an indemnitee for the indemnitee's negligence pursuant to an additional insured provision that the parties have entered into. Additional insured status creates a vehicle through which parties may contravene statutes and precedent, without ameliorating the public policy arguments which strongly disfavor such arrangements. The major public policy argument usually arises within the realm of moral hazard.

2. Moral Hazard as Disfavoring Additional Insured Status

The same moral hazard public policy argument which disfavors broad form indemnities also disfavors additional insured arrangements.

Imagine Party X has agreed to save and hold harmless Party Y for any loss or expense incurred while installing an elevator, regardless of whether the loss or expense is occasioned by Party Y's either sole or concurrent

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N.W.2d 374 (Mich. 1982); Braegelman v. Horizon Dev. Co., 371 N.W.2d 644 (Minn. Ct. App. 1982); Southwestern Bell Tel. Co. v. J.A. Tobin Constr. Co., 536 S.W.2d 881 (Mo. Ct. App. 1976); Port Auth. v. Honeywell Protective Servs., 535 A.2d 974 (N.J. Ct. App. Div. 1987); Kay v. Pennsylvania R.R., 103 N.E.2d 751 (Ohio 1952); Broce Constr. Co. v. Traders & Gen. Ins. Co., 465 P.2d 475 (Okla. 1970); Barrus v. Wilkinson, 398 P.2d 207 (Utah 1965); Northwest Airlines v. Hughes Air. Corp., 702 P.2d 1192) (Wash. 1985); Herchelroth v. Mahar, 153 N.W. 2d 6 (Wisc. 1967).

Texas has adopted the "express negligence" rule in lieu of the "clear and unequivocal" test. The Texas Supreme Court has held, "[t]he express negligence doctrine provides that parties seeking to indemnify the indemnitee from the consequences of its own negligence muse express that intent in specific terms . . . within the four corners of the contract." *See* Meyers & Perlman, *supra* note 7, at 995 (citing Ethyl Corp. v. Daniel Constr. Co., 725 S.W.2d 705, 708 (Tex. 1987)).

65. *See* Meyers & Perlaman, *supra* note 7, at 994-95. *See also* All-State Investigation & Sec. Agency v. Turner Constr. Co., 301 A.2d 273, 275 (Del. 1972); Stren v. Larocca, 140 A.2d 403, 406 (Conn. App. Div. 1958).

66. It should be noted that although some states have statutes which prohibit broad form indemnity in construction contracts, in other contexts such as leases and bailments, the broad form indemnity may or may not be enforceable, depending on the particular state.

negligence.[67] Party Y, armed with the knowledge that it will be fully indemnified should any loss occur, might be tempted to take less care[68] that its negligence may damage a third party. This lower degree of care necessarily increases the chances of an actual loss or injury to a third party. This is the concept of moral hazard.[69] Although moral hazard usually arises in the insured-insurer relationship, indemnity functions similar to insurance and the party receiving indemnity can be thought of as an insured.[70]

This possibility of moral hazard constituted much of the policy argument sparking intense judicial[71] and legislative[72] scrutiny of broad form indemnities. In one of the earliest and oft-cited cases demonstrating courts' unfavorable perception of broad form indemnity, the Utah Supreme Court articulated this major public policy argument against such provisions:

> Undoubtedly contracts exempting persons form liability for negligence induce a want of care, for the highest incentive to the exercise of due care rests in a consciousness that a failure in this respect will fix liability to make full compensation for any injury resulting from the cause. It has therefore been declared to be good

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67. This argument reflects a typical broad form indemnity provision.

68. The assumption is generally made, and preserved in the Comment, that a higher standard of care requires higher expenditures by the party exercising it. In the textual example, the indemnitee, for instance, might decide not to reinforce scaffolding with the view that the time it takes to reinforce scaffolding could be more efficiently spent working directly on the installation, and the faster the installation, the faster it can begin on another project. For a good discussion of the relationship between precaution to reduce risk and the cost it imposes on a potential injurer, *See* Seth J. Chandler, *Visualizing Moral Hazard*, 1 CONN. INS. L.J. 97, 111 (1995).

69. *See* A. MITCHELL POLINSKY, AN INTRODUCTION TO LAW AND ECONOMICS 54 (2d ed. 1989). *See* also Krishna G. Mantripragada, *Depositors as a Source of Market Discipline*, 9 YALE J. ON REG. 543, 548 (1992) ("moral hazard refers to the propensity of the insured institutions to disregard the risk consequences of their actions, if the costs of such actions are shifted to the insurer").

70. Express indemnities can be said to function similarly to insurance in the sense that the indemnitee, like the insured, has successfully transferred the risk of loss of the expense associated with loss to the indemnitor, who likewise is acting as an insurer.

71. SWEET, *supra* note 60, at 735 ("[T]he reluctance of courts . . . to permit contractual freedom in this area is undoubtedly influenced by the belief that indemnification freely permitted will encourage carelessness.").

72. *See infra* Appendix 1 for a list of states limiting or voiding broad form indemnity provisions in construction contracts.

> doctrine that no person may contract against his own negligence.[73]

By extension, this "possibility of moral hazard" argument should also be, but has not been, interpreted by the courts to limit additional insured agreements. Most courts[74] have held that despite statutes prohibiting broad form indemnity, where a party has been named an additional insured, this party is entitled to receive indemnification from the indemnitor's insurer.[75]

Hence, an indemnitor (and its insurer) remains obligated to save and hold harmless an indemnitee, despite the unenforceability of the broad

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73. Jankele v. Texas Co., 54 P.2d 425, 427 (Utah 1936)(citing 6 R.C.L. § 132, p. 727, and cases there cited). *But see* SWEET, *supra* note 60, at 735 ("It is unlikely that unregulated indemnification (enforcing clauses as written) would be a disincentive for creating and monitoring a safety program.").

74. It should be noted that courts have held that additional insured status cannot effect a valid transfer of risk where the underlying indemnity is deemed unenforceable by the court. For instance, pursuant to a provision in their contract, a contractor (Maury Steel, Inc.) agreed to indemnify the owner (Union Carbide) from any claims of bodily injury made on the premises resulting from construction work. The contract also stipulated that the contractor obtain insurance to this end. One of Maury Steel's employees died while working on the construction project and filed suit against Union Carbide. Union Carbide, in turn, pointed to the contractor's broad form indemnity and its status as an additional insured to seek indemnification from Maury Steel's insurer. The court, however, held that the broad form indemnity was unenforceable due to Tennessee's anti-indemnification statute and therefore also nullified Union Carbide's additional insured protection. *See* Posey v. Union Carbide Corp., 507 F. Supp. 39 (M.D.Tenn. 1980) (applying Tennessee law).

75. *See* MALECKI & GIBSON, *supra* note 5, at 38-39. *See also* Brzeczek v Standard Oil Co., 447 N.E.2d 760 (Ohio App. 1982) (holding that a provision requiring an oil refinery be named an additional insured on the policy of a tank company was not unenforceable due to Ohio's statutory prohibition of broad form indemnities); McAbee Constr. Co. v. Georgia Kraft Co. et al., 343 S.E.2d 513 (Ga. App. 1986)(discussed *infra*); Bosio v. Branigar Organization, Inc., 506 N.E.2d (Ill. Dist. 1987) (holding that an additional injured risk provision did not violate the state's law proscribing road form indemnity even if it protected the additional insured from its own sole negligence); Chevron U.S.A., Inc. v. Bragg Crane & Rigging Co., 225 Cal. Rptr. 742 (Cal. Ct. App. 1986) (holding that the additional insured did not violate California's anti-indemnification statute because it was not contracting away liability, but was contracting to procure insurance); Long Island Lighting Co., et al., American Employers Ins. Co., et al., 517 N.Y.S.2d 44 (A.D. 1987)(holding that an additionally insured utility was entitled was entitled to be protected against loss or damage arising even from its own sole or concurrent negligence, despite a New York statute proscribing broad form indemnity); Heat & Power Corp., et al., v. Air Products & Chemicals, Inc., 578 A.2d 1202 (Md. App. 1990) (holding that an indemnitee can be indemnified against loss arising out of its own negligence by being named as an additional insured on an indemnitor's general liability policy, despite a statute prohibiting broad form indemnity).

form indemnity provision in the contract.[76] For example, in *MacAbee Constr. Co. v. Georgia Kraft Co.*[77] the general contractor agreed to save and hold harmless the owner from liability arising even from the owner's concurrent or sole negligence.[78] The court correctly held that this indemnity provision, if taken alone, would violate Georgia law.[79] The court ultimately held, however, that since the contractor also agreed to additionally insure the owner, the owner successfully transferred the risk of loss, even that arising from its own negligence, to the contractor.[80] In doing so, the court made an unexplained distinction between exculpation

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76. *See generally* MALECKI & GIBSON, *supra* note 5, at 36-7 (the additional insured status is thought to reinforce the otherwise invalid broad form indemnity provision).

77. 343 S.E.2d 513 (Ga.App. 1986).

78. The applicable indemnity provision in the contract asserted:

> The Contractor hereby assumes exclusive responsibility for all injury and/or damage to any and all persons whomsoever and to any property whatsoever, and loss of use, resulting from or arising out of the performance of the Work. The Contractor further agrees to indemnify, hold harmless and defend the Owner against all claims, suits, losses, damages and costs, including, but not limited to, court costs and reasonable attorney's fees, on account of such injury, or damages, except when caused by the sole negligence of the Owner. Provided, however, with respect to such injury, including death, to any employees of the Contractor or any Subcontractor, the Contractor agrees to indemnify, hold harmless and defend the Owner from any claims, damages or suits filed against the Owner by any employees of the Contractor and/or any employees of any Subcontractor, even though such injury, including death, was caused by the sole negligence of the Owner.

Id. at 514.

79. The applicable Georgia statute indicates, in part:

> A covenant, promise, agreement, or understanding in or in connection with or a collateral to a contract or agreement relative to the construction, alteration, repair, or maintenance of a building structure, appurtenances, and appliances, including moving, demolition, and excavating connected therewith purporting to indemnify or hold harmless the promise against liability for damages arising out of bodily injury to persons or damage to property caused by or resulting from the sole negligence of the promisee, his agent or employees, or indemnitee is against public policy and is void and unenforceable . . .

GA. CODE ANN. § 13-8-2(b)(1976).

80. McAbee Constr. Co. v. Georgia Kraft Co., 343 S.E.2d 513, 514-15 (Ga.App. 1986).

and indemnification,[81] and asserted that the additional insurance clause did not provide for one party to indemnify the other for the other's negligence, but simply shifted "the risk of loss to the insurance company regardless of which party is at fault."[82] What the court did not address is how this "shifting the risk of loss" avoids the public policy arguments[83] that it has already accepted as voiding broad form indemnity.[84] The owner, free from the possibility that it will be held financially responsible for its own negligence, has no incentive to exercise a higher degree of care which might otherwise save a third party from injury.

The question arises, after being named an additional insured, does a party have any incentive to exercise a high standard of care to avoid loss?[85] In the traditional liability[86] insurance context, it is thought that moral hazard can be avoided by the insured being subject to greater premiums if they engage in activities that induce greater risk. If this were also true in the additional insured context, then the moral hazard argument could be effectively controverted.

There are, however, conditions inherent to additional insured status which preserve the moral hazard problem. One such condition which is inherent to the traditional insurance relationship is magnified in the additional insured relationship: the problem of monitoring.[87] In order for

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81. *See id.* at 515.

82. *Id.*

83. More specifically, the court did not address the aforementioned problem of moral hazard.

84. *See, e.g.*, Morgan v. Westinghouse Electric Corp., 579 F. Supp. 867 (1984) (Georgia court held that an indemnification agreement by which an indemnitor agreed to indemnify an indemnitee for the indemnitee's sole negligence was void against public policy).

It should be noted that Georgia's anti-indemnification statute, as well as many other states' anti-indemnification statutes assert that the law does not affect the validity of insurance contracts. *See infra* Appendix 1. But additional insured status does not imply an insurance relationship between the insurer and the additional insured. This is evidenced by the noticeable lack of responsibility imposed on the insurer to notify the additional insured of any cancellation or non-renewal of the policy. This lack of duty arises from the absence of any "direct contractual relationship" between the insurer and the additional insured. *See* MALECKI & GIBSON, *supra* note 5, at 146. *See also* U.S. Pipe and Foundry Co. v. U.S. Fidelity & Guaranty Co., 505 F.2d 88 (5th Cir. 1974) (holding that an additionally insured lessor was not entitled to notice of cancellation of its policy from an insurer because of the absence of a direct contract between the lessor and the insurer resulting in a lack of privity).

85. It is assumed for the purposes of this Comment that exercising a higher degree of care has an increased cost associated with it. *See supra* note 69 and accompanying text.

86. Traditional in the sense that the insurance relationship is limited to one insurer and one insured.

87. POLINSKY, *supra* note 69, at 57.

an insurer to adjust their premiums to compliment the increased risks which might be taken by an insured, it must be able to evaluate the insured's risk-inducing activities. In practice, such monitoring is often not feasible because it is impossible for the insurer to cheaply monitor the insured.[88] In the additional insured context, the difficulty in monitoring is compounded[89] by the fact that an additional insured must be monitored as well as a primary insured. Furthermore, the insurer, even if it could practically monitor both parties, would confront the difficult problem of how to allocate the cost associated with each party's high risk activities.[90]

When insurers are confronted with the moral hazard problem in lieu of incurring significant monitoring costs, they base their premiums on the average or estimated likelihood of loss and amount of loss.[91] To provide incentive for insureds to prevent loss, insurance companies may also reduce premiums if the insured take certain steps which reduce the risk of loss.[92] Such arrangements benefit all of the parties involved. They reduce the chance of loss or damage to a third party, as well as reduce the likelihood that an insurer will be forced into paying a claim. No such incentive exists, however, for the additional insured to reduce the chance of risk as they are not responsible for direct premium payments to the insurer.[93] Thus, it is the additional insured's lack of direct relationship to the insurer[94] that nullifies any incentive it might have to exercise a lower standard of care. As mentioned above, a party exercising a lower standard of care necessarily increases the risk of damage, loss, or injury to an unsuspecting third party, and is therefore reacting contrary to the public's interest in being free from harm.

In the ordinary insurance relationship, the insured is also deterred from engaging in risky activity by the notion that an accident or occurrence will

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88. *Id.*

89. Compounded by way of the increased cost associated with monitoring two parties instead of one.

90. Presumably this would be of great interest to the parties as they could then each assume the cost increase of premiums due only to their own activities.

91. *See* ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS, 65-67 (1988).

92. *See id.* at 66. An example of an incentive might be a reduction in the premium if the insured maintains a safety director on the site or can provide proof that all of its workers have undergone safety training.

93. The primary insured is responsible for payment of premium on its own behalf, as well as the increase in premiums paid resulting from adding an additional insured. Thomas M. Hamilton, *Problems Arising From Additional Insured Endorsements*, 26 DEF. COUNS. J. 384, 385 (1995).

94. Most courts and scholars agree there is no direct contractual relationship between insurers and additional insureds. *See supra* note 68 and accompanying text.

result in the insurer raising its premiums.[95] Once again, the additional insured is insulated against this prospect by the fact that it is not responsible for premium payments to the insurer and is unaffected by the raising of premiums.[96] Although this arrangement provides the primary insured with motive to pressure the additional insured into exercising a higher standard of care, the additional insured is under no obligation to comply. [97] Hence, once again, there is no motivation or incentive for the additional insured to exercise a high standard of care.

The above propositions mainly stem from the fact that while the primary insured, by way of its direct contractual relationship with the insurer, has a *continuing* motivation to exercise high standards of care, the additional insured has no such motivation once the contract has been executed.[98] Without this continuing motivation, the additional insured's standard of care will expose third parties to the increased likelihood of harm.

3. Insurers Benefit From the Increased Likelihood of Damage

As discussed above, both the additional insured and indemnitor have strong incentive to enter into additional insurance arrangements.[99] But what of the insurer? Traditionally, it is thought that the insurer has an interest in minimizing the frequency of events triggering coverage and the resulting payouts. Given this theory, one would then believe that insurers

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95. Jerrie L. Chiu, *Introducing Market Discipline into the Federal Deposit Insurance System*, 1 CONN. INS. L.J. 197, 203 (1995) (citing risk-adjusted premiums result in higher rates to those who have shown that they represent a greater risk).

96. To illustrate this proposition, suppose Party Y has named Party X as an additional insured. Party X negligently causes damage and is indemnified by Party Y's insurer. As a result of the occurrence, the insurer increases its premiums. As discussed earlier, only the primary insured (Party Y) is responsible for the payment of premiums, and therefore will bear any increase. Party X is therefore not deterred from exercising a low standard of care by the prospect that it will suffer the cost of increased premiums.

97. If the primary insured was able to pass the cost of its increased premiums to the additional insured, then perhaps the moral hazard problem could be alleviated as the additional insured then would have a motivation to exercise a higher standard of care to prevent the increase. But once the contract price between the primary insured and the additional insured has been agreed upon, and the work started, it seems unlikely that the primary insured could successfully readjust the price to reflect its paying increased premiums.

98. Admittedly, the possibility that an additional insured's reputation for negligent behavior will cause it to be shunned by potential indemnitors might deter the additional insured from exercising lesser standards of care.

99. *See* Section IV *supra* and accompanying notes.

would object to contractual relationships (such as additional insured status) which might tend to increase the likelihood of liability. At the very least, insurers have the power to refuse such arrangements.[100] So why do insurers consent to additional insured status? The answer may lie in the complex hypothesis that increased liability promotes expansion of the liability insurance market, ultimately to the benefit of liability insurers.[101]

In short, proponents of this hypothesis argue that the existence and probability of liability drives the liability insurance market.[102] Without the occasional occurrence of events triggering liability, insurers would be hard pressed to justify the sale of liability insurance to would-be insured.[103] This is not to say that insurers *always* endorse activity likely to increase liability, but they may to the extent they wish to expand the liability insurance market. In sum, insurers usually thought to object to arrangements which increase the likelihood of accidents and resulting liability, i.e., additional insurance schemes, might not object to such arrangements with the view they might benefit from such increased liability through increased demand for insurance.

V. CONCLUSION

This Comment has briefly explored the oft-utilized but little examined topic of additional insured status in construction contracts. In doing so, I have asserted that although the existence of additional insured status obviously benefits indemnitors, indemnitees, and insurers, it does so with the effect of increasing the likelihood of injury to a third party.

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100. In order to successfully consummate an additional insured relationship, the indemnitor must endorse its certificate of insurance to reflect that the indemnitee has been added to the policy. The indemnitor must then notify the insurer of this change in coverage, and presumably, the insurer, if unsatisfied with the alteration in coverage, has the option (as long as coverage has not been triggered) to cancel the policy. *See generally* MALECKI & GIBSON, *supra* note 5, at 139-40.

101. *See generally* Kent Syverud, *On the Demand for Liability Insurance*, 72 TEX. L. REV. 1629, 1630-34, 1642-49 (1994). Syverud's controversial theories regarding the supply and demand of liability insurance are very complex, and warrant further examination. This Comment, however, will only rely generally on Syverud's conclusions. For a good discussion of the counter-arguments to Syverud's theory, see Randall R. Bovbjerg, *Liability and Liability Insurance: Chicken and Egg, Destructive Sprial, or Risk and Reaction*, 72 TEX. L. REV. 1655 (1994); Steven W. Pottier & Robert C. Witt, *On the Demand for Liability Insurance: An Insurance Economics Perspective*, 72 TEX. L. REV. 1681 (1994).

102. Syverud, *supra* note 101, at 1633-35.

103. *Id.* at 1633.

I have exposed some of the reasons why parties enter into such arrangements and have demonstrated the hazards of allowing additional insured status to transfer risk in construction contracts. These hazards become especially evident where the underlying broad form indemnity is otherwise unenforceable as against public policy.[104]

104. Samir B. Mehta, B.A., Political Science, Stonehill College, 1994, J.D./M.P.A. anticipated May 1998. The author wishes to extend his gratitude to his family and the Otis Elevator Legal Department, particularly Joseph A. Santos, Esq., for their support and encouragement in completing this undertaking.

Appendix 1: Anti-Broad Form Indemnity Statutes Through 1995

Key:

1 = Statute prohibits an indemnitor from indemnifying an indemnitee for the indemnitee's sole negligence in construction contracts.
2 = Statute prohibits an indemnitor from indemnifying an indemnitee for the indemnitee's sole or concurrent negligence in construction contracts.
3 = Statute stipulates that it does not affect the validity of insurance contracts.

State	Statute
Alabama	NONE
Alaska (1,3)	ALASKA STAT. § 45.45.900
Arizona (1)	ARIZ. REV. STAT. ANN. § 32-1159;ARIZ. REV. STAT. ANN. § 34-226
Arkansas	NONE
California (1, 3)	CAL CIV. CODE. § 2782 (WEST)
Colorado	NONE
Connecticut (1, 3)	CONN. GEN. STAT. ANN. § 52-527K (WEST)
Delaware (2, 3)	DEL. CODE ANN. TIT. 6, § 2704
Florida (2)	FLA. STAT. ANN. § 725.06 (WEST)
Georgia (1, 3)	GA. CODE ANN. § 13-8-2
Hawaii (1, 3)	HAW. REV. STAT. § 431:10-222
Idaho (1)	IDAHO CODE § 29-114
Illinois (2)	ILL. ANN. STAT. CH. 740, PARA. 35/1 (SMITH-HURD)
Indiana (1)	IND. CODE. ANN. § 26-2-5-1 (WEST)
Iowa	NONE
Kansas	NONE
Kentucky	NONE
Louisiana (2)	LA. REV. STAT. ANN. § 2780 (WEST)
Maine	NONE
Maryland (1, 3)	MD. CTS. & JUD. PRO. CODE ANN. § 5-305
Massachusetts (2)	MASS GEN. LAWS. ANN. CH. 149, § 29C (WEST)
Michigan (1)	MICH. COMP. LAWS ANN. § 691.991 (WEST)
Minnesota (1)	MINN. STAT. ANN. § 337.02 (WEST)
Mississippi (2, 3)	MISS. CODE ANN. § 31-5-41
Missouri	NONE
Montana	NONE

Key:

1 = Statute prohibits an indemnitor from indemnifying an indemnitee for the indemnitee's sole negligence in construction contracts.
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3 = Statute stipulates that it does not affect the validity of insurance contracts.

State	Statute
Nebraska	NEB. REV. STAT. § 25-21, 187
Nevada	NONE
New Hampshire (2)	N.H. REV. STAT. ANN. § 338A:1
New Jersey (1, 3)	N.J. STAT. ANN. § 2A:40A-1 (WEST)
New Mexico (2)	N.M. STAT. ANN. § 56-7-1 (MICHIE)
New York (2, 3)	N.Y. GEN. OBLIG. LAW. § 5-322.1 (MCKINNEY)
North Carolina (2, 3)	N.C. GEN. STAT. § 22B-1
North Dakota (2, 3)	N.D. CENT. CODE § 9-08-02.1
Ohio (2, 3)	OHIO REV. CODE ANN. § 2305.31 (BALDWIN)
Oklahoma	NONE
Oregon (2, 3)	OR. REV. STAT. § 30.140 (1988)
Pennsylvania	NONE
Rhode Island (2, 3)	R.I. GEN. LAWS § 6-34-1 (1992)
South Carolina (1, 3)	S.C. CODE ANN. § 32-2-10 (LAW. CO-OP. 1991)
South Dakota (1)	S.D. CODIFIED LAWS ANN. § 56-3-18 (1988)
Tennessee (1)	TENN. CODE ANN. § 62-6-123 (1990)
Texas	NONE
Utah (1)	UTAH CODE ANN. § 13-8-1 (1996)
Vermont	NONE
Virginia (1, 3)	VA. CODE ANN. § 11-4.1 (MICHIE 1993)
Washington (1)	WASH. REV. CODE ANN. § 4.24.115 (WEST 1988)
West Virginia (1, 3)	W. VA. CODE § 55-8-14 (1994)
Wisconsin	NONE
Wyoming (2, 3)	WYO. STAT. § 30-1-131 (1996)

HEALTH CARE REFORM IN THE 1990'S FROM THE CLINTON PLAN TO KASSEBAUM-KENNEDY

TABLE OF CONTENTS

I. INTRODUCTION

Health care reform is the most controversial topic in insurance today. This article examines two significant health care reform proposals in the 1990's: the Clinton plan and the Kassebaum-Kennedy plan. President Clinton's Health Security Act proposed comprehensive reform that effected every aspect of our health care system. In contrast, Senators Kassebaum and Kennedy's Health Insurance Reform Act took an

incremental approach to reform. Although the approaches of these plans contrast each other, they are both products of the same debate on how to address the legitimate problems of America's health care system.

In the 1990's, the Clinton plan and the Kassebaum-Kennedy plan respectively represent the comprehensive and incremental approaches to reform. The nature of this article is primarily descriptive as the following discussion summarizes the major proposals in both plans. This article examines the relationship between the two plans and suggests how the comprehensive and incremental approaches can work together to improve health care in the United States.

II. THE CLINTON PLAN: COMPREHENSIVE HEALTH CARE REFORM

President Clinton attempted to change the landscape of health care in America when he proposed the Health Security Act.[1] Indeed, the Clinton plan was a comprehensive approach to health care reform; no aspect of our health care system went untouched by the President's plan.

The Clinton plan's primary objectives were to control the cost of health care and to extend health insurance to all Americans.[2] The magnitude of these goals meant that new legislation was going to be vast and complicated. The following overview of the Clinton plan will demonstrate the comprehensive nature of the initiative.[3] This summary of the Clinton plan addresses the following issues: universal coverage, the employer mandate, the new role of government, paying for reform, and other related initiatives.

A. Universal Coverage

The hallmark of the Clinton plan is a promise that Americans would be "guaranteed a comprehensive package of health benefits that could never

1. H.R.3600 & S.1757, 103rd Cong., 1st Sess. (1993).

2. Erik Eckholm, *Introduction to The President's Health Security Plan: The Draft Report, The White House Domestic Policy Council*, p. v (1993): "Clinton took office determined to solve two related crises in health care. The first was the growing number of Americans who lacked the basic security of health insurance, a trend that was increasingly seen as a national disgrace. The second was the spiral in health spending that threatened to bankrupt the government and cripple American industry."

3. During the course of the 1993-94 health debate, numerous health care reform proposals were made in Congress that were variations of the Clinton plan. This article studies the original proposal that President Clinton made in 1993.

be taken away."[4] President Clinton, in his address to Congress, unveiled his plan and asserted that whatever legislation Congress might pass, it must include universal coverage.[5] Clinton introduced to Congress a Health Care Security Card that would guarantee an individual a comprehensive package of benefits over the course of their lifetime, roughly comparable to the benefit package offered by most Fortune 500 companies.[6]

The Clinton plan extended coverage to all American citizens, nationals, citizens of other countries legally residing in the United States, and long-term non-immigrants.[7] The required benefits in the Clinton plan were generous, comprehensive, and universal. Every American would receive the same guaranteed benefits, but this would not mean that everyone had the same "health plan" or insurance plan providing these benefits. Individuals would have a choice of various kinds of health insurance plans that would provide the guaranteed benefits package.[8]

The nationally guaranteed benefits package required all health plans to provide coverage for the following areas: hospital services, emergency services, services of physicians and other health professionals, clinical preventative services, mental health and substance abuse, family planning, pregnancy-related services, hospice care, home health care, extended care, ambulance services, lab and diagnostic services, prescription drugs, outpatient rehabilitation, durable medical equipment (including prosthetics), vision and hearing care, preventative dental care for children, and health education classes.[9] Certainly all these benefits were not without cost, and all individuals were expected to contribute to the cost of their health insurance.[10] The proposal allowed individuals to purchase the supplemental insurance plans to cover their part of the cost-sharing, or to extend benefits according to their special needs.[11]

The Clinton plan would provide health care security for all Americans. Although much controversy existed over the provisions of the guaranteed

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4. The White House Domestic Policy Council, *Health Security: The President's Report to the American People 42* (1993) (hereinafter *The President's Report*).

5. *President's Message to Congress on Health Care Reform*, PUB. PAPERS (Sept. 22, 1993).

6. *The President's Report, supra* note 4, at 42-43.

7. The White House Domestic Policy Council, *The President's Health Security Plan: The Draft Report 14* (1993) (hereinafter *The Draft Report*).

8. *Infra* section I.B of the Comment provides detailed discussion of the various options available for employee mandates under the Clinton plan.

9. *The Draft Report, supra* note 7, at 21-22.

10. *See infra*, text section II.B and II.D, for further discussion on cost.

11. *The Draft Report, supra* note 7, at 88-90.

benefits package, there was no question of the plan's intended goal -- universal coverage.

B. Employer Mandate

The vast majority of Americans currently receive health insurance through their employers.[12] "Nine out of ten Americans who get health coverage get it through their employer."[13] The Clinton plan, therefore, incorporated an employer mandate as the foundation of health care reform.[14] In essence, it requires all employers to provide health insurance for their employees by paying for eighty percent of the premium of a health plan providing the guaranteed benefits package.[15] The employee then pays the other twenty percent of the cost of the plan.[16]

Employees would sign up for health insurance through their employers.[17] Once a year every employee would have the opportunity to choose a health plan that provides the guaranteed benefits package.[18] The employee would have at least three different kinds of health plans from which to choose every year.[19] These options would include a health maintenance organization (HMO); a preferred provider organization (PPO); or a traditional fee for service plan (FFS).[20] The price of the plans would vary as each health plan's method for providing health care varies.[21]

Although each of the health plans provide the same guaranteed benefits package, the provisions for obtaining those benefits would be different. Under all HMO plans the individual would pay ten dollars per medical visit, and would have no deductibles.[22] The PPO plans are similar in that there would be a ten dollar co-payment with each medical visit, and no deductibles as long as the individual remains within the PPO network.[23] However, both an HMO and a PPO plan would allow an individual to go

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12. *The President's Report, supra* note 4, at 93.
13. *Id.*
14. *Id.*
15. *The Draft Report, supra* note 6, at 261.
16. *Id.*
17. *The President's Report, supra* note 4, at 27.
18. *Id.*
19. *Id.* at 42.
20. *Id.* at 27.
21. *Id.*
22. *Id.* at 38.
23. *Id.*

outside of that specific health plan's network[24]; which is called a point of service option.[25] The point of service option could require an extra payment for that service.[26] Finally, in the fee for service plan the individual pays twenty percent of the cost per medical visit after the individual has paid either a two hundred dollar or four hundred dollar deductible (depending on the person's status, i.e., single, couple, family).[27] In the FFS plan, there is a maximum yearly health care expenditure of $1,500 for individuals, and $3,000 for families.[28]

"Incentives for patients and doctors alike to use and prescribe preventative methods were woven through out the Act."[29] It is important to note that in all HMOs, PPOs, and fee for service plans, preventative services would be provided without any co-payments.[30] Preventative services without co-payment would include the following: prenatal care, well-baby and well-child checkups, physicals for adults, immunizations, and regular screening tests such as mammograms.[31] Furthermore, in all of these health plans, there would be no limit on an individual or family's total lifetime benefits.[32]

The Clinton plan's employer mandate would give the consumers of health care choices, and make them aware of the cost of their choices.[33] After the employee selected a health plan of his or her choice, both the employer and employee would share the cost of the yearly premium according to a roughly eighty percent to twenty percent division.[34] The employer would actually pay eighty percent of the cost of the average premium for that worker's status.[35] For instance, if the employee is single, the employer would pay the average cost of all the plans available for a single person. The employee would pay the difference between the eighty percent of the cost of the average premium of his or her status and the cost of the actual plan he or she selected.[36] Therefore, if an employee chooses a more expensive plan, most likely a fee for service plan, the employee pays

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24. *Id.* at 85.
25. *Id.*
26. *Id.* at 84.
27. *Id.* at 38.
28. *Id.*
29. *Id.* at 77.
30. *Id.* at 38.
31. *Id.* at 43.
32. *Id.* at 38.
33. *Id.* at 24-25.
34. *The Draft Report, supra* note 7, at 260.
35. *Id.* at 257.
36. *Id.*

more than twenty percent. If an employee chooses a less expensive plan, like an HMO, then the employee's cost would be less than twenty percent.

The Clinton plan would distribute the eighty percent cost of health care among all employers according to a fixed per worker contribution.[37] The employer's per worker contribution is based upon the number of workers in each status within a set geographic region.[38] For example, assume that in a set region, families have an average of 1.5 workers per family. The employer's per worker contribution for a family in that region would be eighty percent of the average family premium divided by 1.5 (the number of workers). According to the per worker contribution, each employer would pay a flat premium for each family worker; thus the total of all employer's contributions for family workers would cover eighty percent of the family premiums.[39] The plan intended to help defray the costs of employer funded health care. According to the plan, the cost to any employer can not exceed 7.9% of its payroll.[40] Finally, employers would have the option of paying all of the cost of its employees' premiums.[41]

Additionally, small businesses would receive subsidies for the cost of their employees' health premiums through discounts in the cost of health plans.[42] The self-employed could deduct all of their health care costs from their taxes.[43] The employer mandate, as the foundation for the Clinton plan, attempts to utilize the current system for providing health insurance. The employer mandate contributes to both the goals of extending health insurance to all Americans and the goal of reducing the cost of health care. The employer mandate does not impose any new broad-based taxes on the American public, but relies instead on the concept of shared responsibility.

C. The New Role of Government

The Health Security Act did not contemplate a national health care system making all physicians employees of the federal government. "The Health Security Act rejected the idea of a government-run health care system."[44] Clinton's proposed legislation relied on the current health care

37. *Id.* at 258.
38. *Id.*
39. *Id.*
40. *Id.* at 259.
41. *The President's Report*, *supra* note 4, at 28.
42. *The Draft Report*, *supra* note 7, at 266.
43. *Id.* at 272.
44. *The President's Report*, *supra* note 4, at 32.

system's method of having the private sector deliver health care services as well as pay for the costs of those services. "Health care would remain in the private sector."[45] However, the Act's two main goals of universal coverage and the control of health care costs could not be achieved without government intervention in the health care economy. So, the plan created the National Health Board and regional health alliances as the government's tools for implementing universal coverage and for reigning in the increasing costs of health care.[46]

The Health Security Act created a new administrative agency of the federal government called the National Health Board. The primary goal of the National Health Board was to implement the provisions of the health care reform act.[47] The National Health Board would consist of seven persons serving four year staggered terms by appointment of the president.[48] The president would appoint a chairman of the National Health Board, who would serve for the president's term.[49]

The Board would enact national regulations and govern decisions related to the national guaranteed benefits package, standards of performance and accountability for all health plans, and the quality of care provided to consumers.[50] As per the Act, the Board would establish a national budget for health care spending to reflect regional variations in the cost of health care.[51] Finally, if a state did not meet the requirements of the Health Security Act, the Board would have the authority under the Act to require the United States Treasury to impose a payroll tax on every employer in that state.[52]

The government vehicles that would achieve health care reform in the Clinton plan were the regional health alliances.[53] Each state would create regional health alliances,[54] unless a state wished to enact a "single payer" health care system within that state.[55] At least one regional alliance would exist in every state and everyone within the geographic area of a health alliance would be required to enroll in a health plan offered by that

45. *Id.* at 32.
46. *The Draft Report, supra* note 7, at 44.
47. *Id.*
48. *Id.* at 46.
49. *Id.*
50. *Id.* at 44.
51. *Id.* at 45.
52. *Id.* at 50-51.
53. *Id.* at 60.
54. *Id.* at 53.
55. *Id.* at 58-59. A "single payer" system is where the state makes all payments to health care providers or to health plans.

alliance.[56] The state would be responsible for appointing a board of directors for the health alliances.[57] The board of each alliance would include an equal number of employers and employees.[58] Each board would consist of employers purchasing health coverage through the alliance; employees purchasing through the alliance; self-employed individuals and private individuals obtaining coverage through the alliance.[59] An advisory board made up of representatives of health care professionals who practice within the alliance's geographic area would assist the board members.[60]

The purpose of the health alliances was to inject competition into the health care world by giving consumers an informed choice about their health care insurance.[61] "The health alliances [would take] on the roles similar to major corporate benefits offices."[62] The regional health alliances primary responsibility would be to contract with insurers who offered HMO, PPO, and FFS plans that provided the guaranteed benefits package.[63] The regional health alliance would be the organization that offered the various health plans for consumers to choose from on an annual basis.[64] The health alliance would ensure that every consumer, when choosing a health plan, receives standard information regarding each health plan's (1) cost to the consumer, (2) participating professionals and institutions, (3) restrictions on access or services, and (4) quality performance reports.[65]

A regional health alliance would establish the set fee for service payment schedule for its geographic region.[66] This set payment schedule would be mandatory for all providers operating on a FFS system.[67] The alliance would establish and submit a health care budget for its region to the National Health Board.[68] This process of setting limits to the cost of health care is often referred to as "global budgeting."[69]

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56. *Id.* at 53.
57. *Id.* at 60.
58. *Id.* at 61.
59. *Id.*
60. *Id.* at 62.
61. *The President's Report, supra* note 4, at 27, 33.
62. *Id.* at 27.
63. *The Draft Report, supra* note 5, at 65.
64. *Id.*
65. *Id.*
66. *Id.* at 68.
67. *Id.*
68. *Id.* at 108.
69. *See* TRANSFORMING THE SYSTEM, *Global Budgets in the United States: Feasibility and Implications* 28 (1994).

The concept of global budgeting, or placing limits on the increases in the costs of health care, was perhaps the most controversial issue in the Clinton plan.[70] The national health care budget would establish a backstop to prevent accelerated costs in the health care system.[71] Global budgets, or a national budget, insure that health care costs do not rise faster than other sectors of the economy.

The National Health Board would take numerous factors into consideration for each regional alliance in an effort to establish premium targets for each alliance.[72] Each regional alliance would negotiate with health plan providers based on the premium targets given to them by the National Health Board.[73] Increases to the target premiums would be tied to the rate of inflation for the rest of the economy (Consumer Price Index).[74] If an alliance's increases in the average premium would exceed the rate of inflation in a given year, future increases would be at a reduced rate the following two years.[75] If an alliance continued to exceed its budgets, an assessment would be imposed on all the premiums in that alliance that exceeded the appropriate inflation factor.[76] However, the Clinton plan intended for alliances to control costs through selective contracts with health plans, and by setting reasonable fee schedules for providers' services.[77]

The Clinton plan's creation of the National Health Board and regional health alliances throughout the nation was the government's new vehicle for changing health care in America. The goals of universal coverage and cost containment necessitated these new bureaucracies. The magnitude of the goals before these agencies necessitated the vast authority given to them.

D. Paying for Reform

As previously discussed, the sharing of costs between employers and employees would pay for the vast majority of reform under the Health

70. *Id.* at 58.
71. *The Draft Report, supra* note 7, at 102.
72. *Id.* at 105-106.
73. *Id.* at 106.
74. *Id.* at 107.
75. *Id.*
76. *Id.* at 106.
77. *Id.* at 108-109.

Security Act.[78] However, the employer mandate alone could not cover all the costs of reform, and President Clinton did not want to impose any new broad-based taxes to pay for reform.[79] The proposed plan sought to cover the costs by specific new taxes, and by reaping the savings of comprehensive reform.[80]

The Health Security Act would impose a seventy-five cent a pack increase in the tax on cigarettes.[81] The Act also called for an assessment or a one percent payroll tax from large corporations which have their own health alliances, referred to as "corporate alliances."[82] These two rather specific and narrow provisions were the only new taxes in Clinton's plan.

Costs would be covered through savings in specific federal programs, and savings throughout the health care system. Cost containment through reform's managed care and global budgeting provisions were likely to bring savings to the Medicare and Medicaid programs.[83] Furthermore, the cost shifting that occurs when millions of uninsured Americans still receive medical care would no longer exist because of universal coverage. The excessive costs that uninsured Americans imposed on the health care system would be reduced.[84] The plan estimated that universal coverage would save $25 billion, because the government would no longer have to reimburse hospitals and doctors for the cost of caring for the uninsured.[85]

This approach, however, did not consider the possible savings that might be achieved from the plan's emphasis on preventative care; the plan's introduction of competition among health providers; as well as other provisions against health care fraud.[86] The "true" costs of the Health Security Act could only be estimated, and estimations are usually subject to much debate. "Estimates of the effect of health reform on the federal budget are an important part of the health reform debate. Yet different analysts' estimates are not always in agreement and questions still remain about the accuracy of all the estimates."[87]

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78. *See supra*, section II.B of this Note.
79. *The President's Report, supra* note 4, at 93.
80. *Id.*
81. *Id.* at 96.
82. *Id.*
83. *Id.* at 97.
84. *Id.* at 94.
85. *Id.* at 96.
86. *Id.* at 98.
87. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONG., UNDERSTANDING ESTIMATES OF THE IMPACT OF HEALTH REFORM ON THE GENERAL BUDGET 1 (July 1994).

E. Related Initiatives

The Act calls for a variety of other changes in the areas of insurance reform, malpractice reform, and antitrust reform. The President's plan would outlaw discrimination or alternative rates based on age, sex, and medical condition for individuals receiving health insurance.[88] Health plans would be required to enroll everyone who wished to join.[89] In the area of malpractice reform, the Plan eliminated the 'collateral source rule' which allows individuals to receive payment from both insurance companies as well as the negligent party.[90] Disputes regarding malpractice would first be required to go through an alternate dispute resolution (hereinafter ADR) procedure established in each alliance, and the plaintiff would be required to have a "certificate of merit" from another physician.[91] If a complainant is not satisfied with the ADR procedure in the alliance, he or she could resort to the courts.[92]

Finally, in the area of antitrust reform, "safety zones" were proposed to allow hospital mergers and joint ventures.[93] PPO joint ventures would be allowed if they controlled less than twenty percent of the relevant market and also shared the financial risk.[94] The Act also provides that physicians could no longer order services or items from an entity where they had a financial interest, unless they themselves performed said service.[95]

Although Clinton's proposed legislation called for sweeping change, not everything was altered. Medicare, America's means for providing health care to the elderly, remained intact. Today, individuals enroll in the Medicare Part B benefit which covers physician visits and other outpatient services. The plan called for a new prescription drug benefit to be included in Medicare Part B coverage. Medicare Part B premiums would be increased by about eleven dollars to cover the cost of the new prescription drug benefit.[96] Medicare recipients would pay twenty percent of the cost of each prescription with a two hundred fifty dollar annual deductible; however, there would be a maximum personal expenditure of $1,000.[97]

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88. *The President's Report, supra* note 4, at 46.
89. *Id.*
90. *Id.* at 90-91.
91. *Id.*
92. *Id.*
93. *The Draft Report, supra* note 7, at 192-193.
94. *Id.*
95. *Id.* at 198.
96. *The President's Report, supra* note 4, at 127.
97. *Id.*

The Health Security Act called for changes in numerous other areas, such as: the creation of academic health centers;[98] health research initiatives;[99] public health initiatives;[100] long term care provisions;[101] health care access initiatives;[102] and a string of tougher laws on fraud and abuse.[103] These additional provisions are important in the effort to reform health care, and underscore the comprehensive nature of the President's plan.[104]

III. THE DEATH OF THE CLINTON PLAN

President Clinton and his plan faced major opposition. Despite initially high public approval ratings for the President's comprehensive health care reform bill, the public rejected the President's approach. Immediately after the President unveiled the Health Security Act, close to sixty percent of the public supported the legislation.[105] One year later, only thirty nine percent of Americans supported Clinton's approach to reform; close to fifty percent outright opposed his plan.[106] The debate over the Clinton plan demonstrated the American public's desire for a less intrusive and more incremental approach to health care reform.

"There is a bedrock reality when it comes to the public and health care reform: people want reform, as long as they don't have to change their own medical arrangements."[107] The Health Security Act's vast goals of universal coverage and cost control looked like promises to change everyone's medical arrangements. The fact that one in four Americans will lose health care coverage at some point in the next two years is a significant fact.[108] This statistic is salient because seventy-five percent of the American public will not lose health coverage during this same period.

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98. *The Draft Report, supra* note 7, at 151.

99. *Id.* at 154.

100. *Id.* at 161.

101. *Id.* at 170.

102. *Id.* at 205.

103. *Id.* at 196.

104. These other provisions are not necessary to understand the essential elements and basic principles of the Clinton plan, and therefore, will not be discussed in detail in this article.

105. Gallop Poll, Storrs, Connecticut: Roper Center for Public Opinion Research, Sept. 1993.

106. Gallop Poll, Storrs, Connecticut: Roper Center for Public Opinion Research, Aug. 1994.

107. Drew E. Altman, *The Realities Behind the Polls*, HEALTH AFFAIRS, Spring 1995, at 25.

108. *The President's Report, supra* note 4, at 19-20.

Many of the Americans who have health coverage became fearful that Clinton's reforms might mean fewer choices and more costly health care for them. Universal coverage and controlled costs sounded good, however, the risk that these reforms might change health arrangements that many Americans are comfortable with was too great a risk. It is not surprising then, that after a year of intensive public debate, the Clinton plan and comprehensive health care reform died in Congress.

IV. THE KASSEBAUM-KENNEDY PLAN

Senator Nancy L. Kassebaum (R - KS) picked up the fallen torch of health care reform, and introduced the Health Insurance Reform Act of 1995.[109] The initiative became a bi-partisan effort as Senator Edward M. Kennedy (D - MA) co-sponsored the legislation.[110] On August 2, 1995, the legislation unanimously passed the Labor and Human Resources Committee chaired by Senator Kassebaum (Senator Kennedy is the ranking minority member).[111] Over forty senators from both parties proceeded to become cosponsors of the Kassebaum-Kennedy bill.[112]

White House advisors encouraged President Clinton to support the Kassebaum-Kennedy legislation and its incremental approach to health care reform.[113] Ironically, President Clinton "who once dismissed narrow, piecemeal health care reforms as inadequate, strongly endorsed a measure of just that sort" when he voiced support for the Kassebaum-Kennedy bill in his State of the Union address.[114] Senator Dole, pursuant to an agreement with the Democratic leadership, slated the legislation for consideration by the full Senate between April 15 and May 3, 1996.[115] On April 24, 1996,

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109. S. 1028, 104th Cong., 1st Sess. (1995).

110. The Health Insurance Reform Act of 1995 is often referred to as the "Kassebaum-Kennedy Bill" after the original co-sponsors of the legislation.

111. S. REP. NO. 156, 104th Cong., 1st Sess. 10 (1995) (hereinafter S. REP. NO. 156).

112. Edwin Chen, *Health Care Bill Travels Rugged Road of Reform*, L.A. TIMES, Feb. 4, 1996, at 1.

113. Interview with William Curry, White House Domestic Policy Advisor, in the Legislative Office Building, Hartford, CT (Jan. 20, 1996). (Mr. Curry also served on the Clinton Health Care Transition Team in 1993.)

114. *A Step Toward Health Reform*, THE WASHINGTON POST, Jan. 28, 1996, at C6.

115. 142 CONG. REC. S913 (1996) (statement of Sen. Dole).

the United States Senate unanimously passed the Kassebaum-Kennedy bill.[116]

The legislation still faced some strong opposition in a conference with the House.[117] The Health Insurance Reform Act was renamed the Health Insurance Portability and Accountability Act of 1996.[118] Finally, in the midst of an election year, Kassebaum-Kennedy was passed by Congress and signed by the President in August 1996.

Unlike the Clinton plan, the Health Insurance Reform Act's purpose is not broad-based comprehensive reform. The proposal does not guarantee every American health coverage, and does not attempt to control the rising costs of health care. The legislation aims to "reduce many of the current barriers to obtaining health coverage by making it easier for people who change jobs or lose their jobs to maintain adequate coverage, and by providing increased purchasing power to small businesses and individuals."[119] The goals of the Kassebaum-Kennedy bill are admittedly less ambitious than President Clinton's initiative, but also less intrusive. The following summary of the original provisions demonstrates the incremental nature of the Kassebaum-Kennedy plan. The discussion will examine the portability of health insurance, the renewability of health insurance, the state flexibility provisions, the cost of reform, and purchasing cooperatives.

A. Portability of Health Insurance

The primary goal of the Health Insurance Reform Act of 1995 is to provide a sense of security for Americans who might lose their health insurance, by allowing them to enroll in individual health plans.[120] Many individuals have had to limit their employment opportunities to maintain their health coverage.[121] Others live with the fear that unemployment means

116. Adam Clayer, *Senate Passes Health Bill With Job to Job Coverage*, N.Y. TIMES, April 24, 1996, at A1.

117. *Id.*

118. Health Insurance Portability and Accountability Act of 1996, Pub.L.No. 104-192, 110 Stat. 1936. The final version of the Kassebaum-Kennedy bill included some extra provisions involving the creation of Medical Savings Accounts (MSAs) and anti-fraud and abuse provisions which were not in the original version of the bill. The discussion that follows focuses on the original provisions of the bill which are at the "heart" of the legislation.

119. S. REP. NO. 156, *supra* note 111, at 1.

120. *Id.* at subtitle B, Individual Market Rules, 9 Individual Health Plan Portability.

121. *See infra* note 186 and accompanying text.

a total loss of health coverage.[122] The Labor and Human Resources Committee's report cited "the prevalence of participation requirements, preexisting condition clauses, and discriminatory enrollment practices" as the obstacles facing individuals who lose their health insurance.[123]

If a person leaves his or her job, the legislation would provide portability of health insurance from a person's group coverage (provided by an employer) to individual coverage. "Eligible individuals who were previously covered under a group plan could not be denied coverage under or enrollment in an individual health plan."[124] Also, an insurance provider could not deny coverage to an individual based on "health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability of the individual."[125]

The Kassebaum-Kennedy legislation does not provide that everyone can receive an individual health plan. The group to individual portability provision only protects an "eligible" party from being denied an individual health plan.[126] The eligibility requirements are as follows: (1) the party must receive group insurance for a continuous period of at least eighteen months prior to enrollment in an individual plan, (2) the party must enroll in an individual plan within thirty days of leaving group coverage or after termination of COBRA[127] benefits, (3) the party is not eligible for a spouse or parent's group health plan, (4) if eligible for COBRA benefits the party must exhaust the coverage period under COBRA, and (5) the individual must not have lost group coverage for failure to pay premiums.[128]

The eligibility requirements encourage individuals to maintain their health coverage. The provisions requiring continuous group coverage for eighteen months and an exhaustion of COBRA benefits are in response "to concern about adverse selection among those who move from group to individual coverage."[129] Under these provisions, an assumption exists that individuals are expected to act fiscally responsible about their health insurance.

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122. *The President's Report, supra* note 4, at 5.

123. S. REP. NO. 156, *supra* note 111, at 4.

124. CONG. RESEARCH SERVICE, LIBRARY OF CONGRESS, 104TH CONG., 2ND SESS., ANALYSIS OF S. 1028 2 (1996) (hereinafter ANALYSIS OF S. 1028).

125. *Id.*

126. ANALYSIS OF S. 1028, *supra* note 124.

127. Consolidated Omnibus Budget Reconciliation Act of 1986, Pub.L.No. 99-272, 100 Stat. 82.

128. ANALYSIS OF S. 1028, *supra* note 124.

129. S. REP. NO. 156, *supra* note 111, at 15.

The legislation recognizes that *affordability* of health insurance is also a major concern for many individuals who lose their group coverage.[130] However, Kassebaum-Kennedy focuses only on increasing access to purchasing health care insurance and leaves the concerns of excessive costs to the states. "In paying premiums that reflect their expected health care costs, workers and their families who enter the individual insurance market through the provisions of S.1028 (Kassebaum-Kennedy) would not be guaranteed premiums at or near the rates for "standard risk" individuals purchasing insurance. To the contrary, these new entrants into the individual health insurance (market), would on average, pay substantially higher premiums."[131] Although the cost of individual health insurance may be excessive, without the provisions of Kassebaum-Kennedy, insurance providers could have denied these individuals health coverage merely for being sick. The legislation leaves the regulation of premium costs to the states[132]; allowing states to decide "whether to enact broader reforms such as individual guarantee issue and individual-to-individual portability."[133]

An insurer could deny coverage to eligible individuals in only two circumstances. First, it could deny coverage if it demonstrated "that it would have financial problems" by accepting individual enrollees.[134] Second, if the insurer proves that "its ability to service individuals already enrolled in the plan would diminish if new enrollees were allowed to join the plan."[135] In both cases, the provider is prohibited from accepting any new enrollees for six months.[136] Finally, to be eligible for this special limitation, the provider must accept individuals on a "first-come-first-served basis, or other basis determined by the state."[137] The exceptions drafted for denying individual health plans attempt to provide some continuity for the denial of coverage, and do not allow for any kind of case-by-case review by the provider. The purpose of these exceptions focus on protecting the legitimacy and solvency of existing insurance plans.

The group to individual coverage portability provision is the cornerstone of the Kassebaum-Kennedy plan. The portability provision is the primary mechanism by which the legislation fulfills its goal of making

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130. *Id.*

131. American Academy of Actuaries, *Comments on the Effect of S.1028 on Premiums in the Individual Health Insurance Market 1*, Mar. 7, 1996.

132. S. REP. NO. 156, *supra* note 111, at 15.

133. *Id.*

134. ANALYSIS OF S. 1028, *supra* note 124.

135. *Id.*

136. *Id.*

137. *Id.*

"it easier for people who change jobs or lose their jobs to maintain adequate coverage[.]"[138] The portability provision is an attempt to throw-open the doors of health care coverage. It gives the individual access to health insurance that previously did not exist.

B. Renewability of Health Insurance

Kassebaum-Kennedy is an effort to create a health care environment where there is a continuity of health coverage. If purchasers wish to renew their policies, the Act guarantees an automatic renewal of both an individual health plan[139] and group coverage health plans.[140] The sections applying to the renewability of individual and group health plans are virtually identical.[141]

An insurance provider must renew health plans at the option of the individual or group purchaser unless one of three exceptions apply. A provider may refuse to renew a policy for any of the following reasons: (1) the purchaser fails to pay premiums or fails to pay premiums in a timely fashion; (2) there is fraud or misrepresentation of a material fact on the part of the purchaser; or (3) the health plan is terminated under specified procedures outlined in this legislation.[142]

If an insurer wishes to terminate a specific health plan, or cease to operate in a designated state it can do so provided that it meets the requirements of the Health Insurance Reform Act.[143] A provider can terminate an individual health plan as long as it provides notice within ninety days prior to the end of the plan.[144] "The insurer would have to allow those individuals covered under the plan being terminated the option of purchasing other individual health plans currently being offered by the insurer."[145] The legislation allows an insurance provider to completely remove itself from a designated market.[146] The company could discontinue

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138. S. REP. NO. 156, *supra* note 111, at 1.

139. *Id.* at subtitle B, *Individual Market Rules, 10. Guaranteed Renewability of Individual Health Coverage.*

140. *Id.* at subtitle *A, Group Market Rules, 5. Guaranteed Renewability of Group Coverage.*

141. *Id.* at §§ 110, 102.

142. S. REP. NO. 156, *supra* note 111, at 40.

143. ANALYSIS OF S. 1028, *supra* note 124, at 3.

144. *Id.*

145. *Id.*

146. *Id.*

all individual or group plans in a state.[147] In order to do this, the insurer must notify the purchasers one hundred eighty days prior to termination and also notify a "certifying authority" of their withdrawal from the market.[148] After removing itself from a state's market, the company is prohibited from operating in that state for five years.[149] Finally, a network plan such as an HMO may not renew a plan if the participating party no longer resides or works in the geographic region of that plan.[150] A network plan can deny coverage "only if the denial is applied uniformly and without regard to health status or the insurability of particular participants" in a group plan.[151]

The guaranteed renewability of health coverage in Kassebaum-Kennedy once again reflects the legislators' purpose of providing availability and access to purchasing health insurance. The guaranteed renewability provisions prevent insurance providers from offering an individual health plan for just one year merely to satisfy the portability provisions of this Act, and then terminating that plan. The Act does allow providers to terminate plans, but only when alternate plans are offered, or when the provider is completely removing itself from a state's market for five years. The guaranteed renewability provisions do not address the costs incurred by purchasers in renewing their health coverage. The provisions do protect both individuals and group purchasers from arbitrarily being denied renewal of their health plans. The Kassebaum-Kennedy plan's guaranteed renewability provisions attempt to create continual access to purchasing health care insurance.

C. State Flexibility and Exemptions from the Act

The Health Insurance Reform Act's provisions guaranteeing portability and renewability for individual health plans may be waived by states who meet the goals of these provisions. State reforms of the individual health insurance market would apply in lieu of the Act's provisions.[152]

All States seeking exemption must apply for a waiver;[153] their reforms must meet the requirements set out by the Act.[154] The Secretary of Health

147. *Id.*
148. Analysis of S. 1028, *supra* note 124, at 3.
149. *Id.*
150. *Id.*
151. S. REP. NO. 156, *supra* note 111, at 37.
152. S. 1028, 104th Cong., 1st Sess. § 112 (1995).
153. *Id.*

and Human Services (HHS) is granted the authority to exempt States from the individual insurance plan provisions.[155] The Secretary must consult with the state's governor and insurance commissioner.[156] A set of four criteria for evaluating the state's plan determines whether the waiver is granted. The Secretary evaluates whether the plan: (1) provides guaranteed access to affordable coverage to eligible individuals; (2) provides coverage for preexisting conditions that were covered under the individual's prior group plan; and (3) provides individuals with a choice of health plans or comprehensive coverage.[157] The fourth factor the Secretary may consider is whether "the application of the guaranteed access and renewability provisions (of the federal Act) would have an adverse impact on the number of individuals in the state having access to affordable coverage."[158]

The purpose of these requirements is to make sure that State reforms "achieve the objectives of individual market portability and renewability."[159] Some of the laws that are likely to meet these objectives are programs that provide guaranteed issue, open enrollment by health plan insurers, high-risk pools, or mandatory conversion policies.[160] "If the Secretary determines that a state law or program fails to meet the criteria . . . adequate notice and reasonable opportunity to modify its law or program to achieve the goal of guaranteed access to affordable coverage to eligible individuals" would be given before a final determination.[161] A state plan that follows model legislation proposed by the National Association of Insurance Commissioners and approved by the HHS Secretary will be deemed to have met the requirements of the Act without further review.[162]

The state waiver provision provides flexibility in achieving the goals of reform set out in Kassebaum-Kennedy. The legislators recognize that the critical issue is not how to achieve guaranteed access to and renewability of individual health insurance plans, but simply that guaranteed access and renewability are achieved. The Kassebaum-Kennedy plan establishes a "touchstone" by which state reforms must measure their programs.

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154. *Id.*
155. *Id.*
156. S.REP. NO. 156, *supra* note 111, at 40.
157. *Id.*
158. Analysis of S. 1028, *supra* note 124, at 3.
159. *Id.*
160. *Id.*
161. *Id.*
162. S.REP. NO. 156, *supra* note 111, at 40.

D. The Cost of Reform

The Kassebaum-Kennedy plan does not create new government programs. The legislation does not propose costly regulatory oversight of the health care industry. The primary concern about the costs of the proposed reforms is that the guaranteed access and renewability provisions for individuals will increase the costs of health insurance premiums. Specifically, there is the assumption that "many newcomers to the individual policy market tend to have illnesses or conditions that lead to high costs" causing higher premiums for everyone.[163] The answers in estimating the costs of proposed legislation are never definite. However, in the case of the Kassebaum-Kennedy plan, current studies estimate that there will only be minimal increases in the costs of premiums.

Some of these studies estimate that the cost of individual premiums would dramatically increase due to the requirement guaranteeing portability from group to individual coverage.[164] The Health Insurance Association of America believes that "the effect of allowing people to purchase the individual policies would be to raise premiums for people who already have individual coverage by anywhere from ten . . . to thirty percent."[165] However, two disinterested studies found that the legislation will not increase premiums dramatically.[166] The American Academy of Actuaries found that individual health insurance premiums are likely to rise two to five percent over the course of three years.[167] The Hay Group, cited in the Congressional Research Service's analysis of the bill, estimated that the cost of existing individual insurance policies would only increase from one to three percent.[168]

The argument that the cost of premiums would substantially increase assumes that insurers would be required to issue insurance to eligible individuals at standard rates.[169] As previously mentioned, Kassebaum-Kennedy does not address the cost of premiums, but only the ability for

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163. Edwin Chen, *Health Care Bill Travels Rugged Road of Reform*, L.A. TIMES, Feb. 4, 1996, at 1.

164. Adam Clymer, *Actuaries Fault Health Insurers' Stand on Bill,* N.Y. TIMES, Feb. 6, 1996, at A16.

165. *Id.*

166. American Academy of Actuaries, *Comments on the Effect of S.1028 on Premiums in the Individual Health Insurance Market 1*, Mar. 7, 1996; ANALYSIS OF S. 1028, *supra* note 124, at 6.

167. American Academy of Actuaries, *Comments on the Effect of S.1028 on Premiums in the Individual Health Insurance Market 1,* Mar. 7, 1996.

168. Analysis of S. 1028, *supra* note 124, at 6.

169. *Id.*

individuals to purchase health insurance. Theoretically, the insurer could charge any rate, and therefore there would be no impact on the cost of other premiums.[170]

In reality, however, the actual costs of these reforms depends on how states respond. States that receive waivers from the HHS Secretary "would have no effect on premiums for their currently insured individual markets."[171] This makes sense, because these states already have methods for providing individual insurance plans and this legislation will not directly alter those methods. However, states may create new regulations in response to Kassebaum-Kennedy that will effect the cost of premiums.

States are likely to respond to the Health Insurance Reform Act by passing legislation that would restrict the range of premiums insurers could charge for individual health insurance plans.[172] "This would have the effect of spreading the cost of those with higher expected health care expenditures across all purchasers."[173] This would result in an increase in premiums to the current individual insurance market. Furthermore, most states who could qualify for a waiver from the Health Insurance Reform Act will not apply for one, because "it would generally be in the state's advantage to restructure its high risk pool to shift new entrants via S.1028 (Kassebaum-Kennedy) to private health insurance plans."[174]

The Hay Group and the American Academy of Actuaries factored into their estimates the likely response of the states to the Act. Even if state law limited premiums to two hundred percent of the average group premium in the state, the total increase on premiums would still be one to three percent.[175] This is not a substantial cost in light of the fact that in the last ten years the average rate paid for an individual plan's premium increased eight to fifteen percent annually.[176] As far as the costs of reform are concerned, the Kassebaum-Kennedy bill "avoids the serious potential pitfalls, and therefore ensures that premium increases are minimized."[177]

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170. *Id.*

171. *Id.*

172. American Academy of Actuaries, *Comments on the Effect of S.1028 on Premiums in the Individual Health Insurance Market 4,* Mar. 7, 1996.

173. *Id.*

174. *Id.* at 6.

175. ANALYSIS OF S. 1028, *supra* note 124, at 6.

176. American Academy of Actuaries, *Comments on the Effect of S.1028 on Premiums in the Individual Health Insurance Market 1,* Mar. 7, 1996.

177. *Id.* at 7.

E. Private Health Plan Purchasing Cooperatives

The Health Insurance Reform Act gives individuals and employers the opportunity to form a cooperative for the purpose of purchasing health insurance.[178] The Act defines a purchasing cooperative as a "group of individuals or employers that form a cooperative on a voluntary basis to purchase individual or group health plans."[179] The cooperatives provide small businesses and individuals increased purchasing power in the health insurance market.

A group of individuals or employers may form a cooperative by meeting some simple criteria. The proposed group must be certified by a state and must register with the HHS Secretary.[180] The Secretary can certify a group if a state refuses to certify them.[181] Each purchasing cooperative must have a board of directors and must also establish requirements for its board.[182]

The cooperative may establish limits as to the size of the group of employers that it chooses to accept.[183] The group may also decide whether individuals will be accepted as members of the purchasing cooperative.[184] After the membership criteria are set, "a health plan purchasing cooperative must accept members on a first come, first-served basis."[185]

The establishment of purchasing cooperatives is another way in which the Health Insurance Reform Act of 1995 meets its goal of eliminating barriers to purchasing health coverage. This provision gives the smaller health care consumer greater leverage in a previously unfriendly market. Although these provisions do not directly address the cost of premiums, the purchasing cooperatives make health insurance more affordable for individuals and small employers because of their collective power in the market place.

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178. S. 1028, 104th Cong., 1st Sess. § 131 (1995).
179. *Id.*
180. S. 1028, 104th Cong., 1st Sess. § 131(b) (1995).
181. *Id.*
182. S. 1028, 104th Cong., 1st Sess. § 131(c) (1995).
183. S. 1028, 104th Cong., 1st Sess. § 131(d) (1995).
184. *Id.*
185. S. REP. NO. 156, *supra* note 111, at 41.

F. The Effects of Kassebaum-Kennedy

Any attempt at predicting the real outcome of newly implemented legislation is destined to fall short. There are always unintended consequences that occur after the legislation becomes law. The Kassebaum-Kennedy plan is no exception. However, in this case there are some likely outcomes that may be expected.

The immediate impact of the legislation's portability and renewability provisions would expand access to health insurance to millions of Americans. Currently, about ten percent of Americans experience "job lock" in that they cannot leave their employment because of the threat of losing health coverage.[186] The General Accounting Office (GAO) estimates that twenty five million Americans would be helped by the portability reforms.[187] Some twelve million Americans with employer-based health insurance leave their jobs annually, while millions more simply lose their jobs.[188] The Kassebaum-Kennedy bill ensures that these individuals could no longer be denied the right to purchase individual health care plans.

The new legislation is likely to increase the costs of health care premiums. Although the plan does not "significantly affect the federal budget,"[189] it will impact the health insurance market by including participants who were excluded from purchasing health coverage, "because the bill would not regulate the premiums that plans could charge, the net number of people covered by health insurance and the premiums that they pay would continue to be influenced by current market forces."[190] There is dispute about the amount of the increase to premiums in the overall market, but this legislation will in some way increase health care premiums.

The effects of the state flexibility provisions are open to broader speculation. The use of federalism as a means for health care reform has become a popular issue in public debate.[191] Some argue that "reform at the

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186. Stephen Utz, *Federalism in Health Care: Costs and Benefits*, 28 CONN. L. REV. 127, 132 (1995).

187. S. REP. NO. 156, *supra* note 111, at 4 (citing GAO, *National Portability Standards Would Facilitate Changing Health Plans*, July 18, 1995).

188. *Id.*

189. *Id.* at 33.

190. *Id.* at 34.

191. *See* Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115 (1995); Stephen Utz, *Federalism in Health Care: Costs and Benefits*, 28 CONN. L. REV. 127 (1995).

state level, coupled with a heavy dose of flexibility . . . offers the best, if not the only chance for meaningful change."[192]

The Kassebaum-Kennedy plan does use our system of federalism to advance change. The plan explicitly calls for "state flexibility". If a state accomplishes the goals of portability and renewability, the state can receive a waiver from the requirements of the plan. However, the Kassebaum-Kennedy plan does create and enforce a national standard. The call for "state flexibility" may not create fifty different laboratories of reform. Furthermore, the legislation explicitly protects the federal government's ERISA[193] preemption of any state regulation of self-insured employers.[194] In light of these facts, it is inaccurate to label the Kassebaum-Kennedy plan as a vehicle to empower state-lead health care reform. On the contrary, the effects of Kassebaum-Kennedy will further increase the federal government's role in health care reform.

V. ANALYSIS: IS THERE A RELATIONSHIP BETWEEN THE CLINTON PLAN AND KASSEBAUM-KENNEDY?

The two plans are so fundamentally different in their approaches to reform that they would appear not to be in any way related. Indeed, many Republicans, including the author of Kassebaum-Kennedy, have emphasized that Kassebaum-Kennedy is not a "warmed over" version of the Clinton plan. The two plans are different in scope and means. However, to say that the plans are totally unrelated may be making too much of the obvious differences.

First, both plans are a product of the same debate and the same dialogue, which address the same root problem: America's insecurity about its health care. Simply, Americans want to be able to maintain affordable health coverage for their families.

The demise of the Clinton plan did not solve any of America's concerns about health care problems. Indeed, in 1994, the year the plan died, fifty-five percent of Americans still believed that health care reform

192. John G. Day and Katherine L. Wade, *The Political Viability of Health Care Federalism*, 28 CONN. L. REV. 151, 156 (1995).

193. Employee Retirement Income Security Act (ERISA) does not allow states to regulate companies which are "self-insured" or have "self-funded" health insurance coverage.

194. S. REP. NO. 156, *supra* note 111, at 16.

was one of the most important problems that government should address.[195] The public's support for universal coverage remained high: 61% believed that the federal government should guarantee health coverage for all Americans.[196] Most Americans believed that making health care affordable for their families was the most important health care reform issue.[197] While the Kassebaum-Kennedy plan did not directly address all of these issues, the plan did attempt to respond to some of the public's concern about their health insurance. In this regard, both plans are related in that they tried to address America's insecurity about health care.

Second, there is nothing in Kassebaum-Kennedy which fundamentally contradicts the principles of the Clinton plan. The concepts of portability, renewability, purchasing cooperatives, and even state flexibility were shared by the Clinton plan. The President's goals of universal coverage and cost containment are not shared by Kassebaum-Kennedy. However, the Kassebaum-Kennedy plan did not ignore these issues.

Kassebaum-Kennedy's committee report explicitly states that "the committee's unanimous approval of S. 1028 should not be read as a sign that certain members of the committee have surrendered the goal of universal coverage."[198] Although the bill does not call for universal coverage, the actual portability and renewability provisions do attempt to significantly expand coverage by increasing access. Despite the plan's modest goals, it is fair to say that the idea of universal coverage still influenced the Kassebaum-Kennedy bill.

The importance of cost containment did not escape the provisions of Kassebaum-Kennedy either. The legislation does not attempt to directly control the increases in health care cost. However, implicit throughout the legislation are concerns about cost containment, especially in regard to the affordability of health insurance. Kassebaum-Kennedy originally created purchasing cooperatives to make health care more affordable, the affordability of insurance is one of the considerations for a state waiver, and it explicitly leaves the regulation of "affordable premiums" to the states. Again, the cost issue is clearly present in the Kassebaum-Kennedy plan.

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195. Robert J. Blendon, *Health Care Reform in the Absence of a National Consensus* in TRANSFORMING THE SYSTEM: BUILDING A NEW STRUCTURE FOR A NEW CENTURY, 3. (*citing* Harris Poll) (Storrs CT: Roper Center for Public Opinion Research, 1994).

196. *Id.* at 4. (*citing* Time/CNN/Yankelovich Partners Poll) (Storrs CT: Roper Center for Public Opinion Research, 1994).

197. *Id.* at 8, 9.

198. S. REP. NO. 156, *supra* note 111, at 13.

As previously mentioned, Senator Kassebaum and others attempted to distinguish this legislation from President Clinton's comprehensive reform plan. In response to the argument that Kassebaum-Kennedy was a "Trojan Horse" for Clinton-like reform, Senator Kassebaum asserted that the bill was not even a "Trojan Pony."[199]

No one intended for Kassebaum-Kennedy to be a "Trojan Horse" for more comprehensive reform. However, virtually all of the supporters of the Clinton plan backed Kassebaum-Kennedy, including the President and Ira C. Magaziner, the primary author of the Clinton plan.

VI. CONCLUSION

Although the advocates of comprehensive reform did not carry the day in 1994, the goals of comprehensive reform are not lost forever. Furthermore, the public's continued support for universal coverage and concern about affordable health care keep the goals of comprehensive reform alive. President Clinton, in a campaign speech, even stated that the Kassebaum-Kennedy bill "does about thirty percent of what we tried to do, and was a big first step."[200] If Kassebaum-Kennedy can use the federal government's authority to increase access to health insurance, then in the future, Congress could enact other stronger incremental reforms. Even before the Kassebaum-Kennedy plan passed, President Clinton spoke of ways to expand the legislation in the future.[201] In particular, incremental reform could be used to provide health coverage to all children; to require a minimum benefits package; to regulate the cost of premiums, or even to initiate an employer mandate.

When asked about the future of health care reform, a White House advisor responded that Kassebaum-Kennedy was currently "the limit of the possible."[202] Those who wanted comprehensive reform, like the supporters of the Clinton plan, were denied in 1994. However, now the same people as proponents of incremental reform can still achieve their goals by slowly but steadily accomplishing the possible.

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199. Adam Clymer, *Dole Presses Clinton to Meet on Budget,* N.Y. TIMES, April 24, 1996, at A6.

200. The White House, *Remarks by the President, Chillicothe, Ohio, August 27, 1996.*

201. "The Clinton Record: Interview with President Clinton," N.Y. TIMES, July 28, 1996, at 29.

202. *See supra* note 113.

The Clinton plan and the Kassebaum-Kennedy plan respectively represent comprehensive and incremental approaches to health care reform. The apparent defeat of comprehensive reform with the demise of the Clinton plan has resulted in many advocates of comprehensive reform now supporting an incremental approach. The Clinton plan may represent the "ideal goals" of reform: universal coverage and cost containment. Kassebaum-Kennedy may be the first step in a long process to achieving those goals. In essence, the Clinton plan shows us where we want to go and the Kassebaum-Kennedy plan represents how we will get there -- one step at a time.[203]

203. James A. Cordone, J.D. expected May, 1997.