Accountable Care Organizations: The Clash of Liability Standards with Cost Cutting Goals”

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Available at: https://works.bepress.com/christopher_smith/4/
ABSTRACT

Accountable Care Organizations: The Clash of Liability Standards with Cost Cutting Goals

This article seeks to examine the conflict between non-cost conscious medical malpractice liability standards and health care cost cutting measures within the context of Accountable Care Organizations (“ACOs”) under the new health care reform law. The article begins by providing an overview of the high level of health care spending within the United States health care system in order to provide a context for better understanding policymakers’ push for cost cutting measures, including ACOs. The article then examines the tension between cost containment efforts and provider medical liability standards through an examination of the “stuck in the middle” mentality that medical providers face when they are forced to meet both liability standards that do not take into account cost concerns and cost cutting standards imposed by or through managed care organizations, pay-for-performance programs and consumer-driven health care. The article then introduces the concept of the ACO and describes elements of the ACOs envisioned under the new health care reform legislation. The article concludes by examining and analyzing whether and how ACOs will exacerbate the cost containment/liability standard tension, and how that tension may impact the effectiveness of ACOs.
ACCOUNTABLE CARE ORGANIZATIONS: THE CLASH OF LIABILITY STANDARDS WITH COST CUTTING GOALS

I. Introduction

Accountable Care Organizations (“ACOs”) are the new kids on the block in the ongoing struggle to achieve the ever elusive dual goals of health care reform, cost containment and high quality care within the United States health care system.¹ Pursuant to the health care reform legislation, the Patient Protection and Affordable Care Act (“PPACA”), the Department of Health and Human Services (“HHS”) is to provide for the creation of ACOs by January 1, 2012.² These ACOs are to be legal entities comprised of primary care physicians, specialists and hospitals that provide care to Medicare patients and receive bonus payments for meeting cost containment and quality standards set by HHS.³

As with any new government program, policy makers, analysts and scholars will likely be focused on predicting whether or not ACOs will effectively achieve their goals and what policy problems will likely arise within the context of ACOs. This Article focuses on the latter issue, and more particularly, whether and how ACOs will impact the tension that health care providers face in meeting cost containment goals, while also meeting medical liability standards of care that do not account for cost containment.⁴ Part II of this Article provides a brief overview of the high level of health care spending that has been and continues to be the impetus for cost containment efforts within the health care system. Part III provides an analysis of how the tension arises between cost containment efforts and provider medical liability standards, as

⁴ James F. Blumstein, Medical Malpractice Standard-Setting: Developing Malpractice “Safe Harbors” as a New Role for QIOs?, 59 Vand. L. Rev. 1017, 1024-26 (2006) (describing the tension between provider cost containment care rationing and a medical malpractice doctrine that views economic trade-offs as having virtually no role in treatment decisions).
well as providing a summary of recent scholarly literature examining this issue within various contexts, such as managed care organizations (“MCOs”) and pay for performance initiatives. Part IV of this Article provides some background on ACOs in general, as well as a discussion of the PPACA-created ACOs. Finally, Part V examines and analyzes whether and how ACOs will exacerbate the cost containment/malpractice tension, and how that tension may impact the effectiveness of ACOs.

II. The Rising Cost of Health Care in the United States

The starting point for understanding ACOs, cost containment efforts in the health care system and the connection and impact of the two on medical malpractice liability is to explore why there is a push for health care cost containment efforts in the first place. The simple explanation for the drive for cost containment is the fact that health care costs and health care spending have been and continue to spiral upwards. However, increasing costs and spending, in and of themselves, are not necessarily evidence of a broken system, provided the increase in spending and costs are correlated with equal or greater improvements in patient outcomes and quality.

Unfortunately, within the United States health care system, increasing health care cost “do not appear to be correlated with better quality.”5 In fact, compared with other countries, the United States spends more of its GDP on health care than many other nations with little to show in terms of better quality outcomes.6 This means that within the United States health care system “there is room for improvement in efficiency; that is, costs could be reduced without harming

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Hence, there is a strong push for cost containment within the United States health care system.

Statistics at both the macroeconomic and microeconomic levels demonstrate that health care costs are spiraling out of control. Starting with the macroeconomic level, in 1998, the United States spent $1.19 trillion on health care. By 2008, a mere ten years later, that number had almost doubled, as the United States spent over $2.338 trillion in health care spending. This 2008 statistic, the most recent data on record, represents 16.2% of the Gross Domestic Product (GDP) and a spending growth rate of 4.4% for 2008. This rate was higher than both the rate of inflation and the growth rate for national income.

The projected national health care spending statistics look no better for the future. By 2019, the government estimates that the United States will spend over $4.482 trillion on health care costs, almost double the spending level for 2008. The projected spending for 2019 will also be 19.3% of the GDP, again a higher percentage of the GDP than health care spending in 2008. Moreover, in between 2010 and 2019, the government predicts that the rate of health care spending will increase between 3.9% and 7% every year.

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7 MedPac, supra note 5, at 53 (arguing that it is easy to conceptualize savings within the United States health care system).
9 Id.
10 Id.
11 ERIC KIMBUENDE, ET AL., U.S. HEALTH CARE COSTS, (2010), available at http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358 (noting that health care expenditures have outpaced inflation and income growth). See also Hall, supra note 2, at 747 (noting that “Medical spending has outstripped inflation for decades”).
13 Id.
14 Id. at Table 2.
Compared to other industrialized countries, the United States’ health care spending also appears out of control. A recent study found that the United States spent $7,290 per capita on health care in 2007, more than Australia, Canada, the Netherlands, Germany, United Kingdom and New Zealand. Each of the other six industrialized countries spent less than $4,000 per capita on health care in 2007. Looking at the data in a different manner, in 2007, United States health care spending as a percentage of the GDP was around 16%, while each of the other six countries spent a substantially lower percentage of their respective GDP’s on health care.

While the macroeconomic picture of health care spending may look dismal, the microeconomic health care spending picture is no brighter. For example, in 1999, the average family employer sponsored health plan cost $5,791 per year in premiums and by 2009, that same plan cost $13,375 per year, an increase of 131%. Breaking these statistics down into employee versus employer contributions to health care spending, the average worker’s contribution changed from $1,543 per year in 1999 to $3,515 per year in 2009, while the average employer’s contribution changed from $4,247 per year in 1999 to $9,860 per year in 2009. Combining the cost of health insurance premiums with all other out-of-pocket expenses, the average person with employer-sponsored coverage spent $2,827 in out-of-pocket health care expenditures in 2001.

16Id. (noting that the other countries studied had per capita expenditures between $2,454 and $3,895).
17Id. at 12 (noting that the percentage of GDP spent by the other six countries ranged between 8.4% and 10.4%).
19Id. at 71.
and by 2006, that same person was spending $3,744 in out-of-pocket health care expenditures, a 30% increase.\(^{20}\)

Whether viewed at the macroeconomic level or microeconomic level, health care costs are high and getting higher, and the burden on individuals and employers is becoming increasingly heavy. These pressures serve as the genesis for the calls for cost containment within the United States health care sector.

III. The Conflict Between Cost Containment and Medical Malpractice Liability

A. The Rationale Behind the Cost Containment Liability Standard Conflict

At the center of the tension between cost containment goals and the medical malpractice liability standard is the debate on whether economic factors, primarily cost containment, should play a role in medical decision making and how medicine is practiced. Some contend that the introduction of economics into medical decision making at any level corrupts medical judgment.\(^{21}\) Others contend that it is acceptable for cost cutting to influence medical judgment within certain limits.\(^{22}\) Still others view the interconnectedness of the two concepts to be inevitable.\(^{23}\)

That said, there is generally less debate regarding whether or not it is acceptable to introduce cost containment initiatives at the flat point of the medical care cost curve. At that point on the curve any cost cutting is merely waste control, or the elimination of medical spending which yields no additional benefits.\(^{24}\) The heart of the debate lies in whether costs


\(^{21}\) James F. Blumstein, Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship, 4 Ind. Health L. Rev. 211, 212 (2007) (outlining the various views on whether economic considerations should factor into treatment decisions).

\(^{22}\) Id.

\(^{23}\) Id.

\(^{24}\) Id. at 215 (arguing that “eliminating zero-benefit diagnoses and treatments is uncontroversial).
should be cut at the cost control point of the medical care cost curve, or the point at which additional spending yields benefits, but marginally so in light of the costs expended.\textsuperscript{25} Therein lies the point at which providers will resist cost containment initiatives for fear of incurring medical liability by cutting marginally beneficial care within the standard of care.

Reflecting the central debate regarding whether or not cost saving concepts should play a role in medical decision making, medical malpractice liability standards are in conflict with the goal of cost containment in a number of ways. First, as a matter of current law and medical ethics, the medical standard of care cannot vary according to ability to pay.\textsuperscript{26} This non-cost conscious standard is entrenched, as demonstrated when patients try to fully or partially waive liability in exchange for less costly, but suboptimal care. In those situations, courts generally refuse to enforce such a waiver because of the fiduciary relationship between a doctor and patient.\textsuperscript{27}

There are two core beliefs behind the legal and ethical standard of entitlement to care regardless of cost and ability to pay. First, is the core belief that every individual is entitled to all beneficial medical care, regardless of cost.\textsuperscript{28} Second, and related, is the belief that it would be socially unjust and ethically repulsive for the law to hold that the indigent and uninsured are entitled to a lower standard of care than the insured population and allow providers to drop their

\begin{itemize}
\item \textsuperscript{25} Id. at 215-16 (arguing that it is more difficult to achieve a goal of eliminating marginally beneficial care in the name of cost savings).
\item \textsuperscript{26} Gail B. Agrawal & Mark A. Hall, \textit{What if You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield}, 47 St. Louis U. L.J. 235, 285 (2003) (arguing that the medical standard of care exists based on a fallacy that there is one correct treatment to be determined without reference to cost); Dionne Koller Fine, \textit{Physician Liability and Managed Care: A Philosophical Perspective}, 19 Ga. St. U. L. Rev. 641, 651 (noting that the medical profession has long believed that cost should never be a part of the treatment relationship); Mark A. Hall, \textit{Paying for What You Get and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care}, 69 Law & Contemp. Prosbs. 159, 176 (2006) (noting that the “medical malpractice standard of care does not vary according to a patient’s insurance or financial situation).
\item \textsuperscript{27} Hall, supra note 26 at 176.
\item \textsuperscript{28} Fine, supra note 26, at 663 (arguing “that the dominant view is that there is an absolute moral prohibition against physicians considering the costs of treatment”).
\end{itemize}
standard of care for such indigent, uninsured patients.\textsuperscript{29} The general problem with this non-cost conscious standard of medical liability is that it falsely assumes that society has unlimited resources to devote to health care.\textsuperscript{30}

A second way in which medical liability standards conflict with cost containment efforts is through providers’ fear of medical malpractice liability and how that fear incentivizes providers to provide as much care as possible in hopes of covering every conceivable basis for a lawsuit.\textsuperscript{31} This fear-driven increase in the amount of care also increases the costs of care.\textsuperscript{32} This is the concept of defensive medicine, under which the fear of being sued for malpractice encourages provider overutilization and over-deterrence in diagnostic testing and treatment.\textsuperscript{33}

Defensive medicine and the tendency to promote overutilization is a result, to some extent, of a medical malpractice system in which the standard of care is not officially set until after the injury has occurred and expert witnesses, during trial, define the standard \textit{post-hoc}.\textsuperscript{34} This \textit{ex ante} uncertainty as to the contours of the standard of care is exacerbated by evidence of widespread “variation in practice patterns unexplained by outcomes data.”\textsuperscript{35} Too often, the customary practice standard may be somewhat of a mystery at the time of diagnosis or treatment.

The practice of defensive medicine is also exponentially promoted through the traditional third-party payment system for insurance, where neither the doctor nor the patient fully “feel”

\textsuperscript{29} Hall & Schneider, supra note 6, at 752-53 (arguing that “judges are loath to have tort law ratify the social injustice of unaffordable health care”).
\textsuperscript{30} Fine, supra note 26, at 664-65 (arguing that current law prohibiting the consideration of costs in treatment decisions ignore economic and medical realities).
\textsuperscript{31} Hall & Schneider, supra note 6, at 748 (arguing that providers follow the belief that the more thorough the care, the less likely they are to be sued).
\textsuperscript{32} Fine, supra note 26, at 685-86 (arguing that liability suits have created pressure to escalate treatment costs).
\textsuperscript{33} Claire Bartholome, \textit{Leveraging Our Strengths: Reinforcing Pay-For-Performance Programs as the Solution for Defensive Medicine}, 4 J. Health & Biomedical L. 333, 333-34 (2008) (describing defensive medicine as providers avoiding high-risk procedures and patients, and ordering clinical-excessive tests in an effort to guard against malpractice claims); Blumstein, supra note 4, at 1020-21 (defining defensive medicine as over-deterrence in medical practice driven by an effort to conform to uncertain standards of care).
\textsuperscript{34} Blumstein, supra note 4, at 1028-29 (noting the practice standards are not definitively established until after an injury has occurred).
\textsuperscript{35} Id. at 1026-28.
the financial impact of the treatment decisions being made.\textsuperscript{36} In the end, physicians provide excessive care to adjust for clinical and structural uncertainty in medical malpractice doctrine, and are rewarded for such behavior by a third-party fee-for-service ("FFS") payment system.\textsuperscript{37}

A third way in which malpractice liability standards conflict with cost containment concepts is through the historically dominant philosophical view of how medical decisions should be made and how medicine should be practiced. That philosophy, touched upon above, is the scientific or professional view, which considers medical decision making to be entirely scientific and views the introduction of economic criteria into that decision making as a corruption of scientific purity.\textsuperscript{38} The scientific paradigm considers costs to be irrelevant because it follows the belief that there is a single unitary standard of care to be followed within the practice of medicine.\textsuperscript{39} The legal doctrine that is medical malpractice liability embodies this professional or scientific model of medical decision making.\textsuperscript{40} By contrast, traditional tort law, outside of the medical malpractice context, evaluates allegedly negligent conduct on the basis of a "reasonableness" standard that incorporates costs and benefits and risks and rewards into the analysis of whether negligence has occurred.\textsuperscript{41} The existence of a third-party payment system, mentioned earlier, takes cost and benefit balancing out of the equation in the medical malpractice context.\textsuperscript{42}

\textsuperscript{36} Id. at 1025 (arguing that third-party medical insurance allows patients and physicians to overutilize medical resources).
\textsuperscript{37} Id. at 1031.
\textsuperscript{38} Blumstein, supra note 21, at 220 (arguing that the professional model "assumes that diagnosis and treatment decisions are not influenced by financial incentives").
\textsuperscript{39} Agrawal & Hall, supra note 26, at 285-86 (discussing medical malpractice doctrine as encompassing a one-right-way approach to the practice of medicine); Blumstein, supra note 4, at 1024 (arguing that medical malpractice doctrine assumes "that science has established a single or unitary standard of practice").
\textsuperscript{40} Blumstein, supra note 4, at 1023.
\textsuperscript{41} Id. at 1025 (arguing that traditional tort law views the customary practice standard as a market-validated standard that encompasses cost and benefits).
\textsuperscript{42} Id.
The fourth way in which medical liability standards and cost cutting concepts conflict is through the requirement of medical ethics and the medical liability standard that “physicians [] promote their [individual] patients’ interests above all others.” This directly conflicts with cost cutting concepts because this standard cannot be met on an individual patient basis for all patients; health care resources are finite and limited and require rationing at some point along the health care spending continuum. As a result, for a physician to strive to meet cost cutting goals “exposes the physician to potential liability for ‘failing to do the impossible.’”

The fifth, and perhaps most self-evident way in which liability standards and cost saving efforts conflict is demonstrated by how the medical liability standard does not take into consideration cost containment goals. As long as this situation remains, the goal of cost containment is impossible to achieve. Providers will resist rationing care and will resist cost containment efforts, so long as they know that such efforts are disregarded in determining the standard of care in the medical liability determination. In the world of a non-cost conscious medical liability standard, there is no reward for cutting costs, only potential punishment.

B. The Medical Liability Standard Cost Containment Conflict Across Contexts

Scholars have explored the tension between cost containment and medical malpractice liability in a variety of contexts over the years, including consumer-driven health care cost containment efforts, Medicare cost containment efforts and private insurer managed care cost

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43 Fine, supra note 26, at 664-65.
44 Id. at 665 (arguing that it is a false assumption to assume that society has unlimited resources for medical care).
45 Id. at 666.
46 Id. at 685 (arguing that the current liability standard undermines cost containment objectives because it subjects providers “to liability for rationing care as a way to control costs”).
47 Id. (arguing that the current liability scheme results in providers who “will not and do not fully embrace cost containment efforts”).
containment efforts. The following section explores some of the more recent literature on this tension across a few different contexts.

Perhaps the most stark example of the tension between health care cost containment and malpractice liability standards arises within the context of managed care, where the MCOs “control health care costs by controlling physician behavior and limiting patients’ utilization of services.”

In these situations, providers’ ethical and legal obligations to see to it that the patient’s needs come first and that patients receive a high quality of care, regardless of cost, clash with the MCOs’ efforts to push providers to ration care and cut costs.

The clash between MCO cost containment and provider liability standards specifically arises within the managed care context when the provider and managed care insurer disagree on a treatment, such that the former believes that the treatment is medically necessary, but the latter refuses to provide coverage, believing that the treatment is not medically necessary.

The


49 Fine, supra note 26, at 646; Katherine L. Record, Wielding the Wand Without Facing the Music: Allowing Utilization Review Physicians to Trump Doctors’ Orders, but Protecting them from the Legal Risk Ordinarily Attached to the Medical Degree, 59 Duke L.J. 955, 977 (2010) (describing the essence of MCOs as having control over provider decision making).

50 Fine, supra note 26, at 641-42 (discussing the providers’ increased liability risk as a result of MCO imposed health care rationing).

51 Record, supra note 49, at 956-57.
decision of the MCO as to what is medically necessary usually trumps the decision of the provider because most patients cannot afford treatment without managed care insurance. As a result, what often happens is that the patient does not receive the provider recommended treatment, suffers a resulting injury from the coverage/treatment decision and files a malpractice suit when he or she discovers that the provider’s treatment recommendation was correct, not the MCO’s coverage decision. This scenario illustrates how sometimes the MCO imposed cost cutting actually causes the provider to cut care “that may be beneficial and within the current standard of care.”

Ironically, even though, under this scenario, the MCO exerts extensive control over the provider’s treatment decision, the Employee Retirement and Income Security Act of 1974 (“ERISA”) preempts most state law claims against many MCOs, and therefore, the provider usually remains solely liable for any adverse outcome.

The reason why most MCOs generally avoid any form of liability for their coverage decisions is because ERISA applies to MCOs that are employer-sponsored health plans, and preempts state law medical malpractice claims against the MCO, while also failing to provide for a federal tort remedy against the MCO. This is a bit of an oversimplification of the confusing and complex liability standards and case law governing the application of ERISA to MCO liability, but for purposes of this Article it is enough to note two summarizing principles from the ERISA statute and guiding case law. First, plan beneficiaries can bring ERISA claims in federal court for breach of contract and collect breach of contract damages against ERISA covered MCOs, but they cannot bring ERISA tort claims and collect tort damages against ERISA covered MCOs.

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52 Id. at 965.
53 Id. at 957.
54 Fine, supra note 26, at 642.
55 Record, supra note 49 at 977 (explaining that federal preemption shields most MCOs from state malpractice “liability even when they make coverage decisions regarding the medical necessity of care”).
56 The Employee Retirement and Income Security Act of 1974, 29 U.S.C. §§ 1132(a), 1144 (2006); Id. at 957 (noting that ERISA preempts state law “liability for employer-sponsored health plans relating to the administration of health benefits, but does not impose parallel federal liability in its place”).
MCOs. Second, plan beneficiaries’ state tort claims against ERISA governed MCOs are ERISA preempted as to any claims involving eligibility decisions or administration of benefits decisions. Those tort claims are also ERISA preempted with regard to MCO coverage decisions involving both treatment and plan benefit decisions, provided the patient’s treating physician was not involved in the utilization review decision and/or “the medical judgment was made by a utilization review physician who never saw the patient.”

In the context of this Article, the important point is that plaintiffs have few if any remedies against MCOs that are subject to ERISA, and instead, must focus their grievances against their providers. Accordingly, the providers are essentially caught in the middle as the standard of care to which they are subject ignores costs, does not account for the cost saving pressures from the MCOs and even treats the provider as “having a duty to resist being tainted.

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57 Fine, supra note 26, at 660 (noting that ERISA allows injured plan beneficiaries to recover only the benefits due under the terms of the health plan and not compensatory or punitive damages); Record, supra note 49 at 965 (noting that ERISA “allows plan beneficiaries to challenge coverage decisions for breach of contract, but not for negligence).

58 Record, supra note 49 at 968, citing Pegram v. Herdrich, 530 U.S. 211, 229-31 (2000) (refusing to allow a claim filed under ERISA to allege breach of fiduciary duty where the contested action involved an element of a treatment decision, rather than a pure eligibility decision).

59 Id. at 969, citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 48 (1987) (reasoning that a state or common law cause of action “based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet[s] the criteria for pre-emption”).

60 Id. at 970, citing Land v. CIGNA Healthcare of Fla., 381 F.3d 1274, 1276 (11th Cir. 2004) (per curiam) (holding that a claim challenging denial of coverage that entails a mixed eligibility and coverage decision is not preempted when that decision was made by either the treating physician or his employer).

61 Id. at 968, citing Danca v. Private Health Care Sys., Inc., 185 F.3d 1, 7 (1st Cir. 1999) (holding that the plaintiffs’ state tort claims against the defendant insurance company for negligent supervision and training of personnel and negligent infliction of emotional distress were preempted by ERISA because they “create[d] a threat of conflicting and inconsistent state and local regulation of the administration of ERISA plans”); Tolton v. Am. Biodyne, Inc., 48 F.3d 937, 941-42 (6th Cir. 1995) (holding that the plaintiffs' state law claims against the defendant insurance company for wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith were preempted by ERISA because they related to the insurance plan); Corcoran v. United HealthCare Inc., 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that, because the defendant insurance company had made “medical decisions incident to benefit determinations,” the plaintiffs' state tort action for wrongful death of their child was preempted by ERISA (emphasis added)); Elsesser v. Phila. Coll. of Osteopathic Med., 802 F. Supp. 1286, 1290-91 (E.D. Pa. 1992) (holding that the plaintiffs' state tort negligence claims, founded on the defendant insurance company's refusal "to pay for the [requested medical device]," were preempted by ERISA when the plaintiffs sought to hold the company “directly liable" for negligence, explaining that "such a claim...clearly has a [connection to] a benefit plan" (second alteration in original)).

62 Id. at 957 (noting that the provider often pays the price for injuries resulting from MCO coverage decisions, not the MCO).
by the pressures of managed health care and cost containment.”

In some areas, providers may sustain liability “for not working hard enough through appeals [of MCO utilization decisions] or otherwise to secure treatment for the patient.” The bottom line is that the managed care system forces the provider to ration care at the bedside and then face potential malpractice liability for engaging in such MCO imposed rationing behavior.

Beyond examining how the tension between cost cutting and liability arises in the managed care context, it is also important to understand more about why it occurs. First, the tension between managed care and medical malpractice liability arises, to some extent, because the provider liability standards focus on the individual patient and what is best for that person, whereas the MCO cost containment efforts focus on what is best for society as a whole by attempting to efficiently utilize the limited resource that is health care.

Second, providers are subject to conflicting incentives in the managed care context. For example, the managed care incentive to cut costs is tied to providers’ incomes from the MCOs, which conflicts with the provider ethical incentive to ensure patient well-being, regardless of cost, as well as the medical liability based incentive that the patient receive any and all care within the standard of care, regardless of costs. Even if the provider stands to benefit financially from cutting costs, the fiduciary relationship between providers and patients requires providers to place their patients’ interests above their own.

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63 Fine, supra note 26, at 642. See also Record, supra note 49, at 984 (noting that providers “must formally protest a plan’s denial of coverage for medically necessary care”).

64 Fine, supra note 26 at 675.

65 Id. at 644, 646 (contrasting the fee-for-service focus on what is best for the individual patient with the MCO focus on what is the best treatment from society’s perspective); Record, supra note 47 at 980 (discussing the physician’s duty of loyalty to individual patients).

66 Fine, supra note 26 at 649 (describing how physicians’ incomes within MCOs are in conflict with patient well-being).

67 Id. at 655 (discussing provider’s duty to serve their patients’ interests above their own).
Third, the MCOs incentives in making treatment decisions are not aligned with providers’ incentives in providing treatment to patients. As discussed above, the former can generally cut costs, at will, with little fear of liability due to ERISA preemption, whereas as the substantial fear of potential medical malpractice liability pushes the latter to engage in costly defensive medicine. \(^68\) ERISA allows MCOs “to behave as they choose with little accountability to their members or the public.”\(^69\) There is no deterrence against negligent coverage denials by MCOs.\(^70\) The provider, on the other hand, ends up bearing responsibility for everything, despite the fact that the MCO exerts great control over treatment decisions through the power of the purse.\(^71\) In the end, the respective liability to which providers and MCOs are subject is inverse to the control that each one has over treatment decisions.\(^72\)

Fourth, the ERISA system encourages lawsuits against providers, but not against the MCOs. Plaintiffs, knowing the ERISA obstacles for a successful tort claim against a MCO, will try to couch all of their medical tort claims as negligence claims against providers, even if the claim is more appropriately directed at the MCO.\(^73\) The beneficiary’s incentive to sue the provider over the MCO is even stronger given that the damages available in tort against providers are much greater than those available in contract against the MCO.\(^74\) Recognizing the beneficiary’s strong incentive to sue the provider over the MCO, providers are probably more encouraged to practice defensive medicine than they otherwise would be. However, these

\(^{68}\) Record, \textit{supra} note 49 at 957-58, 964-65 (discussing how providers serve as the “deep pockets” for patients to recover for injuries caused by MCO coverage decisions, while MCOs escape from liability even when the denial of coverage is negligent).

\(^{69}\) Fine, \textit{supra} note 26 at 660.

\(^{70}\) Record, \textit{supra} note 49 at 987-88 (arguing that “applying contract law [under ERISA] to utilization review decisions fails to deter negligent coverage denials”).

\(^{71}\) \textit{Id.} at 981-83 (noting that providers may bear all of the burden of liability when an MCO wrongfully denies coverage).

\(^{72}\) \textit{Id.} at 994.

\(^{73}\) \textit{Id.} at 982 (arguing that the “ERISA scheme incentivizes wronged beneficiaries to reshape their claim into one relating to the quality of care delivered by the treating physician”).

\(^{74}\) \textit{Id.} at 987.
mounting tort liability pressures occur at the same time as and in conflict with MCO imposed cost cutting pressures on those same providers.

Fifth, the extent of pressure on the provider to ration care within the MCO context is exacerbated by the very real possibility that if the provider does not meet the MCO’s cost cutting expectations, then he or she may be terminated from the MCO’s provider network and from providing care to the MCO’s patients.\(^5\) This pressure is significant, given that MCOs have substantial market power, providers economically rely on MCOs for a sufficient pool of patients to sustain their practices and once terminated, providers’ reputations suffer and they are less likely to be able to join another MCO.\(^6\) One disturbing unintended consequence of this fear of termination is that providers may be reluctant to take on severely ill or chronically ill patients, due to cost concerns.\(^7\) Moreover, the pressure to cut costs combined with the fear of termination can also cause a physician to place his or her self-preservation interest above the patient’s best interests, which could ultimately result in medical malpractice liability.\(^8\)

In terms of solutions to the existing cost cutting/liability standard tension within the MCO context, one scholar has proposed aligning the incentives of providers with the incentives of MCOs by applying the same standard of care to providers and MCOs, with some limitations on the MCOs’ liability.\(^9\) This is essentially a proposal to have Congress remove ERISA preemption from the MCO environment.

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\(^5\) Fine, supra note 26 at 659, 673 (describing how MCOs terminate providers from their networks if they fail to comply with MCO cost containment goals).

\(^6\) Id. at 675.

\(^7\) Id. (discussing that some provider privately admit “that they are reluctant to take on new patients who may be severely or chronically ill because of the high costs involved in treating such patients”).

\(^8\) Id. at 675-76 (discussing how threat of deselection may cause a provider to place his or her livelihood and the MCO’s interest ahead of a patient’s needs).

\(^9\) Record, supra note 49, at 994 (arguing that the foundation for needed legal reform is to align the standard of care of practicing providers with the liability standard for providers conducting utilization review).
Aligning provider and MCO incentives by applying tort liability standards to MCOs would arguably incentivize the MCOs to act in a more reasonable manner during the utilization review process. However, the scholar contends that the tort liability standard must be limited in its application to MCOs in order to avoid over-deterrence, or MCOs ceasing to implement any and all cost-containment policies, including those that are beneficial. Accordingly, the scholar proposes the following parameters for imposing liability on MCOs: 1) MCO liability should not attach when coverage is clearly excluded by the policy; 2) A MCO, in court, must be allowed to introduce, as evidence, cost-effectiveness research to demonstrate reasonableness under a cost-containment policy; and 3) Damages must be capped. In other words, this scholar proposes to impose similar liability-based incentives on providers and MCOs, but to modify the possible scope of MCO liability to avoid deterring the MCOs from implementing cost-containment policies that maintain quality outcomes.

While not focusing on aligning the incentives of providers and MCOs in terms of medical liability, Professors Agrawal and Hall argue that the liability standard/cost containment tension within the MCO context should be resolved by imposing liability on MCOs for the process by which they reach their utilization review or coverage decisions. Professors Agrawal and Hall argue that applying a provider-based ordinary standard of care to the coverage decision is problematic for the same reasons that it is problematic for providers; such a standard of care is open to differing subjective opinions and could overly deter MCOs from legitimate and quality

80 Id. at 995-96 (arguing that holding utilization review physicians liable for breaches of the standard of care would “incentivize the exercise of reasonable caution in denying coverage”).
81 Id. at 996.
82 Id.
83 Agrawal & Hall, supra note 26, at 297-98 (arguing that efforts “to improve the process of coverage determinations [are] socially constructive response[s] to tort law’s deterrence signal”).
maintaining cost cutting.\textsuperscript{84} Therefore, Professors Agrawal and Hall propose that managed care
decisions should be judged on their reasonableness according to the process by which coverage
decisions are reached.\textsuperscript{85} They argue that such a process-based standard provides a better
predictive standard for MCOs, as they would only be held liable if “they use a procedure that is
not designed to acquire and consider relevant factors, or if they depart materially from normal
procedures without adequate justification.”\textsuperscript{86}

A third scholar, Professor Fine, proposes that the solution to the cost
containment/medical malpractice liability conflict within the MCO context is for the medical
profession to reform the standard of care to incorporate or reflect cost containment goals.\textsuperscript{87}
Professor Fine argues that the medical profession, as opposed to the legislature, should be
responsible for creating a revised cost conscious standard of care because doing so recognizes
that physicians have a duty to participate in lowering the high costs of health care, while also
respecting physician autonomy to define the practice of medicine.\textsuperscript{88} More specifically, Professor
Fine urges the medical profession to indirectly incorporate cost containment into clinical practice
guidelines through how those guidelines are defined and then to incorporate those guidelines into
the standard of care.\textsuperscript{89} Professor Fine contends that the use of such guidelines will help
minimize unnecessary care and geographic-based treatment variations, will alert providers to the

\textsuperscript{84} Id. (arguing that application of a standard of ordinary care to MCOs would result in “excessive second-guessing of
the substance of coverage decisions [and] could over-deter insurers’ socially beneficial efforts to contain costs”).
\textsuperscript{85} Id.
\textsuperscript{86} Id. at 298.
\textsuperscript{87} Fine, supra note 26, at 693-94 (arguing that the best solution to the cost containment/liability conflict policy
problem is for the medical profession to “responsibly and effectively incorporate considerations of cost into the
treatment decision”).
\textsuperscript{88} Id. at 695-96 (discussing the importance of allowing the medical profession to redefine the goals of medical
practice).
\textsuperscript{89} Id. at 697 (explaining how clinical practice guidelines have attracted attention as a tool for defining the medical
malpractice standard of care).
greatest cost benefit treatment patterns and will lessen the chance that a MCO will terminate a provider for practicing high cost medicine.90

Along with the MCO context, a few articles have examined the cost containment/liability standard conflict within the context of consumer-driven health care.91 Consumer-driven health care describes a system whereby insured patients are required to pay a large part of their medical out-of-pocket costs, usually through tax-sheltered “health savings accounts.”92 Consumer-driven health care promotes cost-containment and high quality care through the idea that if patients are given information about the costs and benefits of health care treatment options and also have to shoulder more of the financial burden of paying for their health care, then they will have “skin in the game” and face incentives to reduce their volume of health care spending on wasteful care or care with few benefits.93 Although, consumer-driven health care operates with the hope that patients will reduce spending on unnecessary care, there is a very real risk that patients will forgo even necessary care because of the high costs associated with medical care, in general.94

The conflict between consumer-driven health care and malpractice liability standards arises when a patient refuses treatment or requests suboptimal care on the basis of cost, and then suffers an injury that would have been avoided had the optimal, more costly care been provided.95 Under such a scenario, providers may assert the defenses of waiver and/or assumption of risk, but they bear the burden of litigating both defenses with the corresponding

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90 Id. at 700.
91 Hall, supra note 26, at 159 (examining legal and regulatory issues arising when patients are forced or choose to pay a major portion of their medical costs out of pocket); Hall & Schneider, supra note 6, at 743 (examining the effects of health care consumerism on achieving cost constrain and quality standards).
92 Hall, supra note 26, at 159.
93 Hall & Schneider, supra note 6, at 747-48 (stating the principal tenet of consumer-driven health care is the idea that if patients have reliable information about the cost and quality of care and pay more for that care out of pocket, then they “will make decisions that drive costs down and the quality up”).
94 Id. at 749 (providing an example where a physician thinks a patient might have a sprain or torn ligament and the patient chooses to avoid getting an MRI to definitively identify a torn ligament for repair because the MRI is too expensive).
95 Hall, supra note 26, at 171, 175 (examining whether providers can be held liable for delivering suboptimal treatment when the patient chooses to receive less expensive care or buys more limited insurance).
risk that their understanding of the patient’s refusal will be second-guessed by juries.\textsuperscript{96} Accordingly, the medical liability standard, which imposes a standard of care on the physician regardless of the resources available, may result in liability against the physician, even though the patient, on the basis of cost concerns, refused the optimal standard of care in favor of a lesser standard of care or no care at all.\textsuperscript{97}

To harmonize the medical liability standard with the patient choice of suboptimal care in the consumer-driven health care context, Professor Hall has argued that the standard of care should be split into two components, one focusing on the resources available and one focusing on the skill which must be applied to those resources.\textsuperscript{98} Under this suggested liability modification, a provider would be required to meet a set skill standard of care regardless of the patient’s choice of a costly, optimal treatment or a less costly, suboptimal treatment.\textsuperscript{99} However, the standard of care applied to the resources used in treating the patient would vary according to the level of resources chosen by the patient.\textsuperscript{100} Professor Hall further contends, at least with regard to the resources component of the proposed revised standard of care, that a defense be recognized, whereby providers can demonstrate, through informed consent, that the patient knew of more expensive alternatives, yet chose the low cost, suboptimal treatment.\textsuperscript{101}

Pay-for-performance (P4P) programs represent another context in which the tension between medical malpractice liability standards and cost containment efforts arises. Somewhat similar to ACOs, P4P programs tie provider reimbursement to performance, with a focus on

\textsuperscript{96} Hall & Schneider, supra note 6 at762-67 (arguing that the doctrines of waiver and assumption of risk do not provide physicians with sufficient guidance to determine when it is safe to provide suboptimal care).

\textsuperscript{97} Hall, supra note 26, at 175.

\textsuperscript{98} Id. at 177 (arguing for dividing the standard of care determination into a resources component and skill component).

\textsuperscript{99} Id.

\textsuperscript{100} Id.

\textsuperscript{101} Id. at 178-79 (arguing that recognizing assumption of risk or informed refusal of recommended treatment as a defense along with the recommended dual standard of care would further promote adoption of the dual standard of care).
lower costs and higher quality.\textsuperscript{102} Defensive medicine stemming from fear of malpractice liability and the cost containment provisions of P4P conflict because the former inherently drives up spending on health care in hopes of driving down malpractice costs, while the latter encourages less spending in efforts to control treatment costs.\textsuperscript{103} Although, a conflict currently exists between P4P and defensive medicine, at least one scholar has argued that linking malpractice liability standards with the cost-conscious clinical quality guidelines under P4P will harmonize the two because adherence to the P4P cost-conscious clinical guidelines will reduce treatment costs, while incorporating the clinical practice guidelines into the malpractice standard will reduce the risk and cost of malpractice liability.\textsuperscript{104}

Within the context of Quality Improvement Organizations (“QIOs”), Professor Blumstein has proposed a similar solution for aligning the medical malpractice standard of care with cost containment considerations.\textsuperscript{105} More specifically, Professor Blumstein has proposed using QIOs to set the standard of care \textit{ex-ante} through the formulation of protocols that incorporate costs and benefits.\textsuperscript{106} QIOs are a federal statutory creation, originally known as Professional Standards Review Organizations, and were created as “self-regulatory organizations of physicians . . . charged with monitoring individual physicians’ decisions affecting the use of health care

\textsuperscript{102} Bartholome, \textit{supra} note 33, at 333 (describing P4P as linking “provider reimbursement with adherence to certain criteria aimed at reducing costs and increasing quality”).

\textsuperscript{103} \textit{Id.} at 334 (describing PSP and defensive medicine as having conflicting ends with the former focused on reducing health care treatment costs and the latter focused on reducing medical malpractice costs).

\textsuperscript{104} \textit{Id.} at 336 (arguing that “the cost and quality control of P4P will provide physicians with an incentive to adhere to responsible clinical guidelines, reducing their risk of malpractice liability”).

\textsuperscript{105} Blumstein, \textit{supra} note 4, at 1048-49 (arguing that the solution for the cost containment/liability standard tension is for Quality Improvement Organizations to set ex-ante practice standards that incorporate cost concerns and that become the standard of care).

\textsuperscript{106} \textit{Id.} at 1048 (discussing the benefits of ex ante liability standard-setting “as a tool for reducing uncertainty faced by medical providers).
resources under federal health programs.” The federal statute provides immunity to providers who act in compliance with or reliance on the standards set by the QIOs.

Professor Blumstein proposes to use the QIO statute to allow QIOs to set practice standards that incorporate quality and costs concerns, and then allow providers following such standards to avoid state medical malpractice liability under the federal immunity granted by the QIO statute. Professor Blumstein argues that the QIO practice standards will effectively prevent the practice of defensive medicine if they are narrowly designed as safe harbors, such that providers know that they will be immune from liability if they strictly adhere to the protocols, but will conclusively be in breach of those standards if they deviate from the protocols. To be most effective, Professor Blumstein contends that the protocols must target narrow, specific circumstances, including diagnostic medicine and the use of new technology in medicine, areas where “defensive practices are sub-optimal and . . . quality can be maintained while reducing cost.”

As demonstrated above, a variety of scholars have examined the cost containment/liability standard across various contexts, and they have proposed a diverse array of possible solutions. The analysis above provides the backdrop for predicting how the liability standard/cost containment conflict will work within the ACO context and what impact it will have on the ACOs and their success or effectiveness. However, before applying the above analysis within the ACO context, it is important to understand the ACOs and, more particularly, the ACOs anticipated by the PPACA.

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107 Id. at 1038.
108 Id.
109 Id. at 1048-49.
110 Id. at 1048 (arguing that the controlling standards must serve as a sword and shield, defending against liability if they are followed and establishing liability if they are breached).
111 Id. at 1049.
IV. Accountable Care Organizations

In 2009, MedPac issued a report to Congress exploring the idea of creating ACOs as a way to control Medicare spending, while improving the quality of care provided to Medicare beneficiaries.\(^{112}\) In its report, MedPac’s general concept of an ACO was an organization of primary care physicians, specialists and at least one hospital that would be assigned a population of Medicare beneficiaries and would be held jointly accountable for the quality of care and Medicare spending costs associated with that population.\(^{113}\) Medicare would facilitate joint accountability within the ACOs through financial bonus incentives given to the ACO providers and ACOs as a reward for achieving low costs and high quality.\(^{114}\) More specifically, MedPac envisioned a system whereby ACO providers would strive to meet set quality standards, as well as control patient volume or excessive patient use of Medicare services. The ACOs’ actions would, in turn, result in a cut to Medicare spending, thereby qualifying the ACO and its providers for financial incentives. Broadly speaking, the MedPac ACOs would be categorized as functionally falling somewhere between a Medicare FFS system and managed care fully capitated plan system.\(^{115}\)

In its report to Congress, MedPac examined two different types of ACO models. The first model was a voluntary, bonus only model, in which participation in an ACO would be voluntary and accountability would come in the form of financial bonuses to ACOs for improving patient quality outcomes while reducing Medicare spending.\(^{116}\) The second model was a mandatory model in which participation in an ACO would be mandatory with the same

\(^{112}\) MedPac, supra note 5, at 39 (discussing the goals of ACO’s as creating an incentive for ACO providers to “constrain volume growth while improving the quality of care”).

\(^{113}\) Id.

\(^{114}\) Id.

\(^{115}\) Id. at 54-55 (discussing how Medicare associated ACOs would fall somewhere on the spectrum between Medicare FFS and Medicare Advantage).

\(^{116}\) Id. at 40 (describing the two different proposed ACO models).
financial bonuses for good performance and penalties for poor performance. In 2010, Congress, through the PPACA, endorsed and adopted the voluntary, bonus-only model of ACOs.

Under the PPACA, Congress provided for the creation of ACOs through an incentive-based Medicare Shared Savings Program (“MSSP”), to be established by January 1, 2012, and which promotes the establishment of ACOs for Medicare FFS beneficiaries. The PPACA ACOs are to operate in a similar manner to the voluntary, bonus-only ACOs outlined in the MedPac Report. As with the ACOs outlined in the MedPac Report, a PPACA ACO is to be comprised of primary care physicians, specialists and hospitals that monitor Medicare expenditures spent on that ACO’s assigned beneficiaries, as well as the quality of care provided to those beneficiaries. Also, similar to the MedPac Report ACOs, if a PPACA ACO meets certain quality standards and achieves certain Medicare cost savings standards, then providers within that ACO will receive a percentage of the savings in Medicare expenditures that the ACO achieves. The goal of the PPACA ACO program “is to afford health care providers financial incentives to promote delivery of care to Medicare patients in a coordinated manner across a continuum of care.”

Turning to the structural details of the PPACA ACOs, the ACO entities must take one of the following legal structures: group practice arrangements; practice networks; partnerships; joint venture arrangements; or hospitals employing physicians. Each ACO must also include the following characteristics: 1) Accountability for the quality, cost, and overall care of the

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117 Id.
118 Patient Protection and Affordable Care Act § 3022.
120 42 U.S.C. § 1395jjj.
121 Id.
Medicare beneficiaries assigned to it; 2) A legal structure allowing for the receipt and distribution of shared savings to participating physicians and hospitals; 3) A sufficient number of primary care physicians to care for the number of beneficiaries assigned to the ACO; 4) Responsibility for at least 5,000 beneficiaries assigned to the ACO and possibly more; 5) A leadership and management structure that includes clinical and administrative systems; 6) Defined processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care; and 7) Meeting patient-centeredness criteria to be specified by HHS.\textsuperscript{124} Along with these structural requirements, eligible ACOs must also meet certain quality reporting requirements to be set by HHS, which will include, but are not limited to, reporting on: “(i) clinical processes and outcomes; (ii) patient and, where practicable, caregiver experience of care; and (iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).”\textsuperscript{125}

On the incentive payments side of the PPACA ACOs, providers and suppliers within an ACO are eligible for bonus payments based on savings if they meet quality standards to be established by HHS, as well as Medicare spending benchmarks, also to be established by HHS.\textsuperscript{126} ACO providers will continue to be paid on a Medicare FFS basis for the services that they provide, but ACOs and their members will also be eligible for incentive payments if their “estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least [an HHS designated percentage below an HHS designated expenditure benchmark].”\textsuperscript{127} The savings evaluation will be made on an annual basis, but the HHS designated expenditure

\begin{footnotesize}
\begin{itemize}
    \item \textsuperscript{124} Id. at § 1395jjj(b)(2).
    \item \textsuperscript{125} Id. at § 1395jjj (b)(3).
    \item \textsuperscript{126} Id. at § 1395jjj (d)(1)(A).
    \item \textsuperscript{127} Id. at § 1395jjj (d)(1)(B).
\end{itemize}
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benchmark against which the savings are to be measured is based on “the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.” HHS is also required to adjust the benchmark based on beneficiary characteristics and other appropriate factors, and is required to update the benchmark based on “the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary.” The actual incentive payments to the ACOs and their members will be an HHS-designated percentage of the difference between the ACOs average per capita Medicare expenditures in a year and the benchmark for that year.

As mentioned in introducing the PPACA ACOs, the PPACA does not appear to contemplate a mandatory ACO model with penalty provisions. Nonetheless, it does include a penalty provision that permits HHS to impose sanctions or terminate an ACO’s participation in the MSSP if HHS determines that an ACO has taken steps to avoid providing services to at-risk patients in order to decrease Medicare expenditures.

Beyond the provisions outlined above, the PPACA does not provide any further details regarding its contemplated ACOs. Obviously, HHS has wide latitude in how to structure the details of the MSSP and its ACOs. While HHS may diverge from MedPac’s suggestions, this Article assumes that HHS will model the PPACA ACOs after the voluntary, bonus-only ACOs contemplated within MedPac’s Report to Congress. Accordingly, it is helpful to review what the MedPac Report says about how voluntary, bonus-only ACOs should work, how spending targets should be set and how quality targets should be set.

128 Id.
129 Id. at § 1395jjj(d)(1)(B)(ii).
130 Id. at § 1395jjj(d)(2).
131 Id. at § 1395jjj(d)(3).
Starting with how the ACO system should operate, MedPac’s Report envisioned patients being assigned to an “ACO based on the primary care physician who provided the plurality of the patient’s office visits.” Each primary care physician would then “associate with a hospital and other physicians who they believe could most improve the value of the care their patients receive.”

MedPac also commented on the bonus payment side of the ACO system, envisioning the division of bonuses among providers in the form of “a fixed percentage add-on to their FFS payments.” MedPac argued that apportioning the bonuses in such a way would avoid problems with ACO members bickering regarding how bonuses should be apportioned to each other.

Turning to spending targets, MedPac’s Report raised a concern regarding ACOs and existing regional variations in Medicare spending, with certain areas being high-use, high Medicare spending areas and other areas being low-use, low Medicare spending regions. MedPac expressed concerns that ACOs in low-use regions will have more difficulty in cutting costs and finding efficiencies than ACOs in high-use regions. In other words, there will be fewer incentives for the development of ACOs in low-use regions because it will be more difficult to generate cost savings and correspondingly more difficult to earn bonuses based on cost savings.

Given these concerns, MedPac suggested two methods for leveling the playing field between low and high use areas. First, HHS could assign a set dollar allowance for spending.

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132 MedPac, supra note 5, at 43.
133 Id.
134 Id. at 48 (discussing the use of fixed percentage add-on bonuses to avoid conflict on how to divide bonuses).
135 Id.
136 Id. at 43 (discussing the need to reduce regional variation in Medicare spending and lower “the use of unnecessary services in high-use areas”).
137 Id. at 44 (discussing the problem of incentivizing ACOs in low-use regions to cut costs and possible solutions for the dilemma).
growth and apply that same dollar amount to all ACOs, regardless of the ACO’s status quo spending levels.\textsuperscript{138} The result is that ACO’s in high-use regions will only be eligible for bonuses if they grow spending by smaller percentages than ACO’s in low-use regions. Alternatively, HHS could set a growth level that allows for bonuses in high use areas only if the ACO keeps the annual spending increase below a set lower dollar level than the dollar level set for high use areas.\textsuperscript{139}

On the spending side, MedPac expressed concern that the current Medicare FFS system encourages providers in both high-use and low-use areas to provide the maximum amount of services in order to drive up reimbursements.\textsuperscript{140} More specifically, MedPac was concerned as to whether voluntary model ACOs can sufficiently counter this strong incentive.\textsuperscript{141} Accordingly, MedPac urged the creation of a strong and vigorous ACO bonus payments system that will counter the inherent FFS incentive to provide as many services as possible.\textsuperscript{142} Per MedPac, the shared savings with the ACO providers would need to be substantial enough to increase ACO provider incomes while also representing some level of savings in Medicare spending.\textsuperscript{143}

MedPac also raised concerns that Medicare spending randomly varies over time and based on changes in patient health.\textsuperscript{144} In other words, not all decreases in spending are due to intentional cost cutting measures and not all increases in spending are due to waste; some variation is just random and natural. Accordingly, MedPac argued that the ACO bonus structure

\begin{thebibliography}{9}
\bibitem{138} Id. at 44-45 (using an example of an allowance of $500 growth on $7,000 per capita spending as allowing for bonuses for spending growth kept under 7% ($500/$7,000) versus an allowance of $500 growth on $10,000 per capita spending as allowing for bonuses for spending growth kept under 5% ($500/$10,000)).
\bibitem{139} Id. at 45 (discussing the idea of setting “a lower dollar allowance in high-service-use areas and a higher dollar allowance in low-service-use areas”).
\bibitem{140} Id. at 43.
\bibitem{141} Id. (discussing the need “to counterbalance the incentives under FFS payment to increase volume”).
\bibitem{142} Id. (discussing the difficulty in constraining Medicare spending growth).
\bibitem{143} Id.
\bibitem{144} Id. at 49-50, 52-53 (finding in an empirical study that random variations in Medicare spending growth varied by 5% below or above the national average from year to year).
\end{thebibliography}
must be set up such that ACOs are not rewarded with shared savings for random decreases in spending. Otherwise, Medicare is not really saving any money. Medicare would be giving up some of the savings that would have occurred with or without the ACOs. Accordingly, MedPac urged that the bonus structure be formulated so that bonuses only reward ACO practices that have a large enough impact on resource use to be distinguished from random spending variation.

Finally, on the issue of setting quality targets, MedPac’s Report suggested that HHS set targets in terms of outcome based metrics, such as mortality rates, avoidable hospital admissions, avoidable readmissions, “patient satisfaction, additional clinical outcomes, and improvements in functionality.” Ultimately, MedPac anticipated that HHS would aggregate these quality measures into a single weighted quality score.

At this stage of the process, there is little to work with in understanding the intricacies of the PPACA ACOs beyond the statutory provisions outlined above. Presumably, future HHS regulations will fill in many of these gaps. Until that time, the statutory provisions and the MedPac Report to Congress at least provide a foundation for some predictions regarding how the liability standard/cost containment conflict will arise and operate within the ACO context, as well as how the conflict will impact the effectiveness and success of ACOs in achieving their cost cutting and quality goals.

145 Id. at 49, 52-53 (arguing that bonuses should reflect “actual earned changes in performance-and not just random variation”).
146 Id. at 53 (arguing that minimizing bonuses paid for random variation ensures that Medicare saves money through ACO practices).
147 Id.
148 Id. at 49 (arguing that “a successful ACO policy would enable physicians who improve their practice patterns and restrain capacity to have an effect on resource use that is large enough to be distinguished from random variation”).
149 Id. at 45.
150 Id.
V. ACOs and the Cost Containment/Medical Malpractice Liability Conflict

The fundamental focus of this article is what impact the PPACA created ACOs and the ACO structure itself have on the tension that providers face in implementing and achieving cost cutting goals, while also meeting the medical malpractice liability standard of care. The simple answer is that the PPACA and the ACOs that it creates will probably not exacerbate the tension to the same extent that MCOs have done, but the PPACA and its ACOs will also probably not completely eliminate the tension either. Perhaps the clearest way to examine ACOs in terms of the cost cutting/medical liability tension issue is to examine how the PPACA addresses provider liability in an ACO environment, how the PPACA addresses ACO liability for medical liability and then how the cost cutting/medical liability tension will likely impact the success and effectiveness of ACOs.

A. ACOs and the Provider Liability Standard

The PPACA fails to specifically address the medical malpractice liability standard for ACO providers. However, predictions can still be made regarding how the liability standard/cost cutting tension will operate in the ACO context, based on a review of the scholarly works above. Within those works there appears to be somewhat of a consensus that providers will continue to face some tension in implementing cost cutting provisions in the delivery of health care until the medical malpractice liability standard incorporates the concept of costs and efficiency. Unfortunately, the PPACA provision creating ACOs does not address the intersection of cost containment concerns and medical malpractice liability standards for ACO providers.

152 Bartholome, supra note 33, at 336; Blumstein, supra note 4, at 1048-49; Fine, supra note 26, at 693-94; Hall, supra note 26, at 175-77; Record, supra note 49, at 984.
Given the silence of the PPACA on medical liability standards for ACO providers, it is likely that ACO providers will continue to face the same non-cost conscious state medical malpractice standards of care that they face in any other practice setting. Any change in the provider liability standard, within the ACO context or more generally, will have to await the incorporation of cost concerns within the liability standard through further national or state statutory revisions or the evolution of common law through the court system. If the scholarly consensus is correct about what needs to happen before providers will fully embrace cost cutting goals, it is highly unlikely, within the ACO context, that the creation of ACOs will fully address and resolve the tension that providers face in meeting both the goals of cost cutting and the non-cost conscious standard of care.

It may be tempting to think that linking ACO cost cutting goals with achieving high quality care will alleviate provider concerns that cost cutting will subject them to possible liability. Such comfort seems unlikely for two reasons. First, like ACOs, MCOs also aimed to address the dual goals of cutting costs and providing high quality care. However, as demonstrated above, despite the focus on cutting costs and providing quality care, providers within the MCO context still faced the cost cutting/liability tension. The only real difference between the ACO and MCO context is that providers in the MCO context faced possible termination if they did not achieve cost cutting goals, whereas providers in the ACO context fail to receive a bonus if they do not cut costs and achieve certain quality standards.

154 Benjamin Saunier, *The Devil is in the Details: Managed Care and the Unforeseen Costs of Utilization Review as a Cost Containment Mechanism*, 35 Okla. City U. L. Rev. 483 (2010) (noting that the HMO Act was passed to encourage the development of MCOs in order to cut costs and achieve high quality care).


156 *Id.* at 673.

Even though the bonus concept does nothing to alleviate the liability standard/cost cutting tension, notably, the impact of the tension within the ACO context might shift from how the tension operates within the MCO context. In the MCO context, it seems likely that the tension causes MCO providers to strive hardest to meet cost cutting goals over stringently meeting liability standards. In contrast, within the ACO context, it seems more likely that ACO providers will strive hardest to meet liability standards over meeting cost cutting goals. The reason for this anticipated shift is that the bonus concept is a softer incentive and would likely incentivize a provider to be more willing to risk losing a bonus and increase health care spending than to cut costs and avoid liability. Conversely, the harsh penalty of being cut from a provider network in the MCO context is a hard incentive and would potentially incentivize a provider to be more willing to risk liability in an effort to meet cost cutting goals than to risk losing MCO provider network status by providing more expensive care and engaging in defensive medicine. Simply put, ACO providers lose bonuses if they fail to meet cost cutting goals, MCO providers lose their livelihood.

Second, quality standards set by an ACO may not match up with the same quality standards embodied within the standard of care. Unless the two sets of standards are closely aligned, providers following the ACO quality standards may still be subject to liability for violating the standard of care as set by experts in a malpractice litigation case. Even if the ACO quality standards are clearly set forth and allow for providers to adjust their practice of medicine to meet those standards, the medical malpractice standard of care is more variable, less predictable and only truly identified after the fact, in the course of medical malpractice litigation. Accordingly, ACO providers will be concerned that even if they meet the ACO quality and cost-cutting standards, they may still face medical malpractice liability under a

158 Blumstein, supra note 4, at 1026-29.
different post-hoc standard. At this point, it is not even clear how HHS will measure or determine the ACO quality standards. They could be outcome-based or process-based, among various potential options.

From the perspective of the liability standard being imposed on an ACO provider, the PPACA, in creating ACOs, does nothing to ease ACO providers’ fears that they may be subject to state malpractice liability, even if they meet the cost cutting and quality standards of the ACO. Short of passage of additional statutory immunity for medical malpractice liability when an ACO provider meets ACO quality standards, or the incorporation of cost concerns within the medical malpractice standard of care, ACO providers’ concerns about meeting cost cutting goals while also avoiding malpractice liability will likely be similar to those same concerns for MCO providers.

B. ACOs and the ACO Liability Standard

Given that the PPACA fails to address the provider standard of care within the ACO setting, the only other possibility for alleviating the liability standard/cost cutting tension hinges on the ACO’s own exposure to liability and that liability standard. By analogy to the MCO context, if the ACO can cut costs without fear of liability for violating the standard of care, while ACO providers must implement those cuts and bear the burden of potential liability, then the incentives of the two are not aligned and the provider tension in meeting both cost cutting and liability standards is exacerbated by the ACO system.159

As with the ACO provider liability standard, the PPACA is mostly silent on ACO liability for medical malpractice committed by an ACO provider.160 The PPACA does not specifically address whether ACOs may be held liable for injuries flowing from ACO cost

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159 Record, supra note 49, at 957-58, 964-65.
cutting measures, under what theory they may be held liable or what liability standard would apply, assuming an ACO can be held liable for malpractice. Assuming ACOs may be held liable for malpractice, the only guidance provided by the PPACA is the authorized legal structures for ACOs.\(^{161}\) Whether a particular ACO is formed as a practice network versus a hospital employing physicians obviously impacts the applicable theory of liability that would apply to the ACO.

There are many questions which remain unanswered in terms of ACO liability for malpractice. Will the ACOs maintain liability insurance? Will the ACOs self-insure for liability? What will be the most popular legal structure for ACOs, of the statutory options available? In other words, will most ACOs organize with providers as employees, directors, independent contractors, owners or playing some other legal role? How will the concept of joint and several liability function within the ACO context? These are all open questions that will have to be answered through HHS regulations, additional federal legislation, state law and/or application of common law.

One, and possibly the only, seeming certainty is that ERISA will not apply to ACOs, and therefore, will not pose a preemption barrier to state law malpractice claims against ACOs. ERISA only applies to employer sponsored benefit plans or plans sponsored by an employee organization.\(^{162}\) Unlike many MCOs, ACOs are not employer sponsored benefit plans or plans sponsored by employee organizations. ACOs are merely legal structures through which a group of providers provide care and treatment to a designated group of Medicare beneficiaries.\(^{163}\)

Without ERISA preemption, courts will likely extend malpractice liability in some form to ACOs for the decisions that they make, especially if courts follow a pattern similar to that

\(^{161}\) Id.
\(^{163}\) 42 U.S.C. § 1395jj.
followed within managed care liability case law. Such a similar pattern of case law is likely, given the similarities between the impact of MCO and ACO decision making on provider treatment and the quality of patient care. MCOs impact the quality of patient treatment by conducting utilization review of provider treatment decisions, approving or denying coverage, and terminating or penalizing providers who fail to control costs by failing to provide treatment in accord with utilization review decisions. Similarly, under the PPACA, ACOs set quality and cost containment standards and then incentivize those standards through the provision of bonuses to ACO providers for meeting those standards. Under both scenarios, the entity, be it a MCO or ACO, attempts to impose or strongly encourage certain standards of practice and/or treatment decisions that are driven by quality and cost, though some may argue that the MCOs standards are driven more by cost than quality. Regardless, it is that locus of control or influence over provider treatment and practice that should be the linchpin to similar liability treatment of ACOs and MCOs by the courts.

In light of the similarities in how MCOs have and ACOs likely will impact the way that providers practice medicine and the quality of patient care, Professors Agrawal and Hall’s summary of MCO malpractice liability case law is helpful to examine in predicting how liability standards may apply to ACOs. First, if courts view the ACOs as providing direct care to Medicare beneficiaries, analogous to hospitals, then the courts may apply a direct corporate negligence theory to ACOs, imposing a duty upon them to “select and retain competent caregivers, to oversee the care they provide, and to establish and adhere to policies to ensure

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164 Record, supra note 49, at 960.
165 Fine, supra note 26, at 641-42.
166 42 U.S.C. § 1395jjj.
167 Record, supra note 49, at 961-62 (noting that MCO utilization review may be, but is not necessarily antithetical to promoting quality care).
168 Agrawal & Hall, supra note 26, at 241-45 (summarizing and analyzing court treatment of MCOs for state law claims of direct corporate and vicarious liability).
quality care.”169 Within the MCO context, courts extended this concept of direct corporate negligence even where the MCO did not employ the provider, but rather arranged “for the provision of services by contracting with independent caregivers and institutions.”170 In the MCO context, courts expanded the theory of direct liability beyond the employment relationship because of the central role that MCOs played in the delivery of health care services.171

The legal reasoning for imposing direct liability on MCOs applies equally to PPACA ACOs. Like MCOs, the PPACA ACOs also select which providers will be a member of a particular ACO, as well as overseeing the care that is provided by ACO providers and the quality of that care through setting quality standards and providing bonuses based on meeting cost and quality standards.172 Given the legal structural options available to ACOs under the PPACA, this sort of direct liability would certainly apply to at least some ACO partnerships, some group practice arrangements and ACO arrangements where hospitals employ providers.173 However, because of the central role of ACOs in providing quality health care to Medicare beneficiaries within the ACO it is possible that the courts may extend direct liability to the ACO regardless of which of the legal structures that particular ACO adopts.

The second theory of liability that courts might apply to ACOs is the theory of vicarious liability. Within the MCO context, courts extended vicarious liability to MCOs to hold them liable for the negligence of their independent contractor physicians.174 The courts imposed vicarious liability on the MCOs using the doctrine of “apparent or ostensible agency to find an

169 Id. at 241.
170 Id.
171 Id. at 242 (discussing how courts hinged MCO liability on their “central role in the total health care” of enrollees”).
174 Agrawal & Hall, supra note 26, at 243 (discussing how courts applied vicarious liability to MCOs for network provider negligence as an analogy to imposing vicarious liability on hospitals for the negligence of independent medical staff physicians).
agency relationship between a managed care organization and an independent physician.”\textsuperscript{175} Generally, but with some variation, apparent agency requires a plaintiff to establish that the MCO or ACO “held itself out as a provider of health care, and that [the plaintiff] relied upon that conduct, looking to the managed care organization rather than to the individual physician to obtain health care services.”\textsuperscript{176}

Application of apparent agency and vicarious liability within the ACO context is somewhat difficult to predict because it depends on how ACOs market themselves. Most Medicare beneficiaries receiving treatment from an ACO provider will not even be aware that they are receiving treatment from an ACO provider.\textsuperscript{177} Accordingly, it will be difficult for those beneficiaries to apply an apparent agency theory against an ACO to hold the ACO liable for cost cutting measures that result in patient injuries.

In contrast, patients in MCOs are aware of their MCO as their insurer, and the MCO makes them aware of this fact through member handbooks, marketing materials and requiring patients to see MCO network providers.\textsuperscript{178} ACOs are different because “ACOs cannot require Medicare beneficiaries to only use certain providers. Rather, ACOs must obtain savings through efficiency and recommendations to their patients.”\textsuperscript{179} Unless ACOs market themselves to patients, they will not be holding themselves out as a provider of care in the same way as MCOs, and it will be much more difficult to hold them liable for ACO provider negligence under a vicarious theory of liability. However, if courts do apply vicarious liability theories to ACOs,

\begin{itemize}
\item \textsuperscript{175} Id.
\item \textsuperscript{176} Id.
\item \textsuperscript{177} Glenn E. Solomon, Robert W. Lundy & David A. Hatch, Future Models, 33 L.A. Law. 34, 35 (2010).
\item \textsuperscript{178} Agrawal & Hall, supra note 26, at 243 (discussing the ways in which MCOs hold themselves out as providers to their enrollees).
\item \textsuperscript{179} Solomon, et al., supra note 177, at 35.
\end{itemize}
such theories would be most applicable to ACOs organized as practice networks under the PPACA or any other arrangement in which the providers are independent contractors.180

Even if ACOs are able to avoid vicarious liability through apparent agency principles, courts may still use an implied authority theory to hold them vicariously liable for independent contractor ACO providers, as they have done in the MCO context.181 In the MCO context, courts have held MCOs vicariously liable under “the doctrine of respondeat superior for the medical malpractice of an independent physician if the managed care organization had implied authority to exercise sufficient control over the physician to negate an independent contractor status.”182 Whether such a theory would apply to ACOs depends on what the courts determine to be sufficient control. However, there can be no doubt that the setting of quality and cost cutting standards with a bonus structure as an incentive imposes some level of control from the ACO onto the ACO provider. Accordingly, the implied authority theory of vicarious liability is a doctrine that may apply to ACOs for the negligence of ACO providers, at least where the ACO uses independent contractors as ACO providers.

The important point to draw from the discussion above is that without ERISA preemption, it is possible, if not likely, that courts will impose some form of liability on ACOs for the negligence of ACO providers. To that extent, both the ACO provider and the ACO have at least somewhat aligned incentives. Both face liability if the ACO imposes cost cutting that goes too far and impedes the ability of the ACO provider to deliver treatment meeting the non-cost conscious standard of care.183 Certainly, the threat of liability against the ACO eases to

181 Agrawal & Hall, supra note 26, at 244 (discussing state law expansions of the common law bases for holding MCOs liable for the negligence of independent providers with whom they contract).
182 Id.
183 Record, supra note 49, at 989 (arguing that imposing liability on MCOs “for negligent coverage determinations incentivizes reasonable care in making these determinations and would help reduce tension between the physicians providing care and the insurers challenging their treatment decisions”).
some extent the liability standard/cost cutting tension faced by ACO providers, so that, unlike MCO providers, they do not feel stuck in the middle between non-cost conscious liability standards and cost cutting pressures being imposed by an entity that is practically immune from suit.\textsuperscript{184} Still, it is truly unknown to what extent the ACO provider and ACO liability-based incentives will be aligned because it is very much unclear how courts will allocate liability between ACOs and ACO providers, when they do impose liability on both.\textsuperscript{185}

\textbf{C. The Interference of the Liability Standard/Cost Cutting Conflict with the Goals of ACOs}

Along with examining the impact of ACOs on the liability standard/cost cutting tension, it is important to examine what impact that tension will have on the ACOs, their function and their goals of cutting costs and achieving high quality care. This Article focuses on two likely impacts, one on the ACO provider side and one on the ACO entity side. Both impacts are troubling.

On the ACO provider side, the MedPac Report noted that within the ACO framework there exists a “tragedy of the commons” problem in that the individual provider incentive to choose a costly, revenue producing surgical procedure tends to override the ACO-group incentive to choose a less costly, lower revenue producing procedure.\textsuperscript{186} Under the FFS system, the revenue from the more expensive procedure inures solely to the benefit of the individual physician choosing that procedure.\textsuperscript{187} It is reduced only by that provider’s share of the savings that would have been realized in a bonus had he or she chosen the less expensive procedure.\textsuperscript{188}

\textsuperscript{184} Fine, \textit{supra} note 26, at 642.
\textsuperscript{185} Record, \textit{supra} note 49, at 297 (discussing that courts have not addressed the issue of allocating liability between physicians and insurers in the MCO context).
\textsuperscript{186} MedPac, \textit{supra} note 5, at 51 (providing a practical example of the “tragedy of the commons” problem examining the impact of an interventional cardiologist’s decision to treat angina through use of a stent versus treating it medically).
\textsuperscript{187} \textit{Id.}
\textsuperscript{188} \textit{Id.}
The individual incentive to increase revenue outweighs any incentive to save costs for the benefit of the group, so that there is a small financial incentive to reduce costs through individual actions.\footnote{\textit{Id.} at 50.}

This “tragedy of the commons” problem is likely to be exacerbated by the existence of the liability standard/cost cutting tension. As discussed earlier, the threat of a malpractice liability standard that does not account for costs along with an ethical directive to provide all beneficial care regardless of cost\footnote{Fine, \textit{supra} note 26, at 651, 663.} encourages providers to engage in costly defensive medicine.\footnote{Hall & Schneider, \textit{supra} note 6, at 748.} Defensive medicine together with the “tragedy of the commons” problem and the FFS system will likely push ACO providers even further toward providing more expensive care, instead of meeting the cost cutting and quality standards of the ACO. ACO providers may make an individual judgment that the risk and possible cost of liability combined with the individual financial value of providing a more expensive treatment or test over a less expensive one outweighs any shared savings or bonuses that that individual provider would realize from adopting a less expensive treatment or test.

Given the “tragedy of the commons” problem, MedPac contended that “the [ACO] financial incentives would have to change joint practice-level decisions to be effective.”\footnote{MedPac, \textit{supra} note 5, at 52.} MedPac identified those decisions as including “care protocols, equipment purchases, recruitment strategies, and incentive structures offered to physicians (e.g., do not tie physician income to increased revenue generation).”\footnote{\textit{Id.}} To eliminate the overriding individual financial incentives, MedPac argued that ACOs would need to structure themselves such that individuals “give up some autonomy and make clinical practice and technology acquisition decisions
jointly.”^194 However, in making this suggestion, MedPac does not appear to have considered the problem of defensive medicine and the non-cost conscious liability standard of care and how those two factors interact with the “tragedy of the commons” problem. These two factors will likely make the “tragedy of the commons” problem worse, as there should be great concern that the group bonus incentives may not be strong enough to override the trifecta of defensive medicine, FFS payments and the “tragedy of the commons” problem.

Turning to the impact of the liability standard/cost cutting tension on the ACO entity, there should also be concern about whether that tension will undermine the ability of the ACO to be effective or to achieve its goals as an entity. If ACOs can be held liable for the negligence of ACO providers and the impacts of the ACO’s own cost cutting measures, then there should be concern as to whether the imposition of a liability standard that does not consider costs will chill or overly deter ACO cost cutting. In other words will the specter of ACO liability be so strong as to deter even cost cutting that does not impact care within the standard of care, i.e. cost cutting of wasteful care?

Within the MCO context, there are concerns that “the specter of tort liability could chill innovation in techniques to manage care and cost or could lead the managed care industry to abandon the cost-control function entirely.”^195 Even worse, there are concerns that if ERISA preemption were lifted in the MCO context, MCOs would collapse as “massive punitive awards became commonplace.”^196 Though the imposition of liability on MCOs would certainly encourage them to ensure high-quality services, it would also increase the costs of care, if for no other reason than the litigation costs of the new claims against the MCOs.^197

^194 Id.
^195 Agrawal & Hall, supra note 26, at 262.
^196 Id. at 271.
^197 Fine, supra note 26, at 692-93 (discussing the costs and benefits of imposing liability on MCOs).
These same concerns regarding imposing malpractice liability on MCOs should also apply in discussing the imposition of malpractice liability on ACOs. If the bonuses at the ACO level do not outweigh the potential costs of ACO liability, then ACOs will not function and will even fail to make cost cuts aimed at maintaining or increasing quality. Moreover, as in the MCO context, liability and the cost of liability may actually drive up the cost of care, thereby completely undermining any cost cutting initiatives by the ACOs. The bonus system must be set up such that the ACOs receive bonuses that are large enough to offset any increased liability costs flowing from their cost cutting measures. Otherwise, the ACOs face a zero sum game. Even worse, if injured ACO patients are allowed to sue those who set the cost cutting and quality standards within the ACOs by tracing their injuries to those standard setting decisions, then the fear of liability may impede the ability of ACOs to form and even get off the ground.198

The concerns raised in this section are really about a balancing game. Liability imposed on either ACO providers or ACOs is valuable insofar as that liability standard does not discourage cutting wasteful care and discourages cutting costs that result in the provision of care below the standard of care. However, if the liability standards are overly aggressive and the fear of liability at either the ACO provider level or ACO entity level outweighs the savings reaped from beneficial cost cutting, then malpractice liability will undermine ACOs, their purposes and discourage them from forming or functioning as they should. Policymakers and courts should take care to ensure the proper balance between liability standards that properly discourage poor quality care and cost cutting incentives that properly cut wasteful care.

198 Blumstein, supra note 4, at 1045 (expressing concern that QIO cost and quality standard setting would be impeded by placing those responsible for setting the standards at risk for liability).
VI. Conclusion

As demonstrated throughout this Article, as long as United States health care spending has been spiraling upwards, so has the conflict between cost cutting imposed on providers and non-cost conscious liability standards faced by those providers. The tension between the two is not new. What is new is the concept of the ACO and how the tension between cost cutting and liability standards will play out within the ACO environment.

In some ways the tension will merely be a reiteration of a similar tension that already exists within the MCO environment. In other ways it will be different. The liability standard, which fails to account for cost concerns, is the same within the ACO environment as it is within the MCO environment. Accordingly, ACO providers will probably not be that much more enthusiastic to embrace the cost cutting goals of ACOs than MCO providers have been to embrace those same goals for MCOs.

The major distinction between the cost cutting/liability standard conflict in the ACO context versus the MCO context is that the former entities face a much higher likelihood of shouldering liability for cost cutting decisions that negatively impact provider treatment of ACO patients in contrast with the latter entities, for which ERISA often provides a federal preemption barrier. As a result, ACOs should be much less likely to encourage cost cutting, without restraint, on ACO providers than MCOs have been to impose such measures on MCO providers. The threat of liability should work to align the ACO incentive to avoid liability with similar risk avoidance incentives that already exist for the ACO providers.

Despite the ACO’s incentives being more aligned with ACO providers than the alignment that exists within the MCO environment, there should be substantial concern as to whether the threat of liability for both ACO providers and ACOs as entities will undermine efforts to achieve
cutting costs associated with wasteful, non-beneficial treatment and diagnostic testing. Courts and policymakers should be concerned that the threat and cost of liability may overwhelm the bonus-based incentive for ACOs and their providers to cut costs while achieving quality standards. Accordingly, as ACOs develop and move forward Congress, HHS and the judicial system should be cognizant of the possibility that the positive goals of ACOs may be undermined by the existing medical malpractice system and should carefully balance the goal of cost cutting with the imposition of medical malpractice liability on both ACOs and ACO providers.