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ALIGNING INCENTIVES IN ACCOUNTABLE CARE ORGANIZATIONS: THE ROLE OF MEDICAL MALPRACTICE REFORM

LAURA D. HERMER*

Health care cost, quality, and access are perennial “push you, pull me” problems in the United States. Addressing any one or two of the three all too often negatively impacts the other.¹ The Medicare Shared Savings Program (MSSP) in the Patient Protection and Affordable Care Act (ACA) offers a different twist on this paradigm.² The MSSP encourages physicians and other health care providers to work together to lower health care costs while simultaneously improving health care quality and patient outcomes.³ If providers can cut back on care that is truly unnecessary or duplicative, substitute less-costly tests and therapies for ones that are more expensive yet equally effective, and improve (or at least not worsen) patient care in the process, then the providers may receive a share of savings that result.⁴

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* Associate Professor, Hamline University School of Law, St. Paul, MN. The author wishes to thank participants at the 35th Annual Health Law Professors’ Conference, the Fourth Annual Byron Bailey Surgical Society Conference, and the Third Annual Texas State Rheumatology Roundup for helpful comments, criticisms, and suggestions.

1. See Mark V. Pauly, *The Trade-Off Among Quality, Quantity, And Cost: How To Make It—If We Must*, 30 HEALTH AFF. 574, 576 (2011) (discussing how improving the quality of care has resulted in higher costs and limited access to high-quality care). Occasionally other measures are discussed in this context. For example, “access” can substitute for “population health.” See, e.g., Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 760 (2008) (stating that “[t]he components of the Triple Aim are not independent of each other. Changes pursuing any one goal can affect the other two, sometimes negatively and sometimes positively. For example, improving care for individuals can raise costs if the improvements are associated with new, effective, but costly technologies or drugs. Conversely, eliminating overuse or misuse of therapies or diagnostic tests can lead to both reduced costs and improved outcomes.”).

2. See *infra* section II.B.1.

3. *Id.*

4. *Id.*

Many physicians and other providers moved quickly after the ACA was enacted to enter into arrangements that would allow them to take advantage of the MSSP and similar programs sponsored by private insurers that likely would—and did—arrive on the MSSP’s heels.⁵ Within a year and a half of the ACA’s enactment, 164 new Accountable Care Organizations (ACOs) had been formed.⁶ As of April 2014, that number had grown to 522.⁷ While ACOs are not new, the MSSP and related programs have unquestionably provided the impetus to their increase.

Yet despite the initial enthusiasm, it is by no means clear that ACOs will succeed, whether individually or in the greater goal of changing our health care delivery system. To be successful, ACOs will require a substantial amount of coordination and participant buy-in to a particular practice ethos.⁸ How does one convince skeptical and independent-minded physicians to follow guidelines and metrics set forth by ACOs—guidelines and metrics that are devised in part to reduce the volume of certain types of services provided, and hence also potentially lowering physicians’ financial returns? How does one do this, in particular, when physicians not only may be making less money as a result of following these guidelines and metrics, but will also retain full liability for negligent outcomes?

The ACA provides ACOs little support in this last respect. It contains a provision giving malpractice coverage under the Public Health Service Act to physicians who volunteer their services at free clinics.⁹ It also authorized up to ten state demonstration projects to test different means of handling malpractice claims, although Congress later failed to provide the necessary funding for them.¹⁰ Apart from those provisions, the ACA contains nothing more concerning medical malpractice reform. Traditional tort reform simply found no place in the ACA.

5. See David Muhlestein, *Continued Growth of Public and Private Accountable Care Organizations*, HEALTH AFF. BLOG (Feb. 19, 2013, 12:47 PM), <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations>.

6. See, e.g., DAVID MUHLESTEIN ET AL., LEAVITT PARTNERS, GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS 3 (2011), available at <http://leavittpartners.com/wp-content/uploads/2012/03/ACO-Whitepaper.pdf>

7. See Molly Gamble, Total Number of ACOs Tops 520, Becker’s Hospital Review (Apr. 24, 2014), <http://www.beckershospitalreview.com/accountable-care-organizations/total-number-of-acos-tops-520.html>.

8. See *infra* notes 107–115 and associated text.

9. See Patient Protection and Affordable Care Act, 42 U.S.C. § 233(o)(1) (2006 & Supp. V 2012) (making it so that “an officer, governing board member, employee, or contractor of a free clinic shall[,] in providing services for the free clinic[,]” be classified as an employee of the Public Health Service); see also *id.* § 233(o)(6)(A) (allotting \$10,000,000 each year for judgments related to acts or omissions of free clinic health professionals).

10. See *id.* § 280g-15 (authorizing the Secretary of Health and Human Services to award demonstration grants to States for the purpose of medical malpractice tort reform); Phil Galewitz, *Some Programs Ok’d By Health Law Lacking Funding*, KAISER HEALTH NEWS (June 9, 2011), <http://www.kaiserhealthnews.org/stories/2011/june/09/unfunded-appropriations-health-law.aspx>.

If ACOs are to succeed more broadly, it may be important for state legislatures to address medical malpractice to reflect the changes currently underway in our health care system.¹¹ The question is how to do this while also facilitating better integration of care delivery and, ideally, sufficiently improving the practice of medicine such that a critical mass of physicians will support and participate in the proposed changes. The answer may best be given by an idea last entertained during the heyday of managed care: enterprise liability.¹² As the name suggests, enterprise liability would make a health care entity, such as a hospital or an ACO, financially liable for acts of negligence, rather than or possibly in addition to the individual providers staffing it or otherwise providing services under its auspices.¹³ Given the consolidation in the health care market,¹⁴ the increasing movement toward employment of physicians by hospitals, health insurers, and other entities,¹⁵ the incentives that the ACA gives for various forms of integrated care that meet or exceed quality benchmarks,¹⁶ and the persistence of the problems of our traditional means of addressing medical malpractice,¹⁷ the time is ripe to revisit enterprise liability as a means of rationally revamping our medical liability system.

Toward this end, the first section of this article examines the aspirational and actual ends we respectively seek and achieve under our current liability system, and also considers whether additional goals and different means might be more desirable. The second section focuses on the ACA's direct and indirect means of affecting medical malpractice, paying particular attention to the intersection of liability concerns with proposed changes in health care delivery. The third section considers a variety of possible reforms to our medical malpractice system, showing how enterprise liability can solve the problem of the pressures that the ACA will likely put on our already-beleaguered health care liability regime by reorienting that regime to a systems-based approach. Enterprise liability has the potential to substantially remove liability pressures from physicians, encourage teamwork among health care practitioners, urge creation of systemic solutions to health care quality problems, and more appropriately compensate patients who are injured as a

11. The question of whether malpractice ought to be taken up by the federal government rather than continuing to be addressed on a state-by-state basis will not be addressed here. See Abigail R. Moncrieff, *Federalization Snowballs: The Need for National Action in Medical Malpractice Reform*, 109 COLUM. L. REV. 844, 846–48 (2009), for one treatment of this issue.

12. See William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS. 159, 159 (1997).

13. *Id.* at 159.

14. Health care market consolidation has increased more than 50% since 2009, according to PwC, and is expected to continue into 2014. *Factors Affecting 2014 Medical Cost Trend*, PRICEWATERHOUSE COOPERS, available at <http://www.pwc.com/us/en/health-industries/behind-the-numbers/index.jhtml> (last visited May 29, 2014).

15. See *infra* note 166.

16. See *infra* notes 97–100 and associated text.

17. See *infra* notes 23–37 and associated text.

result of negligence. It remains to be seen, however, whether physicians would be prepared to accept the impact these changes may have on professional autonomy and ethical standards in the provision of care, and whether they would have sufficient power to prevent them if they wish to oppose them.

I. THE GOALS AND OUTCOMES OF OUR PRESENT MEDICAL LIABILITY SYSTEM

Without getting into a lengthy discussion of tort jurisprudence, tort law is generally thought to have either a deterrent or compensatory effect, if not both.¹⁸ Medical liability law, as a species of tort law, arguably shares both these goals.¹⁹ It is supposed to provide an incentive for physicians, hospitals, and other health care providers to render careful and high quality care, or at the very least to avoid harming patients.²⁰ Patients who are injured due to negligence allegedly can obtain redress for the damages they suffer.²¹ Medical liability law additionally allegedly promotes economic efficiencies by optimizing distribution of the costs of accidents, such that the “winners” in the system gain more than the “losers” lose.²²

Yet there is little, if any, evidence that our present system substantially deters errors or reasonably compensates most victims of malpractice, and there is much

18. See WILLIAM M. LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* 4–5 (1987) (noting the deterrent effect of torts); see also Ernest J. Weinrib, *The Morsanto Lectures: Understanding Tort Law*, 23 VAL. U. L. REV. 485, 501–02 (1989); see also Gary T. Schwartz, *Mixed Theories of Tort Law: Affirming Both Deterrence and Corrective Justice*, 75 TEX. L. REV. 1801, 1801 (1997). An ethical component via compensation is also frequently proffered as a justification for imposing tort liability. See RESTATEMENT (THIRD) OF TORTS: PHYS. & EMOT. HARM § 6 cmt. d (2010) (“One justification for imposing liability for negligent conduct that causes physical harm is corrective justice; imposing liability remedies an injustice done by the defendant to the plaintiff. An actor who permits conduct to impose a risk of physical harm on others that exceeds the burden the actor would bear in avoiding that risk impermissibly ranks personal interests ahead of the interests of others. This, in turn, violates an ethical norm of equal consideration when imposing risks on others. Imposing liability remedies this violation.”); see also Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOC’Y REV. 275, 300 (2001).

19. See, e.g., STEVEN E. PEGALIS, § 1.4. Risk of Liability as a Deterrent to Malpractice, AM. LAW MED. MALP. (3d ed. 2013) (arguing, inter alia, that the tort system acts as an “external force” that compensates victims while also helping to improve medical care through the threat of embarrassment and economic loss); FRANK A. SLOAN & LINDSEY M. CHEPKE, *MEDICAL MALPRACTICE* 3 (2008); Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 56–64 (2011) (adding the articulation of new duties of care and “expos[ing] obtuse organizations”); Clark C. Havighurst, *Practice Guidelines as Legal Standards Governing Physician Liability*, 54 LAW & CONTEMP. PROBS. 87, 94–95 (1991) (noting that “Malpractice law is usually said to have two coequal objectives: compensating injured persons and deterring medical negligence”).

20. See, e.g., RESTATEMENT (THIRD) OF TORTS: PHYS. & EMOT. HARM § 6, cmt. d; Havighurst, *supra* note 19, at 94.

21. RESTATEMENT (THIRD) OF TORTS: PHYS. & EMOT. HARM § 6, Comment d; see also, e.g., Havighurst, *supra* note 19, at 95; Weinrib, *supra* note 18, at 511.

22. See LANDES & POSNER, *supra* note 18, at 312–13.

evidence to suggest that it is unduly costly and leads to fruitless anxiety for many physicians.²³ Numerous studies have found that only a small fraction of those negligently injured in the receipt of health care seek redress for the harm they suffer.²⁴ Yet, for those who do sue, seeking compensation is more haphazard than it ought to be. Substantial evidence suggests, on the one hand, that the size of the ultimate payout increases with the seriousness of a plaintiff's injury.²⁵ This is as it should be. However, other evidence suggests that, among similar classes of cases, an award or settlement in one suit has, at most, only a modest bearing on outcomes in others.²⁶ Physicians give undue credence to the notion that the threat of suit is omnipresent, and physicians claim this threat must be met through the use of costly defensive medicine.²⁷ Unpredictability about the possible amount of money at stake contributes to psychological stress on the part of all parties and diminishes the

23. Numerous works detail the problems with the medical malpractice system in the United States. For a sampling *see, e.g.*, SLOAN & CHEPKE, *supra* note 19, at 27–83; TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 22–67(2007); David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1088–1111 (2006); Laura D. Hermer & Howard Brody, *Defensive Medicine, Cost Containment, and Reform*, 25 J. GENERAL INTERNAL MED. 470 (2010).

24. The Harvard Medical Practice Study is the classic evaluation of this issue. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991). While other of the study's conclusions have been criticized, the conclusion that most patients injured as a result of medical malpractice never sue has been well substantiated elsewhere. *See, e.g.*, Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions About the Validity of Medical Malpractice Claims*, 33 J. L. Med. & ETHICS 501, 502 (2005).

25. *See* U.S. DEP'T OF JUSTICE, *MEDICAL MALPRACTICE CLAIMS IN SEVEN STATES, 2000–2004* 1 (6 (U.S. Dep't of Justice Bureau Statistics 2007), *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/mmccss04.pdf>; *see also* Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering"*, 83 NW. U. L. REV. 908, 920 (1989).

26. *See, e.g.*, SLOAN & CHEPKE, *supra* note 19, at 115 (citing Edward J. McCaffery et al., *Framing the Jury: Cognitive Perspectives on Pain and Suffering Awards*, 24 VA. L. REV. 1341 (1995); Eric Helland & Alexander Taborrok, *Race, Poverty, and American Tort Awards*, 32 J. LEGAL STUDIES 27 (2003); Randall R. Bovbjerg et al., *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?*, 54 L. CONTEMP. PROB. 5 (1991); Bovbjerg et al., *supra* note 25, at 920, 923–24.

27. *See* Brenda E. Sirovich et al., *Too Little? Too Much? Primary Care Physicians' Views on US Health Care*, 171 ARCHIVE INTERNAL MED. 1582, 1584 (Sept. 26, 2011); Carolyn M. Hettrich et al., *The Costs of Defensive Medicine*, AAOS NOW (Dec. 2010), http://www6.aaos.org/news/PDFopen/PDFopen.cfm?page_url=http://www.aaos.org/news/aaosnow/dec10/advocacy2.asp; MASS. MED. SOC'Y, *INVESTIGATION OF DEFENSIVE MEDICINE IN MASSACHUSETTS* 4–6 (Nov. 2008), *available at* http://www.ncrponline.org/PDFs/2008/Mass_Med_Soc.pdf; K. J. O'Leary et al., *Medical Students' and Residents' Clinical and Educational Experiences with Defensive Medicine*, 87 ACADEMIC MED. 142 (2012). Concerning unpredictability regarding the relevant standard of care, *see also* Havighurst, *supra* note 19, at 99–100 ("It is striking that the main reasons why physicians now feel oppressed by malpractice law are (1) that the professional standards on which the law relied turned out to be so imprecise and variable as to leave juries wide discretion in imposing liability and (2) that the medical profession gradually lost its previous ability to influence the testimony of physician witnesses.").

deterrence value of the threat of suit; hence, for example, physicians in Texas expressed their continued fear of suit nearly ten years after strict limitations were instituted on noneconomic damages and malpractice cases accordingly declined precipitously.²⁸ Unpredictability may also make it more difficult for parties to settle a case due to differing expectations regarding possible verdict size.²⁹ Costs of suit for successful plaintiffs can consume between one-third and one-half (or more) of the award or settlement.³⁰ On average, successful plaintiffs only receive about half of their total reward, with the rest consumed by attorneys' fees, expert witness fees, and costs.³¹ Altogether, medical malpractice law falls far short of its ostensible goals.

Worse yet, traditional tort reforms proffered to address problems in our medical malpractice system are not intended to better address the presumed goals of that system.³² Rather, they take malpractice lawsuits themselves to be the problem. Traditional tort reform efforts assume that such suits result in reduced access to medical malpractice coverage for health care providers, as well as reduced access and higher prices for health care consumers, and therefore seek to make suits more difficult to bring.³³ In this, efforts over the last decade, in

28. Although a much lower percentage than the forty percent of U.S. physicians who gave a corresponding answer, twenty-seven percent of Texas physicians still identified "liability/defensive medicine pressures" as one of the two factors they found most unsatisfying about medical practice. PHYSICIANS FOUND., A SURVEY OF AMERICA'S PHYSICIANS: PRACTICE PATTERNS AND PRESSURES, QUESTION 16 (2012), available at <http://www.texmed.org/WorkArea/DownloadAsset.aspx?id=25570>.

29. SLOAN & CHEPKE, *supra* note 19, at 115.

30. SLOAN & CHEPKE, *supra* note 19, at 4; see also David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2031 (2006), available at <http://www.nejm.org/doi/full/10.1056/NEJMsa054479#t=articleTop> (finding that fifty-four percent of plaintiffs' awards were consumed by administrative expenses); TOWERS WATSON, U.S. TORT COST TRENDS: 2011 UPDATE 8 (2012), available at <http://www.towerswatson.com/assets/pdf/6282/Towers-Watson-Tort-Report.pdf> (finding that administrative expenses alone, excluding prosecution and defense costs, as well as costs of court, averaged 24.3% of total awards between 2000 and 2010).

31. See JAMES S. KAKALIK & NICHOLAS M. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION 41 (1986), available at <http://www.rand.org/content/dam/rand/pubs/reports/2006/R3391.pdf>.

32. Traditional reforms are generally designed to make claims more difficult for plaintiffs to bring, and to limit certain types of damages for successful plaintiffs. Examples of such reforms include hard caps on non-economic damages, tightened statutes of limitations, more onerous expert report requirements for plaintiffs, and limits on attorneys' fees.

33. A number of state legislatures have been quite explicit on this point. See N.M. STAT. ANN. §41-5-2 (2013) ("The purpose of the Medical Malpractice Act is to promote the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers in New Mexico"); *Miller v. Johnson*, 289 P.3d 1098, 1121 (Kan. 2012) (finding that the state legislature enacted a cap on noneconomic damages "in an attempt to reduce and stabilize liability insurance premiums by eliminating both the difficulty with rate setting due to the unpredictability of noneconomic damages awards, and the possibility of large noneconomic damage awards"); *Zdrojewski v. Murphy*, 657 N.W.2d 721, 739 (Mich. Ct. App. 2002) ("The purpose of the damages limitation was to control increases in health care costs by reducing the

particular, have often been quite successful.³⁴ The system's original aims, however, are left behind in the process.³⁵ There is no good evidence that traditional reforms deter error or provide fairer compensation to victims.³⁶ Nevertheless, at most levels of politics and mainstream public discourse, traditional reforms continue to represent nearly the only game in town.³⁷

It is outside the scope of this article to examine why so many physicians and politicians continue to advocate traditional tort reforms. Rather, the objective is more forward-looking: to see how we might alter our medical liability regime in order to better achieve the professed goals of our malpractice system. Given salient changes taking place in our health care system, however, further evaluation of these goals is in order. The present development of public and private incentives that favor integrated practice and an emphasis on health care outcomes means that the dynamics and financial rewards of health care practice are changing.³⁸ While integrated care is little more than a rumor to physicians in some places, there has been substantial progress in many regions of the nation in achieving coordination of care among providers.³⁹ Quantification of the quality and patient-centeredness

liability of medical care providers, thereby reducing malpractice insurance premiums, a large component of health care costs.”); *Scoresby v. Santillan*, 346 S.W.3d 546, 552 (Tex. 2011) (“Fundamentally, the goal of the MLIA and the Medical Liability Act has been to make health care in Texas more available and less expensive by reducing the cost of health care liability claims.”).

34. See Myungho Paik et al., *The Receding Tide of Medical Malpractice Litigation Part 2: Effect of Damage Caps*, 10 J. EMPIRICAL LEGAL STUDIES 612, 619 (2013), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2285230&download=yes (finding strong, consistent evidence that caps on non-economic damages reduce paid claim rates and the payout per claim, which jointly produce a substantial drop in payout per physician); ADMIN. OFFICE OF PENN. COURTS, TABLE 1: MEDICAL MALPRACTICE CASE FILINGS (2012), available at <http://www.pacourts.us/NR/rdonlyres/466B0CA3-96DF-4081-9A20-CFF26728D4D4/0/Table1MedMalCaseFilings200011.pdf> (showing a 43.3% decline in case filings since 2002, following tort reform measures enacted in 2003 and subsequent years).

35. See, e.g., Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool*, 4 DREXEL L. REV. 41, 44 (2011), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2011365&download=yes (stating that all proposed reforms in past years have confused even the most “thoughtful reformers,” who succumb to the ideas of turning everything over to the health courts or the idea of provider-run alternative dispute resolution approaches, therefore missing the main point of healthcare, which is to help injured patients).

36. *Id.* at 42–44.

37. The Patient Protection and Affordable Care Act (ACA) offers, however modestly, a change from this trend. See *infra* Part II.A.

38. See *infra*, Part II.B.1.

39. See Melanie Evans, *Still Seeking Best Practices*, MODERN HEALTHCARE (July 27, 2013), <http://www.modernhealthcare.com/article/20130727/MAGAZINE/307279954> (reporting that while most of the entities surveyed in *Modern Healthcare*'s annual survey of ACOs tracked care-coordination efforts, some failed to do so altogether).

of care delivered are becoming increasingly important as both public and private payers change reimbursement methodologies to prioritize these metrics.⁴⁰

Taking these developments into account, the commonly proffered aims of error deterrence and compensation of victims certainly should both remain and improve.⁴¹ Yet one more aim should be added: promotion of quality of care, particularly in an integrated setting. Merely because physicians must meet a relevant standard of care in order to successfully defend themselves against a medical malpractice suit does not mean that they met an appropriate quality metric.⁴² More than a decade after the Institute of Medicine's groundbreaking report on medical error, health care remains, in many respects, as dangerous as it was when the report was first issued.⁴³ This is true despite the development and implementation of adverse event monitoring and quality improvement systems on both local and national levels.⁴⁴ In many respects, the malpractice deck is stacked

40. See, e.g., *BlueCross Announces Bundled Payment Agreements With Leading Orthopedic Groups in Tennessee*, BLUECROSS BLUESHIELD (May 22, 2012), <http://www.bcbs.com/healthcare-news/plans/bluecross-announces-bundled.html>; Dale Shaller, *Patient-Centered Care: What Does It Take?*, COMMONWEALTH FUND 1, 1–2, 21 (Oct. 2007), www.commonwealthfund.org/usr_doc/Shaller_patient-centeredcarewhatdoesittake_1067.pdf

41. See William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J. L. MED. 1, 2 (1994); Randall A. Bovbjerg & Lawrence R. Tancredi, *Liability Reform Should Make Patients Safer*, 33 J. L. Med. Ethics 478 (2005); Ronen Avraham, *Clinical Practice Guidelines: The Warped Incentives in the U.S. Health Care System*, 37 AM. J. L. MED. 7, 10 (2011).

42. See, e.g., David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 949–50 (2005) (discussing examples in which physicians resisted efforts to study patient outcomes in an effort to determine best practices, wishing instead to follow their traditional standards of care even though suboptimal outcomes might result).

43. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 53–57 (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson, eds., 2000). See also, e.g., Carolyn M. Clancy, *Where We Are a Decade After To Err Is Human*, 5 J. PATIENT SAFETY 199, 199 (2009); Christopher P. Landrigan, Gareth J. Parry, Catherine B. Bones et al., *Temporal Trends in Rates of Patient Harm Resulting from Medical Care*, 363 NEW ENG. J. MED. 2124, 2130 (2010).

44. See, e.g., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *AHRQ PATIENT SAFETY PROJECT REDUCES BLOODSTREAM INFECTIONS BY 40%* 1 (Sept. 10, 2012), available at http://www.hret.org/news/resources/AHRQ_Patient_Safety_Project_Reduces_Bloodstream_Infections_40Percent_09102012.pdf; David A. Hyman & Charles Silver, *Healthcare Quality, Patient Safety, and the Culture of Medicine: "Denial Ain't Just a River in Egypt"*, 46 NEW ENG. L. REV. 417, 428–35 (2012), available at <http://www.nesl.edu/userfiles/file/LawReview/Vol46/3/Hyman-Silver%20FINAL.pdf> (providing several examples of cultural shifts in local or specialty medical practice that led to significant improvements in quality of care); Carolyn M. Clancy, *Patient Safety: One Decade after To Err Is Human*, PATIENT SAFETY & QUALITY HEALTHCARE (Oct. 2009), <http://www.psqh.com/septemberoctober-2009/234-september-october-2009-ahrq.html>). Yet even so, substantial problems remain with adverse event monitoring, among other issues. See, e.g., STUART WRIGHT, *MEMORANDUM REPORT: FEW ADVERSE EVENTS IN HOSPITALS WERE REPORTED TO STATE ADVERSE EVENT REPORTING SYSTEMS* 3–4 (July 19, 2012), available at [http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Documents/072712/oei-06-09-00092\[1\].pdf](http://www.healthlawyers.org/News/Health%20Lawyers%20Weekly/Documents/072712/oei-06-09-00092[1].pdf) (finding that even with the passage of the Patient Safety and Quality

against inducing health care providers to favor a more integrated, systems-based approach to patient care.⁴⁵ Numerous roadblocks must be surmounted, not the least of which includes fragmentation of care due to proprietary and financial interests and the medical culture.⁴⁶ If there is some way to use the malpractice system to motivate providers to offer better-coordinated, higher-quality health care, we ought to give it serious consideration.

II. POTENTIAL LIABILITY REFORMS, POST HEALTH CARE REFORM

The problem of continued and substantial deficiencies in quality of care suggests that, if there is any basis to a deterrence theory of medical malpractice law, we need to examine how better to align the law with current efforts to meet specific quality standards in medicine. Most physicians presently have substantial latitude to determine diagnostic methods and treatments for most conditions.⁴⁷ Disease management can vary widely from location to location, and may differ as much based on exposure to a given method of training or local convention as on what is most likely to yield the best outcome.⁴⁸ Multiple cases exist where a sizeable percentage of physicians continue to utilize a discredited disease management or surgical methodology, even after one or more definitive studies are

Improvement Act of 2005, and the National Healthcare Quality Report that monitors adverse events, patient safety has worsened).

45. See, e.g., Lucian L. Leape & Donald M. Berwick, *Five Years After To Err Is Human: What Have We Learned?* 293 J. AM. MED. ASS'N 2384, 2387–88 (2005) (noting that the current complex culture of medicine is difficult to improve due to the array of specialties, subspecialties, and lack of leadership at hospitals and in health plans, and lack of a common vision).

46. *Id.* at 2387 (stating that various aspects of healthcare, including “complexity, professional fragmentation, and a tradition of individualism, enhanced by a well-entrenched hierarchical authority structure and diffuse accountability”, form a “daunting barrier” to creating a safe culture in healthcare).

47. See, e.g., Reidar Tyssen et al., *Physicians' Perceptions of Quality of Care, Professional Autonomy, and Job Satisfaction in Canada, Norway, and the United States*, 13 BMC HEALTH SERVICES RES. 516 (2013), available at <http://www.biomedcentral.com/content/pdf/1472-6963-13-516.pdf> (finding that a substantial majority of physicians practicing in the United States agree or strongly agree that they possess clinical freedom).

48. See Paul S. Chan et al., *Appropriateness of Percutaneous Coronary Intervention*, 306 J. AM. MED. ASS'N 53, 53, 60 (2011), available at [http://mhcc.dhmc.maryland.gov/cardiacadvisory/Documents/sp.mhcc.maryland.gov/cardiac_advisory/Chan%20et%20al%20JAMA2011\(306\)53-61%20PCI%20AUC.pdf](http://mhcc.dhmc.maryland.gov/cardiacadvisory/Documents/sp.mhcc.maryland.gov/cardiac_advisory/Chan%20et%20al%20JAMA2011(306)53-61%20PCI%20AUC.pdf) (finding that 38% of nonacute indications for PCI were “uncertain” and nearly 12% were “inappropriate;” additionally, “rates of inappropriate PCI varied markedly at the hospital level”); Stephen M. Bowman et al., *Hospital Characteristics Associated with the Management of Pediatric Splenic Injuries*, 294 J. AM. MED. ASS'N 2611, 2614 (2005), available at <http://jama.jamanetwork.com/article.aspx?articleid=201924> (finding that, where nonsurgical management was more appropriate, children with splenic injuries were significantly more likely to receive a splenectomy at general hospitals, rather than at children’s hospitals or level I or II trauma centers); Jonathan C. Routh et al., *Variation in Surgical Management of Vesicoureteral Reflux: Influence of Hospital and Patient Factors*, 125 PEDIATRICS e446, e450 (2010) (finding that the most important factor driving management for VUR was the hospital at which a patient was treated).

published that show the ineffectiveness or even harmfulness of that methodology.⁴⁹ It is certainly true that, in the case of many conditions, there exists no clearly superior management or treatment strategy.⁵⁰ However, where such does exist, or where widely used strategies have been convincingly shown to not work or be harmful, then this should be recognized in malpractice cases.

At least two possibilities exist for better aligning medical malpractice law with adherence to available quality metrics: use of clinical practice guidelines to establish the applicable standard of care, and adoption of enterprise liability for affiliated physicians. As will be shown below, however, only one of them has substantial potential to meet not only the goals of deterring negligence and promoting appropriate quality measures, but also the goal of more regularly and uniformly compensating injured patients.⁵¹

A. Clinical Practice Guidelines

While the ACA offers little in the way of direct change to the malpractice system, it is generous in providing means by which malpractice reform might piggyback on delivery reform and health care quality improvements to make substantial headway in addressing these proposed goals.⁵² Ideally, we want, among other goals, a malpractice system that meshes well with efforts to improve quality of care. The ACA focuses substantial attention on improving quality of care. Among other provisions, it supports research and implementation of best practices

49. Notable examples include studies contraindicating routine postmenopausal hormone use in women, contraindication of arthroscopies for arthritis of the knee, and stenting patients for stable coronary artery disease. JoAnn E. Manson et al., *Estrogen Plus Progestin and the Risk of Coronary Heart Disease*, 349 NEW ENG. J. MED. 523, 533 (2003); Alexandra Kirkley et al., *A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee*, 359 NEW ENG. J. MED. 1097, 1103–04 (2008); William E. Boden, Robert A. O'Rourke, Koon K. Teo et al., *Optimal Medical Therapy with or without PCI for Stable Coronary Disease*, 356 NEW ENG. J. MED. 1503, 1506–09 (2007). For further information, see generally Vinay Prasad et al., *A Decade of Reversal: An Analysis of 146 Contradicted Medical Practices*, 88 MAYO CLINIC PROCEEDINGS 790 (2013), available at <http://download.journals.elsevierhealth.com/pdfs/journals/0025-6196/PIIS0025619613004059.pdf> (out of 363 articles published in the *New England Journal of Medicine* between 2001 and 2010 that tested an established medical practice, 146 of the studies found the standard of care under review to be either no better or worse than either the prior standard of care or omission altogether).

50. See, e.g., John T. Wei et al., *Comprehensive Comparison of Health-Related Quality of Life After Contemporary Therapies for Localized Prostate Cancer*, 32 J. CLINICAL ONCOLOGY 557 (2002), available at <http://jco.ascopubs.org/content/20/2/557.full.pdf+html> (finding that each method of treatment for prostate cancer had its own associated morbidities that could adversely affect health-related quality of life).

51. See *infra* Part II.B.2.

52. See, e.g., Mark A. Rothstein, *Health Care Reform and Medical Malpractice Claims*, 38 J.L. MED. & ETHICS 871, 871 (2010) (suggesting that the ACA may lead to a decrease in adverse events and an increase in the quality of patient care because of “better coordination through continuity of care and ‘medical homes,’” electronic health records, and greater emphasis on evidence-based medicine).

via funding of patient-centered outcomes research⁵³ and payment reductions for both hospital readmissions⁵⁴ and development of hospital-acquired conditions.⁵⁵ The use of best practices could arguably be both complemented and furthered by reforming medical malpractice law to expand the use and importance of appropriately-developed clinical practice guidelines (CPGs) in medical malpractice cases. The Institute of Medicine defines CPGs as “statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.”⁵⁶ If used at all, CPGs are generally employed at present in malpractice cases to help buttress or rebut expert testimony regarding the standard of care.⁵⁷ Under appropriate circumstances, however, a number of commentators have suggested that CPGs could be used to establish that standard of care without the need for expert testimony. For the defense, CPGs could provide a safe harbor if followed appropriately, or, alternatively, a rebuttable presumption of malpractice for the plaintiff if unheeded.⁵⁸

As many commentators observe, using CPGs as a safe harbor for medical practice is attractive on initial observation because it would replace the current uncertainty with what appear to be gold-standard recommendations developed by experts. Mark Hall states, for example, that

[p]ractice policies offer a potentially powerful mechanism for rehabilitating the role of custom in defending against malpractice charges. The breakdown between the theory that the law applies a rule of professional custom and the practice of many malpractice trials occurs for the very reason that the law has always presumed the

53. 42 U.S.C. § 1320e(c) (West 2014).

54. 42 U.S.C. § 1395ww(p) (West 2014).

55. *Id.* § 1395ww(q). *See also, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., THE AFFORDABLE CARE ACT: LOWERING MEDICARE COSTS BY IMPROVING CARE 3–5 (2012), available at <http://www.cms.gov/apps/files/aca-savings-report-2012.pdf> (noting the different ways that ACA supports payment reductions for hospital readmissions and the goal of reducing hospital-acquired conditions).

56. INST. OF MED., CLINICAL PRACTICE GUIDELINES WE CAN TRUST 4 (Robin Graham et al., eds., 2011).

57. *See, e.g.*, Avraham, *supra* note 41, at 19; Andrew L. Hyams et al., *Medical Practice Guidelines in Malpractice Litigation: An Early Retrospective*, 21 J. HEALTH POL., POL'Y & L. 289 (1996); Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 665 (2001).

58. Whether both plaintiffs and defendants should be able to use CPGs as evidence in malpractice suits has been debated. Thus, for example, some have argued that CPGs should only be available as evidence that a defendant followed the standard of care, and should be unavailable to plaintiffs to prove the contrary given, for example, accepted variations in practice that may not be adequately captured by guidelines, whereas others hold that both plaintiffs and defendants should be able to make use of CPGs in appropriate circumstances. *See, e.g.*, Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 LAW & CONTEMP. PROBS. 119, 131 (1991); Andrew L. Hyams et al., *supra* note 57, at 310–11.

existence of that which does not exist—established, concrete professional standards. Because the law has operated in an unreal twilight zone that assumes professional consensus when in fact much of medical practice is governed by instinct and localized habit, malpractice suits have tended to degenerate into individual skirmishes between opposing experts. Malpractice law can be vastly improved, then, by greater rationalization and standardization of medical practice.⁵⁹

Those who support the use of guidelines as a safe harbor accept, whether implicitly or explicitly, that we should encourage improved regularity in physician practice.⁶⁰ In its most ideal form, the use of CPGs as defensive safe harbors⁶¹ could provide physicians with a safer strategy for protecting themselves from liability, while at the same time providing physicians with a substantial incentive to adopt proven best practices.⁶² Using CPGs as defensive safe harbors could also facilitate national harmonization of practice.⁶³ Depending on how CPGs were used, it could also further a more population-based approach to medical practice and reduce defensive medicine.⁶⁴

However, there are some significant problems with relying on guidelines in this fashion. First, developing reliable, unbiased, and sound guidelines has historically been notoriously tricky, given the varying interests of the relevant

59. See Hall, *supra* note 58, at 129–30.

60. *Id.* at 144 (“It is impossible for physicians to have both wide clinical discretion and, at the same time, freedom from scrutiny in malpractice litigation, nor is it appropriate to make an across-the-board choice between these two extremes. Where the science is clear, there should be a single, national standard. Where there is more divergence of opinion, conflicting, but still respectable, standards will be seen.”); see also Avraham, *supra* note 41, at 16, 30–31 (noting problems with the diffusion of medical innovations and best practices in the medical field and proposing the implementation of a system of privately-developed clinical practice guidelines with liability protection to address these issues, among others).

61. Plaintiffs can also use CPGs in an offensive manner. See, e.g., Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1251, 1253–54 (2006), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1262898&download=yes (stating that courts have allowed offensive and defensive use of CPGs in the courtroom, and that offensive use by plaintiffs can be helpful if the physician has set a standard guideline to use in practice since the patient would clearly know which aspect of the guideline the physician failed to follow).

62. See, e.g., Hall, *supra* note 58, at 129–30.

63. *Id.* (arguing that use of guidelines in malpractice suits will encourage “rationalization and standardization “of practice across different localities).

64. See, e.g., Stefan Timmermans & Aaron Mauck, *The Promises and Pitfalls of Evidence Based Medicine*, 24 HEALTH AFF. 18, 19 (2005) (observing that evidence based medicine and resulting guidelines can be viewed as population-based recommendations resulting from the evaluation of the scientific basis for medical and surgical treatments); INST. OF MED., *supra* note 56, at 172 (noting conflicts between the practice of defensive medicine and CPG use).

parties.⁶⁵ As the Institute of Medicine noted in its discussion of how best to develop reliable CPGs, “the quality of CPG development processes and guideline developer adherence to quality standards have remained unsatisfactory and unreliable for decades.”⁶⁶ Lack of unanimity, failure to consistently obtain independent review, commercial conflict of interest, and personal bias all complicate CPG development.⁶⁷ Varieties of schema have been developed to address these problems, but none has yet been systematically implemented.⁶⁸

Guidelines must also be easily and quickly amendable, with changes rapidly and effectively communicated to practitioners.⁶⁹ If CPGs are not reliably kept up to date and published regularly where practitioners can easily find them,⁷⁰ their utility

65. See Amir Qaseem, *A Perspective on the Guidelines International Network and the Institute of Medicine’s Proposed Standards for Guideline Development*, NAT’L GUIDELINE CLEARINGHOUSE (Apr. 8, 2013), <http://www.guideline.gov/expert/printView.aspx?id=43913> (stating that “concern about the varying quality of guideline development methodologies and recommendations” has led to frustration as there is “variation in the quality of evidence supporting the guidelines, lack of transparency, inadequate disclosure and management of actual or perceived conflicts of interests, concerns about the funding of CPG development, and a lack of agreement . . .”).

66. See INST. OF MED., *supra* note 56, at 2.

67. See, e.g., Allan D. Sniderman & Curt D. Furberg, *Why Guideline-Making Requires Reform*, 301 J. AM. MED. ASS’N 429 (2009) (arguing that, among other protective measures, guideline committees should include epidemiologists, statisticians, and health policy experts, and that guidelines should both have an expiration date and undergo independent scientific review); Jennifer Newman *et al.*, *Prevalence of Financial Conflicts of Interest Among Panel Members Producing Clinical Practice Guidelines in Canada and United States: Cross Sectional Study*, 343 BMJ d5621 (2011), available at <http://www.bmj.com/content/343/bmj.d5621.pdf%2Bhtml> (finding that 52% of panelists who participated in developing guidelines on hyperlipidemia or diabetes published by national organizations between 2000 and 2010 had declared or undeclared conflicts of interest, and that, while only 16% of panelists on government-sponsored guidelines had conflicts, 69% of those on non-government sponsored guidelines did).

68. See, e.g., Avraham, *supra* note 41, at 31 (arguing that we should have a “Private Regulation Regime,” where private entities develop guidelines and license them to be used by physicians, and where aggrieved patients could sue guideline developers for development of poor or negligently-created guidelines and payers could sue for developing excessively careful (and hence costly) guidelines); Arnold Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform: An Update*, 21 ANNALS HEALTH L. 21, 30–31 (2012) (addressing conflicts of interest and quality concerns by subjecting committee members to strict disclosure and COI requirements, making the process of creation transparent, and ultimately harmonizing competing guidelines); INST. OF MED., *supra* note 56, at 26 (guidelines should be based on systematic review of, and evaluation of the quality of, existing evidence, should provide a clear statement of the relationships between interventions and outcomes, and should be undertaken by a multidisciplinary panel of experts and key affected groups, with transparency concerning both process and conflicts of interest).

69. See Peter D. Jacobson, *Transforming Clinical Practice Guidelines Into Legislative Mandates: Proceed with Abundant Caution*, 299 J. AM. MED. ASS’N 208, 209 (2009); INST. OF MED., *supra* note 56, at 146–47.

70. See Paul G. Shekelle *et al.*, *Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly do Guidelines Become Outdated?*, 286 J. AM. MED. ASS’N 1461, 1461 (2001) (noting that guidelines are not useful to physicians if they are not up to date and present updated information). The Agency for Healthcare Research and Quality

in support or defense of a malpractice suit becomes tenuous at best. While the ACA makes provision for rapid dissemination of new guidelines and research findings, it is not enough that guidelines are available for physicians to read or otherwise obtain.⁷¹ Physicians must not only be aware of them, but also must put them into practice. At least one recent study has found that while a large majority of physicians are aware of current guidelines that are relevant to their specialty, far fewer of them actually apply those guidelines.⁷²

Guidelines must be sufficiently flexible so they can be tailored, when relevant, to the particular needs of patients, yet not so lax as to lose much of their force.⁷³ They must permit rather than penalize reasonable experimentation.⁷⁴ Finally, there are simply many circumstances in which, at least for the foreseeable future, no definitive guidelines will—or can—exist.⁷⁵ These issues make it unlikely that CPGs could, on their own, provide a satisfactory and sufficient response to the problems inherent in our medical malpractice regime at present, or anytime in the near future.⁷⁶

B. Accountable Care Organizations and Enterprise Liability

maintains the National Guideline Clearinghouse, where one can find not only guidelines that meet the NGC's inclusion criteria, but also comparisons and syntheses of competing guidelines. *National Guideline Clearinghouse – Compare Guidelines*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, <http://www.guideline.gov/compare/index.aspx> (last visited Sept. 24, 2013).

71. Patient Protection and Affordable Care Act, 42 U.S.C. § 299c-3 (Supp. V 2010).

72. See, e.g., Sharon Mickan, Amanda Burls, & Paul Glasziou, *Patterns of “Leakage” in the Utilisation of Clinical Guidelines: A Systematic Review*, 87 POSTGRADUATE MED. J. 670, 674 (2011) (finding that while the median rate of physician awareness of guidelines included in the studies was ninety percent, the median rate of adherence was only thirty-six percent).

73. Thus, for example, David Eddy, among others, has argued for the use of “individualized” guidelines, where “readily available” information obtained regarding each patient is used, where relevant, to tailor more general guidelines for the patient’s specific characteristics. He and colleagues have, for example, published a study finding that, of a middle-aged cohort without a prior history of heart disease that was randomized into three treatment groups for hypertension – one receiving care according to the most recent set of guidelines, one receiving care according to individualized guidelines, and one receiving “random” care – both the best outcomes and lowest costs were incurred by the individualized guidelines group. David M. Eddy et al., *Individualized Guidelines: The Potential for Increasing Quality and Reducing Costs*, 154 ANNALS INTERNAL MED. 629, 629, 631, 633 (2011).

74. See, e.g., *Improving Physician Adherence to Clinical Practice Guidelines: Barriers and Strategies for Change*, NEW ENG. HEALTHCARE INST. 1, 12–13 (2008) (discussing the importance of flexibility in CPGs in order to “accommodate provider judgment”).

75. See *supra*, notes 67–68 and associated text.

76. See, e.g., Maxwell Mehlman, *Professional Power and the Standard of Care in Medicine*, 44 AZ. STATE. L. REV. 1165, 1216-17 (2012) (citing, *inter alia*, the lack of consensus regarding what makes a standard “evidence based,” the disparity between real-world conditions and those pertaining in clinical trials, and the need to conform care to the situations of individual patients).

Clinical practice guidelines pose significant problems when contemplated for use as complete shields against malpractice liability.⁷⁷ Yet perhaps an even greater problem that CPGs pose is their focus on individual, rather than coordinated, physician practice. As Elliott Fisher and his colleagues observe, the U.S. health care system's focus on individual providers

. . . reflects the historical development, oversight mechanisms, and payment systems that prevail in the U.S. health care system and the interest of providers to be held accountable only for care that is within their direct control. The limitations of this approach are increasingly apparent. The provision of high quality care for any serious illness requires coordinated, longitudinal care and the engagement of multiple professionals across different institutional settings. Also, many of the most serious gaps in quality can be attributed to poor coordination and faulty transitions.⁷⁸

Improved quality of care, as discussed earlier, depends in part on defragmenting our health care delivery.⁷⁹ The ACA enacts a number of demonstration projects designed to do precisely that.⁸⁰ The following section discusses perhaps the most prominent of these projects: ACOs designed to participate in the MSSP. It then considers how best to alter our medical liability regime to support the goals of ACOs.

I. Accountable Care Organizations

The ACA is concerned not only with researching and encouraging the implementation of best practices, but also with finding better ways to integrate and coordinate patient care.⁸¹ Accordingly, the most prominent of the Medicare

77. See Mello, *supra* note 57, at 649 (discussing how the use of CPGs can be problematic because CPGs do not represent prevailing medicine, and discussing how allowing CPGs to be used as an affirmative defense while preventing plaintiffs from using them offensively could create problems).

78. Elliott Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. w44, w44–w45 (2006).

79. See *supra* Part I; see also THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS, 15–20, (Einer Elhauge ed., 2010), available at <http://www.law.harvard.edu/faculty/elhauge/pdf/Elhauge%20The%20Fragmentation%20of%20US%20Health%20Care%20--%20Introductory%20Chpt.pdf> (discussing reforms that may help defragment health care in the United States).

80. Patient Protection and Affordable Care Act, 42 U.S.C. § 294j(a) (Supp. V 2010) (discussing demonstration program to integrate quality improvement and patient safety training).

81. See, e.g., Pub.L. 111-148, Title II, § 2704, Mar. 23, 2010, 124 Stat. 323 (establishing the Medicaid bundled payment demonstration program); 42 U.S.C. § 1395cc-4(a)(1) (West 2014) (establishing the Medicare bundled payment demonstration program); 42 U.S.C. § 256a-1(a) (establishing “community-based, interdisciplinary, interprofessional teams” to support primary care practices).

demonstration projects authorized by the ACA are intended to facilitate health care integration. Chief among them are ACOs under the MSSP: groups of health care providers and institutions that work together to manage and coordinate the care of traditional Medicare beneficiaries, and who ultimately share responsibility for both the cost and quality of the care provided.⁸² The Centers for Medicare and Medicaid Services (CMS) envisages MSSP ACOs as having a “three-part aim” of achieving: “(1) better care for individuals; (2) better health for populations; and (3) lower growth in Medicare Parts A and B expenditures.”⁸³ If ACOs and other coordinated care organizations ultimately take root, our malpractice regime will need to function effectively in conjunction with them. This will entail more than just cosmetic changes, as will be discussed further below.⁸⁴

Models for ACOs predate the ACA.⁸⁵ Examples include Geisinger Health, Community Care of North Carolina, and Kaiser Permanente, among others.⁸⁶ While most pre-existing models are large, multispecialty group practices serving tens of thousands of often privately-insured patients, the ACA’s MSSP requires only that an ACO serve a minimum of 5,000 Medicare beneficiaries⁸⁷ and that the ACO offer a variety of potential practice organizational forms, including physician-led practice networks, individual hospital systems, partnerships between hospitals and physician groups, and affiliations among health insurers, hospital systems, and physician networks.⁸⁸ Regardless of the model chosen, participants are responsible for managing and coordinating their patients’ care in an effort to both reduce costs and improve quality.⁸⁹ Each ACO must accordingly have a sufficient number of

82. See 42 C.F.R. § 425.100(a) (2012).

83. *Id.* § 425.108(a).

84. See *infra* section II.B.2.

85. See, e.g., Francis J. Crosson, *21st-Century Health Care – The Case for Integrated Delivery Systems*, 361 NEW ENG. J. MED. 1324, 1324 (2009) (discussing how in 1933 the Committee on the Costs of Medical Care published its findings and recommendations that medical services should consist of groups of physicians and related practitioners in order to maintain a high standard of care and to maintain a personal relationship between physicians and patients).

86. *Id.* (noting that although the Committee on the Costs of Medical Care recommended a transition to group practice environments, the Mayo Clinic, the Geisinger Health System, and Kaiser Permanente were among the few organizations that actually followed the recommendation).

87. 42 C.F.R. § 425.110(a)–(b) (providing for termination of an ACO’s participation agreement with CMS if the number of Medicare beneficiaries assigned to it drops below 5,000 for more than one performance year).

88. See *id.* § 425.102(a). For examples of ACOs formed to date, see, e.g., Molly Gamble, *80 Accountable Care Organizations to Know*, BECKER’S HOSPITAL REVIEW (Apr. 16, 2012), <http://www.beckershospitalreview.com/hospital-physician-relationships/60-accountable-care-organizations-to-know.html>.

89. See 42 C.F.R. § 425.100(a) (“Under the Shared Savings Program, ACO participants may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an ACO that meets the criteria specified in this part. The ACO must become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO.”).

participating primary care providers (PCPs) to care for its Medicare ACO population.⁹⁰ Solo PCPs are restricted to participating in only one ACO at any given time; those PCPs who practice in a group are not similarly bound.⁹¹ Because CMS chose to permit Medicare beneficiaries to be assigned to ACOs on the basis of primary care delivered by specialists as well as generalists, this means that specialists who deliver primary care also fall under these rules.⁹²

Whether an individual physician participates in only one ACO or in multiple ones, both the cost and quality of the physician's care is included in the overall cost and quality data that will be key not merely to CMS's determinations of an ACO's cost-effectiveness but also to the ACO's payment.⁹³ In most cases, Medicare payment is made pursuant to the present fee-for-service system.⁹⁴ However, the choices that ACO providers make regarding the quality and quantity of the patient care that they collectively deliver will ultimately affect their earnings.⁹⁵ CMS is responsible for developing risk-adjusted and updateable cost benchmarks for each ACO based on the per capita Part A and B expenditures for Medicare beneficiaries who would have been assigned to the ACO in the preceding three years.⁹⁶ ACOs that meet quality standards and save at least a specific, minimum percentage of the cost benchmark⁹⁷ are eligible to receive a percentage of the savings realized by CMS, up to a cap.⁹⁸ Those that exceed the applicable cost benchmark by at least

90. See 42 C.F.R. § 425.110(a)(1).

91. 42 C.F.R. §§ 425.20 & 425.204(c)(5)(i). CMS restricted solo physician participation to a single ACO to facilitate ACO evaluation based on the ACO's unique patient group. See Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,810 (Nov. 2, 2011) (codified at 42 C.F.R. pt. 425).

92. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,811 (Nov. 2, 2011) (codified at 42 C.F.R. part 425).

93. See 42 C.F.R. § 425.500(a)–(b) (outlining the measures taken by CMS to assess the quality of care provided by the ACO).

94. 42 C.F.R. § 425.20. Some ACOs may seek to opt for bundled, capitated, or other forms of payment while still participating in the Shared Savings Program. See, e.g., 76 Fed. Reg. at 67,833, 67,905.

95. See, e.g., Elias N. Matsakis, *Partnering with Hospitals to Create an Accountable Care Organization*, in ACOS, CO-OPS, AND OTHER OPTIONS: A "HOW-TO" MANUAL FOR PHYSICIANS NAVIGATING IN A POST-HEALTH REFORM WORLD 4 (Am. Med. Ass'n, ed., 3d ed. 2012) (noting that savings will come from a reduction in operative interventions, changes in service location, preventive and supportive care to better manage chronic conditions, and reductions in readmissions and need for skilled nursing care).

96. 42 C.F.R. § 425.602(a)–(b). The updates are based on the "projected absolute amount of growth of national per capita expenditures for Parts A and B services." 42 C.F.R. § 425.602(b).

97. The applicable percentage ranges from 3.9% to 2% below the benchmark, depending on the track chosen and, for track 1 ACOs, the number of beneficiaries. 42 C.F.R. §§ 425.604(b) & 425.606(b).

98. *Id.* § 425.606(e) (2012). The first interim results from the Medicare Shared Savings Program were released in January 2014. Fifty-four of the 114 ACOs participating in the program in 2012 had lower expenditures than predicted, producing a net savings of \$128 million. Of those fifty-four, twenty-nine generated sufficient savings to receive a share of the savings. Press Release: Medicare's Delivery System Reform Initiatives Achieve Significant Savings and Quality

two percent will, depending on which of two tracks they opt for, ultimately be penalized.⁹⁹ Presumably, if a critical mass of ACOs remains in the program as the penalizations go into effect, then the cost-efficiency bar will rise as ACOs increasingly endeavor to eke greater savings from the care that they provide without sacrificing quality.¹⁰⁰

The premium placed on the reduction of duplicated and unnecessary care is intended to place pressure on physicians who participate in ACOs to change their practice patterns. As Fisher and colleagues observe,

Improvement – Off to a Strong Start (Jan. 30, 2014), <http://www.hhs.gov/news/press/2014pres/01/20140130a.html>.

99. 42 C.F.R. § 425.606(b)(2). While MSSP ACOs may opt for the “one-sided” track, in which they share in savings but not in losses, that track is available only for the first three-year agreement period. *See id.* § 425.600 (a)–(b). Only two of the ACOs in the MSSP that opted for the “two-sided” track generated shared losses in the first year. CTRS. FOR MEDICARE & MEDICAID SERVS., PERFORMANCE YEAR 1 INTERIM RESULTS FOR ACOs THAT STARTED IN APRIL OR JULY 2012, available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/PY1-InterimResultsTable.pdf> (last visited May 29, 2014) [hereinafter PERFORMANCE YEAR 1 INTERIM RESULTS]. Pioneer ACOs, on the other hand, all started on two-sided tracks. *See* Medicare Program; Pioneer Accountable Care Organization Model: Request for Applications, 76 Fed. Reg. 29,249, 29,250 (May 20, 2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-20/pdf/2011-12383.pdf>. Results for the first year show that two Pioneer ACOs had to share in losses, which totaled \$4 million. Press release: Pioneer Accountable Care Organizations Succeed in Improving Care, Lowering Costs (July 16, 2013), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html>. Nine Pioneer ACOs left the program following the first year.

Id.

100. Todd Freeman, a healthcare attorney, put the matter as follows:

There is a good chance that this is “fool’s gold” in that thresholds under which the ACO must provide care to generate savings will likely drop if the programs are successful at all. For example, if the threshold in 2012 for a given ACO population of patients is \$10 million and the ACO provides care at \$8.5 million (with a \$1.5 million savings), then it is unlikely that the threshold will remain at \$10 million for that population very long. Rather, the new “standard” will be the \$8.5 million which may be difficult, if not impossible, to generate an incentive payment under the shared savings program. It is also possible that once ACOs are established with identified participating providers, that CMS will institute a program of penalizing the ACOs for overutilization. For example, using the illustration described above, if the new threshold is set at the \$8.5 million and the providers lose all hope that there is any possibility of future incentive payments, they could easily revert to their old ways and aggregate cost of care would rise to the \$10 million level again. It is naïve to think that CMS, now having complete data from the ACO, would tolerate such an increase in cost.

See TODD I. FREEMAN, AM. ASS’N OF ACCOUNTABLE CARE ORGS., PHYSICIANS’ ACO DILEMMA: SHOULD WE OR SHOULDN’T WE? 4 (2011), available at http://www.larkinhoffman.com/files/OTHER/Physicians_ACO_Dilemma_PDF3.pdf. While not quite analogous in certain fundamental respects, the history of managed care organization participation in the former Medicare+Choice program, in particular, suggests that ACOs may never reach this point unless ACO formation and participation become mandatory, or penalties are suspended or reduced, or other events occur to either encourage voluntary participation or make participation required. *See, e.g.,* Nancy-Ann DeParle, *As Good as It Gets?: The Future of Medicare+Choice*, 27 J. HEALTH POL. POL’Y & L. 495, 500–03 (2002).

. . . [h]igher spending across U.S. health systems is largely attributable to greater use of discretionary “supply sensitive” services: visits, specialist consultations, tests, imaging services, and the use of institutional settings (rather than outpatient settings) for care. Patients’ preferences do not explain these differences in care, and responses to survey-based clinical vignettes reveal that physicians in higher-spending systems have developed a more intensive practice pattern in exactly these discretionary clinical settings.¹⁰¹

How much change participation in an ACO will ultimately yield is uncertain.¹⁰² Fisher and colleagues at the Dartmouth Institute for Health Policy and Clinical Practice suggest that, while physician services account for only around twenty percent of health care spending in the United States, physicians also have substantial influence over whether and how much of the remaining eighty percent is spent.¹⁰³ Some believe that primary care physicians may be able to capitalize on this by claiming greater profit by participating in ACOs, while at the same time causing total health care spending to decline by reducing unnecessary hospitalizations, emergency department use, procedures, and medications, as well as preventing adverse events and avoidable readmissions.¹⁰⁴ Indeed, this will likely be a necessary feature of achieving savings.¹⁰⁵

Yet more may be at stake than pure profit. Participation in ACOs necessarily entails a certain amount of subordination of individual interest and self-direction to the common mission, if that common mission is to be successful.¹⁰⁶ Inducing physician participation, particularly in ACOs that are spearheaded by institutions rather than physician groups, may be difficult, especially in regions of the country

101. Fisher et al., *supra* note 78, at w53.

102. Preliminary data from the first year of the Pioneer ACO demonstration yielded promising results, with Pioneer ACOs reporting better results than those reported in fee-for-service Medicare generally in all fifteen of the quality measures for which data was available. See PERFORMANCE YEAR 1 INTERIM RESULTS, *supra* note 99. See also Kavita Patel & Steven Lieberman, *Taking Stock of Initial Year One Results from Pioneer ACOs*, HEALTH AFF. BLOG (July 25, 2013), <http://healthaffairs.org/blog/2013/07/25/taking-stock-of-initial-year-one-results-for-pioneer-acos/>.

103. Fisher et al., *supra* note 78, at w53.; see also, e.g., HENRY J. KAISER FOUND., HEALTH CARE COSTS: A PRIMER 10 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf>.

104. See HAROLD D. MILLER, CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM, HOW TO CREATE ACCOUNTABLE CARE ORGANIZATIONS 3 (2012), available at <http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf>. See also, e.g., Harold D. Miller, *Succeeding Under Shared Savings, Global Payment, and Other Payment Reforms*, presented at the Annual Meeting of the AMA House of Delegates (June 18, 2012). Miller rightly notes that physicians’ share of any savings through an ACO will depend on a variety of factors, not the least of which include the nature of entities participating in the ACO and the composition of the ACO’s board membership.

105. See, e.g., MILLER, *supra* note 105, at 2–4.

106. See, e.g., Fisher et al., *supra* note 78, at w55–w56.

where integrated care has not yet taken significant root.¹⁰⁷ Physicians have long prized their clinical autonomy.¹⁰⁸ Some have protested the gradual diminution of this autonomy in various respects over the last few decades.¹⁰⁹ While physicians have acclimated to numerous changes over the years, many show little sign of relenting in their opposition to new encroachments.¹¹⁰ Among some physicians,

107. *Id.* at w53–w54.

108. *Id.* (explaining that “[p]hysician practice and professional identity in the United States have long been characterized by a high degree of professional autonomy and a culture of individual responsibility—both of which are reinforced by current medical training, professional malpractice liability programs, and payment systems. Although there are numerous examples of physicians being deeply engaged in collaborating with hospital administrators and nurses to improve the delivery of care within their local systems, these remain relatively isolated examples in the broad mainstream of clinical practice. Many physicians will resist the notion of accepting a degree of responsibility for the care of all patients within their local delivery system.”).

109. Dr. Daniel H. Johnson, Jr., a former President of the American Medical Association, foretells the following regarding health reform, which was being debated at the time of his remarks:

Once private insurance is crowded out by the unfair competitive tactics of the federal government intruding into an already flawed marketplace, it will be a simple matter to consolidate all of these different groups into one single entity. What does this mean to physicians and their patients? “Clinical effectiveness research,” when operated by government instead of the medical profession, will become “cost effectiveness” restrictions on what care is available and to whom—determined by the federal government. It will only be a matter of a short time before Americans will enjoy the pleasures of “quality adjusted life years” wherein people my age will be denied services from which they might benefit because of their age and/or some other infirmity. We don’t have to make this stuff up: It is already the law of the land in some other developed countries, such as the United Kingdom, and has been long advocated here in the U.S. by voices from the left, including major media outlets. The federal government will exert total control over payment for all medical services.

Daniel H. Johnson, Jr., *Memo to My Fellow Physicians: We Have Reached the Moment of Truth*, THE FOUNDRY (July 27, 2009, 3:40 PM), available at <http://blog.heritage.org/2009/07/27/memo-to-my-fellow-physicians-we-have-reached-the-moment-of-truth>; see also, e.g., Robert Reinhold, *Medical Leaders Growing Wary Over Reagan Health Plans*, N.Y. TIMES, Feb. 16, 1981 (noting physician worries over possible rationing of care and use of health maintenance organizations for Medicaid recipients in the event of proposed budget cuts under President Reagan); HCPLEXUS, 2011 NATIONAL PHYSICIANS SURVEY 29 (2011), available at <http://mikemeikle.files.wordpress.com/2011/01/2011-thomson-reuters-hcplexus-national-physicians-survey.pdf> (finding that specialists, in particular, worry about losing autonomy under the Affordable Care Act); Bruce E. Landon et al., *Changes in Career Satisfaction Among Primary Care and Specialist Physicians, 1997 – 2001*, 289 J. AM. MED. ASS’N 442, 447 (2003) (finding that changes in professional autonomy were among the most consistent predictors of changes in career satisfaction among both primary care and specialist physicians during the study period).

110. See, e.g., JASON FODEMAN, GALEN INST., THE NEW HEALTH LAW: BAD FOR DOCTORS, AWFUL FOR PATIENTS 2 (2011), available at http://www.galen.org/assets/NewHealthLaw_BadForDoctors_AwfulForPatients.pdf (arguing that the ACA will decrease physician autonomy, increase bureaucracy, and reduce satisfaction, thus causing older doctors to retire and younger doctors to switch careers).

their attitudes toward ACOs have been no exception.¹¹¹ As Victor Fuchs and Leonard Schaeffer observe, “physicians’ traditional emphasis on autonomy runs counter to the standardization, group decision making, measurement of outcomes, and peer review that are important for the success of ACOs.”¹¹² Ensuring that physicians are on board with their ACOs’ missions is critical if ACOs are to be successful.¹¹³ Money alone may be insufficient where other interests work at cross-purposes with the goals that ACOs are intended to further.¹¹⁴

The practical changes that ACOs would like affiliated health care providers to make will likely be a major point of conflict. This returns us to the role of CPGs. ACOs, like many other health care entities, encourage—if not expect—participating physicians to practice pursuant to guidelines developed and promulgated either in-house or by independent organizations.¹¹⁵ Physician adherence to guidelines is variable.¹¹⁶ Researchers have found adherence to depend on a variety of factors, including simplicity of comprehension and use, clarity of the guidelines’ scientific basis, and involvement by the targeted professionals in guideline development.¹¹⁷ Eliciting adherence can be even more problematic when

111. While ACOs have hardly precipitated a backlash of the sort seen concerning the rise of managed care or the sustainable growth rate in Medicare and while many physicians have been interested in participating in ACOs, other physicians have been more skeptical. *See, e.g.*, Daniel H. Johnson, Jr., *Patient Beware of Accountable Care Organization*, WASH. TIMES, (Oct. 27, 2010), <http://www.washingtontimes.com/news/2010/oct/27/patient-beware-of-accountable-care-organization/?page=all>.

112. Victor R. Fuchs & Leonard D. Schaeffer, *If Accountable Care Organizations Are the Answer, Who Should Create Them?*, 307 J. AM. MED. ASS’N 2261, 2262 (2012).

113. *See* HOWARD FREDRICK HAHN & TORRI A. CRIGER, ACCOUNTABLE CARE ORGANIZATIONS: PHYSICIAN PARTICIPATION REQUIRED, AHLA CONNECTIONS 25 (Jan. 2011), http://www.huschblackwell.com/~media/Files/BusinessInsights/BusinessInsights/2011/01/Accountable%20Care%20Organizations%20Physician%20Partici_/Files/Accountable%20Care%20Organizations%20Physician%20Partici_/FileAttachment/1101_AHLA.pdf.

114. *See id.* at 29 (explaining that education, customization, and addressing medical culture are needed to foster success in an integrated organization); MILLER, *supra* note 105, at 15 (noting problems in aligning the interests of primary care physicians and hospitals in ACOs).

115. *See* 42 C.F.R. § 425.122(b)(1) (providing in relevant part that ACOs “must define, establish, implement, evaluate, and periodically update processes to . . . promote evidence-based medicine[;] . . . [d]evelop an infrastructure for its ACO participants and ACO providers/ suppliers to internally report on quality and cost metrics that enables the ACO to monitor, provide feedback, and evaluate its ACO participants and ACO provider(s)/supplier(s) performance and to use these results to improve care over time . . . [; and] [c]oordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers.”). For examples of clinical practice guidelines promulgated by various entities, *see National Guideline Clearinghouse*, U.S. DEP’T OF HEALTH AND HUMAN SERVS., www.guideline.gov (last visited Sept. 28, 2013).

116. *See, e.g.*, Mickan, Burls, & Glasziou, *supra* note 72; *see also* McDonnell Norms Group, *Enhancing the Use of Clinical Guidelines: A Social Norms Perspective*, 202 J. AM. C. SURGERY 826, 827 (2006), available at <http://www.jsmf.org/about/s/norms.pdf>.

117. *See, e.g.*, INST. OF MED., *supra* note 56, at 148; Anneke L. Francke, *Organizational and Clinical Factors Influencing Use of Clinical Practice Guidelines*, 8 BMC MEDICAL INFORMATICS

a stakeholder who may financially benefit from their use has developed the guidelines.¹¹⁸ ACOs present this situation.¹¹⁹ Physicians, hospitals, and other providers will, in most cases, continue to be paid as they presently are;¹²⁰ whether or not they receive any shared savings through participation in the ACO depends on whether they and other providers have been sufficiently frugal in their provision of care while meeting quality targets.¹²¹ ACOs may encourage cost saving through the CPGs that they may adopt or promulgate.¹²² This may accordingly increase physicians' skepticism of CPGs.¹²³ Physicians may regard guidelines that prioritize both care coordination and cost control, in addition to quality care, as particularly problematic for the reasons discussed above.¹²⁴ Finally, physicians may be particularly hesitant when following the guidelines will entail a significant deviation from their current practice.¹²⁵ They, and not the ACO, will be the ones ultimately responsible for alleged negligence in adhering to the guidelines, yet cost control is not presently an accepted factor for physicians to consider in the diagnosis and treatment of patients, even though it would only be, at most, a secondary or tertiary factor in a physician's discussion of treatment options.¹²⁶

AND DECISION MAKING 1, 6–7 (2012), available at <http://www.biomedcentral.com/content/pdf/1472-6947-8-38.pdf>.

118. See INST. OF MED., *supra* note 56, at 60–62; see also McDonnell Norms Group, *supra* 116, at 828, 831.

119. Cf. INST. OF MED., *supra* note 56, at 188–89 (noting that the needs of organizations that create guidelines can create conflicts in certain circumstances).

120. See *supra* notes 95–100 and associated text.

121. See *id.*

122. See MILLER, *supra* note 105, at 3 (explaining that ACOs can reduce costs through the use of evidence-based treatment guidelines by promoting a reduction in unnecessary tests, interventions, and medications).

123. Cf. INST. OF MED., *supra* note 71, at 53–69 (noting issues negatively impacting guideline trustworthiness, including conflict of interest).

124. See Cynthia M. Farquhar et al., *Clinicians' Attitudes Toward Clinical Practice Guidelines: A Systematic Review*, 177 MED. J. AUSTL. 502, 505 (2002) (finding, inter alia, that fifty-three percent of physicians surveyed in several countries, including the United States, believed that CPGs were intended to cut costs). But see Marjorie E. Ginsburg et al., *A Survey of Physician Attitudes and Practices Concerning Cost-Effectiveness in Patient Care*, 173 WESTERN J. MED. 390, 393 (2000) (finding that physicians believed that cost-effectiveness of interventions was an appropriate factor to consider in patient treatment determinations).

125. See McDonnell Norms Group, *supra* note 116, at 831–32. Critics of CPGs often deride CPGs as fostering “cookbook” medicine, rather than the practice of medicine as a craft. See, e.g., Stefan Timmermans & Aaron Mauck, *supra* note 64, at 21 (citing O Constantini, KK Papp, J Como et al., *Attitudes of Faculty, Housestaff, and Medical Students Towards Clinical Practice Guidelines*, 74 ACADEMIC MED. 1138 (1999)).

126. See, e.g., Mark A. Hall & Carl E. Schneider, *When Patients Say No (to Save Money): An Essay on the Tectonics of Health Law*, 41 CONN. L. REV. 743, 752–52 (2009) (“For the law to tell poor patients that ‘you get what you pay for’ would mean imposing virtually no lower limit on a doctor's performance. Judges are loath to have tort law ratify the social injustice of unaffordable health care.”).

To the extent that cost concerns are to become relevant in determining the appropriate standard of care, juries in medical malpractice suits will need to start taking cost into account as a relevant consideration.¹²⁷ This will likely take time, given the expert-driven standard of care. In the meantime, providers who are first adopters may run a higher risk of liability for bad outcomes, even if their overall quality of care is superior.¹²⁸ Accordingly, if an ACO wants physicians to buy-in to the standards it adopts or promulgates, it will need to be able to convince physicians that they will not suffer increased liability by following cost- and waste-conscious CPGs that the ACO might promulgate.¹²⁹ Physicians may be skeptical, however. Short of ACOs offering indemnification to physicians for following the CPGs that they adopt, our medical malpractice system would have to change by, for example, permitting CPGs to be used as a shield in malpractice suits. Yet this would, at minimum, entail addressing many of the problems raised by guideline development, choice, and uses that were discussed earlier.¹³⁰

2. Enterprise Liability for ACOs

As a different solution, it may instead be time once again to consider adopting exclusive enterprise liability, at least in the context of ACOs. Enterprise liability would move the locus of liability from physicians and other individual health care providers to the enterprise in which or for which they work.¹³¹ It was most recently suggested in the 1990s, when health maintenance and other managed care organizations were ascending and were conceptualized as the “enterprise” in question.¹³² Although hospitals had originally been proposed as the liability-

127. See, e.g., Christopher Smith, *Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations*, 20 ANNALS HEALTH L. 165, 192–193 (2011) (reasoning that any changes to cost considerations in changing the medical liability standard of care, particularly within the ACO context, will have to await for either statutory enactments or the common law evolution).

128. See Michael D. Greenberg, *Medical Malpractice and New Devices: Defining an Elusive Standard of Care*, 19 HEALTH MATRIX 423, 432–33 (2009) (observing that, while adoption of a new device or technique may come with greater liability exposure at first, it may ultimately become the new standard of care over time).

129. See, e.g., Smith, *supra* note 159, at 194 (arguing that physicians may be concerned that quality standards set by an ACO may not match up with the same quality standards embodied within the standard of care).

130. See *supra* notes 86–96 and accompanying text.

131. See Myron F. Steves, Jr., *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*, 1975 DUKE L. J. 1305, 1324–35 (1975) (suggesting that shifting the legal liability exposure, and the cost of insuring it, from individual practitioners to institutional providers would ameliorate the problem of increasing premiums while at the same time, strengthening incentives to prevent injuries).

132. Kenneth Abraham, Paul Weiler, & William Sage brought the concept into prominence in the 1990s, particularly in the context of the Clinton health reform proposal. See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 436 (1994) [hereinafter *Enterprise Medical Liability*]; Sage et al., *supra* note 41, at 2.

bearer,¹³³ the prospect that a health care system based on managed care would come into being through the Clinton health reform proposal in the 1990s prompted some to suggest that managed care organizations should instead assume liability.¹³⁴ William Sage, Kathleen Hastings, and Robert Berenson argued, for example, that enterprise liability for managed care entities paid through capitation would make managed care entities bear the costs of substandard or inadequate care that they might otherwise be tempted to deliver in an effort to reduce expenses and increase profits.¹³⁵ Managed care plans, they argued, have the ability to coordinate providers, manage health care delivery, and oversee quality, making it both economically and practically efficient for them to bear liability.¹³⁶

The Clinton health reform plan was never enacted, so the health coverage landscape that Sage and his co-authors contemplated did not come into being.¹³⁷ With the ACA, we now have a different landscape.¹³⁸ Health plans are not being asked to tightly manage and oversee care; rather, groups of providers are, via clusters of demonstration projects involving care coordinated through delivery or financing innovations.¹³⁹ ACOs constitute one such demonstration project, and arguably are the best suited of the different proposed models to support a system of enterprise liability.¹⁴⁰ As they must be able to serve a large number of patients and to invest in the tracking and data management services the MSSP requires, their

133. See Steves, *supra* note 132, at 1324–25; see also Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Choice of the Responsible Enterprise*, 20 AM. J. L. MED. 29, 35 (1994).

134. See Sage et al., *supra* note 41, at 11–12.

135. See *id.* at 10–11 (“Because health plans will not be permitted to shed sicker patients through surcharges or other risk-selection strategies they will directly bear the cost of future medical care for enrollees, including additional medical expenses caused by medical malpractice. Future medical expenses comprise about half of economic damages and approximately one-quarter of all damages. By ‘internalizing’ these expenses into the cost of providing health insurance, national health care reform along the lines of the Clinton proposal should induce health plans to design health care delivery systems that balance the risk of undertreatment or mistreatment with the risk of overutilizing services. Enterprise liability would in addition force plans to internalize the other components of malpractice damage awards, lost wages and pain and suffering, thereby requiring a health plan’s quality and efficiency calculus to reflect complete cost information.”).

136. See *id.* at 11–14.

137. See Abraham & Weiler, *supra* note 133, at 38.

138. See, e.g., H. Benjamin Harvey & I. Glenn Cohen, *The Looming Threat of Liability for Accountable Care Organizations and What to do About It*, 310 J. AM. MED. ASS’N 141, 141 (2013).

139. See, e.g., 42 U.S.C. § 1115A(b)(2)(B) (West 2014) (discussing various payment and delivery models that the Center for Medicare and Medicaid Innovation, as established by the ACA, will prioritize when considering projects to fund); 42 U.S.C. § 1395cc-4(a)(1) (West 2014) (establishing the Medicare bundled payment demonstration project); 42 U.S.C. § 256a-1(a) (establishing grants for community-based interdisciplinary teams to support primary care practices).

140. See, e.g., Harvey & Cohen, *supra* note 138, at 141–42 (arguing that enterprise liability is an appropriate solution for ACO health systems).

capitalization is likely to be greater than other, smaller entities.¹⁴¹ The larger ACOS will likely also have sufficient personnel and capacity not only to spread costs more thinly, but also to make use of risk rating.¹⁴² Additionally, as ACOS must collect substantial data regarding provider activities and patient outcomes, the tools and processes necessary to conduct risk rating will already be at their disposal.¹⁴³

Finally, and regardless of any developments with respect to enterprise liability, ACOS will almost certainly face the prospect of liability, whether on their own or in conjunction with other defendants, for alleged medical negligence through their provision of health care.¹⁴⁴ Given that they will likely share exposure at times for their providers' liability, and given the difficulty they may face in eliciting provider buy-in to cost containment and waste reduction measures they may adopt, it may make sense for them to assume the risk from their providers in exchange for better alignment of interests. As discussed above, the success of an ACO depends on the coordinated efforts of multiple different healthcare providers seeking better and more economically efficient health outcomes for patient populations. Choosing partners wisely will be important for ACO participants.¹⁴⁵ However, perhaps even more so than hospitals or even health maintenance organizations, which had originally been proposed as subjects for enterprise liability, ACOS will need to have the capacity to exercise a certain amount of control over participating health care providers in order to more reliably meet quality and cost targets.¹⁴⁶ Given the need for such control, it makes sense that the

141. See, e.g., Sidney S. Welch, *Accountable Care Organizations: Overview*, in *ACOS, CO-OPS, AND OTHER OPTIONS: A "HOW-TO" MANUAL FOR PHYSICIANS NAVIGATING IN A POST-HEALTH REFORM WORLD 17* (Am. Med. Ass'n, ed., 3d ed. 2012), available at <http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf> (noting that significant financial investment required for an ACO's formation and operation requires deep pockets, significantly more so than is usually available to physician participants).

142. For example, Park Nicollet Health Services, one of the Pioneer ACOS, has 8,200 employees, including 1,000 physicians. *Pioneer ACOS*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://data.cms.gov/dataset/Pioneer-ACO/izub-xmpg> (last visited Apr. 29, 2014); *Integrated Network of Care*, PARK NICOLLET, <http://www.parknicollet.com/About> (last visited Apr. 29, 2014).

143. Cf. ROBERT A. BERENSON & RACHEL A. BURTON, HEALTH AFF., HEALTH POLICY BRIEF: NEXT STEPS FOR ACOS 3 (Ted Agres et al. eds., 2012), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_61.pdf (explaining that ACOS performance on numerous metrics is essential to reduce spending and benefit from shared savings bonuses).

144. See Harvey & Cohen, *supra* note 138, at 141 (explaining that ACOS as a health system are exposed to institutional liability for medical malpractice).

145. See, e.g., Managed Healthcare Execs. *State of the Industry 2013: Accountable Care Organizations*, (Oct. 1, 2012), <http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/state-industry-2013-accountable-care-organizations>.

146. See Stephen M. Fatum & Robert M. Martin, *Accountable Care Governance Issues*, at 3-5, in *ACOS, CO-OPS, and Other Options: A "How-To" Manual for Physicians Navigating a Post-Reform World* (Am. Med. Ass'n, 3d ed. 2012); DELOITTE CENTER FOR HEALTH SOLUTIONS, *ACCOUNTABLE CARE ORGANIZATIONS: A NEW MODEL FOR SUSTAINABLE INNOVATION 15* (2010).

enterprise should bear the financial risk of negligent medical errors, rather than the individual practitioners acting as a part of it.¹⁴⁷ Physicians would likely continue to share in the costs of suit by, for example, reimbursing the ACO for what they otherwise would have owed as a premium to their liability insurer.¹⁴⁸ Physicians would not, however, be named targets; rather, the ACO would take that place.¹⁴⁹

Placing the onus of liability on the ACO rather than on participating physicians would accomplish several important goals. First, while juries may, as some have argued, be more likely to award larger damages against a faceless institution with a deeper pocket rather than against an individual physician,¹⁵⁰ many ACOs, by virtue of their size alone, will have better resources than individual practitioners and most physician groups to investigate claims and negotiate with injured patients.¹⁵¹ As such, an ACO would be better situated to have, for example, a “disclosure and offer” program that proactively investigated adverse events and offer prospective compensation to negligently injured patients—a strategy that is financially and administratively out of the reach of most office-based physicians.¹⁵² A prospective system such as this could offer compensation and necessary medical care as reparation to many injured patients who may never have brought a claim in the first place.¹⁵³ In addition, all this would ideally take place in the context of

147. In the case of intentional or reckless harm, ACOs may seek a contractual clause allowing them to seek indemnity from the physician; however, allowing plaintiffs to name a practitioner individually where punitive damages might be sought might encourage excessive punitive damage claims, even if for no other reason than to encourage a fragmented and divisive defense. *See Sage et al.*, *supra* note 41, at 26.

148. *Id.* at 17.

149. *See, e.g.*, Kristie Tappan, *Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform?*, 46 B. C. L. REV. 1095, 1105 (2005).

150. The sentiment is found as far back as 1852, when the court in *Haring v. New-York and Erie Railroad Co.* observed that “We can not shut our eyes to the fact that in certain controversies between the weak and the strong—between a humble individual and a gigantic corporation, the sympathies of the human mind naturally, honestly and generously, run to the assistance and support of the feeble, and apparently oppressed; and that compassion will sometimes exercise over the deliberations of a jury, an influence which, however honorable to them as philanthropists, is wholly inconsistent with the principles of law and the ends of justice.” *But see* Neil Vidmar, *Empirical Evidence on the ‘Deep Pockets’ Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 DUKE L.J. 217, 255 (1993) (finding that juries are not inclined to award disproportionate amounts for pain and suffering when a defendant has a deep pocket).

151. *See* Frank A. Sloan & Mahmud Hassan, *Equity and Accuracy in Medical Malpractice Insurance Pricing*, 9 J. HEALTH ECON. 289, 313–17 (1990); *see also* SLOAN & CHEPKE, *supra* note 19, at 212 (noting that hospitals’ “size, resource, and status as continual defendants” would ultimately “create deterrence and provide incentive to implement systemwide safety measures”).

152. *Cf.* MICHELLE M. MELLO & ALLEN KACHALIA, MEDPAC, EVALUATION OF OPTIONS FOR MEDICAL MALPRACTICE SYSTEM REFORM 36–39 (2010), *available at* http://www.medpac.gov/documents/Apr10_MedicalMalpractice_CONTRACTOR.pdf (describing common elements of disclosure and offer programs, such as rapid investigations of errors and expedited decisions regarding appropriate compensation, and noting that presently such programs are only operated by a “handful of hospitals and liability insurers”).

153. *See id.* at 37 (noting that disclosure programs seek to remedy harm done to patients, even if the harm is not known to a patient or results in no medical-malpractice claim); *see also* Randall

quality improvement, with the ACO better able, after investigation, to take measures to help prevent such occurrences in the future.¹⁵⁴ Transaction costs would be much lower and, if the experience of entities such as the University of Michigan Health System are any indication, having a disclosure and offer program may lower liability costs overall, even presuming that patients retained the right to sue if they were unsatisfied with the ACOs' offer.¹⁵⁵ To be sure, enterprise liability is not required in order to have such a system, but, by transferring liability to the ACO, it could help encourage its formation.

ACOs would be aided in these pursuits by self-insuring or insuring via a captive insurance company, rather than by purchasing coverage on the market.¹⁵⁶ While self-insurance had once been more commonly used by larger health care entities, the use of captive insurers created by one or more business entities (parents) solely to insure the risk of that entity or entities has grown substantially in recent years.¹⁵⁷ The parent pre-funds losses by paying premiums to the captive, which the IRS considers a tax-deductible business expense to the parent.¹⁵⁸ Thus, rather than deducting losses as they are paid, which would be the case under a self-insured model, the parent takes the deduction up-front.¹⁵⁹ Excess premiums can be

R. Bovbjerg & Robert Berenson, *Enterprise Liability in the Twenty-First Century*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 231 (William M. Sage & Rogan Kersh, eds. 2006).

154. See *id.* at 41 (arguing that the disclosure and offer approach will improve patient safety by promoting a culture of transparency and safety, facilitating error reporting, and allowing for "the open discussion of errors so that efforts to improve [patient safety] can be initiated").

155. See Richard Boothman & Margot M. Hoyler, *The University of Michigan's Early Disclosure and Offer Program*, *THE BULLETIN OF THE AM. COLL. OF SURGEONS* (Mar. 2, 2013), <http://bulletin.facs.org/2013/03/michigans-early-disclosure/>.

156. See, e.g., Eleanor D. Kinney, *The Potential of Captive Medical Liability Insurance Carriers and Damage Caps for Real Malpractice Reform*, 46 *NEW ENG. L. REV.* 489, 498 (2012); C. Mitchell Goldman, *Why Physician Groups Are Self-Insuring* (2006), available at <http://www.duanemorris.com/articles/static/goldmanmedpracmgmt0706.pdf>.

157. See Richard M. Colombik, *Captive Insurance Companies for Closely Led Businesses and Their Owners*, 19 *EXPERIENCE* 42, 42 (2009); LEE R. RUSS & THOMAS F. SEGALLA, *CAPTIVE INSURANCE COMPANIES, COUCH ON INSURANCE* § 39.2 (3d ed., 1995); James A. Christopherson, *The Captive Medical Malpractice Insurance Alternative*, 5 *ANN. HEALTH L.* 121, 121–22 (1996); *What Is Captive Insurance – Learn What Captive Insurance Is*, CAPSTONE ASSOCIATED, <http://www.capstoneassociated.com/what-is-a-captive.html> (last visited May 29, 2014). "Rented" and agency captives are also options, but would not offer ACOs the same benefits concerning direction of investigation and insurance activities that captive ownership would.

158. See RUSS & SEGALLA, *supra* note 157, at § 39.2.

159. See *Moving from Self-Insurance to a Captive: How Much is the Potential Tax Benefit Worth?*, MILLIMAN (Aug. 9, 1999), http://www.captive.com/service/milliman/article4_tax.shtml (explaining that under a self-insurance model, the parent company deducts losses as they are paid, but a captive insurance company may be able to "accelerate" the deductions). This provides a modest financial benefit over taking the deduction on the back end; according to one *Milliman* estimate, a company would realize an estimated two percent to three percent in tax savings. *Id.*

held in reserve and invested to fund future losses, or distributed to the parent as profit.¹⁶⁰

Insuring via a captive or via self-insurance permits a parent to direct the policies of the captive.¹⁶¹ This is particularly relevant for ACOs in the context of medical malpractice insurance. If an ACO wanted to employ a disclosure and offer program, as discussed above, it could direct its captive to do so. It could additionally coordinate research on medical errors and quality improvement programs. Captives that do such things and more already exist; Harvard's CRICO, for example, is one such entity.¹⁶²

3. *Enterprise Liability Versus Enterprise Insurance*

Given that many of the innovations discussed above do not require the institution of enterprise liability but instead can be done through our present liability regime, one might ask why one might prefer enterprise liability over, for example, enterprise insurance, where an ACO would simply provide malpractice coverage to its participating physicians through a captive,¹⁶³ self-insurance, or otherwise. Enterprise insurance is widely used by academic medical centers to cover their faculty.¹⁶⁴ It has been less common elsewhere in the health care industry, but that may be in part because physician employment has not been as common outside of academic medicine until more recently.¹⁶⁵ As consolidation continues in the health care sector, it is likely that enterprise insurance will also become more common. Not only does enterprise insurance offer improved financial benefits to larger health care entities with an employed physician staff, but it also allows for better risk- and quality-management.¹⁶⁶

Some have observed that, if enterprise insurance were such an attractive option, it ought to be more widespread now than it is.¹⁶⁷ Among other issues,

160. Retaining profit that otherwise would have accrued to the unassociated insurer is, of course, one of the primary general reasons for insuring via a captive rather than through a traditional insurer. See Colombik, *supra* note 157, at 42.

161. See Philip England et al., *Captive Insurance Companies: A Growing Alternative Method of Risk Financing*, J. PAYMENT SYSS. L. 701, 702 (2007), available at <http://www.andersonkill.com/webpdfext/cic-riskfinancing.pdf>.

162. *Protecting Providers. Promoting Safety.*, CRICO, <https://www.rmhf.harvard.edu/About-CRICO> (last accessed Sept. 28, 2013).

163. See MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 268 (William M. Sage & Rogan Kersh eds., 2006).

164. See, e.g., SLOAN & CHEPKE, *supra* note 19, at 316.

165. Merritt Hawkins' most recent survey of physician recruitment found that, in 2011–2012, sixty-three percent of the firm's search assignments were for hospital employment, up from only eleven percent in 2003–2004. MERRITT HAWKINS, 2012 REVIEW OF PHYSICIAN RECRUITING INCENTIVES, 4 (2012), available at <http://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Pdf/mha2012survpreview.pdf>.

166. See SLOAN & CHEPKE, *supra* note 19, at 316, 318.

167. *Id.* at 319.

enterprise insurance presently makes sense only where physicians are either employed or participate in a closed staff model, so that the enterprise providing the malpractice insurance is also responsible—legally, financially, or otherwise—for all the patients that the covered physicians see.¹⁶⁸ While this would not be the case in an ACO, the strong distinction between “internal” and “external” patients will be diminished. Because an ACO will not know in advance which of its patients will be counted toward the ACO’s performance and which will not, the ACO has an incentive to encourage its participating providers to meet cost and quality metrics for all the patients they see, and not just the “ACO” patients.¹⁶⁹

Yet an ACO’s control over both risk and quality could improve further through assumption of enterprise liability, rather than enterprise insurance.¹⁷⁰ As the ACO would bear the burden of litigation, it would possess not merely institutional authority, but also moral authority for deterring errors and enforcing quality measures.¹⁷¹ This would be particularly important, given that most ACO participants will not provide services exclusively to ACO patients, but also to others, both within and outside the context of the ACO.¹⁷² If an ACO provided only enterprise insurance, it would possess fewer means by which to enforce quality standards for care provided outside the ACO.¹⁷³ Financial means would

168. *Cf.* SLOAN & CHEPKE, *supra* note 19, at 319 (noting that one of the reasons enterprise insurance is not more common is because most physicians are independent and not employed by a hospital).

169. *Cf.* 42 C.F.R. § 425.400(a)(2)(iii) (“Final assignment [of beneficiaries] is determined after the end of each performance year, based on data from the performance year.”); *see also* HOOPER, LUNDY, & BOOKMAN, P.C., ACCOUNTABLE CARE ORGANIZATION FINAL REGULATION: ANALYSIS AND IMPLICATIONS 9 (Oppenheim et al., eds. 2011), available at http://health-law.com/wp-content/uploads/2011/12/HLB_ACO_White_Paper_-_Final_Rule.pdf (“A principal reason given by CMS for retaining retrospective beneficiary assignment is its desire for ACO networks to apply the same efficient and effective approaches to delivering health care to all Medicare beneficiaries, regardless of whether they are ultimately assigned to the ACO. The notion is that if the ACO is not sure whether a beneficiary its providers are treating will be assigned to the ACO, the ACO’s providers will treat all of the beneficiaries under the assumption that they will ultimately be assigned to the ACO, and as a consequence, the Medicare program and all of its beneficiaries will share in whatever benefits are derived from the SSP [shared savings program].”).

170. *See* SLOAN & CHEPKE, *supra* note 19, at 211, 319 (explaining that “enterprise liability potentially allows integration of patient safety activities with medical malpractice insurance, implementing systems-based loss control mechanisms and quality assurance programs,” whereas enterprise insurance, in allowing physician autonomy, “conflicts with the goal of improving patient safety”).

171. *Cf.* Bovbjerg & Berenson, *supra* note 153, at 237 (noting in the context of systems safety that “[w]hat is blameworthy is not the normal human propensity to slips and lapses but the refusal to cooperate with systematic efforts at improvement, which requires disclosure and learning from problems.”); *see also* *Mission, Vision and Values*, MICHIGAN PIONEER ACO (2013), <http://www.michiganpioneeraco.com/?id=14&sid=1> (indicating that ACOs have an ethical and moral obligation to providing patients with the highest care).

172. *See supra* note 169 and associated text.

173. *Cf.* SLOAN & CHEPKE, *supra* note 19, at 315 (describing one of the objections to enterprise insurance as lack of control by hospitals over independent physicians).

still exist: in the shared savings program, the structure provides that ACOs will not prospectively know which of its Medicare patients will be counted in determining costs and quality for shared savings.¹⁷⁴ An ACO could also use risk rating in re-credentialing providers.¹⁷⁵ Yet the degree of coordination that CMS envisioned may require more impetus for success, particularly in convincing physicians to reduce their use of unnecessary tests, medications, and procedures, and in prompting them to work more closely with other providers in the care of individual patients.¹⁷⁶ Enterprise liability would take risk off of physicians in adhering to new standards, while providing ACOs with added leverage in enforcing quality and practice strictures.

One might think physicians would eagerly accept a shift in liability from themselves to another entity.¹⁷⁷ Yet this issue may pose the largest hurdle, at least politically, in a switch to exclusive enterprise liability.¹⁷⁸ In 1993, the Task Force on National Health Reform proposed exclusive enterprise liability as part of the Clinton Health Security Act,¹⁷⁹ with managed care plans as the relevant enterprise. However, physicians vociferously rejected it.¹⁸⁰ According to William Sage and Robert Berenson, among others, the primary problem was physicians' fear of loss of professional autonomy.¹⁸¹ This should not come as a surprise. Here, physicians regard the threat of liability not so much as something to be feared, but rather as leverage to help retain the ability to practice as they see fit. They can cite fear of litigation, should they miss a malignancy, as justification not to follow the recommendations of the U.S. Preventive Services Task Force on breast cancer

174. See *supra* note 169 and associated text.

175. Cf. DELOITTE, ACCOUNTABLE CARE ORGANIZATIONS: A NEW MODEL FOR SUSTAINABLE INNOVATION 16 (2010), available at http://www.deloitte.com/assets/dcom- unitedstates/local%20assets/documents/us_Ch_s_accountableCareorganizations_041910.pdf (discussing risk-management infrastructure).

176. See, e.g., Peter B. Bach, *The Trouble with "Doctor Knows Best,"* N.Y. TIMES, June 4, 2012, at D5.

177. See, e.g., Bovbjerg & Berenson, *supra* note 153, at 229.

178. See, e.g., CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 171–72 (1995) (noting that in response to the Clinton administration's proposal for health plan enterprise liability, the American Medical Association (AMA) and over a hundred medical groups sent a letter opposing the plan).

179. See Health Security Act, H.R. 3600, S. 1757, 103d Cong. § 5311 (1st Sess. 1993).

180. See Bovbjerg & Berenson, *supra* note 153, at 230 (reporting that, in response to Berenson's advocacy of enterprise liability during consideration of the Health Security Act, a physician reportedly said, "I have a constitutional right to be sued, and you can't take it away from me.").

181. See Sage, *supra* note 12, at 170. (noting that organized medicine feared the most that with enactment of enterprise liability, health plans would "micromanage clinical practice"); see also Bovbjerg & Berenson, *supra* note 153, at 230 (explaining that the most important reason for physicians to oppose to the enterprise liability is the loss of professional autonomy, which they also fought against in managed care).

screening or PSA testing.¹⁸² A similar citation can justify the ordering of a screening exercise electrocardiogram on a middle aged, “worried well,” patient, despite the lack of indicating risk factors, even though available evidence clearly suggests the test is unnecessary and ought not to be done.¹⁸³ While the fear of suit may remain a constant and unwelcome presence when liability reposes on physicians, that fear can always also be cited as a justification for broad autonomy in their practice. The ACA’s movements toward determining best practices, and regularizing and coordinating care, while certainly welcome by some practitioners, are in conflict with this ethos.¹⁸⁴

Additional factors might work against such a change. Enterprise liability would not eliminate all suit-driven ills for physicians. On the positive side of the ledger, they would neither face individual liability, nor the rare but extant possibility of financial ruin.¹⁸⁵ Additionally, the institution may act as a beneficial buffer between practitioners and patients in the context of malpractice, making the issue less personal. Yet physicians would still need to expend substantial amounts of time in connection with a lawsuit.¹⁸⁶ The shame factor would also likely still exist in lesser form.¹⁸⁷ Reduced control over conduct of suit and settlement could also become an issue, with a physician’s reputation possibly in the balance.¹⁸⁸

182. See Craig E. Pollack et al., *Primary Care Providers’ Response to the US Preventive Services Task Force Draft Recommendations on Screening for Prostate Cancer*, 172 ARCHIVES INTERNAL MED. 668, 669 (2012) (observing that despite the advice from the U.S. Preventive Services Task Force (USPSTF) against routine prostate-specific antigen (PSA) screening for prostate cancer, one of the barriers to adopting that recommendation is fear of malpractice litigation).

183. See *When to Say ‘Whoa!’ to Your Doctor*, CONSUMER REPS. 12, 13 (June 2012), <http://consumerhealthchoices.org/wp-content/uploads/2012/05/ChoosingWiselyWhoaPkg.pdf> (discussing that doctors sometimes order medical procedures, such as a routine EKG exam, for patients who do not have symptoms of heart disease or are not at high risk of it, and it is pointed out that one of the reasons of these unnecessary tests is to protect themselves from lawsuits).

184. See *supra* notes 139–143 and associated text.

185. See *supra* section II.B.1.

186. See Armand Leone, Jr., *ADR and Enterprise Liability*, BRITCHER, LEONE & ROTH, reprinted in N. J. L. J., Nov 8, 1993, <http://www.medmalnj.com/Legal-Articles-by-Armand-Leone-Jr/ADR-and-Enterprise-Liability.shtml> (last visited October 3, 2013) (explaining that even if an institution, such as a health maintenance organization (HMO), would substitute for individual doctors in a malpractice suit, they would still participate in litigations as fact witnesses).

187. See, e.g., Maxwell Mehlman, *The Shame of Medical Malpractice*, 27 J. LEGAL MED. 17, 26–27 (2006) (noting the feelings of shame that physicians report when patients sue); but see Philip G. Peters Jr., *Resuscitating Hospital Enterprise Liability*, 73 MO. L. REV. 369, 388–89 (arguing that because physicians consider being personally sued for malpractice as a form of punishment, an enterprise liability system would ease this concern as it would eliminate the formal claim against individual physicians and would not require reporting of malpractice to the National Practitioner Data Bank).

188. See Bovbjerg & Berenson, *supra* note 153, at 230 (stating that another reason that physicians resist enterprise liability is a concern that a third party may settle a case of physician liability and potentially impair their reputations).

These hurdles may make enterprise insurance a more attractive, intermediary option.¹⁸⁹ ACOs could insure participating health care providers for all the care that the latter provides in exchange for a risk-adjusted premium. While the preliminary safety and quality data an ACO would have to work with may be limited, it could—and should—easily collect more detailed information over time that it could use to adjust the premium upward or downward, as well as provide practical feedback on quality performance to providers, at least within the context of the ACO.¹⁹⁰ Data from non-ACO patients would not automatically be available to the ACO, but an ACO could require its submission if it wished to use it, or at least a sampling of it, to compare against ACO data.¹⁹¹ The use of risk-adjustment would encourage providers with better safety and litigation records to participate in the ACO, while acting as a disincentive to others.¹⁹² With time, a move to enterprise liability could be considered, if it would help to better align provider interests with measures to improve quality of care and reduce less effective or unnecessary care.

III. CONCLUSION

With the continued movement toward prioritizing the integration and coordination of health care and the use of evidence-based clinical practice guidelines to support improved health care outcomes, enterprise liability should once again be given serious consideration. If done well, it has greater potential than enterprise insurance to enhance patient safety and quality of care, while at the same time facilitating compensation for negligently injured patients. As we implement the ACA, the time may be ripe to give enterprise liability a new try.

189. I am grateful to William Sage for this observation.

190. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH AND HUMAN SERVS., SUMMARY OF FINAL RULE PROVISIONS FOR ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM 4 (2012), available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf (noting that the final rule for ACOs requires them to give timely feedback regarding quality measures to providers for improved quality performance).

191. See AM. ACADEMY OF ACTUARIES, AN ACTUARIAL PERSPECTIVE ON ACCOUNTABLE CARE ORGANIZATIONS 9 (2012), available at http://www.actuary.org/files/ACO_IB_UPDATE_Final_121912.pdf (discussing that for successful care, an ACO needs to collect the data from various sources, including non-ACO providers, because some patients would still receive medical care outside the ACO network).

192. See, e.g., Catherine I. Hanson, *Risk Adjustment*, in EVALUATING AND NEGOTIATING EMERGING PAYMENT OPTIONS 3 (Am. Med. Ass'n. ed., 3d ed., 2012), available at <http://www.ama-assn.org/resources/doc/psa/payment-options.pdf#page=109> (pointing out that without adequate risk adjustment, physicians providing quality of care would be disadvantaged because they attract patients with serious illness, but have to practice under the same budgets with peer physicians who do not treat similar patients).