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A NEW “CATCH 22” FOR MANAGED CARE: ERISA’S FAILURE TO PREEMPT ANY WILLING PROVIDER AND VICARIOUS LIABILITY LAWS CREATES A SERIOUS PROBLEM FOR MANAGED CARE

By Kathryn Leaman*  

I. Introduction
In response to the crisis of increasing health care costs in the 1970s, Congress passed the Health Maintenance Organization Act,1 sparking a health care revolution in which managed care organizations (MCOs) became and remain the dominant form of health insurance in the United States.2 As MCOs gained dominance, physicians realized that they were a prime target in the MCOs’ cost containment strategy.3 Physicians responded by lobbying their state legislatures to enact “any willing provider” (AWP) statutes, which generally require that MCOs allow any physician who meets the MCO’s set requirements and agrees to the payment system, to join the MCOs’ provider network.4 MCOs with plans that fell under the Employee Retirement Income Security Act (ERISA)5 fought back, arguing that ERISA preempted AWP laws, and therefore these MCOs did not have to accept “any willing provider” into their network.6 Importantly, the Supreme Court unanimously held that AWP laws are subject to ERISA’s saving clause, meaning AWP laws are excepted from ERISA preemption and ERISA MCOs must abide by AWP laws.7

Recent circuit court decisions have held that state vicarious liability laws are also not preempted by ERISA, posing an even greater problem for MCOs because they can now be found liable for negligent network physicians even if the physician did not invite the physician into its network.8

This article first assesses how the lack of ERISA preemption for state AWP and vicarious liability laws affects an MCO's ability to control costs, and then argues that subjecting MCOs to both AWP and vicarious liability laws places a huge burden on MCOs because they have to accept “any willing provider” and, at the same time, be ready to bear liability for that provider. Part II discusses how MCOs, AWP laws, and vicarious liability laws generally operate. Part III examines courts’ analysis of ERISA preemption for AWP and vicarious liability laws. Part IV explores the flawed policy MCOs must deal with when subjected to both state AWP and vicarious liability laws. Part V concludes that the lack of ERISA preemption for both state AWP and vicarious liability laws places an undue burden on an MCO’s ability to control health care costs, undercutting the very reason for their existence. Finally, this article recommends that Congress amend ERISA’s preemption provision in order to protect MCOs from vicarious liability suits in states that force MCOs to take any willing provider.

II. Three’s Company: Managed Care, Any Willing Provider, and Vicarious Liability

A. Managed Care
In general, an MCO is a health insurance company that provides a set of health care benefits for a negotiated price. An MCO’s main goal is to provide patients with quality health care while containing costs. MCOs achieve this in various ways, illustrated by the MCO models that have developed over the years, including health maintenance organizations (HMOs) and preferred provider organizations.

i. Health Maintenance Organizations
HMOs are responsible for financing and delivering health care services to an enrolled population. HMOs may refuse to pay for services provided by a non-HMO physician, unless the HMO authorized the treatment before it occurred or in cases of an emergency.9 This policy encourages, if not de facto requires, that all HMO members receive their health care services from HMO physicians.10 HMOs use this arrangement in order to negotiate more advantageous financial terms between the HMO and the physician, usually resulting in capitation payment. Capitation payment is when the HMO pays the physician a set fee per month, based on the characteristics of the HMO’s enrollees, rather than the amount of medical services a physician performs during the month.11 Therefore, HMOs that are able to contract with a select number of physicians to provide services for the HMOs’
beneficiaries are able to negotiate a lower per member per month (PMPM) capitation payment, because physicians are guaranteed payment for a large number of patients, many of whom will not seek services every month. If an HMO is unable to limit the number of physicians in its network, it is less able to negotiate a low PMPM payment because each physician will have fewer patients, meaning lower PMPM payments and a greater risk of patients utilizing health care services each month.

HMO members must choose a primary care physician, also known as the “gatekeeper.” Health care providers control 70 percent of health care spending by providing treatment, ordering tests, and referring patients to health care specialists. Upon realizing this, HMOs sought to minimize the amount of unnecessary services by providing financial incentives to the gatekeeper physician through capitation, capitation withholds, and capitation pools. HMOs reasoned that these financial incentives would be balanced by a physician’s risk of medical malpractice to ensure that a physician provides quality care without any unnecessary spending.

ii. Preferred Provider Organizations (PPOs)
PPOs contract with a select network of physicians to provide health care services for their members. PPOs differ from HMOs in three main ways. First, members of PPOs can choose to receive health care services from a non-network physician. PPOs try to discourage members from seeking health care outside the network by requiring that the member pay a higher deductible than if the member chooses a network physician. While PPOs provide patients with greater access to physicians than HMOs, PPOs still want to maintain a select group of network physicians in order to control costs. The second major difference is that PPOs do not require members to have a primary care (gatekeeper) physician. Finally, physicians in PPOs do not accept capitation risk; rather, the financial risk of paying out more money for medical expenses than the total amount of money initially taken in remains with the insurance company. Since PPOs retain this financial risk, it is even more imperative that they select network physicians wisely because PPO physicians lack financial incentives to provide the highest quality of care at the lowest possible cost.

B. Any Willing Provider Laws
Health care laws are typically made at the state level and not by the federal government. After significant lobbying to prevent MCOs from limiting the number of network physicians, some state legislatures enacted any willing provider laws. Currently, 22 states have AWP laws. In general, AWP laws require that an MCO permit “any willing provider” who satisfies the MCO’s hiring requirements, accepts the MCO’s reimbursement rate, and agrees to the MCO’s utilization guidelines, to join the MCO’s network. AWP laws fit into three categories. First, “freedom of choice” laws require that an MCO reimburse any non-network provider that accepts the MCO’s fee rate for the service rendered. Second, “mandatory admittance” laws require MCOs to accept into its network any health care provider who agrees to the MCOs’ network contract terms. Third, “due process” statutes require that MCOs abide by certain administrative procedures when admitting and terminating a network provider. Regardless of the type, all AWP laws prohibit MCOs from limiting the number of network providers and thus directly contradict MCOs’ cost containment strategies.

C. The Doctrine of Vicarious Liability
All employers risk liability under the doctrine of respondeat superior, which holds the employer liable for an employee’s tortious actions that occur within the scope of employment. The rationales for imposing liability under this doctrine include: (1) a business is best able to balance the benefits and risks of its operations; (2) the employer can anticipate the risk, buy insurance, and pass costs on to consumers; (3) it provides a strong incentive for the employer to control its employees’ actions; and (4) the employer typically has the financial capacity to properly compensate the injured party.

These policy considerations also extend vicarious liability for independent contractors. Under the apparent agency doctrine, an employer can be held liable for an independent contractor’s tortious actions if the injured party reasonably, but mistakenly, believed that the independent contractor was a direct employee of the employer.

Because MCOs typically hire health care providers as independent contractors, rather than employees, respondeat superior is rarely applied to MCOs. However, recently, courts found MCOs liable for their health care providers’ negligent actions through the doctrine of apparent agency. In order to establish an apparent agency claim, the plaintiff generally must show: (1) the MCO held itself out as the health care provider without informing the patient that the provider is an independent contractor; and (2) the plaintiff justifiably relied upon the MCO’s actions by looking to the MCO, rather than the physician, to provide health care services.

With the lack of clear guidance on how MCOs should adequately inform its members of a health care provider’s employment status and the courts’ reluctance to leave a wrongly injured plaintiff without
compensation, it is even more imperative that MCOs carefully select their network physicians in order to reduce the risk of liability and maintain cost-effective business operations.

IV. How the Courts Decided that State AWP and Vicarious Liability Laws Were Not Preempted

Congress enacted ERISA in 1974 in order to establish a national standard for employer-sponsored pension and benefit plans, thereby making it easier for large companies to provide benefits to their employees because the plans are no longer subject to 50 different state’s regulations. ERISA accomplishes this simplification with administrative ease by preempting any state law that relates to a self-insured employee benefit plan, including health insurance. ERISA’s preemption analysis begins with whether the state law in question “relates to” an employee benefit plan. The Supreme Court held that “relates to” should be understood in a broad commonsense way. A state law “relates to” an ERISA plan, “if it has a connection with or reference to a welfare benefit plan.”

Secondly, the court determines whether the state law falls under ERISA’s savings clause and is thus saved from preemption. Congress added the savings clause in order to harmonize ERISA with the McCarran-Ferguson Act of 1945. In essence, a state law that regulates the business of insurance is “saved” from ERISA preemption and thus an ERISA MCO is subject to state insurance laws. If, however, a state law does not regulate the business of insurance, then it falls outside the limited scope of ERISA’s savings clause and remains preempted. To determine whether a state law regulates the business of insurance, the Supreme Court recently repudiated a test of McCarran-Ferguson factors and announced two requirements, the state law must: (1) be “specifically directed toward” insurance entities; and (2) “substantially affect the risk pooling arrangement between the insurer and insured.”

The final step of ERISA preemption analysis requires courts to decide whether a state law “deems” that an employer providing a self-insured employee benefit plan to employees is an insurer. ERISA’s deemer clause is an exception to the savings clause, thus, even if the state law regulates the business of insurance, it can still be preempted by ERISA. In general, the deemer clause ensures that employers who self-insure are exempted from state insurance regulations. ERISA’s complicated preemption analysis establishes a heavy burden on plaintiffs seeking to avoid ERISA preemption and bring state law claims against an ERISA MCO, but recent decisions show the courts’ willingness to chip away at ERISA’s broad preemption power.

A. ERISA Fails to Preempt State AWP Laws

The increasing prominence of state AWP laws and confusion among the circuit courts as to whether ERISA preempted these laws led the Supreme Court to settle the issue in Kentucky Association of Health Plans Inc. v. Miller. In this case, several Kentucky HMOs sued Kentucky’s Commissioner of Insurance, Mr. Miller, claiming that ERISA preempted Kentucky’s AWP laws and therefore these laws did not govern the HMOs. The HMOs believed Kentucky’s AWP laws related to the plan because they impaired the HMOs’ ability to limit the number of providers in their network, thereby reducing their ability to assure in-network physicians high patient volume in exchange for discounted service rates, leading to higher health care costs for patients.

The Supreme Court did not address the first prong of ERISA preemption analysis, letting stand the Sixth Circuit’s affirmation of the District Court’s analysis that Kentucky’s AWP laws “relate to” ERISA employee welfare plans. The District Court reasoned that since Kentucky’s AWP laws defined “health benefit plans” to include, among other things, “a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA,” that the AWP laws “refer to” and thus “relate to” an ERISA plan.

The Supreme Court began its ERISA preemption analysis with the savings clause. The HMOs had argued that Kentucky’s AWP laws fell outside ERISA’s saving clause because the laws were not directed at the insurance industry and did not regulate an insurance practice. The Supreme Court found neither argument persuasive, noting that Kentucky’s AWP laws only come into effect when a health insurer or a health benefit plan excludes a provider from its network, and thus Kentucky’s AWP laws are directed toward the insurance industry. Furthermore, the fact that the Kentucky AWP laws prohibit health insurance plans from discriminating against any willing provider imposes conditions upon the business of insurance, and, therefore, regulates the business of insurance.

The Court then looked to whether the state law substantially affected the risk pooling arrangement between the insurer and insured. The Supreme Court reasoned that AWP laws
affect risk pooling arrangements because they expand the number of potential providers and restrict the scope of legal contracts between insurers and insured because Kentucky patients can no longer seek health care from closed network HMOs in exchange for a lower premium. \(^6\) For these reasons, the Supreme Court concluded that ERISA did not preempt Kentucky’s AWP laws and that the HMOs were subject to their requirements. \(^6\)

**B. Circuit Courts Hold ERISA Fails to Preempt State Vicarious Liability Laws**

i. United States Court of Appeals, Tenth Circuit

The Tenth Circuit was one of the first circuits to hold that ERISA fails to preempt state vicarious liability claims. In *Pacificare of Oklahoma v. Burgess*, Ms. Schachter brought suit against Pacificare, an HMO, on behalf of Ms. Davidson’s surviving children alleging that it was vicariously liable for the physician’s negligent care when he released Ms. Davidson from the hospital while she was still bleeding internally; and she later bled to death at home. \(^5\) The Tenth Circuit found that issues of the physician’s negligence and the HMO’s apparent agency could be assessed without referencing the plan and therefore did not “relate to” an ERISA plan. \(^6\) Additionally, the vicarious liability claim did not involve a claim for benefits, a claim to enforce rights under the benefit plan, or a challenge to the administration of the plan, and thus the malpractice action was too remote to find that it relates to an ERISA plan. \(^6\) The Tenth Circuit further noted that “just as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO held out the doctor as its agent.” \(^6\)

ii. United States Court of Appeals, Third Circuit

The Third Circuit has held that ERISA fails to preempt state vicarious liability claims when the complaint concerns the quality, rather than the quantity, of the benefits provided by the ERISA HMO. \(^5\) In *Lazorko v. Pennsylvania Hospital*, Mr. Lazorko alleged that the HMO was vicariously liable for its physician who negligently refused to re-hospitalize Mrs. Lazorko, at her request, after her suicidal thoughts returned. \(^5\) Mrs. Lazorko later committed suicide. \(^5\) The Third Circuit concluded that Mr. Lazorko’s vicarious liability claims failed to “relate to” an ERISA plan because the financial incentives placed on the physician by the HMO affected the quality of care provided, rather than the type or quantity of benefits provided. \(^5\) Because Mr. Lazorko’s allegations concern the propriety of care, rather than the administration of care, the vicarious liability claim was not preempted. \(^6\)

iii. United States Court of Appeals, Seventh Circuit

The Seventh Circuit took a more circuitous route in finding no ERISA preemption when, in *Rice v. Panchal*, the court found ERISA failed to preempt the plaintiff’s vicarious liability claim against the plan after the plaintiff became seriously handicapped due to alleged physician negligence. \(^5\) In this case, the court began its analysis with the well-pleaded complaint rule, and found that the plaintiff’s *respondeat superior* claims did not rest on the ERISA plan because: (1) the plaintiff never asserted that he failed to receive benefits due to him under the plan; (2) the plaintiff did not argue that the ERISA plan guaranteed malpractice-free services; and (3) the plaintiff failed to claim that the plan was negligent in selecting its in-network physicians. \(^5\)

In finding that the ERISA HMO was liable under *respondeat superior*, the court did not find the need to utilize ERISA, thereby preventing preemption of the *respondeat superior* claim. \(^6\) In order to determine whether the ERISA plan held the physicians out as its agents, the court must to look to the plan as evidence of the agency relationship. \(^6\) However, the alleged apparent agency did not “rise and fall” with the plan, since the plaintiff could present other evidence of apparent agency without solely relying on the plans’ representations. \(^7\) The plaintiff’s *respondeat superior* claim was remanded back to state court for further proceedings. \(^2\)

**IV. Caught Between a Rock and a Hard Place: MCOs Cannot Choose Their Doctors, but They Can Be Liable for Any Doctor’s Negligence**

In granting ERISA broad preemption power, Congress intended to subject national health plans to a single body of law rather than 50 variations. However, it appears that courts are becoming more reluctant to apply broad preemption power. \(^3\) Not only are ERISA plans now subject to 22 AWP laws, they are increasingly subject to an individual state’s vicarious liability laws. The irony of these legal impositions becomes clear only after examining the policy reasons behind vicarious liability.

First, the idea of enterprise liability links the benefits and risks of running a business. \(^4\) However, health care is unlike any other business in that it concerns people’s lives. It is difficult to make purely economic or business decisions because one cannot ignore the fact that denying, delaying, or encouraging more cost-efficient medical care could cause that person to die, leading to anger, resentment, and, in some cases, a lawsuit. \(^5\)

Second, the employer can anticipate the risk, buy insurance, and pass costs on to consumers. \(^6\) In a closed provider network, the health plan can choose physicians who present the least amount of risk for the plan. \(^7\) However, AWP laws require health plans to take
any willing provider, regardless of the risk the provider poses to the plan, undermining this rationale of apparent agency. While it is true that many AWP laws allow a health plan to establish criteria that a physician must meet in order to be a “willing provider,” such as board certification or having no prior medical malpractice lawsuits, these are poor indicators of whether a physician is likely to be sued. Many physicians settle malpractice claims because the costs of successfully defending against the lawsuit often may not be worth it. Moreover, most physicians carry malpractice insurance and thus are better equipped to assess the risk they pose to their own patients. If MCOs continue to be held liable for negligent physicians that must be allowed into their networks, health care costs will inevitably rise, undermining the entire cost-saving purpose of MCOs.

Third, vicarious liability provides a strong incentive for the employer to control employees’ actions. While this is especially true for MCOs, as they are put in the position of needing to exert more control over providers in order to contain costs, physicians are pushing back, demanding that MCOs exert less control. Therefore, vicarious liability laws further strain the MCO-physician relationship and undermine the primary goal of providing quality health care at a low cost.

Finally, the employer typically has the financial capacity to properly compensate the injured party. As mentioned, physicians typically are able to compensate an injured patient through their own malpractice insurance. In addition, an insurance company can more accurately assess and underwrite the risk of individual physicians than it can assess and underwrite the risk of an entire network of providers.

V. Conclusion

While courts need to follow the law, they must also realize that the law does not operate in a vacuum. Congress expressly desired ERISA plans to be subject to a single body of federal law, not 50 various state laws, in order to ease administration and control the costs of health care. However, as courts chip away at the broad power of ERISA preemption, they are creating an unrealistic environment for MCOs to operate in. What other industry is required by law to accept any supposedly qualified employee and then be held liable when that employee, who the employer never wanted to employ in the first place, acts in a negligent manner? MCOs have two options: (1) cut the number of benefits covered; or (2) raise the premiums rates for each patient. In the end, both solutions place the financial burden on the patient, completely contradicting the reason for establishing MCOs in the first place.

In order to avoid this, Congress should amend ERISA expressly to preempt state vicarious liability laws in states with AWP laws. This proposal strikes a delicate balance by allowing patients to hold MCOs liable for a negligent physician selected by the MCO, while not forcing liability on MCOs for negligent network physicians who were allowed into the network only by virtue of an AWP law.

1 See 42 U.S.C. § 300(c) (2006).
3 See James W. Childs, Jr., You May Be Willing, But Are You Able?: A Critical Analysis of “Any Willing Provider” Legislation, 27 Cumberland L. Rev. 199, 204 (1996-97) (discussing how MCOs realized long-term cost savings could only be achieved if provider networks were limited to physicians who practiced cost-effective medicine).
4 See, e.g., Idaho Code Ann. § 41-3927 (2006) (mandating that any MCO be “ready and willing” to contract with all “qualified providers” so long as the provider is qualified, desires to become part of the MCO network, meets the MCO’s hiring requirements, and practices within the MCO’s geographical region).
6 See Ky. Ass’n of Health Plans v. Miller, 538 U.S. 329, 333-34 (2003) (rejecting petitioner’s claims that AWP laws were not specifically directed toward the insurance and did not regulate the insurance industry).
7 See id. at 342.
8 See, e.g., Lazorko v. Pa. Hosp., 237 F.3d 242, 249 (3d Cir. 2000) (holding that plaintiff’s state vicarious liability claims against her HMO were not preempted by ERISA and therefore the HMO could be held liable for the negligent acts of its network physician).
10 See Malcolm Gladwell, The Moral-Hazard Myth, The New Yorker, Aug. 29, 2005 at 44 (citing that the number one cause of bankruptcy in America is unpaid medical bills).
11 See Kogstvedt, supra note 9, at 106-08 (explaining that the capitation payment for each member per month (PMPM) depends on the age and sex of each member, and the actual PMPM payment to a physician may vary from month to month as the age and gender demographics of the enrolled population change).
12 See id.
13 See id.
15 See id. at 565.
16 See Kogstvedt, supra note 9, at 110-11 (explaining how capitation works as an incentive for physicians to make fewer referrals or provide fewer institutional services).
17 See id.
18 See id. at 20.
19 See id. at 110-11
20 See id. at 21 (noting that PPOs typically contract with select providers based on his/her cost-efficient practices, community reputation, and scope of services).
21 See id. at 7-8.
22 See id. at 7.
23 See Sharon Reece, Puncturing the Funnel – Saving the “Any Willing Provider” Statutes from ERISA Preemption, 27 U. Ark. Little Rock L. Rev. 407, 412 (2005) (citing that providers argued that MCOs’ restrictions on provider selection resulted in patients having limited choices, long travel times to see a provider, and restrained competition among).
24 See Rich & Erb, supra note 2, at 261.
25 See Bahr, supra note 14, at 568-69.
26 See id. at 569.
27 See id.
28 See id. at 570.
30 See generally, DANIEL S. KLEINBERGER, AGENCY, PARTNERSHIPS, & LLC’S 86-87 (2d ed. 2002).
31 See RESTATEMENT (SECOND) OF AGENCY § 220 (2006) (distinguishing a servant from an independent contractor based upon the employer’s ability to control the servant’s physical conduct in the performance of the employer’s services).
32 See id. at § 267.
33 See id. at § 219 (requiring that the employee be a servant rather than an independent contractor in order for liability to attach).
34 See, e.g., Petrovich v. Share Health Plan of Ill. Inc., 719 N.E.2d 756, 766 (Ill. 1999) (holding an HMO may be held liable for its independent contractor’s negligent actions).
35 See id.
36 See Aaron S. Kesselheim & Troyen A Brennan, The Swinging Pendulum: The Supreme Court Reverses Course on ERISA and Managed Care, 5 YALE J. HEALTH POL’Y & L. & ETHICS 451, 454 (2005).
40 See 29 U.S.C.S. § 1144(b)(2)(A) (2006) (explaining that “nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance”).
42 See Reece, supra note 23, at 415.
44 See 29 U.S.C.S. § 1144(b)(2)(B) (2006) (explaining that “[n]either an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies (c)).
45 See Bahr, supra note 14, at 573.
46 See, e.g., Miller, 538 U.S. at 342 (holding that ERISA failed to preempt Kentucky’s AWP law); Lazorko v. Pa. Hosp., 237 F.3d at 249-51 (finding that ERISA failed to preempt the state vicarious liability claims).
47 538 U.S. 329.
48 See id. at 332-33.
49 See id.
50 See Ky. Ass’n of Health Plans Inc. v. Nichols, 227 F.3d 352, 359 (6th Cir. 2000), aff’d Miller, 538 U.S. at 332.
51 See id at 227 F.3d at 359.
52 See Miller at 334.
53 See id.
54 See id. at 335.
55 See id. at 338 (emphasizing that ERISA’s savings clause is not concerned with how to characterize insurance conduct, but how to characterize state law with respect to what they regulate).
56 See id. at 338-39, 342.
57 See id. at 342.
58 See 59 F.3d 151, 155 (10th Cir. 1995).
59 See id. at 154 (noting that to determine if the physician was negligent the relevant evidence is what transpired between the patient and physician and whether the physician’s actions breached the standard of care).
60 See id.
61 See id. at 155.
63 See 237 F.3d at 245-46.
64 See id.
65 See id. at 249-50.
66 See id. at 250.
67 See 65 F.3d 637, 638-39 (7th Cir. 1995).
68 See id. at 642.
69 See id. at 645.
70 See Lawrence E. Smart, Tort Reform, Presentation for Physician Insurers Association of America (Feb. 23, 2005) (noting that the mean settlement amount was just less than half the mean cost of a physician successfully defending himself/herself against suit).
71 See id.
72 See id. at 646.
73 Compare Kesselheim & Brennan, supra note 36, at 454, with Petrovich, 719 N.E.2d at 766.
74 See generally, KLEINBERGER, supra note 30 at 86.
76 See generally, KLEINBERGER, supra note 30, at 87.
78 See Steven Lubet, Like a Surgeon, 88 CORNELL L. REV. 1178, 1189-90 (2003) (noting that a surgeon’s book argued that physicians are sued in a bell curve fashion, generally not indicative of how “good” or “bad” the physician is).
79 See Lawrence E. Smart, Tort Reform Presentation, Physician Insurers Association of America, Feb. 23, 2005 (noting that the mean settlement amount was just less than half the mean cost of a physician successfully defending himself/herself against suit).
80 See id.
81 See generally, KLEINBERGER, supra note 30, at 87.
82 See Carl F. Ameringer, Devolution and Distrust: Managed Care and the Resurgence of Physician Power and Authority, 5 DePaul J. HEALTH CARE L. 187, 203 (2002) (explaining that the best physicians are beginning to leave managed care to start their own concierge services for those who can afford it).
83 See generally, KLEINBERGER, supra note 30, at 87.
84 See Smart, supra note 79.
85 See Lubet, supra note 78.