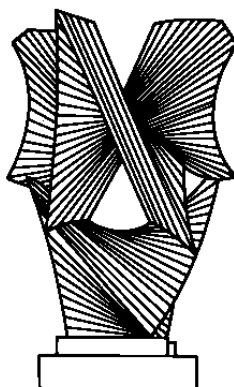


CHICAGO

JOHN M. OLIN LAW & ECONOMICS WORKING PAPER NO. 112
(2D SERIES)



THE ASSAULT ON MANAGED CARE: VICARIOUS LIABILITY, CLASS ACTIONS AND THE PATIENT'S BILL OF RIGHTS

Richard A. Epstein and Alan O. Sykes

This paper can be downloaded without charge at:

The Chicago Working Paper Series Index:
<http://www.law.uchicago.edu/Publications/Working/index.html>

The Social Science Research Network Electronic Paper Collection:
http://papers.ssrn.com/paper.taf?abstract_id=253328

The Assault on Managed Care: Vicarious Liability, Class Actions and the Patient's Bill of Rights

by

Richard A. Epstein* and Alan O. Sykes**

The purpose of this paper is to offer an evaluation of recent legal initiatives targeting managed care organizations (MCOs) for their allegedly deficient supply of health care to their consumers. These MCOs--which tend to inject the provider of health care coverage into decisions over the type and amount of health care services provided--have grown in number, size and market penetration since the 1980s. Speaking in the round, the best explanation for their success is that they have responded to the serious shortfalls in the earlier private regimes for delivery of health care insurance, namely, the use of indemnity insurance contracts that required the insurer to reimburse the designated health care provider on a fee-for-service basis. That arrangement created strong incentives for the formation of a physician/patient alliance to increase the level of health care consumed above and beyond levels that would be regarded as cost-justified in the absence of a third party provider. It is far easier to demand services, which at the time of delivery are paid for by others, rather than by one's self.¹

The rise of the MCO responded to these structural weaknesses of the indemnity insurance model. The efficiency gains came not from substituting a flawless alternative to fee-for-service, but from substituting smaller contracting problems for larger ones. And the market penetration of the MCO suggests that its organizational structure is better tailored to the control of risk, to the introduction of new technology, and to the management of a patient base than the prior alternatives.

Yet so long as MCOs assume the care of millions of people, the law of large numbers warns us to expect legal disputes between patients and their MCO. Medical services are difficult to monitor and on specified occasions may easily go astray. Bad outcomes could be attributable to hopeless medical situations, to callous indifference of health care providers, or to a simple want of

* James Parker Hall Distinguished Service Professor of Law, The University of Chicago.

** Frank and Bernice Greenberg Professor of Law, The University of Chicago. We thank Robert Alt for excellent research assistance.

¹ For a basic account of the problem, see Patricia Danzon, Tort Liability: A Minefield for Managed Care? 26 J. Legal Stud. 491 (1997); Richard A. Epstein, Managed Care Under Siege, 24 J. Medicine & Phil. 434 (1999).

ordinary care under the circumstances. In this environment, the greater control over patient care exerted by MCOs has invited greater assaults on the activities of MCOs. The modern attack on them takes place along two key dimensions.

First, in the most conspicuous recent developments, injured plaintiffs have to come rely on theories of vicarious liability and negligence to reach not only the hospital or physicians group that employs the individual physician, but also the MCO responsible for the selection, management and payment for medical services delivered by physicians and hospital groups. These individual lawsuits brought against these MCOs fall into two broad categories. The first category involves claims for personal injuries that arise out of the delivery of medical services. In these suits, the plaintiff alleges that his condition was brought about by, or worsened by, the MCO's decision, often made on cost grounds, to deny or limit some treatment that the treating physician had recommended for the patient. Sometimes, these suits allege negligence on the part of both the individual physician and the MCO that oversaw its action. At other times, the allegations of negligence are directed solely to the physician in question. The MCO is joined as a defendant either on the ground that it held out the physician as its employee or exerted sufficient control over his activities so as to treat the physician not an independent contractor, but as an employee.² These suits are brought under state law, where the plaintiffs assert that the defendants are not entitled to refuge under the so-called ERISA preemption doctrine that otherwise prevents medical malpractice actions from being brought against the administrators of medical health plans.

Side-by-side with the expanded set of malpractice and coverage actions against MCOs is a fresh onslaught of class actions. Typically, these suits do not allege any medical malpractice toward class members. Rather, they seek to attack as a business and financial matter the entire range of practices that MCOs institute in order to control the cost of care in medical cases. As is the habit today, these suits are not only based on common law theories of breach of contract, fraud and nondisclosure, but they also escalate the struggle by including counts that might allow punitive damages and attorney's fees—counts that allege racketeering under both RICO (the Racketeer Influenced and Corrupt Organizations³ and ERISA (the Employee Retirement and Income Security Act)⁴. The filing of these lawsuits is often accompanied by an extensive publicity and public relations campaign, much of which is directed to the stock analysts. As was the case with the tobacco litigation, the purpose of these suits may be not so

² For a recent illustration involving both theories, see *Petrovich v. Share Health Plan, Inc.* 719 N.E.2d 756 (Ill. 1999).

³ 18 U.S.C. §§1961-68.

⁴ 29 U.S.C. §1001 *et. seq.*

much to win a jury verdict, but to inflict sufficient interim reputational damages so as to create the climate for an industry-wide settlement that both alters standard medical practice, and places a tidy sum of wealth in the hands of the plaintiffs' lawyers who initiated the suit.

This paper intends to evaluate these two legal movements. In order to do so it is necessary to state the benchmark against which this evaluation will take place. Here our basic position is that most of the maneuvers involved in these attacks on managed care are inconsistent with the basic legal theories that define (a) the contract/tort boundary, (b) the principles of vicarious liability and (c) the proper role of class action as a procedural device to amalgamate individual claims that would otherwise not be brought. The first part of that analysis begins with the proposition that the undisputed place for the law of torts is in the prevention of harms that one person (or organization) inflicts on strangers—that is those persons with whom it has no ongoing business relationships, or any convenient opportunity of establishing one prior to some harmful encounter. Typical illustrations of this relationship is the hunter whose stray bullet kills or injures an innocent bystander, the railroad whose sparks destroy a nearby farmhouse, or the factory whose pollution causes widespread physical damage to streams and the fish that swim in them. In these cases, the unregulated actor is able to internalize all of the gain, but is forced to bear only part of the loss associated with its activity. The upshot is that these actors will on average engage in too much risky activity. Only if forced to bear the losses inflicted on others will they monitor activities that they undertake and the care used in undertaking them.

The principles of tort law have another component that deals with the role of the plaintiff. In the ordinary stranger case, the plaintiff's own action sometimes helps to bring about the harm, at which point a defense of contributory negligence could allow the defendant to bar or reduce the recovery in question. In non-stranger cases, the potential plaintiff, having a prior relationship with the potential defendant, may wish to anticipate the possibility of harm and enter into some kind of advance agreement that allocates the risk of loss before it occurs. To be useful, such agreements must have the capacity to override the legal default rules that would otherwise apply. But the dominant legal position today often tends to disfavor or disallow these deviations.⁵

On our view of the world, however, the entire area of medical services should be understood as involving a network of contracts and should not

⁵ See, e.g., *Tunkl v. Regents of University of California*, 383 P.2d 441 (Cal. 1963). The literature on this issue is enormous. See generally, Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, 49 *Law & Contemp. Problems*, 1 (1986).

unthinkingly invoke the norms of tort law in stranger cases.⁶ The key inquiry is whether something in the process of contract formation, or in the structure of the health care industry, precludes the use of the standard market principle that binds parties, regardless of personal status or social station, by agreement. Our position cuts against the received wisdom, and much of the difficulty that we have with the recent attacks on managed care stems from the refusal of courts and legislators to allow contract to dominate tort rather than the other way around.

Part I of this paper looks at the individual lawsuits against MCOs with reference to the principles of vicarious liability and to the question of what, if anything, displaces the primacy of contract in this area. Part II then extends the analysis to the special wrinkles introduced by class actions.

I. The Liability of Managed Care Organizations

In this section, we lay out the existing law governing the liability MCOs, and examine certain prominent proposals to expand its scope. We then discuss the wisdom of the current law and the proposed alternatives for policing managed care.

A. The Legal Landscape

Although individual arrangements may vary, MCOs usually contract with employers and occasionally individuals to provide a bundle of health care services for a predetermined fee. In some instances, the MCOs employ salaried health care professionals to deliver these services. In other instances, health care services are delivered through a network of independent contractors (such as the typical preferred provider network).⁷

Two principal types of disputes arise between MCOs and the patients covered by them. First, patients may complain that their physicians have made errors in their treatment -- conventional claims of malpractice. Second, patients may complain that their MCO has denied coverage that it is contractually bound to provide. Although complaints about malpractice and improper denial of coverage are conceptually distinct, in practice they sometimes blend together. The refusal of an MCO to provide an expensive treatment that might have

⁶ For the early defense of this position, see Richard A. Epstein, *Medical Malpractice: The Case for Contract*, [1976] *Am. Bar Found. J.* 87; see also, Patricia Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (1985); Clark C. Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform* (1995).

⁷ See, e.g., *Petrovich v. Share Health Plan of Illinois, Inc.*, 719 N.E.2d 756, 763-64 (Ill. 1999) (citing 215 Ill. Comp. Stat. 125/1-2(7) (LEXIS through Public Act 91-712) (defining "Independent Practice Association" Health Maintenance Organizations (HMOs) as "financing entities that arrange and pay for health care by contracting with independent medical groups and practitioners.")).

improved the patient's outcome, for example, may be characterized as a failure of its physicians to live up to the industry standard of care (malpractice), or as an erroneous refusal to provide proper coverage, perhaps on grounds that the treatment was not "medically necessary" or was "experimental."⁸ The legal remedies available to patients in these disputes involve a complex amalgam of state and federal law.

1. MCO Liability for Physician Malpractice

Lawsuits against physicians alleging medical malpractice are governed by state tort law. The plaintiff must show that the physician was "negligent"—usually, a failure of the physician to provide the treatment that a reasonable practitioner with comparable medical training would have provided under the circumstances.⁹ Successful plaintiffs can recover the standard array of damages in personal injury cases, including medical expenses, lost wages, damages for loss of consortium, damages for pain and suffering, and statutory wrongful death damages. In egregious cases, punitive damages may be recovered, although punitive awards are rare in medical malpractice actions.¹⁰

If a physician who is found liable for medical malpractice is a salaried employee of a hospital or medical center, the doctrine of respondeat superior allows the plaintiff to obtain a judgment against the employer as well. Such liability is often termed "vicarious liability." Even if the physician is an independent contractor, the associated hospital or medical center may be vicariously liable for the physician if an argument can be made that the hospital misled the public into believing that the physician was its employee.¹¹ The

⁸ See, e.g., *Pegram v. Herdrich*, 120 S. Ct. 2143, 2155 (2000) (noting that all the petitioner's allegations target medical necessity determinations).

⁹ Minnesota's Jury Instruction Guide provides a typical example of this standard: "a doctor must use that degree of skill and learning which is normally possessed and used by doctors in good standing in a similar practice in similar communities and under like circumstances." 4 Minnesota District Judges Association Committee on Jury Instruction Guides, *Minnesota Practice* § 425 G-S (2d ed. 1974), approved in *Kalsbeck v. Westview Clinic, P.A.*, 375 N.W.2d 861, 868 (Minn. App. 1985).

¹⁰ In a survey of Cook County, for example, there was only one punitive damage award for medical malpractice from 1960 – 1984. See Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?*, 140 U. Pa. L. Rev. 1147, 1256 (1992) (citing Mark A. Peterson, et al., *Punitive Damages, Empirical Findings* 13 (1987)). See also, Theodore Eisenberg, et al., *The Predictability of Punitive Damages*, 26 J. Legal Stud. 623, 637 (1997): "[P]unitive damages are most frequently awarded in the areas of law where breach of a legal duty suggests intentional or morally flawed behavior. In traditional tort areas where morally culpable conduct is not necessarily involved, including automobile, medical malpractice, and products liability cases, punitive damages awards are very rare."

¹¹ *Hardy v. Brantley*, 471 So. 2d 358, 371 (Miss. 1985). See also, *Petrovich*, 719 N.E.2d at 765 (applying the apparent authority standard announced in *Gilbert v. Sycamore Mun. Hospital*, 622 N.E.2d 788 (Ill. 1993) to the HMO context). For a similar view, see, *Restatement (Second) of Agency* §267: "One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to

imposition of liability on this basis occurs pursuant to the “apparent authority” or “ostensible agency” doctrine. Similarly, even if the physician and the affiliated hospital or medical center treat the physician as an independent contractor for internal purposes, vicarious liability may be imposed if the hospital or medical center exercises a high degree of control over the physician’s medical decisions. Liability on this basis arises because of “implied agency.”¹²

The liability of an MCO for malpractice by an affiliated physician is more complicated because of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA to a degree displaces (“preempts”) state law affecting employee benefit plans in the private sector (it does not apply to employee benefit plans for government employees).¹³ Many MCOs, of course, provide health care services through employer-sponsored group insurance plans, and are thus covered by ERISA preemption. The scope of this preemption, however, is not entirely clear.

Specifically, ERISA preempts state laws that “relate to” a covered employee benefit plan.¹⁴ The precise meaning of this phrase has been a subject of extensive litigation and a number of Supreme Court decisions. Following the Court’s decision in *Pilot Life*,¹⁵ conventional wisdom had it that ERISA preempted state law in virtually any lawsuit relating to health care coverage or quality under a covered plan. Some courts thus held that MCOs could not be held liable for medical malpractice under state law even if standard agency principles would otherwise impose liability.¹⁶ But subsequent Supreme Court decisions limited the scope of preemption,¹⁷ and a number of lower federal and state courts then concluded that MCOs can be held liable for malpractice by their actual, implied or ostensible agent physicians.¹⁸

the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.”

¹² See, e.g., *Petrovich*, supra.

¹³ 29 U.S.C. §§1002(32), 1003(b)(1). See, e.g., *McEvoy v. Group Health Cooperative of Eau Claire*, 570 N.W.2d 397, 406 n.6 (Wis. 1997) (noting that ERISA preemption does not apply to benefits plans offered by government employers).

¹⁴ 29 U.S.C. §1144(a).

¹⁵ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

¹⁶ See, e.g., *Elsesser v. Hospital of the Phila. College of Osteopathic Medicine*, 802 F. Supp. 1286 (E.D. Pa. 1992) (finding that ERISA preempted direct liability claim)

¹⁷ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55 (1995) (finding in the field of health care that there is no ERISA preemption without clear manifestation of congressional purpose). See also, *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997) (relying on *Travelers Ins.*, and declaring a state statute imposing a gross receipt tax on medical centers is not pre-empted by ERISA).

¹⁸ See, *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir 1995) (finding that ERISA did not preempt ostensible agency claims). See also, *Petrovich*, 719 N.E.2d at 775 (“An HMO may be held vicariously liable for the negligence of its independent-contractor physicians under both the doctrines of apparent authority and implied authority.”).

The emergent distinction in the law of ERISA preemption is between claims regarding a denial of coverage (preempted because they “relate to” the administration of the benefit plan), and claims regarding the quality of care provided by the plan (not preempted because they involve medical decisions rather than plan administration decisions). The utility of this distinction may be questioned for the reason given above -- malpractice claims and coverage claims are not always readily separable -- and some courts have on this basis rejected the notion that ERISA preemption can be cabined to “coverage” disputes.¹⁹ Nevertheless, it is probably fair to say that in most jurisdictions, MCOs covered by ERISA preemption can nevertheless be reached for physician malpractice to the extent that they would otherwise be held liable under the conventional rules of vicarious liability.

The expansion of vicarious liability for physician malpractice under state agency law has *not* been matched by a judicial willingness to recognize a Federal cause of action against the MCO under ERISA. In *Pegram v. Herdrich*,²⁰ a health plan covered by ERISA provided for treatment by non-HMO physicians only in emergencies. The patient’s HMO physician decided that her condition was not serious enough to justify an emergency ultrasound procedure at an unaffiliated hospital, and the patient suffered a ruptured appendix as a consequence. In addition to a conventional malpractice claim, the plaintiff argued that her injury resulted from an incentive device within the HMO that rewarded physicians for reducing costs by, *inter alia*, cutting back on referrals to physicians outside of the HMO. This physician compensation system had not been disclosed to plan subscribers, and its non-disclosure was alleged to be fraud under state law. The state court held that the fraud allegation was preempted, and the patient then filed in Federal court claiming that the HMO had committed a breach of its fiduciary duty under ERISA (precisely how was somewhat unclear). In the Seventh Circuit, Judge Coffey held that the MCO could be held liable for breach of fiduciary duty to the extent that it relied on cost-control devices to limit a subscriber’s consumption of medical services.²¹ The case created much of a stir at the time because it branded as unlawful cost-containment devices that were in common use in virtually all MCOs.²² It was no surprise therefore that the

¹⁹ For example, in *Pegram*, the Supreme Court in analyzing the “dual medical/administrative roles of HMOs” described in *Dukes*, 57 F.3d at 361, found that “[i]n practical terms, these eligibility decisions cannot be untangled from physicians’ judgments about reasonable medical treatment” *Pegram*, 120 S. Ct. at 2152-55.

²⁰ 120 S. Ct. 2143 (2000).

²¹ 154 F.3d 362 (7th Cir 1998).

²² See, *Herdrich v. Pegram*, 170 F.3d 683, 686 (7th Cir. 1999) (Easterbrook, J. dissenting). For pointed criticism, see David Hyman, *Medicine in the New Millennium: A Self-Help Guide for the Perplexed*, 26 *Am. J. Law & Med.* 143-150 (2000).

Supreme Court reversed the Seventh Circuit and held that decisions within a health plan that involve medical judgment, such as whether an emergency exists that would trigger coverage at an unaffiliated hospital, are not “fiduciary” decisions and thus cannot result in a breach of fiduciary duty. The Court thus created a substantial roadblock for plaintiffs who would transform their state malpractice claims into Federal ERISA claims (which, among other things, would allow them to recover attorneys fees). The Court also observed that cost-cutting devices were central to the operation of HMOs, and strongly hinted that the mere existence of a particular cost-cutting scheme could not support a claim for breach of fiduciary duty.²³

It remains to consider the division of liability between the MCO and the physician in cases where both are liable for the physician’s malpractice. Their liability is joint and several, so the plaintiff can collect the judgment from either or both defendants as the plaintiff wishes, subject to the constraint that the total amount collected cannot exceed the total judgment.²⁴ Under the common law of vicarious liability, employers who pay judgments because of torts by their employee or independent contractor have a right to seek “indemnity” from them.²⁵ That is, the employer may sue the employee or independent contractor for the amount paid out by the employer, and collect up to the limit of the employee’s or independent contractor’s assets. In addition to this common law right to indemnity, employers and their employees or independent contractors are generally allowed to allocate the risk of liability between themselves by contract. Although any contractual allocation of liability will not be binding against a successful plaintiff in the face of joint and several liability, it will allow the employer and its employee or independent contractor to shift the liability between themselves after the plaintiff has collected so that the ultimate liability falls wherever the parties to the contract wish it to fall.

2. MCO Liability for Wrongful Denial of Coverage

All courts seem to agree that disputes over the coverage of an employee benefit plan “relate to” the administration of the plan and thus come within ERISA’s general preemption clause. Another part of ERISA, however, exempts from preemption the “state regulation of insurance.”²⁶ But the Supreme Court

²³ After noting that “inducement to ration care goes to the very point of any HMO scheme,” the Court repelled from the potential consequences of the fiduciary claims: “Recovery would be warranted simply upon showing that the profit incentive to ration care would generally affect mixed decisions, in derogation of the fiduciary standard to act solely in the interest of the patient without possibility of conflict.” The court found that this could lead to the reorganization or elimination of HMOs, a decision it averred to be best left to the legislative branch. *Id.* at 2150, 56.

²⁴ For an explanation of joint-and-several liability, see Richard A. Epstein, *Torts* § 9.2 & n.19 (1999).

²⁵ *Id.*, § 9.8 (citing Restatement (Second) of Torts §886B & cmt. e.).

²⁶ 29 USC §1144(b)(2)(A).

has also held that the civil enforcement provisions of ERISA (the provisions that afford plan beneficiaries a private right of action for denial of benefits) were intended by Congress to be the exclusive remedy for employees suing over a denial of benefits.²⁷ Thus, when a dispute arises between a patient and an MCO over a coverage matter, the first question is whether the MCO's activities are part of an employer-sponsored plan covered by ERISA. If the answer is no, then state law applicable to such contractual disputes will govern. If the dispute involves a plan covered by ERISA, state law is preempted unless it is part of the state law "regulating insurance." Even then, it will be preempted to the extent that it purports to provide any "remedy" for the denial of benefits (as distinguished from, say, a rule of insurance contract construction).

The practical consequence of this convoluted structure is that a civil enforcement action under ERISA is presently the sole legal remedy available to a patient who challenges the denial of coverage by an MCO under a plan covered by ERISA. The fact that the plaintiff is confined to the ERISA cause of action may not make much difference on the question of liability,²⁸ but it can have profound impact on the remedy available to the successful plaintiff. Under ERISA, the successful plaintiff is entitled to an order directing the plan to provide the benefits in dispute, plus attorney's fees.²⁹ Or if the employee has paid for the covered benefits out of his own pocket, he can obtain reimbursement.³⁰ Most critically, however, consequential damages are not allowed. Thus, if the denial of coverage leads to unfortunate medical consequences, there is no recovery for any pain and suffering, lost wages, wrongful death, loss of consortium and the like, and no recovery of punitive damages.³¹

Under state law, by contrast, consequential damages may be recoverable as long as they are "foreseeable" by the party who breaches the contract,³² at least in those cases where the defendant has not successfully disclaimed consequential damages, which is difficult, if not impossible to do, in connection with the personal injuries.³³ The foreseeability hurdle seems likely to be a modest one where an MCO has denied coverage for some treatment of medical importance to the patient. In addition, many states now allow punitive damages against insurers who deny coverage without a reasonable basis for doing so (denial of

²⁷ Pilot Life, 481 U.S. at 52.

²⁸ To be sure, there may be some differences between ERISA law and state law that will affect the determination of whether or not the MCO has breached its contract with the plaintiff.

²⁹ 29 USC §1132(g)(2)(D).

³⁰ 29 USC §1132(g)(2)(A).

³¹ See also, Pilot Life, 481 U.S. at 53-54 (finding that ERISA does not permit punitive damages) (citing Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 135, 147 (1985) (quoting Northwest Airlines, Inc. v. Transport Workers, 451 U.S. 77, 97 (1981)).

³² Hadley v. Baxendale, 9 Ex. 341, 156 Eng. Rep. 145 (1854).

³³ See U.C.C. § 2-719 (3).

coverage in “bad faith”). The Supreme Court held in *Pilot Life* that the state law cause of action for bad faith was indeed preempted by ERISA, but state courts have allowed that action against MCOs in circumstances where ERISA preemption did not apply.³⁴

3. Statutory Initiatives at the State Level

Public dissatisfaction with managed care has led to a number of initiatives in the state legislatures, some of which affect the civil liability of managed care organizations. In California, for example, an MCO will have “a duty of ordinary care to arrange for the provision of medically necessary health care service to its subscribers and enrollees”³⁵ Liability attaches to any careless decision that results in the “denial, delay or modification” of a service recommended for, or furnished to, a subscriber who suffers “substantial harm” as a result.³⁶ Georgia requires “ordinary diligence” in reviewing claims for health benefits, and imposes liability for injuries that result from a want of care.³⁷ In Texas, an MCO “has the duty to exercise ordinary care when making health care treatment decisions.”³⁸ An MCO is also statutorily liable for the health care treatment decisions of its employees, agents and ostensible agents.³⁹ These statutes generally indicate that they do not impose liability for the failure to provide a service that is not covered by the benefit plan in question, but only for negligence in the delivery of covered services.⁴⁰

Another common provision in these state initiatives prohibits indemnification clauses that would require affiliated physicians to reimburse an MCO for liabilities it incurs for breach of its duty of care,⁴¹ as well as a provision that prohibits MCOs from retaliating against physicians that advocate particular treatments on behalf of their patients.⁴² Some statutes also prohibit waiver of the MCO’s duty of care, at least by subscribers or enrollees⁴³ and in some cases by employers as well.⁴⁴ A few states have also enacted statutes that require MCOs

³⁴ See, e.g., McEvoy, 570 N.W.2d at 406 n.6 (enforcing common law tort of bad faith against HMOs where ERISA preemption did not apply).

³⁵ Cal. Civ. Code §3428(a) (West, WESTLAW through 1999 portion of 1999-2000 Reg. Sess. and 1st Ex. Sess.).

³⁶ See, id. §3428(a)(1)-(2).

³⁷ Ga. Code Ann. §51-1-48 (LEXIS through the 1999 General Assembly).

³⁸ Tex. Civ. Prac. & Rem. §88.002(a) (LEXIS through the 2000 Supp. (1999 Sess.)).

³⁹ See, id. §88.002(b)(1)-(4).

⁴⁰ See, e.g., id. §88.002(d).

⁴¹ See, e.g., id. §88.002(g); see also, Cal. Civ. Code §3428(d); and Conn. Gen. Stat. §38a-472a (LEXIS through 1997-98 Sess.).

⁴² See Tex. Civ. Prac. & Rem. §88.002(f). See also, Okla. Stat. tit. 63, §2528.5 (LEXIS through 1998 Second and 1999 First Ext. Sess.) (prohibiting retaliation against physicians who testify at internal or external reviews on behalf of patients in coverage disputes).

⁴³ See, e.g., Cal. Civ. Code §3428(f).

⁴⁴ See, e.g., Ga. Code Ann. §51-1-48(b).

to afford subscribers an opportunity to obtain an independent review of any decision to deny coverage.⁴⁵

In the absence of amendments to ERISA, it is uncertain how many of these statutes can survive challenge on grounds of ERISA preemption. Statutes that merely codify the common law of vicarious liability for malpractice are likely to survive preemption challenges. Statutes that create state causes of action for the denial of benefits under plans covered by ERISA, or require that independent review procedures to be followed after a denial of benefits, are likely to be preempted on the grounds that ERISA's civil enforcement provisions provide the exclusive remedy for aggrieved subscribers.⁴⁶

The gray area concerns the statutes that impose a duty of care on MCOs to provide covered services in a timely manner, and that prohibit indemnification clauses, retaliation against physicians, and waiver of statutory protection. A Texas statute containing such provisions (except the no-waiver provision) survived a preemption challenge in the Fifth Circuit.⁴⁷ The court reasoned that the statute really does no more than impose vicarious liability for malpractice, given its stipulation that it does not in any way expand "coverage" under health plans. Likewise, the anti-indemnification provisions and anti-retaliation provisions do not compel any particular level of coverage, the court argued, but simply regulate MCOs in the interest of patient safety, much like state malpractice law. The soundness of this reasoning may certainly be questioned. Suits alleging a want of ordinary care in a decision made by an MCO will very often implicate issues of coverage (such as the question whether an emergency existed in *Herdrich*), and state actions regarding coverage are generally held to be preempted as noted. The problem is even more acute with statutes (such as Georgia's) that require "diligence" in claims processing, and that may well lead to lawsuits over delays relating to uncertainties about coverage. Likewise, anti-indemnification and anti-retaliation provisions effectively constrain the terms on which MCOs can offer health care coverage to employers, and may thus be said to "relate to" the benefit plans quite directly. Absent legislative clarification at the Federal level, therefore, these issues may require guidance from the Supreme Court.

4. Federal Initiatives -- the "Patient's Bill of Rights"

The U.S. Senate and House of Representatives are presently considering a number of competing versions of a "Patient's Bill of Rights," aimed largely at the

⁴⁵ See, e.g., Okla. Stat. tit. 63, §2528.5.

⁴⁶ See *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 2000 WL 792435 (5th Cir. 2000) (holding that Texas statute requiring independent review of claims denials was pre-empted).

⁴⁷ *Id.*

managed care industry and the problems it is perceived to have created. Much of the proposed legislation concerns the scope of coverage offered by MCOs, and would have little direct effect on the civil liability of managed care organizations. One of us has already written at some length on these proposals with a critical eye.⁴⁸ A few of the provisions do affect the liability of MCOs directly, however, and warrant attention here.

One Senate Bill, S. 1344, would revamp the disclosure obligations under ERISA, and require plans to provide considerably more information to subscribers than presently. Among other things, plans would have to disclose the way in which physicians are compensated, including any incentives for cost reductions that might come at the expense of patient care (recall *Herdrich*).⁴⁹ The Bill would also impose new requirements regarding the procedures for denial of claims by an ERISA-covered health plan. In particular, an internal appeals process is required along with an option for a subsequent independent review, and each procedure is regulated as to its timeline. Failure to adhere to the timeline or to respect the results of an outside review is punishable by fines, and patients can seek reimbursement plus attorneys fees for any services that the plan should have covered but did not.

Other proposals, such as H.R. 2990, contemplate more extensive changes. Like S.1344, this Bill introduces new requirements respecting the procedures for the denial of claims, including internal appeals and the option for an independent review,⁵⁰ and it would also enhance the disclosure requirements under ERISA.⁵¹ But it adds an anti-retaliation provision, similar to those enacted at the state level, to protect physicians who advocate care on behalf of their patients.⁵² And perhaps most importantly, it would amend ERISA's preemption provisions to provide that actions under state law may be brought for personal injury or wrongful death against any person "in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan..."⁵³ If enacted, this language would plainly protect many of the recent state initiatives from a preemption challenge. It goes on to provide that in such actions, punitive damages may not be recovered as long as the health plan has complied with the requisite procedures for internal and independent review of claims denial.⁵⁴

B. Analysis

⁴⁸ Richard Epstein, *Managed Care Under Siege*, 24 *J. Medicine & Philosophy* 343 (1999).

⁴⁹ S. 1344, 106th Cong. § 111 (1999).

⁵⁰ H.R. 2990, 106th Cong. §§ 1101-04 (1999).

⁵¹ *Id.* §1121.

⁵² *Id.* §1135.

⁵³ *Id.* § 1302.

⁵⁴ *Id.*

The extant and proposed rules governing MCO liability are complex and raise a number of distinct normative issues. It is helpful to divide them into three broad categories: (1) the wisdom of imposing vicarious liability on MCOs for the malpractice of affiliated physicians in accordance with state agency law; (2) the wisdom of efforts to introduce a new remedy for wrongful denial of coverage in addition to or in lieu of the existing civil enforcement action under ERISA; and (3) the wisdom of various measures that constrain freedom of contract between MCOs and their physicians or subscribers, including anti-indemnification rules, anti-retaliation rules, and rules that prohibit waiver of statutory duties.

1. Vicarious Liability for Malpractice

Economic Background. Vicarious liability responds to two potential problems.⁵⁵ First, the financial assets of many employees are insufficient to cover judgments against them for the torts that they commit in the course of their jobs. If employees are unable to pay judgments, they may lack the incentive to invest in the efficient level of care to avoid accidents. In addition, if employees lack the assets to pay judgments, their wage demands may not reflect the full extent of their expected liability. Business enterprises will then avoid paying the full cost of harms that they cause, and the scale of risky activity may become inefficiently large. Finally, because a contractual assumption of liability by the employer would put more assets at risk, employers and employees may elect to leave the liability on the employee even when the employee is risk averse and the employer is the superior risk bearer. For essentially the same reason, risk averse employees may elect not to buy any liability insurance and instead to take their chances on bankruptcy.

Vicarious liability can ameliorate these inefficiencies. By placing the employer's assets at risk, employers will have an incentive to exercise whatever control they have over their employees to induce them to behave more carefully, and the joint incentive to invest in care will be optimal as long as the combined assets of the employer and employee are sufficient to cover judgments against them.⁵⁶ If employers can observe carelessness directly, they can require careful behavior as a condition of employment. Where care is not directly observable at all times, a moral hazard arises but other monitoring devices may nevertheless be employed to induce employees to be more careful than they would be otherwise. Threats of discharge or demotion in the event of accidents, spot

⁵⁵ The general analysis of vicarious liability is developed at length in Alan O. Sykes, *The Economics of Vicarious Liability*, 93 *Yale L.J.* 1231 (1984). For an account of the rules, see Richard A. Epstein, *Torts* § 9.9 & 9.10 (1999).

⁵⁶ This proposition assumes that damages judgments are equal to the social value of the harms caused by employees.

checks for the level of care, and perhaps the threat of an indemnity action can combine to enhance the employee's incentives for care.

In addition, vicarious liability forces the business enterprise to internalize the costs of harms that it causes. It thus tends to reduce the scale of risky activity to the proper level.⁵⁷

Finally, because a contractual assumption of liability by the employer no longer has the effect of placing more assets at risk, vicarious liability eliminates the possible incentive to leave liability inefficiently on a highly risk averse employee. Likewise, if the risk is better laid off on the insurance market, there is no longer any disincentive to doing so, and indeed the employer may be the best party to purchase insurance, buying a single policy to cover everyone in the workforce.

Putting aside the possible insolvency of the employee, a second potential problem in the absence of vicarious liability -- albeit a less important one -- arises where the transaction costs of contracting between employers and employees impede a contractual allocation of risk between them. The rules of vicarious liability can then serve as potentially useful "default" rules, allocating the risk of liability to the employer or the employee, as the case may be, in accordance with which of them is likely to be the better risk bearer.

A third rationale for vicarious liability also deserves mention. In many business situations, it is clear that the harm in question has been caused by some employee or employees, but it is not clear by which.⁵⁸ Absent vicarious liability, the firm can hide behind the inability of the injured party to identify the individual wrongdoer, thus leading to systematic underdeterrence of the wrong. This problem can be effectively avoided by vicarious liability no matter whether the risk was caused jointly or individually by workers. And once vicarious liability is imposed, the firm has strong incentives to keep track of the behavior of its own employees.

Vicarious liability will be of little benefit, and may simply increase litigation costs, when the above conditions that favor it do not arise. Thus, if there is no potential insolvency on the part of employees, little reason to think that employers are the superior risk bearer, and no causal uncertainties, vicarious liability is likely undesirable. Similarly, if employers have little ability to induce their employees to behave more carefully, the benefits of vicarious liability are lessened.

⁵⁷ The caveat is that if liability is only for negligence, any harms that occur when due care is taken will still be externalized. Of course, under a rule of strict liability, a reverse externality runs from victims to injurers. Ronald H. Coase, *The Problem of Social Cost*, 3 *J.L. & Econ.* 1 (1960).

⁵⁸ Richard A. Epstein, *The Temporal Dimension in Tort Law*, 53 *U. Chi. L. Rev.* 1175, XXX (1986).

One of us has argued elsewhere that the common law rules of vicarious liability are broadly responsive to these economic considerations.⁵⁹ The doctrine of respondeat superior tends to impose liability on employers when employees have limited assets, and when employers have monitoring techniques available to them to induce employees to behave more carefully. The typical employee for whom employers are held liable may also be quite risk averse and thus a poor risk bearer. The general rule that employers are not liable for torts by their independent contractors can similarly be justified on the grounds that independent contractors tend to have more substantial assets (often including their own liability insurance), that the ability of employers to monitor them and induce greater care is much weaker, and that there is often little reason to believe that the employer is less risk averse.

Application to MCOs. At times, it may well be efficient for entities such as hospitals and MCOs to bear vicarious liability for physician malpractice. The young resident or intern, for example, on salary at an HMO hospital, may well have limited assets and be unlikely to purchase adequate malpractice coverage if left to her own devices. In addition, the young physician may well require (and receive) considerable supervision by more senior physicians to avoid errors in care, so that the HMO hospital has considerable capacity to monitor her. On these assumptions, the standard arguments for vicarious liability apply readily.

When physicians establish independent practices and carry substantial malpractice insurance on their own, by contrast, the case for vicarious liability is much weaker. The physicians' personal assets, including malpractice coverage, become considerable and the problem of potential insolvency greatly diminishes. Further, the ability of hospitals or MCOs to monitor these independent physicians is extremely limited, as there is no one with greater medical expertise in the hierarchy regularly overseeing their work. We thus doubt that vicarious liability for independent physicians with their own malpractice coverage will accomplish much beyond adding an additional party to litigation, which of course is costly in itself. And the likely result of vicarious liability under these circumstances may simply be an effort to shift the liability back to careless physicians by contract (if that is allowed, as we discuss below).

To a degree, the application of standard common law principles to MCOs and their affiliated physicians will track this economic logic. Vicarious liability at common law is likely to be imposed for malpractice by a physician on salary at a hospital or HMO. By contrast, a physician who has an independent practice and her own malpractice coverage is likely to be deemed an independent contractor,

⁵⁹ See Sykes, *The Economics of Vicarious Liability*.

and any hospitals or MCOs with which the physician is affiliated will ordinarily not be subject to vicarious liability.

Certain exceptions to this “independent contractor rule,” however, have been at the heart of much recent litigation in the area.⁶⁰ As noted earlier, plaintiffs can reach beyond the negligent physician on a theory of “implied agency” or “ostensible agency.” Both of these doctrines, in the abstract, have some logic as traditionally applied at common law. Where an “independent contractor” is in fact controlled by another entity in making decisions about care (the “implied agency” case), the imposition of liability on that entity may be desirable to help promote proper incentives for care. If the independent contractor has substantial assets at risk, of course, he may seek a contractual assumption of liability by the entity that exercises control, and the imposition of vicarious liability may be superfluous. But whether it is accomplished by contract or by the common law, it makes good sense for the party who selects the level of care to bear the risk of error. Likewise, liability for the “ostensible agent” makes sense where the public is induced to deal with a particular independent contractor on false pretenses. The paradigm case here would be one in which the public is led to believe that an impecunious independent contractor is in fact an employee of another entity, so that the apparent employer’s assets would be available to satisfy a judgment in the event of carelessness by the apparent employee. The actual cases that have been litigated often deny independent contractor status to groups of emergency physicians who appear to the outside world to be an operating division of the hospital or medical center of which they are a part.⁶¹

In principle, either scenario might justify the imposition of liability on an MCO for independent contractor physicians. In practice, however, we doubt that the conditions justifying such liability will be satisfied very often.

The fact that an MCO exercises some independent judgment about the medical necessity of particular care, for example, or utilizes some cost control device that makes physicians think twice about ordering expensive procedures, is quite insufficient in our view to convert the physician into an “implied agent” anytime a malpractice allegation arises. As long as the care decision resides with the independent contractor physician, economic logic suggests that liability should reside with that physician as well. It is only when the MCO overrules the physician and dictates a course of care contrary to the physician’s recommendations that a shift of liability may be warranted. Indeed, the physician may have a defense to a malpractice claim in such cases, and it may then become quite important that a patient have a distinct cause of action against

⁶⁰ See Petrovich, *supra*.

⁶¹ Hardy v. Brantley, 471 So.2d 358 (Miss. 1971).

the MCO -- we return to this issue below when we discuss actions relating to denial of coverage. But putting aside this class of cases, findings of implied agency against MCOs are likely inappropriate.

Likewise, claims of “ostensible agency” typically ring quite hollow. The independent contractor physicians who affiliate with MCOs are not in general impecunious, and rarely can the argument be made that they are unable to pay for their torts. Nor is it often plausible that patients have been induced to deal with these physicians on the false premise that the MCO has somehow certified their financial soundness. The mere fact that the physicians are part of a network or HMO, and that the details of their affiliation with the MCO are not widely disseminated, are wholly insufficient to induce the sort of mistaken reliance on the physician’s status that might justify a finding of ostensible agency.

If we are right that insolvency is usually not a serious concern with independent contractor physicians, however, why are plaintiffs’ lawyers so interested in reaching the MCOs as well? The answer, we suspect, as noted above, is that the MCO is a much less sympathetic defendant than the individual physician. Juries will be more generous with their compensatory awards, and more disposed toward punitive awards, when the faceless, cost-cutting MCO is implicated as contributing to the plaintiff’s bad medical outcome. Unless one believes that juries undercompensate today in malpractice cases involving individual physicians, therefore, adding the MCO to the mix may result in nothing more than an excessive award and additional litigation costs that will reduce the capacity of MCOs to control expenses in the interests of all.

The effort by the plaintiff in *Herdrich* to convert a garden variety malpractice claim into a claim for breach of fiduciary duty under ERISA raises still further concerns. Some of the remedies for breach of fiduciary duty -- such as disgorgement of profits -- simply do not fit well with the malpractice action. Damages to compensate the plaintiff for his injuries, and thus to encourage the care-provider to internalize the costs of mistakes, are more appropriate. And while one can wonder about the wisdom of the American rule regarding attorneys fees in tort actions generally, there is no reason to depart from it simply because a physician happens to be affiliated with an MCO.

In sum, when the physician qualifies as an independent contractor under agency law and has substantial malpractice coverage of her own, we believe that efforts to impose vicarious liability on the MCO because of implied or ostensible agency should generally be rejected. The significant class of exceptions arises when the MCO has refused to permit the physician to provide the care that the physician recommends, and that decision has arguably caused the harm to the plaintiff. As this situation is

more properly viewed as a coverage dispute than as a malpractice claim, we deal with it separately below.

2. Liability for Wrongful Denial of Coverage

Because of ERISA preemption, many participants in MCOs are limited to a civil enforcement action under ERISA when challenging the denial of benefits by their health plans. As noted, the ERISA remedy simply allows the successful plaintiff to obtain an order directing the plan to provide the benefits, or to reimburse the plaintiff for services purchased elsewhere, plus attorneys fees. No consequential damages are allowed, even if the wrongful denial of coverage resulted in great pain and suffering or even death.

It is not difficult to fashion an argument that the ERISA remedy is inadequate. Because the premiums charged by health plans to employers and subscribers are generally fixed at an amount that is independent of the care provided, the argument runs, reduced expenditures on care mean more profits for the health plan. A plan that wrongfully denies benefits at a minimum defers an expenditure and captures the time value of the money, even if the sums saved today eventually be spent tomorrow. And if the patient does not have the sense or wherewithal to challenge the denial effectively, the wrongful denial is pure gain. A self-serving health plan may balance the prospect of paying plaintiff's attorney fees at the end of litigation against the benefits of delaying an expenditure or perhaps avoiding it altogether, and might conclude that a deliberate, wrongful denial of benefits is a good bet. Indeed, the calculus may be even more favorable toward wrongful denial if the plan anticipates that it can settle the cases that are brought quickly with minimal expenditures necessary to compensate plaintiffs' attorneys.

The problem is not limited to deliberate, wrongful denials. Callous or overworked plan administrators may also deny benefits without exercising sufficient care to ascertain whether they should be provided. These careless denials of benefits may work great harm to a subscriber in medical need, and because the consequential damages associated with such harms are not recoverable, carelessness in processing claims for or in authorizing treatment may be seriously underdeterred. To provide proper deterrence of such behavior, the argument runs, the plan must be made to pay for the harms that are caused by wrongful denial of benefits, whether deliberate or careless. Only an award of consequential damages, in addition to the current relief provided by ERISA, will achieve that objective. And of the legal initiatives discussed earlier, only a Federal statute can provide the needed changes in ERISA.

This argument has considerable force, and may in the end be convincing. But we add some important cautions. First, the notion that ERISA-covered plans

can deny benefits willy-nilly without significant penalty is plainly exaggerated. If administrators regularly deny valid claims or authorization for treatment, employers will hear about it and will be strongly urged by their employees to change health plans. Word of such behavior can also disseminate across firms as human resources administrators communicate with each other. In short, the usual market constraints associated with repeat dealing and reputation are operative to a significant degree, even if they do not eliminate all problems.

Second, changes to the available remedy will no doubt introduce new error costs. In the malpractice area, scholarly studies suggest that the courts are rather poor at identifying malpractice -- many bona fide cases of malpractice are overlooked, while lawsuits often focus on cases where the physician did nothing wrong.⁶² The question whether the denial of a claim or an authorization for treatment was wrongful may not raise quite the same issues, but certainly raises related ones. The plan's judgment about medical necessity, or the existence of an emergency, will often be at the heart of a dispute (as the Supreme Court noted in *Herdrich*). And given the diversity of medical opinions on the proper course of treatment for particular patients, it may not be difficult for a plaintiff to find an expert willing to opine that some treatment was "necessary" or "non-experimental." Juries may be no better at sorting out such complicated issues, and no less inclined to help out the sympathetic plaintiff, than they are in standard malpractice cases. One must therefore wonder whether erroneous judgments against health plans might increase the costs of care significantly and discourage greatly efforts at cost control.

Third, we note the practice of contracting away from consequential damages is routine in virtually all sales transactions governed by the Uniform Commercial Code and similar statutes. The same pattern appears whether the transactions are between merchants or, as is the case here, between merchants and consumers.⁶³ Given the range of transactions that adopt the same position, we think that is unlikely that the uniform practice could be attributable—much less attributable solely—to some defect in market structure or to some systematic want of information by the consumer party. Rather we think that it is likely that some of the economic pressures that produce these contracts between commercial equals can also operate here. Certainly the need to control

⁶² See generally, Paul C. Weiler, *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (1993); Statement of Robert Brook, in *Medical Necessity: From Theory to Practice* 47-51, Hearing Before the Senate Committee on Health, Education Labor and Pensions, 106th Cong., 1st Sess. (March 2, 1999) (discussing studies finding that about 1/3 of medical procedures provided are unnecessary, and that patients who need procedures do not get them about 1/3 of the time).

⁶³ See Richard A. Epstein, *Beyond Foreseeability: Consequential Damages in the Law of Contract*, 18 *J. Legal Stud.* 104 (1989).

administrative costs, reduce error, and to prevent the implicit cross-subsidy between those plan members that are likely to protest from those who are compliant has a lot to do with the overall picture.

However one comes out on the broader issue of whether to amend ERISA to permit higher damages awards, we have particular concerns about some of the recent changes in state law noted earlier. Recall that a number of the state statutes impose a duty of ordinary care on MCOs, noting that they do not expand the “coverage” of benefit plans, while the courts continue to suggest that the sole remedy for a denial of coverage is a civil enforcement action under ERISA. This situation invites some unintended complications. Consider an employer-sponsored health plan that has initially refused to cover or authorize some treatment that a subscriber wants. After further consideration, the plan changes its mind and is willing to pay for the treatment in question, but in the meantime the patient has suffered some harm because of the delay. If the plan admits that the treatment was “covered” all along, it opens itself up to a state action for breach of its duty of care. By contrast, if the plan stonewalls in its original position and insists that the treatment is not “covered,” it has an argument that the sole remedy is the ERISA civil enforcement action. Accordingly, the incentive may be for the plan that initially denies coverage to fight tooth and nail to defend its denial, even if it later comes to believe that it made a mistake. The unintended consequences for subscribers may thus be quite unfortunate.

The question also arises whether state actions for “bad faith” denial of benefits, which in some jurisdictions allow the recovery of punitive damages, should be allowed if ERISA is amended. One argument for punitive damages against insurers who breach first-party insurance contracts is that in their absence, insureds with high subjective discount rates would be induced to settle for considerably less than they are entitled to under their insurance contracts. In other words, insurers will exploit their insureds’ desperate need for money to induce them to settle for a smaller sum than they should properly receive -- the prospect of compensatory damages at the end of a long litigation is an inferior alternative.⁶⁴ At first blush, this argument might seem applicable to MCO subscribers, who may desperately need particular care to improve their quality of life or even to survive. But on further reflection, the desperation of a seriously ill patient is not likely to induce the patient to settle for less than the care that he believes is necessary to make him well. When the issue is what health care will be provided, as opposed to what amount of money the insured will accept to settle a monetary claim, it is not clear that an insurer can exploit the insured’s

⁶⁴ See, Alan O. Sykes, “Bad Faith” Breach of Contract by First-Party Insurers, 25 J. Legal Stud. 405 (1996).

high “discount rate.” The argument for punitive damages to prevent such exploitation then carries little weight.

Another more familiar argument for punitive damages is that they can correct for an underdetection or underenforcement problem. Applying the argument to MCOs, the theory would be that when an MCO denies benefits wrongfully, the denial will be challenged with probability less than 1.0. If damages are merely compensatory, the argument runs, the expected cost to the MCO of wrongful denial is less than the actual cost to subscribers on average, and too much of it will occur.

This argument is more convincing, as it simply requires a degree of ignorance on the part of MCO subscribers that would lead them to forego treatment to which they are entitled with some regularity. But even here we could expect some increased level of consumer awareness, given the high stakes to the parties, and the presence of aggressive intermediaries (unions, cooperatives, lawyers, public officials) who will take steps to inform plan members of their statutory rights. Further, if an argument for punitive damages may be fashioned along these lines, it is important that they be calibrated sensibly. The goal should be to correct for any underenforcement problem, and the difficulty is that punitive damages for “bad faith” are not calibrated to that end. Juries are told to look at factors such as the egregiousness of the defendant’s conduct and the defendant’s wealth.⁶⁵ None of these factors bears much relationship to the underlying issue. Hence, there can be little confidence that allowing punitive damages to be assessed against MCOs under existing state law would improve matters. It is noteworthy that H.R. 2990 (and some of the other bills introduced in Washington) would protect MCOs against punitive damages as long as they comply with certain appeal procedures for subscribers who challenge a denial of benefits.

3. Limitations on Contracts with MCOs

With proper remedies in place for malpractice and for wrongful denial of coverage, there is little basis for interfering with the ability of MCOs, physicians and employers to allocate liability risks by contract. Accordingly, anti-indemnification rules, anti-retaliation rules and rules against waiver of new causes of action are suspect.

Anti-Indemnification Rules. The typical anti-indemnification rule under recent state statutes, as noted, prohibits MCOs from pursuing indemnity against

⁶⁵ See, *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 379 (Wis. 1978) (noting that the appropriate standard for permitting punitive damages the context of bad faith is the showing of “an evil intent deserving of punishment or of something in the nature of special ill-will or wanton disregard of duty or gross or outrageous conduct”). This is essentially the standard for punitive damages adopted by the Restatement (Second) of Torts § 908 (punitive damages are appropriate for “outrageous” conduct, “evil motive,” or “reckless indifference to the rights of others”).

affiliated physicians after the MCO has been held liable for breach of its duty of care. The prohibition applies even if the contract between the physician and the MCO expressly provides for indemnity. The argument for such rules, we suppose, is that the MCO will otherwise exercise its “bargaining power” to force physicians to accept an indemnity agreement that is not in the best interests of physicians and their patients. The MCO will avoid having to pay for its own intentional misconduct or carelessness, resulting in an undesirable increase in such behavior by the MCO.

Such arguments are familiar from other settings, and almost always deeply flawed for essentially the same reasons. An MCO will wish to include an indemnity arrangement in its contract with physicians only if it profits from the arrangement. Physicians have reservation wages just like all other participants in labor markets, and if an MCO requires physicians to indemnify it against liability, that reduces the level of physician compensation, other things being equal. The MCO must then pay physicians more direct compensation to induce them to affiliate with the MCO. The indemnity arrangement will be desired by the MCO, therefore, only if the increase in direct compensation that it necessitates is less than the expected value of the MCO’s own liability in the absence of the indemnity arrangement. In turn, the required increase in direct physician compensation under an indemnity arrangement will be at least equal to the expected value of the indemnity payments that physicians must make. Indeed, it may be considerably greater than that if the physician, whose portfolio of risk is underdiversified, is risk averse and worried about the variance in her expected income with an indemnity arrangement.

Suppose, then, that the indemnity arrangement indeed increases the amount of wrongful behavior by the MCO, and increases the attendant liability to subscribers, which is now borne by the physicians pursuant to an indemnity agreement. In that event, the requisite increase in direct compensation to physicians under the indemnity arrangement will exceed the direct costs of liability to the MCO without an indemnity arrangement. If this were the case, it would be irrational for the MCO to insist on an indemnity arrangement. The fact that an indemnity arrangement is commonly observed suggests that the parties to the contract expect it to lower, not increase, their joint liability to subscribers. And that will be true only if it reduces, not increases, the damages payable as a result of the wrongful behavior by the MCO. Notice that this argument in no way turns on any assumptions about the relative “bargaining power” of MCOs and physicians.

A possible objection to the above reasoning relates to the information available about the value of indemnity. If physicians systematically underestimate the expected cost of indemnity to them, they may “sell”

indemnity agreements too cheaply. MCOs might then profit from them even if they increased the harm from actionable negligence. But we can imagine no basis for supposing that physicians will as a group underestimate the costs of agreeing to indemnify MCOs. Accordingly, we would expect any indemnification arrangements negotiated with MCOs to be efficient rather than inefficient.

The possible utility of indemnification is easy to see. Even where an MCO has been found negligent for, say, refusing to provide some treatment on the grounds that it is not “medically necessary,” affiliated physicians may well share in the blame. The denial of coverage might result as much from the failure of the physician to provide clear and credible justification for the recommended treatment as from carelessness on the part of the MCOs decisionmaker. If so, the value of inducing greater care on the part of physicians in making their recommendations may exceed the costs of reducing the incentives for care within the MCO.

The value of allowing indemnity actions may be even greater owing to the dynamics of tort litigation. So long as the treating physician is protected against suit by statutory prohibitions against indemnity actions, then she could easily team up with the plaintiff in order to send, as it were, a message to the MCO. Juries in many cases are reluctant to impose extensive liability against individual physicians who live in their own communities, but that reluctance is likely to vanish when it becomes possible “to send a message” to an impersonal or distant corporation.

In short, the parties to the contract are better situated than anyone else to determine what allocation of liability will minimize the losses from mistakes, and the law should thus respect their allocation of liability. Blanket prohibitions on indemnification arrangements, such as those found in a number of recent state statutes, are unsound.

Anti-Retaliation Rules. These rules prohibit MCOs from punishing physicians who advocate care on behalf of their patients. If adequate remedies exist for wrongful denial of coverage, however, the costs to subscribers from such behavior will be internalized by the MCO and its affiliated physicians. When it appears that a physician has been the target of “retaliation” under these circumstances, there is nevertheless no case for interfering with freedom of contract between physicians and MCOs because no harm results to third parties by hypothesis.

The caveat relates to the assumption that the remedy for wrongful denial of coverage is adequate. We have already suggested in the last section that changes in the ERISA remedy may be appropriate. Further, for an MCO subscriber to establish that coverage was wrongfully denied, testimony from the

subscriber's physician will often be required. If MCOs are allowed to retaliate against physicians who provide honest cooperation to a subscriber complaining about a denial of coverage, therefore, the adequacy of the remedy may be undermined. It may thus make sense for the law to prohibit retaliation against a physician who provides helpful information to a subscriber seeking to secure coverage through an internal or independent review process, or during a lawsuit alleging a wrongful denial of coverage. The analogy is to rules that prevent an employer from retaliating against an employee who reports a statutory violation or who files a workers' compensation claim. Broader anti-retaliation rules, however, such as those in the Texas statute that prohibit retaliation for all advocacy on behalf of patients (whether or not connected to the dispute resolution process) may make it impossible for MCOs to rid themselves of physicians whose medical judgment is regularly at odds with reasonable efforts at cost containment.

Anti-Waiver Rules. Some state statutes restrict the capacity of parties who deal with MCOs to waive their statutory rights of action. In discussing these rules, it is useful to distinguish two variants -- those that make it impossible for subscribers to waive their rights, and those that make it impossible for employers to waive the rights of all employee-subscribers to a health plan.

The argument for preventing patients from waiving their rights is a familiar one -- they may be induced to waive rights of action in some standard consent to treatment form or other document filled with fine print, without ever reading it or understanding it. They will then grant the waiver too cheaply (or for nothing), and the valuable incentives created by the statutory cause of action will be lost.

Although this concern perhaps justifies restrictions on the ability of individual subscribers to waive their rights under a health plan, it is noteworthy that such restrictions on waiver could be written into the plan itself. The market can thus provide wavier restrictions if they are valuable. And if employers, who are informed on these matters, do not seek them on behalf of their employees, their utility is then in some doubt.

Our greater concern, however, is with restrictions on the ability of employers to waive or limit causes of action against MCOs. Simple economics suggests that employers have an interest in providing fringe benefits to their employees when the employees will value them at an amount greater than the cost to the employer. If waivers or limitations on rights to sue are inefficient, so that the price to the employer for excluding them from the plan is exceeded by the loss to the employees from including them, the employer's self-interest should lead to their exclusion.

This simple argument assumes, of course, that employers and employees collectively do not undervalue the right to sue *ex ante*, and agree to waivers or other limitations too cheaply. One can imagine this problem occurring on occasion, particularly with small employers that may have little sophistication in employee benefits matters. But if large employers with substantial human resources departments would agree to waivers or other limitations on suit, the inference that they are harmful is largely dispelled.⁶⁶

The possible utility of agreements between employers and MCOs to reduce the MCOs' exposure to liability is again easy to see. If MCOs' become liable for consequential damages for negligently denying treatment to subscribers, or punitive damages for "bad faith," the potential costs to them of denying treatment increase greatly. And as noted earlier, it would be a mistake to suppose that courts can adjudicate these cases without error. Plaintiffs will generally be sympathetic to juries and MCOs quite unsympathetic. We have no way to know how serious this problem might become, but it is by no means inconceivable that the costs of errors in the administration of a new remedy might exceed its benefits. If at that point large employers prefer to agree to a curtailment of the right to sue, the system should not prevent it, but should instead take that development as a strong signal that things have gone awry.

II. The Class Actions

Few institutional practices in the modern legal scene invite sharper differences of opinion than the modern class action. In the eyes of some, the class action supplies the ordinary person the keys to the courthouse, which would otherwise be inaccessible to individuals with small claims. To others, the class action is a giant club that allows plaintiffs lawyers to extract large settlements from defendants who fear adverse verdicts in "you-bet-your-company" situations.⁶⁷ Both over generalizations are dangerous. The broad subject matter

⁶⁶ Of course, even small firms can hire third parties to supply the expertise that they lack internally.

⁶⁷ See *In re Rhone-Poulenc Rorer, Inc.*, 51 F.3d 1293 (7th Cir. 1995), in which Judge Posner acting on a petition for mandamus ordered decertification of a class based in part upon a concern with forcing these defendants to stake their companies on the outcome of a single jury trial, or be forced by fear of the risk of bankruptcy to settle even if they have no legal liability, when it is entirely feasible to allow a final, authoritative determination of their liability . . . to emerge from a decentralized process of multiple trials, involving different juries, and different standards of liability, in different jurisdictions; and when, in addition, the preliminary indications are that the defendants are not liable for the grievous harm that has befallen the members of the class.

Id. at 1299. It is worth noting that since this decision, the Federal Rules of Civil Procedure have been amended to include R. 23(f), which grants to circuit courts discretionary review of district

range of class actions—antitrust, corporate derivative suits, consumer and securities fraud, tort claims, breach of warranty—defies easy characterization. In some contexts, the use of class actions seems relatively uncontroversial, but in others, such as the suits against tobacco companies and MCOs, the use of class actions is anything but. We begin our analysis with a brief review of the logic of class actions, with attention to their benefits and pitfalls in various circumstances.

A. The Costs and Benefits of Class Actions

The Plaintiff's Perspective. Let us assume that an individual has a valid claim worth \$1,000 that costs \$1,500 to collect. Under the American rule where each side bears its own legal expenses, as a first approximation we can be confident that suit will not be brought. The plaintiff who wins the action is worse off than if he had never brought the case at all. That calculation, of course, can be made far more complex by the introduction of a few confounding variables. The defendant may have to spend \$1,500 to defend the claim as well, so that a well-timed demand letter by a plaintiff may elicit a payment or settlement without having to incur the full \$1,500 in legal costs. Yet the defendant who knows the plaintiff's cost structure may just ignore the demand, believing that the plaintiff has no interest in forcing the defendant to lose \$2,500 in fees and payments for the privilege of losing \$500 himself. The basic calculations only become more complicated when the plaintiff's claim is of uncertain validity or uncertain amount.

The basic assumption behind the class action is that the amalgamation of individual claims will alter for the better the ratio between the size of the anticipated recovery and the costs of obtaining it: the cost per unit claim drops as the number of claims rises. Thus if 1000 claims are brought together, the total size of the pot goes from \$1,000 to \$1 million. But the costs of bringing that action may increase say by between 10 and 100 fold, to between \$15,000 and \$150,000: all of a sudden the economics of suit from the plaintiff's side start to make sense, for the expected recovery exceeds the expected cost of litigation, even for claims uncertain in validity and extent. The situation necessarily works a stunning reversal in fortune for the defendant who could be saddled with an adverse judgment of \$1 million plus his own defense costs. But without more that claim for mercy deserves little sympathy. The class action only makes affordable underlying cases that were already valid. The real problem was the prior inability of injured plaintiffs to counteract the defendant's wrongful conduct.

court orders regarding class certification, and thereby allows parties the opportunity to challenge class certification without resorting to the more arduous standards required for mandamus.

Yet overcoming that cost barrier introduces management problems of its own concerning the relationship of the class to its individual members. Prior to the class action, the initial legal position gives all individuals the sole and exclusive ownership of all legal claims, including those for invasion of property, personal injuries, fraud or breach of contract. It only makes sense that a cause of action for injury to these protected individual interests should ordinarily go to the individuals whose interests have been impaired, because they have the best information about the issues surrounding the dispute, and they are the ones who suffer the unanticipated drop in wealth from the incident. Vesting the claim in the initial holder of the right also prevents endless competition over who controls the suit, and helps to achieve both deterrence of and compensation for injuries, generally regarded as the twin objects of the tort system.

The initial assignment of the claim to the individual plaintiff may be overridden in response to the administrative complications alluded to above. The value of the claim depends on the chances for its successful prosecution: where the claim is large in amount and unique in content, the individual plaintiff will normally be in the best position to decide whether to pursue it. But once the claims become smaller in amount and larger in number, then the presumption may have to give way but not absolutely. One way to understand the class action is as a system of forced exchanges whereby the individual plaintiff surrenders control of his or her claim in exchange for the benefit of fractional class participation of equal or greater value.

The most obvious applications of this principle do *not* involve actions for damages, but rather cases in which the relief sought is a class good (nonrivalrous and nonexclusive) for the members of the class. Thus when an individual shareholder seeks to enjoin or require particular actions from a corporate officer, that decision will necessarily impact all shareholders in proportion to their interest. A rule that allows an individual to prosecute only on his own behalf thus allows other shareholders to free-ride on that decision. The class action device, insofar as it allows the moving shareholder to recover legal fees conditional upon the successful prosecution of the suit, is an effective counter to the freerider problems, but does not seem to raise deep concerns about individual autonomy given the close alignment of interests between the active and the passive shareholders. And where those conflicts do arise, then some method may be reached to allow certain shareholders, with notice, to opt out of the class.

These questions of structural relief are part and parcel of the suits against MCOs, many of which claim the need for structural reform of MCO practices for the benefit of plan members. But these cases also seek monetary damages. Class action damage cases do not give rise to the necessary freerider problem that

arises in cases seeking injunctive relief. It is in principle possible for one person to pursue his own claim while another individual may decide to settle or abandon his suit. Indeed, it is just that possibility of separability, which allows each claimant to pursue independent strategies, which makes the class action most controversial in the case of damage actions.⁶⁸ In this context, the case for allowing class actions is necessarily different, and runs as stated above: the surrender of the private right to suit is offset by the efforts taken by the class representatives and their lawyers on behalf of passive class members, and the associated economies of scale which reduce the per claim cost of litigation more than enough to offset any costs of amalgamating claims and suppressing their differences. That condition is most likely to hold when the class representatives have claims typical of members of the class generally, when the lawyers who have led the charge are capable of adequately representing both the named and the unnamed plaintiffs, and when the common issues in the class are sufficiently important and uniform so as to obviate potential conflicts of interests between the class representatives and the remaining members of the class. The ability to exit from the class and preserve the individual action is one check on the dangers of conflict, and judicial oversight of the various decisions of the class representatives and lawyers offers a second line of protection against abuse. It is an open question in principle whether the administrative costs of running the class actions—many of which fall on the public at large—are low enough to justify the use of the class action mechanism in a given case. Among other things, the system requires some degree of supervision over the attorneys' fees generated under the class action so that the lawyers receive only a competitive rate of return on the services that they supply. And there are immense difficulties in making sure that the class definition, the actions of the class representative, and the decisions concerning whether to litigate or to settle are consistent with keeping the passive members of the class better off than they would have been had no class action been brought—and better off in roughly uniform proportion with the named plaintiffs. That said, the general view is that the class action survives a frontal assault against its very existence, whatever the abuses or errors in its application to individual cases.⁶⁹

⁶⁸ For recognition of this point, See Fed R. Civ. P. 23(b)(3) advisory committee's note (1966), dealing with amalgamation of damage actions, which states that "[i]n the situations to which this subdivision relates, class action treatment is not as clearly called for as in those described above," i.e. in sections 23(b)(1) and 23(b)(2).

⁶⁹ A convenient summary of the protections is offered in Fleming James, Jr., Geoffrey Hazard, Jr., & John Leubsdorf, *Civil Procedure* §10.22 at 564 (4th ed. 1992) (footnotes omitted):

Revised Rule 23 provides for court control of the representative's conduct, including giving notice to absent members of the class, allowing absentees to intervene, subdividing the class into subclasses along the lines of their interest, limiting the issues as to which the class proceeding shall be binding on absentees, and requiring court approval

The Defendant's Perspective. As already noted, the class action exposes the defendant to liabilities greater than those which it faces in a setting where only individual claims (even with permissive joinder) can be brought. When this development follows solely from the consolidation of meritorious claims into a single claim with lower aggregate litigation costs, defendants should not be heard to complain. But the formation of the class gives rise to two other potential disadvantages for defendants that are not so easily dismissed.

Substantive Law Transformation Through Claim Amalgamation. The first danger involves the risk of some implicit transformation of the substantive law during the course of claim aggregation. Thus, suppose that the plaintiff must prove A, B, and C in order to win an individual judgment. The class action takes on a far more ominous role if the requirement A is dropped, or if the burden of proof on element B is switched from what it would be in an individual suit. Now in effect the conservation of legal accountability (as we might call it) is not respected in the amalgamation of claims in the class action format, and to that imposition the defendant has a legitimate protest.

Just how powerful these transformations can be is illustrated by the successes that plaintiffs had in the tobacco litigation, which proceeded through a modified form of the class action.⁷⁰ The usual tort claim in tobacco litigation contained elements for pain and suffering, lost income and medical expenses.

of any settlement. In addition, members of a Rule 23(b)(3) class —the damages class suit — may opt out by signifying that they do not wish to have their claims included in the action. Revised Rule 23 thus appears fully to meet the requirements of Hansberry v. Lee, on adequate protection of the absentees' interests.

⁷⁰ See, *Agency for Health Care Admin. v. Associated Indus. of Florida*, 678 So.2d 1239 (Fla. 1996), in which the Florida Supreme Court upheld a statute abrogating “[p]rinciples of common law and equity as to assignment, lien subrogation, comparative negligence, assumption of risk, and all other affirmative defenses normally available to a liable third party . . . to the extent necessary to ensure full recovery by Medicaid from third-party resources. . . .” *Id.* at 1244-45 (quoting Medicaid Third-Party Liability Act, 1994 Fla. Laws ch. 251, §4). With the ordinary tort law defenses cast aside by a marriage of legislative fiat and judicial acquiescence, the tobacco companies predictably settled, first in Mississippi, Florida, Texas, and Minnesota, respectively, and ultimately in a “global” settlement covering 46 states, 5 U.S. territories, and the District of Columbia. For more on the “global” settlement, see Attorneys General, Tobacco Industry Finalize \$206 Billion Settlement, *Health Law Rep. (BNA)* No. 47, at 1885 (Dec. 3, 1998); for more on the Minnesota settlement, see Tobacco Industry Settles Lawsuit with Minnesota, Blue Cross/Blue Shield, *Health Law Rep. (BNA)* No. 20, at 779 (May 14, 1998); for more on the Texas settlement, see Texas’ \$15.3 Billion Settlement with Tobacco Companies is Largest Yet, *Health Law Rep. (BNA)* No. 4, at 125 (Jan. 22, 1998); for more on the Florida settlement, see Tobacco Companies to Pay \$11.3 Billion to Settle Florida’s Reimbursement Suit, *Health Law Rep. (BNA)* No. 35 at D-10 (Aug. 28, 1997); and for more on the Mississippi settlement, see Attorney General Announces \$3 Billion Deal with Tobacco Industry, *Health Law Rep. (BNA)* No. 28, at D-12 (July 10, 1997). But see *State ex rel. Miller v. Philip Morris Inc.*, 577 N.W.2d 401 (Iowa 1998) (finding the State has no common law right to indemnity, that it failed to make a subrogation claim, and that it asserted claims against tobacco companies as third-party injurers that failed under the remoteness doctrine).

The ordinary rule of liability required the plaintiff to show some defect in the defendant's product (usually in the warnings supplied), and allowed the defendant some version of the assumption of risk defense--in this case the continuous awareness of the individual smoker to the risks and hazards of smoking--which had proven a powerful defense in these cases.

But in the Medicaid suits, the medical costs portion of the claim was severed from the rest of the basic cause of action and brought by the states in their roles as Medicaid suppliers. This move might have meant that all of these medical claims were transferred by subrogation from individual claimants to their health care providers. As a matter of fact, the original Medicaid contracts with individual enrollees contained subrogation provisions that required the transfer of the medical component of the claims to reimburse Medicaid for its statutory expenditures. Under this subrogation regime, the assignments would result in the formation of a quasi-class, subject of course to the individual defenses, such as assumption of risk, that could be raised against each individual smoker. Accordingly, Medicaid as subrogee would have been subjected to the same merciless dissection of its patients' personal habits as an individual smoker/plaintiff (coupled with a convincing demonstration of the pervasive public knowledge of the risks of smoking--knowledge that could not have escaped the attention of even the most oblivious of smokers).

But the Medicaid claims were not treated as subrogation claims, and instead became "independent" Medicaid claims, which achieved the same class-like amalgamation without any formal assignment of claims or class actions.⁷¹ And because Medicaid programs themselves are not smokers and in no way contributed to their patients' smoking, they faced no assumption of risk defense or the like. This independent claim was often said to rest on the state's public duty to aid persons in need, but it is hardly clear why it should not be treated the same way as any other subrogation claim. Indeed, if taken seriously, the independent claim approach should be available to the insurer in every automobile accident or product liability case, so that in each situation the only thing that would need to be shown is some defect by the defendant that is said to cause harm to the plaintiff. Yet the rule in question was only applied for the benefit of Medicaid, and then only against the tobacco companies--the classic case of ad hoc justice. The transformation of smokers' claims into headless claims for Medicaid reimbursement did exactly what no ordinary device of

⁷¹ In *Agency for Health Care Admin.*, the statute at issue allowed the State to recover damages for itself on behalf of a group of Medicaid recipients (functionally a class) who allegedly suffered injuries from tobacco. While granting Florida the benefit of litigating for its own benefit on behalf of a class, it also expressly abrogated the principles of assignment and subrogation and the concomitant burden of overcoming affirmative defenses--including assumption of risk. 678 So.2d at 1244-45.

assignment or amalgamation could achieve: it tilted the table in plaintiffs' direction.

This same strategy—to avoid the affirmative defenses available in a subrogation action— was also tried in cases brought by private health plans (who are subject to the class action risk in MCO cases).⁷² The health plans claimed that the systematic misrepresentation of the dangers of tobacco fooled the health plans (and the plan enrollees) so that both were required to spend more in treating tobacco-related illnesses than they would have if they had received accurate information about the risks. One possible way to maintain these claims is through subrogation parallel to that of the Medicaid cases, but this strategy again created the danger that the individual defenses in each individual case had to be litigated—a distinctive element that reduces the number of common issues needed for class certification under Rule 23(b)(3). The direct action for losses in their own stead avoided these difficulties, but only at the cost of introducing other and greater distortions. The health plans in question may not have known (although this is doubtful) of the risks associated with smoking, but they did have accurate knowledge of the cost of treatment for the populations that they insured. It is the pool characteristics generally that determine the total costs of servicing the assumed risk, and the ultimate question is whether the plans received a normal rate of return for their services as a group, which in the competitive situation that existed surely seems to be the case. The typical judicial response has denied the cause of action by appealing to a notion—privity—that has surely lost its cachet in other contexts. The representations in question were made to smokers, not to the health plans. But the doctrinal head is less important, generally speaking, than the result, which is to recognize that the diffusion of information about the risks of smoking were sufficiently well known to health plans that they cannot claim any unfair surprise. Indeed the nebulous damages sought—“infrastructure” damages and the lost benefits of educational programs (which cost before they can supply any benefit)--speak to a cause of action composed of missing links. For our purpose it indicates the same disturbing trend found in the Medicaid suits against the tobacco companies--the development of novel theories of liability to circumvent the critical proposition of class actions: amalgamation of claims should not lead to an expansion of substantive rights.

Claim Diversification. The second major difficulty associated with the use of class actions is perhaps more subtle but also profound: the loss of

⁷² See, e.g. *Laborers Local 17 Health and Benefit Fund v. Philip Morris, Inc.*, 191 F.3d 229 (2d Cir. 1999). Subsequent to this decision Judge Weinstein opted for the subrogation approach, with all its internal complexities, in *National Asbestos Workers Medical Fund v. Philip Morris, Inc.*, 74 F. Supp. 2d 213 (E.D.N.Y. 1999).

diversification in the portfolio of adverse claims. The defendant that faces a large number of individual suits does not face an all-or-nothing risk in actions of this sort. Some cases will win, others lose; and some will settle on the strength of the performance of the other cases. But once all claims are amalgamated, then all claims stand or fall at once. The defendant often faces a risk of financial ruination. Although finance theory may teach that the diversified shareholders of public companies ought care little about such risk, CEOs and general counsels may behave as though they are quite concerned about the possible demise of the company, and may be driven to settlement of cases even if they have doubtful merit. That result can be limited by dividing the large class into smaller ones: certain years, certain states, certain products, or whatever. But even smaller classes can be quite large, and the separations may only eliminate the lockstep connections, but not the positive correlations.

To be sure, large groups of similar claims always present certain nondiversifiable risks: precedent increases the correlation of outcomes, and at a more concrete level the use of offensive collateral estoppel--which has achieved some limited adoption--does the same thing by allowing the plaintiff in case B to rely on the successful proof of some critical fact in case A. All of this is done in the name of administrative cost control, but with real risks: offensive collateral estoppel should not be allowed for the plaintiff who breaks through with success after ten prior failures.⁷³ The same attitude should carry over to class actions, where broad certifications should be carefully watched to take this risk into account.

B. Class Actions Against MCOs

With these preliminaries established, it is worthwhile to look more closely at the class actions recently brought against MCOs on behalf of their plan participants. We begin with the standard elements in the complaint. The plaintiffs well understand that they must be able to show the predominance of common issues over separate ones in order to obtain class certification. The first maneuver is to disclaim any intention of "seeking to remedy claims of personal injury, medical malpractice, and/or wrongful death."⁷⁴ Personal injury, medical malpractice claims and wrongful death actions all involve particularized proof of professional negligence that vary substantially from case to case, and no court would ever certify a class with such enormous breadth and such ill-defined contours. A further concern is that the class action attorneys do not wish to start

⁷³ See, e.g., *State Farm Fire & Cas. Co. v. Century Home Components*, 550 P.2d 1185 (1976) (rejecting offensive collateral estoppel where the defendant had succeeded in one previous judgment and lost two others). For a classic treatment of this problem, see Brainerd Currie, *Mutuality of Collateral Estoppel: Limits on the Bernhard Doctrine*, 9 *Stan. L. Rev.* 289 (1957).

⁷⁴ See, e.g., Plaintiff's Class Action Complaint at 6, ¶ 12, *Williamson v. Prudential Insurance Company of America*, No. 2:99CV326 (S.D. Miss. filed Nov. 22, 1999).

a class war with ordinary contingent fee lawyers who specialize in medical malpractice.

A strategic retreat, however, does not a lawsuit make. What then do the plaintiffs allege under their common law and RICO and ERISA hats? The answer is a mix of fraud, nondisclosure and breach of contract and fiduciary claims, all of which stem from the proposition that the health plans consistently promise more than they are able to deliver to their full roster of private subscribers. The number of subscribers tends to be quite large, and thus one class action covers nearly four years, from November 1995 to August 1999, and includes 6.6 million subscribers nationwide.⁷⁵ Key allegations read as follows:

9. Contrary to Prudential's false, misleading, and deceptive misrepresentations, Prudential during the relevant time herein alleged aggressively engaged in implementing covert systematic internal policies and practices that resulted in the reduction of the quality of healthcare services provided the plaintiff and the class, rather than maintaining and improving the quality of their healthcare. These covert systematic internal policies and practices were designed, *inter alia*, to discourage Prudential's healthcare providers from delivering medical services and intrude with the medical judgment of Prudential healthcare providers by substituting the judgment of claims reviewers—who had neither the appropriate medical training nor the medical specialization to determine the medical needs of Prudential enrollees—for the medical judgment of its physicians.

13. During the relevant herein alleged, the healthcare services provided or made available to the plaintiff, the class, and the subclass were worth far less than the health care services described in Prudential's advertising, marketing and member materials.⁷⁶

In dealing with allegations of this sort, one District Court had little difficulty in dismissing the class complaint by noting that “as a matter of law, it is highly doubtful that advertising one's commitment to ‘quality of care’ can serve as the predicate for a fraud claim. Such general assertions as to quality are puffery, and do not constitute a fraudulent inducement to membership in defendants' HMO plans, particularly where the complained-of cost containment provisions are disclosed to prospective members.”⁷⁷

⁷⁵ “The class consists of individuals who paid premiums or subscription payments, or on whose behalf such payments had been made, and were or were named enrollees in any of Prudential's HMOs, PPOs, and POS plans at anytime during the class period from November 22, 1995 to August 6, 1999.” *Id.* at 3, ¶3. Excluded from the class are Medicare and Medicaid members and any director, employee and officer of the defendant.

⁷⁶ *Id.* at 5-6.

⁷⁷ *Maio v. Aetna Inc.*, No. CIV.A. 99-1969, 1999 WL 800315, at *2 (E.D. Pa. Sept. 29, 1999).

This line of argument is as valid against a single action brought by one MCO enrollee as by an entire class, and does not address the question of whether class action status should be applied to this case if the substantive deficiencies in the claim were somehow overcome. In this regard, it is useful to distinguish the fraud from the breach of contract portions of the argument.

The basic law of class actions has long made it clear that suits for fraud are possible, but fragile candidates for class action status: “although having some common core, a fraud case may be unsuited for treatment as a class action if there was material variation in the representations made or in the kinds or degrees of reliance by the persons to whom they were addressed.”⁷⁸

Thus, the nature and source of the defendant’s representations in question must be examined carefully. The plaintiffs duly allege that all the defendant’s representations in question were “standardized and uniform” because they came through the usual set of “marketing materials, including certificates of coverage, member handbooks, member information, provider directories, and other documents.”⁷⁹ Unfortunately, this mode of pleading operates as a clear slight-of-hand. The complaint sets out no particulars whatsoever, itself a problem given the somewhat puzzling Federal Rules requirement that fraud be pleaded “with particularity.”⁸⁰ But even if one did catalogue all the communications in these various categories, that proof would provide no reason to believe that each subscriber read and relied on the same set of materials. The case is not like a typical securities case where the defendants have issued a single prospectus that was read and relied upon by all. Different programs had different standardized materials; and even two individuals who were part of the same plan need not have read the same information at the same time. These standardized materials are not, moreover, the only source of communications: oral communications with physicians, nurses and plan personnel certainly help shape the responses of different individuals. These deviations from standard norms were used to

⁷⁸ Fed R. Civ. P. 23(b)(3) advisory committee’s note (1966). For cases that have denied class certification in fraud/RICO contexts, see *Martin v. Dahlberg, Inc.*, 156 F.R.D. 207 (N.D. Cal. 1994). In *Martin*, the court analyzed alleged misrepresentations by manufacturers, retailers, franchisees and hearing consultants on the sale of hearing aids and found “[t]he diversity of sources of information, the diversity of messages generated by those interested in selling Dahlberg products, and the potential for differing reliance on varied information weigh strongly against class adjudication of the critical issue of reliance.” *Id.* at 215. See also, *Rodriguez v McKinney*, 156 F.R.D. 112 (E.D. Pa. 1994) (rejecting fraud/RICO cases for insufficient benefits given to students without high school diplomas who attended trade schools, noting the difficulties on the reliance question, both from affirmative misrepresentations and nondisclosures).

⁷⁹ Plaintiff’s Class Action Complaint at 4, ¶¶4-5.

⁸⁰ Fed R. Civ. P. 9(b) states: “In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity.”

undercut the adequacy of written warnings in drug and vaccine cases,⁸¹ and those differences should not be ignored here. Add to these structural features the observation that many of the negotiations for plan membership were made by informed intermediaries (e.g. employers, unions, churches, fraternal organizations) and the like, and it seems as though the issue of what counts as fraud, and what counts as reliance will differ substantially. One possible response is to break down the single class of 6.6 million into subclasses, so that all persons who were enrolled in HMOs, for example, could be treated separately from those who were enrolled in PPOs and POS plans. But even this move conceals the differences that might arise when individuals join plans at different times, or are subject to somewhat different disclosure requirements as mandated under different systems of state law.

Another way to skirt these difficulties is to hold the plans responsible for what they did not disclose rather than what they said. The argument here is that silence is uniform across different audiences even if speech is not. But the counterarguments seem more cogent here as well. Initially, the content of the required disclosures depends in part on the types of coverage being offered and in part on the nature of the target audience, and these will vary from case to case. In addition, the impact of the nondisclosures will at a minimum depend on both what else has been said, and on what statutory obligations to disclose can be found under local law. In the end, therefore, the same class action fate ought to await the nondisclosure claims as the misrepresentation claims. They do not present the single decisive moment that allows for class amalgamation.

The next question is whether the outcome differs when the issue switches from misrepresentation to breach of contract, as suggested in paragraph 13 set out above. The answer is clearly “no”: to figure out whether individuals have been short-changed in the delivery of health care services, someone has to decide just how much health care was given to what individuals. None of the actions contemplate such analysis with respect to individual class members. The theory has to be that on average all individuals received care inferior to what was promised them at the outset so that relief comes in one of two forms: either a comprehensive refund to every class member, or some form of prospective structural relief for the benefit of all class members. These forms of relief raise serious questions, both for the question of class certification and for the soundness of the underlying complaint.

⁸¹ See, e.g. *Incollingo v. Ewing*, 282 A.2d 206 (Pa. 1971) (finding the written warnings of the dangers of chloromycetin were insufficient in light of overpromotion by Parke, Davis’ detail man); *Reyes v. Wyeth Laboratories, Inc.*, 498 F.2d 1264 (5th Cir. 1974) (finding liability in part based upon the lack of individual representations by nurses administering vaccines).

The implications of the nonperformance allegations from paragraph 13 of the basic class action complaint are made clearer when those allegations are juxtaposed against the rhetoric that accompanies it: “Aetna is one of the most reprehensible companies in this respect. . . . It’s been fairly aggressive about pursuing a policy of cost-containment with its doctors.”⁸² These statements leave it unclear whether the claim for loss of the benefit of bargain works in the interests of any, let alone all members of the putative class. It is easy enough to assume that refunds to all class members might be desirable for past periods, at least if they do not cripple the ability of the firm to operate as before in future periods. But it is far from clear that the class members share a common interest in the nature and quality of services that they wish to receive from MCO organizations. The plaintiffs in effect claim that there is a particular standard of care is required from the defendant across a range of its health plans, but the complaint offers no evidence whatsoever that the standard of care that it stipulates as desirable is in fact optimal for all members of the group given their different financial constraints and consumer preferences. It could well be that the class action would, if allowed to go forward, set the standard of care such that in the mandated equilibrium large numbers of potential enrollees drop out, which in turn could increase the costs on the shrunken group that now remains. The problem of organizing a class action becomes more acute when it is noted that some members of the class may suffer from preexisting conditions, with the special problems that it entails, while others do not. The thought that one should supply uniform care levels to all participants of all plans makes none of the quality differentiation by income and taste that is characteristic of markets. This observation should be more than sufficient for the conclusion that the class action is an inappropriate vehicle for imposing either minimum or uniform standards on the health care industry.

Likewise, the hallmark of managed care is cost-containment, and its proliferation suggests that many consumers desire it *ex ante*, even if it is reviled *ex post* by the fraction of individuals to whom it is applied. To take the position that all such efforts are misguided, or even that cost containment must be done in certain judicially prescribed ways, is not a proper fix for the MCO, but its death knell. There can be all sorts of mechanisms for controlling costs: the trade-off between increased (or earlier) access and cost is hardly straightforward. The one wrong approach would be to suppose that a trial court judge knows best what mechanism to decree.

⁸² Jennifer M. Gangloff, “*Repair Team*” Hits Aetna with Another Class Action Lawsuit (last modified Nov. 1, 1999) <<http://www.insure.com/health/aetnasuit1199.html>>. REPAIR stands for RICO and ERISA Prosecutors Advocating for Insurance industry Reform.

Finally, some note must be made of the relationship between these suits alleging lost benefits in quality of care and the availability of individual malpractice actions. As noted earlier, the class action complaint carves out from consideration all malpractice actions and remits them to the tort system. But the consequence of supplying insufficient medical benefits to patients in relation to what was promised may often be actionable malpractice as well. If a court chooses to order a refund under these umbrella contract claims plaintiffs may in effect receive double compensation for at least those mistakes in treatment that are caught by the medical malpractice system

As a concluding caution, while we oppose many of the substantive provisions of the various so-called patients' bills of rights, we think that the merits of managed care regulation are better resolved in the legislative arena. Regulatory proposals have been the source of contentious debates in Congress and the states, and it is dangerous to assume that the democratic process has in some sense failed because these proposals have not always been enacted into law. Both sides have a fair crack at success, and each is armed with ample funds to pursue its object in the political arena. A political defeat should not be regarded as a miscarriage of justice to be remedied by other means, often judicial in character. Rather, the central question should be the level at which legislative reforms, if any, should be introduced. If single, comprehensive national reforms are required, then federal legislation becomes the appropriate vehicle of reform. If matters are properly resolved differently by different states, then statewide legislation seems to be appropriate. Our instinct is that a period of experimental reform at the state level certainly makes sense before any blanket policy is mandated nationally. But in any event, everyone should have some rights of participation on matters of this importance, not just the parties to a particular lawsuit. The class action is simply not a suitable vehicle for any system-wide reform of the health care delivery system.

Readers with comments should address them to:

Richard A. Epstein
James Parker Hall Distinguished Service Professor of Law
University of Chicago Law School
1111 East 60th Street
Chicago, IL 60637
repstein@nsit-popmail.uchicago.edu

Alan O. Sykes
Frank and Bernice J. Greenberg Professor of Law
University of Chicago Law School
1111 East 60th Street
Chicago, IL 60637
alan_sykes@law.uchicago.edu

Chicago Working Papers in Law and Economics
(Second Series)

1. William M. Landes, Copyright Protection of Letters, Diaries and Other Unpublished Works: An Economic Approach (July 1991).
2. Richard A. Epstein, The Path to *The T.J. Hooper*: The Theory and History of Custom in the Law of Tort (August 1991).
3. Cass R. Sunstein, On Property and Constitutionalism (September 1991).
4. Richard A. Posner, Blackmail, Privacy, and Freedom of Contract (February 1992).
5. Randal C. Picker, Security Interests, Misbehavior, and Common Pools (February 1992).
6. Tomas J. Philipson & Richard A. Posner, Optimal Regulation of AIDS (April 1992).
7. Douglas G. Baird, Revisiting Auctions in Chapter 11 (April 1992).
8. William M. Landes, Sequential versus Unitary Trials: An Economic Analysis (July 1992).
9. William M. Landes & Richard A. Posner, The Influence of Economics on Law: A Quantitative Study (August 1992).
10. Alan O. Sykes, The Welfare Economics of Immigration Law: A Theoretical Survey With An Analysis of U.S. Policy (September 1992).
11. Douglas G. Baird, 1992 Katz Lecture: Reconstructing Contracts (November 1992).
12. Gary S. Becker, The Economic Way of Looking at Life (January 1993).
13. J. Mark Ramseyer, Credibly Committing to Efficiency Wages: Cotton Spinning Cartels in Imperial Japan (March 1993).
14. Cass R. Sunstein, Endogenous Preferences, Environmental Law (April 1993).
15. Richard A. Posner, What Do Judges and Justices Maximize? (The Same Thing Everyone Else Does) (April 1993).
16. Lucian Arye Bebchuk and Randal C. Picker, Bankruptcy Rules, Managerial Entrenchment, and Firm-Specific Human Capital (August 1993).
17. J. Mark Ramseyer, Explicit Reasons for Implicit Contracts: The Legal Logic to the Japanese Main Bank System (August 1993).
18. William M. Landes and Richard A. Posner, The Economics of Anticipatory Adjudication (September 1993).
19. Kenneth W. Dam, The Economic Underpinnings of Patent Law (September 1993).
20. Alan O. Sykes, An Introduction to Regression Analysis (October 1993).
21. Richard A. Epstein, The Ubiquity of the Benefit Principle (March 1994).
22. Randal C. Picker, An Introduction to Game Theory and the Law (June 1994).
23. William M. Landes, Counterclaims: An Economic Analysis (June 1994).
24. J. Mark Ramseyer, The Market for Children: Evidence from Early Modern Japan (August 1994).
25. Robert H. Gertner and Geoffrey P. Miller, Settlement Escrows (August 1994).
26. Kenneth W. Dam, Some Economic Considerations in the Intellectual Property Protection of Software (August 1994).
27. Cass R. Sunstein, Rules and Rulelessness, (October 1994).
28. David Friedman, More Justice for Less Money: A Step Beyond *Cimino* (December 1994).
29. Daniel Shaviro, Budget Deficits and the Intergenerational Distribution of Lifetime Consumption (January 1995).
30. Douglas G. Baird, The Law and Economics of Contract Damages (February 1995).

31. Daniel Kessler, Thomas Meites, and Geoffrey P. Miller, Explaining Deviations from the Fifty Percent Rule: A Multimodal Approach to the Selection of Cases for Litigation (March 1995).
32. Geoffrey P. Miller, Das Kapital: Solvency Regulation of the American Business Enterprise (April 1995).
33. Richard Craswell, Freedom of Contract (August 1995).
34. J. Mark Ramseyer, Public Choice (November 1995).
35. Kenneth W. Dam, Intellectual Property in an Age of Software and Biotechnology (November 1995).
36. Cass R. Sunstein, Social Norms and Social Roles (January 1996).
37. J. Mark Ramseyer and Eric B. Rasmusen, Judicial Independence in Civil Law Regimes: Econometrics from Japan (January 1996).
38. Richard A. Epstein, Transaction Costs and Property Rights: Or Do Good Fences Make Good Neighbors? (March 1996).
39. Cass R. Sunstein, The Cost-Benefit State (May 1996).
40. William M. Landes and Richard A. Posner, The Economics of Legal Disputes Over the Ownership of Works of Art and Other Collectibles (July 1996).
41. John R. Lott, Jr. and David B. Mustard, Crime, Deterrence, and Right-to-Carry Concealed Handguns (August 1996).
42. Cass R. Sunstein, Health-Health Tradeoffs (September 1996).
43. G. Baird, The Hidden Virtues of Chapter 11: An Overview of the Law and Economics of Financially Distressed Firms (March 1997).
44. Richard A. Posner, Community, Wealth, and Equality (March 1997).
45. William M. Landes, The Art of Law and Economics: An Autobiographical Essay (March 1997).
46. Cass R. Sunstein, Behavioral Analysis of Law (April 1997).
47. John R. Lott, Jr. and Kermit Daniel, Term Limits and Electoral Competitiveness: Evidence from California's State Legislative Races (May 1997).
48. Randal C. Picker, Simple Games in a Complex World: A Generative Approach to the Adoption of Norms (June 1997).
49. Richard A. Epstein, Contracts Small and Contracts Large: Contract Law through the Lens of Laissez-Faire (August 1997).
50. Cass R. Sunstein, Daniel Kahneman, and David Schkade, Assessing Punitive Damages (with Notes on Cognition and Valuation in Law) (December 1997).
51. William M. Landes, Lawrence Lessig, and Michael E. Solimine, Judicial Influence: A Citation Analysis of Federal Courts of Appeals Judges (January 1998).
52. John R. Lott, Jr., A Simple Explanation for Why Campaign Expenditures are Increasing: The Government is Getting Bigger (February 1998).
53. Richard A. Posner, Values and Consequences: An Introduction to Economic Analysis of Law (March 1998).
54. Denise DiPasquale and Edward L. Glaeser, Incentives and Social Capital: Are Homeowners Better Citizens? (April 1998).
55. Christine Jolls, Cass R. Sunstein, and Richard Thaler, A Behavioral Approach to Law and Economics (May 1998).
56. John R. Lott, Jr., Does a Helping Hand Put Others At Risk?: Affirmative Action, Police Departments, and Crime (May 1998).
57. Cass R. Sunstein and Edna Ullmann-Margalit, Second-Order Decisions (June 1998).

58. Jonathan M. Karpoff and John R. Lott, Jr., Punitive Damages: Their Determinants, Effects on Firm Value, and the Impact of Supreme Court and Congressional Attempts to Limit Awards (July 1998).
59. Kenneth W. Dam, Self-Help in the Digital Jungle (August 1998).
60. John R. Lott, Jr., How Dramatically Did Women's Suffrage Change the Size and Scope of Government? (September 1998)
61. Kevin A. Kordana and Eric A. Posner, A Positive Theory of Chapter 11 (October 1998)
62. David A. Weisbach, Line Drawing, Doctrine, and Efficiency in the Tax Law (November 1998)
63. Jack L. Goldsmith and Eric A. Posner, A Theory of Customary International Law (November 1998)
64. John R. Lott, Jr., Public Schooling, Indoctrination, and Totalitarianism (December 1998)
65. Cass R. Sunstein, Private Broadcasters and the Public Interest: Notes Toward A "Third Way" (January 1999)
66. Richard A. Posner, An Economic Approach to the Law of Evidence (February 1999)
67. Yannis Bakos, Erik Brynjolfsson, Douglas Lichtman, Shared Information Goods (February 1999)
68. Kenneth W. Dam, Intellectual Property and the Academic Enterprise (February 1999)
69. Gertrud M. Fremling and Richard A. Posner, Status Signaling and the Law, with Particular Application to Sexual Harassment (March 1999)
70. Cass R. Sunstein, Must Formalism Be Defended Empirically? (March 1999)
71. Jonathan M. Karpoff, John R. Lott, Jr., and Graeme Rankine, Environmental Violations, Legal Penalties, and Reputation Costs (March 1999)
72. Matthew D. Adler and Eric A. Posner, Rethinking Cost-Benefit Analysis (April 1999)
73. John R. Lott, Jr. and William M. Landes, Multiple Victim Public Shooting, Bombings, and Right-to-Carry Concealed Handgun Laws: Contrasting Private and Public Law Enforcement (April 1999)
74. Lisa Bernstein, The Questionable Empirical Basis of Article 2's Incorporation Strategy: A Preliminary Study (May 1999)
75. Richard A. Epstein, Deconstructing Privacy: and Putting It Back Together Again (May 1999)
76. William M. Landes, Winning the Art Lottery: The Economic Returns to the Ganz Collection (May 1999)
77. Cass R. Sunstein, David Schkade, and Daniel Kahneman, Do People Want Optimal Deterrence? (June 1999)
78. Tomas J. Philipson and Richard A. Posner, The Long-Run Growth in Obesity as a Function of Technological Change (June 1999)
79. David A. Weisbach, Ironing Out the Flat Tax (August 1999)
80. Eric A. Posner, A Theory of Contract Law under Conditions of Radical Judicial Error (August 1999)
81. David Schkade, Cass R. Sunstein, and Daniel Kahneman, Are Juries Less Erratic than Individuals? Deliberation, Polarization, and Punitive Damages (September 1999)
82. Cass R. Sunstein, Nondelegation Canons (September 1999)
83. Richard A. Posner, The Theory and Practice of Citations Analysis, with Special Reference to Law and Economics (September 1999)
84. Randal C. Picker, Regulating Network Industries: A Look at *Intel* (October 1999)
85. Cass R. Sunstein, Cognition and Cost-Benefit Analysis (October 1999)

86. Douglas G. Baird and Edward R. Morrison, Optimal Timing and Legal Decisionmaking: The Case of the Liquidation Decision in Bankruptcy (October 1999)
87. Gertrud M. Fremling and Richard A. Posner, Market Signaling of Personal Characteristics (November 1999)
88. Matthew D. Adler and Eric A. Posner, Implementing Cost-Benefit Analysis When Preferences Are Distorted (November 1999)
89. Richard A. Posner, Orwell versus Huxley: Economics, Technology, Privacy, and Satire (November 1999)
90. David A. Weisbach, Should the Tax Law Require Current Accrual of Interest on Derivative Financial Instruments? (December 1999)
91. Cass R. Sunstein, The Law of Group Polarization (December 1999)
92. Eric A. Posner, Agency Models in Law and Economics (January 2000)
93. Karen Eggleston, Eric A. Posner, and Richard Zeckhauser, Simplicity and Complexity in Contracts (January 2000)
94. Douglas G. Baird and Robert K. Rasmussen, Boyd's Legacy and Blackstone's Ghost (February 2000)
95. David Schkade, Cass R. Sunstein, Daniel Kahneman, Deliberating about Dollars: The Severity Shift (February 2000)
96. Richard A. Posner and Eric B. Rasmusen, Creating and Enforcing Norms, with Special Reference to Sanctions (March 2000)
97. Douglas Lichtman, Property Rights in Emerging Platform Technologies (April 2000)
98. Cass R. Sunstein and Edna Ullmann-Margalit, Solidarity in Consumption (May 2000)
99. David A. Weisbach, An Economic Analysis of Anti-Tax Avoidance Laws (May 2000)
100. Cass R. Sunstein, Human Behavior and the Law of Work (June 2000)
101. William M. Landes and Richard A. Posner, Harmless Error (June 2000)
102. Robert H. Frank and Cass R. Sunstein, Cost-Benefit Analysis and Relative Position (August 2000)
103. Eric A. Posner, Law and the Emotions (September 2000)
104. Cass R. Sunstein, Cost-Benefit Default Principles (October 2000)
105. Jack Goldsmith and Alan Sykes, The Dormant Commerce Clause and the Internet (November 2000)
106. Richard A. Posner, Antitrust in the New Economy (November 2000)
107. Douglas Lichtman, Scott Baker, and Kate Kraus, Strategic Disclosure in the Patent System (November 2000)
108. Jack L. Goldsmith and Eric A. Posner, Moral and Legal Rhetoric in International Relations: A Rational Choice Perspective (November 2000)
109. William Meadow and Cass R. Sunstein, Statistics, Not Experts (December 2000)
110. Saul Levmore, Conjunction and Aggregation (December 2000)
111. Saul Levmore, Puzzling Stock Options and Compensation Norms (December 2000)
112. Richard A. Epstein and Alan O. Sykes, The Assault on Managed Care: Vicarious Liability, Class Actions and the Patient's Bill of Rights (December 2000)