The Looming Threat of Liability for Accountable Care Organizations and What to Do About It

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The promotion of accountable care organizations (ACOs), a new health care delivery and payment model designed to curb rising medical costs while improving quality, is one of the most important elements of the Affordable Care Act. The ACO model is based on shared-risk contracts, in which ACOs agree to share the financial risk of health care overspending with third-party payers. Although they originate in Medicare, these shared-risk arrangements are quickly spreading to the private insurance markets, where they aim to dismantle the volume-driven fee-for-service revenue model.\(^1\) Hundreds of health systems across the country have already adopted the ACO model and in so doing have taken on a new role of cost containment. What may be less clear to them is that they are taking on new liability risks.

When cost-saving efforts play a role in medical decision-making, there is an inevitable tension between cost containment and medical liability.\(^2\) As agents of cost containment in the 1990s, managed care organizations (MCOs) were subject to a wave of member lawsuits that alleged negligent medical decisions and that were supported by a common assertion that MCOs negligently prioritized their financial success over the health of their members. However, in 2004, the Supreme Court gave MCOs some immunity against these types of state law tort claims by recognizing federal preemption (ie, that federal law blocked enforcement) of these claims for employer-provided health insurance plans subject to the requirements of the Employee Retirement Income Security Act (ERISA).\(^3\) Although the prudence of MCO immunity is up for debate, the result is not. ERISA protection reduced direct and indirect liability costs for MCOs by preventing constant second-guessing of the motivations behind their medical coverage decisions.\(^4\)

ACOs will be walking this same precarious line between cost savings and patient care. Unlike MCOs, however, ACOs will generally not have the benefit of ERISA, which does not cover them; nor are they slated to get comparable federal liability protections.\(^2\) As a result, ACO cost-containment efforts may be scrutinized by the court when poor patient outcomes result in malpractice litigation. For example, if a poor outcome occurs in a patient with congestive heart failure (CHF), a plaintiff could challenge an ACO’s more stringent CHF hospital admissions criteria, asserting a prioritization of cost savings over patient care. In the absence of a federal law that could offer protection, this medical liability claim would be judged by state-based standards, which do not consider federal cost containment goals when determining whether a medical decision was appropriate.\(^2\) Based on MCO liability case law, state courts may hold ACOs liable in this situation.\(^2\)

Under “agency theory” in tort law, a plaintiff in a malpractice suit is permitted to hold a health system liable for the negligent actions of its employee, ie, the treating clinician. A patient may also sue a health system directly, claiming that policies or actions of the health system are negligent. Thus, whether ACOs or not, health systems are exposed to institutional liability related to medical malpractice. How big of a divergence is ACO liability from the existing forms of institutional liability common to health systems? The key difference is the introduction of a new dimension of medical malpractice liability that goes hand in hand with the cost containment charge: the claim that the ACO’s actions or policies prioritized cost savings over patient safety, contributing to the plaintiff’s harm.

Allegations of institutional malfeasance related to cost-saving efforts could increase liability costs and create a chilling effect on ACOs. Moreover, these suits need not progress to trial to threaten ACOs. The assertion of institutional malfeasance alone adds strength to a lawsuit and introduces the potential for punitive damages. This could increase jury awards and settlement amounts. In addition, the broader nature of the claims will enable more robust discovery beyond the care received by the patient. Discovery could now reach into the corporate boardroom as a plaintiff attempts to show that institutional policies regarding resource utilization or physician compensation stifled appropriate treatment. For the ACO, this increased complexity means greater defense costs and increased pressure to settle. Beyond cost increases from more garden-variety medical malpractice cases, ACOs could also be exposed to new theories of liability. It is possible to envision a class action suit seeking injunctive relief or damages against institutional policies felt to be potentially harmful to patients, such as physician incentives payments. Also, ACOs and the physicians working for them, perhaps because of fear of being judged by a medical malpractice system that does not take cost consciousness into account, may hesitate to factor costs into utilization decisions, deretering the very cost-saving goals on which the ACO model was founded.

ACOs have significant advantages over MCOs for achieving cost containment without negatively affecting patient care. First, mandatory quality and outcomes standards are common to shared-risk contracts and act as an internal quality check for an ACO’s cost-containment efforts. This balance was not explicitly present in the MCO era. Second, ACOs are able to approach the task of cost containment armed with the lessons gained from the MCO experience, better patient-related analytics, and more control over physician behaviors.\(^5\) This has led one expert to suggest that ACOs

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are less likely than MCOs to provoke claims of institutional malfeasance related to their cost-containment efforts; however, the overall number of medical malpractice claims aimed at health systems is far greater, likely negating this difference.

With the ACO model still in its infancy, it could take some time for the courts to fully sort out the scope of ACO liability. This task is made all the more challenging by the broad continuum of business models that ACOs have assumed, from minimally integrated group practice arrangements to fully integrated hospital-based ACOs with staff physicians. Moreover, as ACOs become comfortable with assuming risk, they could decide to also take on the roles of an insurer. One recent example involves Partners HealthCare’s acquisition of Neighborhood Health Plan, an insurer of more than 100,000 Massachusetts residents. Thus, aspects of these health systems could become indistinguishable from staff model MCOs, making them eligible, in part, for ERISA protections.

To be sure, there are many unanswered questions. However, until this murky liability environment becomes clearer, ACOs can take steps to protect themselves from potential liability—steps that may help dictate the structures of these new entities. For starters, ACOs can purchase managed care errors and omissions insurance to at least partially protect against these new types of liability. ACOs also could embrace self-help remedies to reduce their future liability, such as matching institutional care algorithms like the CHF hospital admissions criteria to published guidelines or evidence-based medicine. In doing so, ACOs tie their policies to recognized standards of care. In addition, ACOs could be cautious when implementing incentive-based compensation that ties a substantial portion of physicians’ income to their ability to reduce patient care costs. Such a compensation structure might be seen as tacitly encouraging undertreatment, exposing the ACO to additional liability. Congress could also take steps to protect ACOs from the effect of too much liability. Whether that is desirable, of course, depends on one’s view of whether the existing level of MCO liability is too strong or too weak. For those who think liability should be scaled back, the simplest but most coarse solution would be for Congress to amend ERISA such that its protections for employer-provided plans apply equally to ACOs and MCOs. However, many would argue that ERISA protections went too far by not adequately holding MCOs accountable for their actions—specifically, negligent denials of coverage. Thus, providing ACOs an equivalent protection may not be desirable. The best way forward would be to subject ACOs to a more balanced approach that would avoid the overdeterrence of cost-containment efforts associated with current liability standards while still holding ACOs accountable for medical decisions not based on recognized standards of quality. One such approach would be to establish safe harbors in the form of best practices relating to compensation structures and the use of evidence-based medicine. ACOs that meet those safe harbor requirements would receive protection from state tort law claims in these areas. A federally funded demonstration project in Oregon intends to test a version of this safe harbor approach for general medical malpractice claims. It may also be worthwhile to consider mounting a demonstration project focused on enterprise liability for ACO health systems, which would shift liability away from individual physicians toward the health system.

In sum, although ACOs represent an important and exciting innovation in health care payment and delivery, that innovation may be stymied by the threat of an uncertain liability environment. Through the self-help remedies as well as possible congressional intervention, there are several possible ways forward that would appropriately balance cost savings, patient care, and liability and enable ACOs to be safe and effective agents of change.

REFERENCES