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MANAGED CARE TORT LIABILITY: THE NEW TEXAS STATUTE,

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Introduction

In 1997, by an overwhelming margin, the Texas Legislature made Texas the first state to explicitly allow insurers, HMOs, and managed care organizations ("MCOs") to be sued for medical malpractice.¹ Support for the legislation was fueled by the advocacy of consumer groups, plaintiffs' lawyers, and many physician groups. Proponents of the bill argued that subjecting managed care organizations to tort liability was necessary, since managed care organizations were making decisions to deny referrals or deny care and were, therefore, practicing medicine.² The Texas Senate sponsor of the bill argued that he could think of no reason why a doctor should be held accountable for a decision, but an HMO should not.³ Proponents of the bill argued that treating HMOs and subjecting them to the same liability as medical doctors was long past overdue and would advance the cause of quality of care.⁴ This article will contain a critical analysis of the new law and whether subjecting managed care organizations to tort lawsuits for medical malpractice will accomplish the purposes espoused of achieving quality care and whether imposing liability will assist in balancing the need for controlling the cost of health care and health insurance.

Alarming, an increasing number proponents at the state and federal levels advocate subjecting insurers, HMOs, and other MCOs to tort lawsuits as a means to solve quality of care issues in health care.⁵ There has been an increasing public and political perception that the quality of care is sacrificed when a managed care organization is involved as compared to traditional fee-for-service health care.⁶ Responding to these public perceptions and political pressures, a growing number of legislatures have considered legislation that would subject managed care organizations to tort liability. One state, Missouri, repealed an exemption from tort liability for HMOs and passed a new law that would subject HMOs to tort liability.⁷ California and New York are also considering legislation that imposes tort liability on managed care entities.⁸

"Managed care" is a term that is used loosely and broadly in many circles. The new Texas law has a very broad definition of "managed care" that will affect not only HMOs but all types of health insurers.⁹ Generally speaking, however, "managed care" is a term that is used to broadly describe a variety of different organizations and techniques that can *control costs* in the utilization of health care services and often contains some involvement in both the medical and financial aspects of patient's care.¹⁰ The proliferation of managed care in the early 1990s was seen as a necessary means to manage the ever-escalating cost of health care.¹¹ Now, the pendulum seems to be swinging in the other direction.¹² The two main pressures on managed care are cost and quality.¹³ At times, these may be conflicting considerations, but it is proper and appropriate that a balance be struck.

This author feels that the political pressures that the Texas Legislature felt caused it to sacrifice legitimate concerns about the cost of health care as a means to satisfy the hungry cries of some for reform of HMOs. Cost concerns were sacrificed at the expense of allegedly insuring quality care. A careful analysis of the new Texas statutory cause of action will show that, perhaps, the new Texas law will not drastically improve the quality of care but may drastically improve the quality of legal business on both the plaintiff and defense sides.

While it is clear that recipients of health care who receive care provided either directly or that is facilitated by a managed care organization may have some genuine reasons to complain about the quality of health care received, the imposition of tort liability and resolution of issues through a statutory liability system will create uncertainty and may threaten the solvency of

liability and resolution of issues through a statutory liability system will create uncertainty and may threaten the solvency of many managed care organizations. Health insurance, unlike some other lines of insurance, involve a huge volume of claims. The threat of litigation poses tremendous concerns due to the volume of claims. While I do not believe that state insurance regulators and their ability to regulate are a cure-all for the problem of balancing quality concerns with cost concerns, I believe the ultimate solution to finding a proper balance between the quality of care and the cost of health care is better placed in the hands of regulators rather than through private litigation and statutory causes of action.

It is hoped that a better understanding of the Texas law and some of its shortcomings will assist counsel in other states in avoiding some of the same mistakes that have been made in Texas. Hopefully, the legal pitfalls that the new Texas law creates can be avoided, and there will be better ways to find the proper balance between the needs for quality care and the needs for cost containment.

Texas Statute on Health Care Liability

Background. The new Texas cause of action for health care liability is codified at Tex. Civ. Prac. & Rem. Code Ann., Chapter 88.¹⁴ Reference will be made to Chapter 88 claims in this article. Prior to the enactment of Chapter 88, there had been numerous barriers to enforcing tort liability on managed care entities. These barriers included issues about ERISA preemption;¹⁵ whether HMOs can legally be held to practice medicine;¹⁶ issues of vicarious liability;¹⁷ issues of negligent selection or retention of health care providers;¹⁸ ostensible agency and other problems.¹⁹

The new Texas law has been challenged by Aetna in federal court on whether ERISA will preempt Chapter 88 claims.²⁰ Whether Aetna will succeed is debatable. The recent trend of United States Supreme Court cases seems to be to narrow, rather than enlarge, ERISA preemption.²¹ Chapter 88 clears away a number of hurdles for suing insurers, HMOs or managed care entities but still leaves a number of questions open to interpretation. This section will analyze key parts of the Texas statute.

Definitions. Managed Care Entity. Texas law defines "managed care entity" to mean "any entity which delivers, administers or assumes risks for health care services with systems or techniques to control or influence the quality, accessibility, utilization or cost and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of one of its employees or the employees of one or more subsidiaries or affiliated corporations or the employer or a pharmacy licensed by the State Board of Pharmacy."²²

Comment: The Texas House of Representatives amended this definition. The amendment was intended to tighten the language in the new Texas law to exclude employers from liability. If these amendments have that intended purpose and the definition of "managed care organization" excludes employer groups, then a significant portion of the Texas marketplace has virtually been excluded from the ambit of this bill that was aimed at assuring "quality care for all individuals." It is estimated that nearly 40% of Texans are insured through self-funded employer plans. This bill may have the effect of forcing more employers into self-funded arrangements, if the expense and cost of litigation forces the price up for traditional managed care organizations operated by HMOs and insurance companies.

There is considerable concern regarding the breadth of the definition of "managed care entity" which arguably encompasses not only entities that are traditionally thought of as managed care entities, such as health insurers, PPOs, utilization review agents and HMOs, but multiple-entity networks and their component entities as well. Of considerable concern is whether entities providing managed care on behalf of self-funded ERISA plans may be subject to liability under this law. A lawsuit is pending in Federal Court in Texas concerning the ERISA preemption on this new law.²³

preemption on this new law.²³

Appropriate and Medically Necessary. The new law defines "appropriate and medically necessary" as follows:

Appropriate and medically necessary means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.²⁴

Comment: The definition in the new law does not conform to most generally approved definitions contained in many policies of insurance, especially indemnity policies.²⁵ Virtually every insurance policy provides exclusions for treatment that are not medically necessary. There are numerous issues that are normally characterized as issues relating to medically necessary treatment including: accepted treatment vs. experimental treatment, in-hospital vs. out-of-hospital treatment, elective vs. necessary procedures, and methods of determining necessity.²⁶

There are a number of court cases that have litigated issues on medical necessity. Often these cases involve suits for injunctive relief to provide injunctions against the managed care organization from denying coverage before the procedure is implemented. Examples of the type of serious cases involving medical necessity include treatment for Down's Syndrome,²⁷ experimental treatments for life-threatening cancers,²⁸ or elective restorative surgery to allow pregnancy.²⁹

The application of the new Texas law, however, in using a definition of "appropriate and medically necessary" that is different than in the policy, will create uncertainty on the part of the managed care organization or the insurance company determining how to apply coverage under its policy. This definition also may serve to encourage more lawsuits to litigate whether the provisions of the statute or the provisions of the contract apply.

Liability Imposed. The new statute allows health insurance carriers, health maintenance organizations and other managed care organizations to be sued for negligence in making health care treatment decisions.³⁰ The term "health care treatment decision" is an important defined term in the statute. "Health care treatment decision" is defined to mean:

A determination made when *medical services are actually provided by the health care plan* and a decision which affects the quality of the diagnosis, care or treatment provided to the plan's insureds or enrollees.³¹
(Emphasis supplied.)

The statute provides that health insurance carriers, HMOs and other managed care entities have a duty to exercise ordinary care when making health care treatment decisions and are liable for damages for harm to any insured or enrollee proximately caused by their failure to exercise such ordinary care.³² In addition, the organization, carrier or other entity has liability for damages or harm proximately caused to an insured or enrollee by such decisions that are made by the organization's employees, agents, ostensible agents or representatives.³³

Comment: The definition of "health care treatment decision" is defined in a way that would seem to clearly apply to staff model type HMOs. In a staff model type HMO, the physicians and health care providers are employed directly by the HMO.³⁴ However, it has long been argued in Texas that a staff model type HMO is prohibited by the Medical Practice Act which bans the corporate practice of medicine.³⁵ Some have argued that federal law may supersede state prohibitions and

have argued that federal law may supersede state prohibitions and allow corporations to employ licensed physicians.³⁶ It is not clear if other types of HMOs (group, IPA) or PPO arrangements are "actually providing" medical services. The new Texas law provides that a physician is not an employee, agent or ostensible agent of a health insurer, HMO or managed care entity based solely on proof that such person's name appears on a listing of approved physicians made available to insureds.³⁷

The statute also provides that nothing in the law of Texas prohibiting a health insurance carrier, HMO or other managed care entity from practicing medicine or being licensed to practice medicine is a defense to an action under Chapter 88.³⁸

This provision was intended to reverse Texas case law that had previously held that an HMO could not be liable for tort under common law since, as a matter of law, it could not be a corporation that could be licensed to "practice medicine."³⁹

The ambiguity in the definition of "health care treatment decision" and the defenses that are in the new Texas law will certainly have to be resolved in later court actions. This definition of health care treatment decision also causes particular confusion for fee-for-service health care plans offered by health insurance companies. Certainly, it is difficult to conceive of how an indemnity policy of health insurance can be designed to "provide medical services" when it is clearly a contract for the payment of the cost of either hospitalization or other health care services as provided in the policy or contract. Traditional fee-for-service type health insurance is clearly an option designed to determine payment mechanisms for health and medical services being provided by licensed practitioners, and it is not intended, nor should it have been intended, to be construed that such indemnity should be considered to be providing medical services. The Texas Medical Practices Act, which is similar to that in many states, and the term "practicing medicine" as used in that Act does not appear to provide any authority that a company that provides indemnity health insurance is "practicing medicine" as that term is used in the Texas Medical Practices Act.⁴⁰

Standard of Care. For purposes of a claim under Chapter 88, health insurance carriers, HMOs, and other managed care entities have a duty to exercise ordinary care. "Ordinary care" is defined as "that degree of care that a health insurance carrier, HMO or managed care entity of ordinary prudence would use under the same or similar circumstances."⁴¹ However, in the case of a person who is an employee, agent, ostensible agent or representative of a health insurance carrier, HMO or managed care entity, ordinary care means that degree of care that a person of ordinary prudence in the same profession, specialty or area of practice as the employee, agent, ostensible agent or representative would use in the same or similar circumstances.⁴²

Comment: Insurers, HMOs, and managed care entities, thus, have two different standards of care that they must be concerned about in making health care treatment decisions under Texas law. First, they must use standards of ordinary care that an insurer of ordinary prudence would use, but, because of their potential vicarious liability for the acts of their employees, agents, ostensible agents or representatives, they are held to a much different and broader standard. This is vague and ambiguous. Compliance may be difficult for many insurance companies, HMOs, and managed care organizations.

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For example, if a utilization review agent is reviewing utilization issues for a physician in a particular community with a particular specialty, then the particular standard of care for that utilization review agent is the same standard as for the physician. In a standard medical malpractice case, under Texas law, the plaintiff must prove what a reasonable doctor of the same school or practice as the defendant would have done under the same or similar circumstances.⁴³ The standard of care relates to and is established by the expert testimony of physicians practicing in the same or a similar community.⁴⁴ Thus, the community standard rule does not require a small office of a rural medical practitioner to possess either the skills or the equipment of a sophisticated clinic. An insurance company, HMO or managed care organization, however, would have to understand those standards of care in all of the service areas and specialties, depending on the circumstances of the question, to determine issues under its policy. This is clearly an area where insurance companies have, and managed care entities have, much broader liability than that in the medical community.

Agency and Ostensible Agency. As stated earlier, liability is imposed for acts of employers, agents, ostensible agents or representatives using a broad standard of care.⁴⁵ "Representatives" are defined as those people who are acting on behalf of the insurer, HMO or managed care entity and over whom the insurer, HMO or managed care entity has the right to exercise influence or control or has actually exercised such influence or control over health care treatment decisions.⁴⁶

Comment: In Texas, the ostensible agency theory has been applied in the hospital setting involving a case against the hospital that contracted with emergency room doctors.⁴⁷ One court stated that the elements required to defeat a summary judgment under an ostensible agency theory included:

- (1) The patient must look to the hospital for treatment, rather than the individual physician; and
- (2) The hospital must "hold out" the physician as its employee.⁴⁸

It will be interesting if Texas courts apply these standards to "approve physicians" in HMO, PPO or IPA type plans. If so, it is difficult to imagine that a patient would look to its insurer, HMO or managed care entity for treatment rather than the treating physician. As you can see, this area of the Act will create a lot of uncertainty for managed care arrangements.

Defenses. Various defenses are included in the statute in addition to defenses that might otherwise be available in a negligence cause of action. First, the statute provides that it is a defense if (1) neither the health insurance carrier, HMO or managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct the health insurance carrier, HMO, or other managed care entity is liable, controlled, influenced or participated in the health care treatment decision, and (2) the carrier, HMO or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.⁴⁹ The statute also provides that no obligations are imposed on carriers, HMOs, or managed care entities to provide treatment that is not covered by the entity's health care plan.⁵⁰ The statute does not apply to workers' compensation insurance coverage.⁵¹

Finally, an enrollee who files an action under Chapter 88 must comply with the Medical Liability and Insurance Improvement Act of Texas as it relates to cost bonds, deposits and experts reports.⁵² This last section is technically not a defense even though failure to comply with the requirements to post cost bonds and expert reports can result in dismissal of a cause of action.⁵³

Comment: The defenses afforded under Chapter 88 are illusory at best. Considering the fact that there is vicarious liability for employees, agents and ostensible agents, defense under the new law may be difficult to ever achieve. It is also not clear if the defenses afforded by statute are affirmative defenses where the burden of proof would be on the insurer to establish the defense and what proof is necessary to establish the defense.

The type of cases that are most likely to result in serious lawsuits where considerable damages are involved are cases involving "medical necessity" cases that involve some type of experimental treatment for a terminal disease or illness. Examples include various types of new treatments for cancers in advanced stages or new forms of treatment that may involve considerable expense but may be considered experimental in the medical community.⁵⁴ Under the new Texas statute, these types of issues may be resolved in a lawsuit. Other examples could include decisions for inpatient hospitalization for a certain number of days.⁵⁵ If such determination proves after the fact to be inadequate, then a lawsuit may be the end result.

Of particular concern is where the insurer, HMO or managed care entity "participates" in a decision with the primary physician for the insured. If the insurer, HMO or managed care entity agrees with an attending physician's recommended course of treatment that later proves to be negligence on the part of the physician, then the defenses provided by the statute may not be available. The defense of payment also would not be available to utilization review agents or third parties that have no legal obligation to pay. An obvious question also must be asked about this defense. If insurers or HMOs start paying expensive experimental treatment claims to avoid liability, then what effect will this have on the overall cost of insurance?

The proponents for this statute argued that insurers, HMOs, and managed care entities should be liable just like physicians. However, many of the protections afforded physicians in the Medical Liability and Insurance Improvement Act ("MLIIA") are not afforded under Chapter 88.⁵⁶ The safeguards for filing of cost bonds, deposits and expert reports at the time of filing an action were added in 1995 as part of the Texas Legislature's tort reform package.⁵⁷ Many other protections afforded physicians were not extended in Chapter 88 causes of action including (1) a shorter statute of limitations scheme, (2) a cap on wrongful death damages, (3) limits on prejudgment interest, and (4) discovery and notice procedures.

The statute of limitations for wrongful death actions brought against insurers, HMOs or managed care entities would run from the date of death while the statute of limitations in a medical malpractice action under the Texas law is shorter and runs from the date of the tort, the date of last treatment, or in the case of hospitals, the date of discharge from the hospital, rather than the date of death.⁵⁸ Thus, insurers, HMOs, and managed care entities face increased exposure to the risk of

HMOs, and managed care entities face increased exposure to the risk of litigation since they may face liability after the applicable statute of limitations has run against the "health care providers."

Certain procedural requirements of notice are also required for lawsuits against physicians and other health care providers. Sixty days notice is required before filing a lawsuit against a health care provider.⁵⁹ This protection is not afforded in Chapter 88 claims. Also, the expressed criteria for experts codified in the Texas law for medical malpractice cases is not applicable in a Chapter 88 claim.⁶⁰ Thus, common law interpretations of experts may make it easier to qualify certain experts against the insurer when such expert may not be qualified against the health care provider.

Texas law restricts prejudgment interest in medical malpractice claims to past damages but not on future damages.⁶¹ Additionally, prejudgment interest is not allowed if a claim settles before the 181st day after the notice of claims is sent to the health care provider.⁶² This restriction on prejudgment interest is not applicable to entities subject to suit under Chapter 88.

Finally, damages for wrongful death cases against health care providers are capped.⁶³ The current cap is approximately \$1.3 million. The cap applies on a per defendant basis. Entities subject to Chapter 88 causes of action would not fall under this cap.

Finally, a question arises as to whether the health care treatment decisions will be construed to also mean that it is a professional service which is exempt from the Texas Deceptive Trade Practices Act.⁶⁴ The exemption from the Deceptive Trade Practices Act (DTPA) was intended to exempt physicians. If this exemption applies only to physicians and not to managed care entities, then the remedies available in the DTPA could also provide a broader base of liability on managed care entities.

All of this sums up to the fact that an insurer, HMO or managed care entity will be a much more attractive defendant in a medical malpractice case because of the lack of availability of the defenses and procedural rules that will be available to the health care provider.

Independent Review. One of the better features applicable to Chapter 88 claims is the requirement for review of an insured or an enrollee's claim by an independent review organization. This requirement only applies if the insurer, HMO or managed care entity is required to comply with the utilization review requirements.⁶⁵ A claim must be submitted for independent review prior to the filing of a lawsuit unless the enrollee has already been harmed and the review would not be beneficial to the enrollee.⁶⁶ The statute provides that failure to seek independent review is not jurisdictional and a court may not dismiss a cause of action but may abate the action for up to 30 days for such purposes.⁶⁷

The Texas Department of Insurance (TDI) has adopted rules to implement the IRO process.⁶⁸ These rules provide procedures for licenses of IRO organizations, procedures to submission of claims, fees, confidentiality of records, and standards to permit the effective oversight by the TDI of the IRO process.⁶⁹

Comment: The IRO process has resulted in submission of only approximately 157 cases since its inception in September 1997. Approximately 42% of the cases have resulted in a recommendation upholding the findings of the insurer, HMO or managed care entity.

upholding the findings of the insurer, HMO or managed care entity. The TDI anticipated over 4,000 claims. The procedures utilized by the TDI and statutory language are recommended for consideration by other states. The IRO process, even without a statutory cause of action, is a process that effectively allows a prompt independent determination of important coverage issues, especially disputes about medical necessity, on health insurer claims. The procedure is less expensive than litigation including litigation seeking injunctive relief to determine issues of medical necessity or experimental coverage. If the IRO process is used with a statutory cause of action, it is recommended that it be made mandatory and jurisdictional. This is the only way to protect against numerous lawsuits and also provides an appropriate outlet to quickly determine medical necessity questions under applicable coverage. Administration of the program by a regulator also allows a proper method to balance the interests of quality of care with the interests in maintaining viable managed care that controls the escalating costs of health care.

Conclusion

Texas is the first state to impose a statutory tort liability scheme on managed care as the means to address perceived problems. The federal government and numerous other states will no doubt look at the Texas law as they address issues and concerns with managed care. There are those who intelligently argue that tort liability is a necessary mechanism on managed care organizations to pressure them to correct their abuses as they compete for patients.⁷⁰ If this is true, then, whatever tort liability system is imposed should be drastically improved from the Texas model.

Many other solutions involve increased regulation that does not involve a new cause of action against managed care entities. The Texas IRO model may be such a solution and a good way to handle quickly and efficiently important coverage questions on medical necessity. Certainly, providing causes of action will not necessarily resolve coverage issues of medical necessity quickly or efficiently even though it may give certain survivors the right to sue for money damages. It is my hope that this article will help educate readers about the new Texas law and raise important questions about its effectiveness to assure quality care while at the same time allowing managed care to help slow down the ever-escalating costs of health care.

Endnotes

1. Tex. Civ. Prac. & Rem. Code Ann., Chapter 88; Acts 1997, 75th Leg., R.S., ch. 163, 1, effective September 1, 1997.
2. "Texas is Lowering the HMO Legal Shield," N.Y. Times, June 5, 1997, at A16.
3. *Id.*
4. *Id.*
5. Crawford, "Tort Law - The Appropriate Vehicle to Control HMO Abuse of 'Gag Clauses'" 29 No. 4 Ariz. St. L.J. 1103-1126 (1997); Anders, Health Against Wealth: HMOs and the Breakdown of Medical Trust, (Houghton Mifflin Co. 1996); H.R. 1415, 105th Congress; H.R. 1749, 105th Congress; President's Advisory Commission on Consumer Protection and Quality in Healthcare at www.hcqualitycommission.gov; Furrow, "Managed Care Organizations and Patient Injury: Rethinking Liability," 31 Ga. L. Rev. 419-509 (1997).
6. Noah, "The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?" 48 Mercer L. Rev. 1219; Auerbach, "Managed Care Backlash: As Marketplace Changes, Consumers are Caught in the Middle," Wash. Post, June 25, 1996 at 212.

Consumers are Caught in the Middle," Wash. Post, June 25, 1996 at 212.

7. 354.505(3), R.S. Mo.; H.B. 335 approved June 25, 1997.

8. California: S.B. 977 was amended in the California Assembly July 30, 1998--creates tort liability similar to Texas; New York: 1816--A, pending in the New York Senate. This bill would impose tort liability for failing or refusing to approve, pay for, provide or arrange for, in a timely manner, any health care service to the extent it is contractually or legally obligated to do so.

9. Tex. Civ. Prac. & Rem. Code Ann., 88.001(8).

10. S. Dasco & C. Dasco, Managed Care Answer Book (1995).

11. Private Sector Advocacy and Support Team, American Medical Association, "Managed Care and the Market: A Summary of National Trends Affecting Physicians," (1995).

12. "States Pass Record Number of Laws on Industry," American Medical News, February 11, 1997, summarizing a report from the National Conference of State Legislators.

13. Pedroza, "Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effects on Liability," 38 Ariz. L. Rev. 399 (1996).

14. Another Chapter 88 was also added in 1997 dealing with Donation of Medical Devices in Acts 1997, 75th Leg., ch. 662, 1. It is expected that this chapter will be renumbered by the Texas Legislature in 1999.

15. The leading 5th Circuit case is *Corcoran v. United Healthcare*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed. 2d 837 (1992), where the Court determined a wrongful death claim arising out of United Healthcare's erroneous medical decision was preempted by ERISA; *See also, Dukes v. U.S. Healthcare of Pennsylvania*, 57 F.3d (3rd Cir. 1995), *cert. denied*, 116 S.Ct. 564, 133 L.Ed. 2d 489 (1995), which distinguishes *Corcoran* but held ERISA preempts medical malpractice claims when made a part of a welfare plan's precertification program; and, *Rodriguez v. Pacificare of Texas, Inc.*, 980 F.2d 1014 (5th Cir. 1992), *cert. denied*, 506 U.S. 103, 113 S.Ct. 812, 121 L.Ed. 2d 684 (1992).

16. *Williams v. Good Health Plans, Inc.*, 748 S.W.2d 373 (Tex.App.--San Antonio 1987, no writ).

17. The key in Texas law to *Respondent Superior* is "control." *Thompson v. Travelers Indemnity*, 789 S.W.2d 277,278 (Tex. 1990). The staff model HMO gives the clearest example of this. "Emerging Issues of Liability in the Managed Care Industry," 47 Baylor L. Rev. 285, 291 (1995).

18. *Lopez v. Central Plains Regional Hospital*, 849 S.W.2d 600 (Tex.App.--Amarillo 1993, no writ); *Hand v. Tarera*, 864 S.W.2d 678 (Tex.App.--San Antonio 1993, no writ).

19. In Texas, ostensible agency has been applied in the hospital setting. *Brownsville Medical Center v. Garcia*, 704 S.W.2d 68 (Tex.App.--Corpus Christi 1985, writ ref'd n.r.e.); *Baptist Memorial Hospital v. Smith*, 822 S.W.2d 67 (Tex.App.--San Antonio 1991, writ denied). Other states have found the theory of ostensible agency applicable to HMOs. 547 A.2d 1229, 1234 (Pa. Super. 1988); *Raglin v. HMO Ill., Inc.*, 595 N.E.2d 153 (Ill.App. [1st. Dist.] Ct. 1992).

20. *Corporate Health Insurance, et al. v. Texas Dept. of Insurance*, No. H-97-2072 in the United States District Court, Southern District, Houston Division.

21. *New York State Conf. of Blue Cross-Blue Shield Plans v. Travelers*, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *DeBuono v. NYSA-ILA Medical and Clinical Service Fund*, 1997, US LEXIS 691 (1997), 138

(1995); *DeBuono v. NYSA-ILA Medical and Clinical Service Fund*, 1997, US LEXIS 691 (1997), 138 LEd.2d 21 (1997); and *California Division of Labor v. Dillingham Construction*, 117 S.Ct. 832, 136 LEd.2d 791, 1997 US LEXIS 691 (1997).

22. Tex. Civ. Prac. & Rem. Code Ann. 88.001(8).

23. *See* note 20.

24. *Supra* at 88.001(1).

25. Hartnett & Lesnick, The Law of Life & Health Insurance, Vol. 2, 6.01(2); 6A.33, Matthew Bender (1997).

26. *Supra* at 6A.33, pp. 6A 204-6A 226.

27. *Fassio v. Montana Physician Services*, 170 Mont. 320, 553 P.2d 998 (1976).

28. Hartnett, *supra* 6A.33 and cases cited involving issue of experimental versus accepted treatment. *Henderson v. Bodine*, 7 F.3d 961 (8th Cir. 1995) (involving chemotherapy); *Loyola University of Chicago v. Humana Insurance*, 996 F.2d 895 (7th Cir. 1993) (artificial heart transplant was excluded); and, *Westover v. Metropolitan Life*, 771 F. Supp. 1172 (MD Fla. 1991) (this case allowed exclusion from benefits chelation therapy for treatment of arteriosclerosis).

29. *Connecticut General Life v. Shelton*, 611 S.W.2d 928, 930 (Tex. 1981). This case has an excellent discussion on the theory of insurance.

30. Tex. Civ. Prac. & Rem. Code Ann. 88.002.

31. Tex. Civ. Prac. & Rem. Code Ann. 88.001(5).

32. Tex. Civ. Prac. & Rem. Code Ann. 88.002(a).

33. Tex. Civ. Prac. & Rem. Code Ann. 88.002(b).

34. Abouldice, "Introduction to Managed Care and Health Maintenance Organizations, Preferred Provider Organizations, and Competitive Medical Plans," (1991).

35. Tex. Rev. Civ. Stats. Ann. art. 4495b 1.10; See also *Garcia v. Texas State Board of Medical Examiners*, 384 F. Supp 434 (WD Tex. 1974) *aff'd* 421 U.S. 995 (1975).

36. 42 U.S.C. 300e *et seq.*

37. Tex. Civ. Prac. & Rem. Code Ann. 88.002(i).

38. Tex. Civ. Prac. & Rem. Code Ann. 88.002(h).

39. *Baptist Memorial v. Smith, supra.*

40. Tex. Rev. Civ. Stats. Ann. art. 4495b 1.10(12).

41. Tex. Civ. Prac. & Rem. Code Ann. 88.001(10).
42. *Id.*
43. Edgar & Sales, Texas Torts and Remedies 11.01[2][b][ii] Matthew Bender (1997); *Williams v. Bennett*, 610 S.W.2d 144 (Tex. 1980).
44. *Supra*; *Hickson v. Martinez*, 707 S.W.2d 919, 925 (Tex.App.--Dallas 1995, writ ref'd n.r.e.).
45. Tex. Civ. Prac. & Rem. Code Ann. 88.02(b).
46. Tex. Civ. Prac. & Rem. Code Ann. 88.002(b)(4).
47. *Baptist Memorial v. Smith, supra*; *Brownsville Medical v. Garcia, supra.*
48. *Sampson v. Baptist Memorial Hospital*, 940 S.W.2d 128 (Tex.App.--San Antonio 1996).
49. Tex. Civ. Prac. & Rem. Code Ann. 88.002(c).
50. Tex. Civ. Prac. & Rem. Code Ann. 88.002(d).
51. Tex. Civ. Prac. & Rem. Code Ann. 88.002(j).
52. Tex. Civ. Prac. & Rem. Code Ann. 88.002(k).
53. Tex. Rev. Civ. Stats. Ann. art. 4590i, 13.01 (Vernon).
54. *Hartnett, supra.*
55. *Supra.*
56. Tex. Rev. Civ. Stats. Ann. art. 4590i (Vernon).
57. *Id.*, Art. 4590 13.01 *et seq.* added by Acts 1993, 73rd Leg., ch. 625, 3, effective September 1, 1993.
58. Tex. Rev. Civ. Stats. Ann. art. 4590i 10.01 (Vernon).
59. *Id.*, 4.01.
60. *Id.*, 14.01.
61. *Id.*, 16.01 *et seq.*
62. *Id.*, 16.02(a).
63. *Id.*, 16.01 *et seq.* Caps on damages in all cases, other than wrongful death, were struck down in *Lucas v. U.S.*, 757 S.W.2d 687,670 (Tex. 1988); *See also Rose v. Doctors Hospital*, 801 S.W.2d 841 (Tex. 1990).
64. Tex. Bus. & Comm. Code 17.49(c).

65. Tex. Civ. Prac. & Rem. Code Ann. 88.003.

66. *Supra*.

67. Tex. Civ. Prac. & Rem. Code Ann. 88.003(e).

68. Tex. Civ. Prac. & Rem. Code Ann. 88.003(d).

69. 28 Tex.Admin.Code 12.1-12.502 (Texas Insurance Dept. Web Site: www.tdi.state.tx.us).

70. Furrow, "Managed Care Organizations and Patient Injury: Rethinking Liability," 31 Ga. L. Rev. 419-509 (1997).