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WHERE IS HEALTH LAW GOING?: FOLLOW THE MONEY

Robert L. Schwartz[†]

IN LATE AUGUST 2003, the Minnesota Supreme Court rendered an important health law decision placing the ultimate cost of liability for silicon breast implants on more than twenty-five insurance companies for the manufacturer, 3M, rather than on the manufacturer itself.[1] In rendering this decision, the court was required to address the question of when the plaintiffs' causes of action accrued, and what the terms of the insurance contracts required. The result will be a transfer of hundreds of millions of dollars to the manufacturer of these implants. Of course, the court was also called upon to address the question of the millions of dollars of attorneys' fees that had accrued to 3M in the course of the litigation. If one were to try to fit this case into a structure of the subject of health law (or its predecessor) twenty-five years ago, one would fail; it simply was not a part of this discipline. Today, as the lawyers who sought millions in fees in this case recognize, it is at the heart of it.

Where has health law come from? Where will it be going? To follow the development of this discipline, follow the money. Where substantial financial interests entered the health care enterprise, lawyers have been sure to follow—or, sometimes, to lead. Where we can predict there will be concentrations of money, we can predict there will be concentrations of lawyers, and, not too far behind, legal academics. The very birth of "health law" (or, at least, its transformation out of "medical law") was a consequence of a newly developing medical economy. Since the term "Health Law" was first used as a casebook title by a major law publisher to describe the discipline in 1987,[2] those studying the subject, and those practicing it, have turned their focus from malpractice actions against individual physicians to corporate and economic issues that affect the financing of the largest

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[1] *In re* Silicone Implant Insurance Litigation, 667 N.W.2d 405 (Minn. 2003).

[2] BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS (1st ed. 1987).

industry in the country.[3] A boutique subject that was an outgrowth of tort law (with a nod toward charity law) has become a mainstream subject with its underlying legal principles found in the law of corporate finance (with a nod to the law of fraud). Attention to the obligation of not-for-profit board members has given way to attention to not-for-profit conversions to for-profit entities. The amount of money invested in this "industry" has grown substantially, and, as we might expect, so has the interest of lawyers.

There have been several attempts to create a theme—or several themes—that define "health law." One recent casebook, *Health Care Law and Ethics*, says that "organizing principles can be found in the phenomenology of what it is to be ill and to be a healer of illness."[4] Another casebook explains that four themes could be identified in health law – quality, cost, access, and respect for patient autonomy.[5] *Health Care Law and Ethics* refines those four themes into quality, cost, access, and ethics.[6] A recent article suggests that the true defining characteristic of the field (or, at least, a large part of it) is trust.[7] A particularly esteemed health law colleague has pointed out that health law "deals with some of the most fundamental and troublesome issues in society: life and death, reproduction and the fate of humanity."[8] There is something to each of these themes, of course. In fact, though, if we look at what health lawyers actually do, we find these proposed themes to be altruistic, at best. Health care is an industry, and health lawyers serve its needs. Over the past few decades it has moved from a largely charitable enterprise to a for-profit enterprise, with a more consolidated market in which the advent of managed care has led to rationalization (and thus rationing) of increasingly expensive kinds of medical care. It cannot be a surprise that lawyers have been involved in every step of the change.

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[3] *Compare id.* at xviii-xiv (describing health law as addressing quality of care, cost, equitable access, and respect for the person of the patient) *with* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS, at v-vi (4th ed. 2001) (expanding their text to include chapters on private and public financing of health care, the business of health care delivery, government regulation of the financial relationships of providers, and antitrust law).

[4] WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS, at xxxi (Aspen, 5th ed. 1998).

[5] FURROW ET AL., *supra* note 2, at xviii-xiv.

[6] CURRAN ET AL., *supra* note 4, at xxx.

[7] Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002) (arguing that in the disjointed world of health law, trust can be a unifying theme).

[8] THE LAW-MED. CTR., CASE W. RES. UNIV., WHERE HEALTH LAW BEGAN: CELEBRATING 50 YEARS 1953-2003 (inside back cover) (2003).

Before the 1970s, medical law was an obscure corner of the law dealing with forensic pathology; very few class sessions—much less courses—in the subject were available at any law schools. By the time that malpractice actions became financially significant in the late 1970s, the subject changed its focus to these actions and reform of the tort system. As the industry began to go for-profit and consolidate, health law practitioners turned their focus to mergers, acquisitions, the establishment of nonprofit status, and, essentially, the basic elements of corporate law. Most recently, health lawyers have turned to the question of how health care will be financed, and to disputes between providers and insurers. Even disputes over quality are now as likely to be in the form of disputes over the necessity of the health care (and whether claims for reimbursement for unnecessary care are fraudulent) as over traditional issues of malpractice.

Even in bioethics, the academic production has followed the available cash, which is primarily in the form of grant funding. Bioethics law developed from the "right to die" considerations sparked by the *Quinlan*[9] and the *Cruzan*[10] cases, as well as by a series of Baby Doe cases.[11] When Congress decided to provide a percentage of the resources allocated to the human genome project to ethics, law, and social issues, it acted as a very powerful magnet drawing established bioethicists into work in that area. Those whose names were associated with the "right to die" discussions became the leading lights on the law and ethics of gene research and manipulation as soon as money was available to support that work. Fortunately for the bioethics law establishment, just as the human genome project began to close down, the nation's fear of bioterrorism created a nearly bottomless barrel or research funding for those who can justify their work as helping the fight against terrorism. The same bioethics lawyers who wrote so eloquently about *Quinlan* and *Cruzan*, and who then helped define the appropriate limits on the use of the human genome project, have now signed on as grant-funded warriors against terrorism.

Where will health law go over the next decade or five? Follow the cash. The health care industry is likely to remain the country's biggest industry, and those who foresee a national health care system will eventually recognize that nationalizing the for-profit health care

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[9] *In re* Quinlan, 355 A.2d 647 (N.J. 1976).

[10] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990).

[11] *E.g., In re* Infant Doe, No. GU 8204-004A (Monroe County Cir., Apr. 1982) *declaratory judgment, writ of mandamus dismissed sub nom.* State *ex rel.* Infant Doe v. Bloomington Hosp., *cert. denied*, 464 U.S. 961 (1983). For an explanation of this case, see Bowen v. American Hosp. Ass'n, 476 U.S. 610, 617 (1986) (explaining that certiorari was denied because the baby died). *Id.* at n.5.

industry is about as likely as nationalizing the automobile manufacturing or steel industries. There are politically powerful shareholders who expect returns from their investments in the health care industry. So, where will the cash be found? First, money is critical in disputes over reimbursements between health care payers and health care providers. In early September, 2003, a federal court judge was expected to review a proposed $540 million settlement offer by Cigna in a class action suit brought by doctors claiming that the managed care organizations delayed and denied claims improperly.[12] The complaint alleges, among other things, RICO violations by the insurers.[13] What is the problem with the proposed settlement? One of the doctors was "extremely offended" that the settlement would provide $55 million to the plaintiffs' lawyers, while the doctors would have to refile their denied claims and their recovery would be capped.[14] Expect more health lawyers to be interested in this kind of action.

Private plaintiffs are not necessary to generate work for lawyers in this area. As the Centers for Medicare and Medicaid Services (CMS) increasingly uses fraud and abuse statutes to go after health care providers which make claims for unnecessary services or services provided below the standard of care, both the government and those providers will employ attorneys to manage the cases.

Medical malpractice has not disappeared, either, although it is changing. While states are limiting the nature and size of some claims, whole new classes of plaintiffs have been discovered. With the aging of the nation, more attention has been paid to nursing homes, and the traditional problems with seeking substantial damages for those with short and nonproductive life expectancies have been overcome by jury outrage (and, perhaps, identification with plaintiffs). Nursing home malpractice claims are settled at rates far above those of other malpractice claims, and there are now several billion dollars in claims faced by nursing homes each year.[15] One study found that

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[12] *See Cigna: Physicians Disagree on Class-Action Suit Settlement*, AM. HEALTH LINE, Sept. 4, 2003. Dr. Timothy Kaiser is quoted as saying, "My interest in this was getting money to doctors. . . . Doctors did the work. Doctors were the ones that didn't get paid." *Id.* Doctors will eventually be paid a great deal if the settlement is approved, but lawyers will get paid first.

[13] *See In re* Managed Care Litigation, 185 F.Supp.2d 1310 (D.Fla. 2002) (dismissing all but one RICO claim against managed care organizations in class action suit).

[14] *Cigna: Physicians Disagree on Class-Action Suit Settlement*, *supra* note 12.

[15] For an accessible summary of the increase in nursing home litigation, *see* Alice Dembner, *Legal Claims on Rise Against Nursing Homes*, BOSTON GLOBE, Sept. 2, 2003, at A1 (reporting that plaintiffs get some recovery in 90% of claims "pressed"

in some states 15% of the annual nursing home budget was drawn into legal fees.[16] One can, therefore, expect more lawyers to be drawn into this area. Similarly, other kinds of claims that deal with utilization and quality review—often in the form of the review of payments for services—are likely to continue to increase, so expect lawyers to be there as well. While the era of consolidation and the pace of integration and disintegration may be slowing, there will be plenty of work for the corporate lawyers, too, in allocating liability among the many entities that touch every health care transaction.

Bioethics lawyers need not worry about the work, either. While private foundations continue to fund some work on end of life care, the real pot of gold remains bioterrorism. As long as there is a political need to keep the attention of the nation directed to terror and the war upon it, federal resources will be available to help those willing to be soldiers.

There are, of course, other issues that will keep health lawyers busy. The overreaction to the promulgation of the HIPAA privacy regulations has created an army of health privacy lawyers. Like the Y2K crisis, this one is likely to fade away as time suggests that much of the concern is a matter of hype created by those who then profit from it. Due process claims may require changes in our current professional licensing practices, some of which are left over from an era of gentlemanly guild protection.[17] Traditional medical malpractice claims will not disappear, even if current reform proposals are successful and the stake in each case is lowered once again. In the end though, if you want to know where health law is going, follow the money. Where you find the cash, you will find the lawyers.

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compared to about 30% in other medical malpractice cases). For a fuller report, see also David G. Stevenson & David M. Studdert, *The Rise of Nursing Home Litigation: Findings From a National Survey of Attorneys*, HEALTH AFF. Mar./Apr. 2003, at 219 (documenting rising nursing home litigation and speculating on its effect on quality of care as limited financial resources are diverted for legal defenses).

[16] Stevenson & Studdert, *supra* note 15, at 224 (ascribing this percentage to Texas nursing homes and 23% to nursing homes in Florida. Texas and Florida comprise 10% of the national nursing home population and one-third of this study's sample. *Id.* at 220.).

[17] For example, in many states there is little separation between those who prosecute an action seeking to impose sanctions on those with medical licenses and those who decide those cases (or those who advise those who decide). When medicine was a gentleman's guild that might have been acceptable, but today it is not.