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THE LEGAL ATTACK ON COST CONTAINMENT MECHANISMS: THE EXPANSION OF LIABILITY FOR PHYSICIANS AND MANAGED CARE ORGANIZATIONS

ALLISON FABER WALSH*

Jane Doe, a woman in her thirties, notices what she believes is a mole on her arm becoming larger and darker in color.¹ Concerned with recent talk and numerous articles on the threat of skin cancer, Jane becomes worried about the mole and decides to seek the medical advice of a doctor. Through her employer, Jane is a member of a Health Maintenance Organization (HMO)² which

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1. The events in the hypothetical are based on the facts of an actual situation a board certified dermatologist faced when he sought approval from a for-profit HMO for the removal of pilar tumors on his patient's scalp. Laurie Zoloth-Dorfman & Susan Rubin, *The Patient as Commodity: Managed Care and the Question of Ethics*, 6 J. CLINICAL ETHICS 339, 342 (1995). However, the physician in the actual situation felt strongly that a pathology exam of the tumors was necessary and sent the specimen to the lab for testing at his own expense. *Id.* He then documented the HMO's denial of the test and sent his documentation to his local medical society. *Id.* A panel of doctors presented this case to a bioethics committee as an example of the dilemmas physicians face when trying to maintain quality of care in a managed care setting. *Id.* at 343. See also *McClellan v. Health Maintenance Org. of Pa.*, 546 Pa. 463 (Pa. 1996), for a lawsuit setting forth similar facts as those presented in the hypothetical.

2. HMOs are health care systems responsible for the delivery, management and financing of health care services to a group of covered members. PATRICIA A. YOUNGER ET AL., *MANAGED CARE L. MAN.* 2 (1996). HMOs are responsible for arranging medical services and treatment through health care providers and for covering the medical costs of the treatment. GORDON K. MACLEOD, *AN OVERVIEW OF MANAGED HEALTH CARE* 4 (2d ed. 1993). The costs of treating the subscribers are prepaid and either the HMO, the health care providers, or both are at financial risk for the overuse of medical services. James P. Freiburg, *The ABCs of MCOs: An Overview of MCOs*, 81 ILL. B.J. 584, 584 (1993). Typically, in an HMO, patients who subscribe or enroll in the plan pay a fixed annual premium. YOUNGER, *supra*, at 2. Enrollees must then obtain their medical treatment from a limited list of providers approved by the HMO. CHARLES G. BENDA & FAY A. ROZOVSKY, *MANAGED CARE AND THE LAW LIABILITY AND RISK MANAGEMENT A PRACTICAL GUIDE* § 2.4.1, at 11 (1996). The HMO provides a predetermined set of basic health services to the enrollee through its approved providers. *Id.* The services provided to the en-

provides and pays for her medical treatment and care. To receive medical benefits, Jane's HMO mandates that she make an initial consultation with a primary care physician contracted with her HMO before seeking the advice of a specialist.³

rollee typically include required medical services, hospitalization and emergency care. Freiburg, *supra*, at 585. However, HMOs usually do not cover unnecessary medical treatment such as dental treatment or treatment for cosmetic purposes. *Id.* HMOs contract with health care providers to administer health care to enrollees. *Id.* at 586.

A preferred provider organization (PPO) is another popular system used to deliver health care at reduced rates. Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1225 (1997). In a PPO, a payer such as an insurer, employer or administrator contracts with an organization of health care providers to deliver discounted health care to patients enrolled in the plan. *Id.* Unlike an HMO, PPOs do not use the capitated reimbursement system. William J. Bahr, Comment, *Although Offering More Freedom to Choose, "Any Willing Provider" Legislation is the Wrong Choice*, 45 U. KAN. L. REV. 557, 56 2 (1997). PPOs reimburse providers at a discounted fee-for-service rate which forces the PPO to bear the financial risk of overuse of estimated medical services. BENDA & ROZOVSKY, *supra*, at 12. Therefore, the financial risk is never shifted to the provider in a PPO. *Id.* An enrollee in a PPO is not required to receive medical treatment from a physician in the PPO network. PETER R. KONGSTVEDT, *THE MANAGED HEALTH CARE HANDBOOK* 14 (2d ed. 1993). However, PPOs provide incentives such as reduced deductibles and co-insurance payments to encourage enrollees to utilize providers contracted with the PPO. *Id.* Insurers can form PPOs to provide services to enrollees or providers themselves can form PPOs in an attempt to acquire contracts from insurers, employers or administrators. BENDA & ROZOVSKY, *supra*, at 12.

A point of service (POS) plan adopts the concept of managed care while at the same time maintains some aspects of the traditional health care system by allowing enrollees more freedom to choose providers. *Id.* As in HMOs and PPOs, POS plans provide medical services to a group of enrollees at a reduced cost. YOUNGER, *supra*, at 2. However, unlike HMOs and PPOs, the participants have an option to use providers not contracted with the plan. *Id.* at 7. When an enrollee needs medical treatment, the enrollee has a choice of whether to obtain medical services from a participating provider or from a provider outside of the plan. *Id.* However the enrollee suffers greater costs if he chooses to take advantage of the freedom to choose his own provider. *Id.* Deductibles and co-payments are increased and coverage is decreased if the enrollee decides to use a non-participating provider. *Id.*

3. Under an HMO plan, enrollees are limited in their choices of physicians. Lisa Panah, *Common Law Tort Liability of Health Maintenance Organizations*, 29 AM. HOSP. ASS'N J. HEALTH & HOSP. L., 146 (1996), available in LEXIS, GenMed Library, Med & Health Jnl File. Enrollees must choose a physician that is contracted with the HMO. Bahr, *supra* note 2, at 557. The primary care physician act as the patients "gatekeeper" and becomes solely responsible for the enrollees medical treatment. Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1823-24 (1995). An HMO enrollee must initially seek treatment from her gatekeeper for any medical problems she is experiencing before seeking the medical expertise of a specialist. MANAGING MANAGED CARE IN THE MEDICAL PRACTICE - THE PHYSICIAN'S HANDBOOK FOR SUCCESS AND SURVIVAL 25-26 (Kay Stanley ed., 1996)

After examining the mole, the primary care physician determines that the mole should be surgically removed and tested to determine whether the mole is a malignant melanoma. Before removing Jane's mole, the primary care physician is required to receive authorization from Jane's HMO for payment of the surgery and testing of the mole. The primary care physician calls the HMO for authorization of the procedure. The HMO physician consultant approves the procedure to remove the mole, but informs the primary care physician that the HMO will not approve payment for a pathology examination of the mole. The primary care physician explains to the HMO consultant that there is a slight chance the mole is a malignant melanoma. Despite the primary care physician's efforts, the HMO physician consultant concludes that the pathology exam is not medically necessary and denies the physician's request for the biopsy. The primary care physician removes Jane's mole and informs her of the HMO's decision to deny payment for a pathology examination of the mole.

One year later, Jane Doe returns to her primary care physician complaining of a swollen lymph gland behind her ear. The lymph gland is surgically removed and a biopsy is authorized by the HMO. The biopsy reveals a malignant melanoma undoubtedly related to the previously removed scalp lesion. The cancer is advanced and all further medical care is fruitless. One year after the discovery of the cancer, Jane Doe dies.

Who is responsible for Jane Doe's death? Is Jane's HMO liable for denying approval for the initial pathology examination of the mole, thereby allowing the malignant melanoma to remain undetected and spread for one year? Or, is Jane's primary care physician liable for not sending the skin graph to pathology for examination? Before managed care,⁴ the answer was obvious. Physicians were held exclusively responsible for the care and treatment of their patients. Today, however, the answer is not so obvious due to the growth of managed care organizations (MCOs) in the health care industry.⁵

[hereinafter Stanley]. The gatekeeper is the patient's advocate and must act on the patient's behalf. *Id.* He is responsible for initial treatment and diagnosis, making and following up on referrals, providing information about treatment to the patient, and making treatment decisions. *Id.* A gatekeeper provides overall treatment and guidance to his patients and is accountable for the patient's treatment. *Id.* at 25-26.

4. The American Medical Association (AMA) defines managed care as: "The control of access to and limitations on physician and patient utilization of services by public or private payers or their agents through the use of prior and concurrent review for approval of or referral to service or site of service, and financial incentives or penalties." John J. Ingelhart, *Health Policy Report: The American Health Care System*, 326 NEW ENG. J. MED. 962, 965 (1992).

5. Ralph O. Bischof & David B. Nash, *Managed Care Past, Present, and Future*, 80 MED. CLINICS N. AM. 225, 225 (1996).

Escalating health care costs forced the concept of managed care to rapidly enter the American health care delivery system.⁶ The dramatic effect of the implementation of MCOs is apparent throughout the health care system.⁷ Managed care attempts to lower and contain medical costs by controlling the treatment of patients and by implementing various cost-containment mechanisms.⁸

This Comment discusses various cost containment mechanisms MCOs implement to lower health care costs and discusses their impact on traditional medicine. It also addresses successful and unsuccessful legal attacks upon cost containment mechanisms, and analyzes theories of liability used against physicians and MCOs when patients such as Jane Doe die or are injured as a result of the MCO's efforts to lower healthcare costs.

Part I provides a background of the development of managed care. Part II explains the various types of cost containment mechanisms MCOs implement to achieve the goal of lowering or containing health care costs. Part III analyzes the various expanded theories of liability against physicians and MCOs and focuses on cases that have addressed these causes of action. Finally, Part IV proposes solutions on how to continue the use of cost containment mechanisms without decreasing the quality of health care. Further, Part IV addresses liability concerns that arise when cost-controlling measures result in the death or injury of a patient. Although this Comment focuses on the discussion of cost containment mechanisms implemented by MCOs and their effect on health care, an understanding of the concepts of managed care is essential to understanding the effect of cost containment mechanisms.

I. THE DEVELOPMENT OF MANAGED CARE

In an attempt to curb escalating health care costs, policymakers, the government, insurers and employers adopted the concept of managed care.⁹ Although many view the emergence of managed care as a new method for the delivery of health care, managed care is not a new concept.¹⁰ Prepared managed care plans were used in the nineteenth century by slave owners who needed to provide medical attention to their slaves, by powerless individual workers concerned with adequate health care, and by large industries, such as mining, lumbering, and railroading, who were forced to deal

6. E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1720-21 (1987).

7. YOUNGER, *supra* note 2, at 1.

8. David Orentlicher, *Paying Physicians More to do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 156 (1996).

9. McGraw, *supra* note 3, at 1821-23.

10. Zoloth-Dorfman & Rubin, *supra* note 1, at 339.

with work-related injuries.¹¹ Section A discusses the development of traditional medicine throughout the years and addresses this country's move from traditional fee-for-service medicine to managed care. Section B examines what managed care means and what managed care attempts to achieve.

A. Traditional Fee-For-Service Medicine

Prior to the advent of managed care, medical care and treatment was rudimentary.¹² Primitive medical technology and limited medication restricted a physician's treatment options.¹³ Physicians could offer patients little more than house calls, observation, basic surgical procedures and rudimentary medications.¹⁴ Reimbursement for medical treatment was also basic.¹⁵ People who could afford medical treatment were treated at home.¹⁶ After the physician provided treatment to the patient, the physician would set a fee and the patient would pay the fee out-of-pocket.¹⁷ This simple reimbursement method was, and still is, referred to as fee-for-service.¹⁸

11. *Id.* at 339-40. See also Bischof & Nash, *supra* note 5, at 226 (discussing the emergence of prepaid plans for employers of large industries).

12. E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J. L. & MED. 79, 80 (1994).

13. *Id.*

14. *Id.*

15. *Id.*

16. E. Jane Ross, *Refusing to Pay for Health Care-Part I (of III): Evolution of the Third-Party Payment System*, PROGRESS IN CARDIOVASCULAR NURSING, Winter 1996, at 42.

17. Morreim, *supra* note 12, at 80.

18. MARC A. RODWIN, *MEDICINE MONEY & MORALS 2* (1993). In the United States, the traditional reimbursement system for physicians is called fee-for-service. Freiburg, *supra* note 2, at 584. Under a fee-for-service reimbursement system, a medical provider determines an appropriate fee for his services and then either bills the patient directly or bills the patient's insurance company. *Id.* at 584-85. The fee-for-service system creates two contracts, a contract between the patient and physician and a contract between the patient and the insurance company. *Id.* at 585. While the insurance company may receive the bill from the physician, it cannot lower the charged fees though the insurance company may elect not to cover all of the costs. *Id.* The patient is then responsible for any charges not covered by the insurance company. *Id.* The physician, therefore, always receives reimbursement for any services provided to his patients. *Id.*

Under the traditional fee-for-service system, cost is not an issue for physicians. Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1359 (1994). Physicians who make more referrals or order excessive tests receive greater profits under a fee-for-service system. Morreim, *supra* note 12, at 80. When considering different methods of treatment or various diagnostic tests under the fee-for-service system, doctors do not hesitate to provide the patient with the most extensive, thorough and innovative medical services or treatments. *Id.* If a particular test or method of treatment

In the early 1900s the number of hospitals increased and patients admitted themselves into hospitals rather than receiving treatment at home.¹⁹ As a result of the Depression, many sick and injured people were unable to pay for treatment at a hospital and were forced to stay at home and remain untreated.²⁰ Recognizing this problem, insurance companies created private health insurance in an attempt to deliver health care at affordable costs.²¹ In the late 1920s and early 1930s the concept of an HMO emerged when industrial groups began to offer prepaid health care to their employees.²² After World War II, wage and price freezes and tax exemptions for employers prompted employers to begin offering their employees health insurance programs.²³

provides even a five percent benefit to the patient, but at a much greater cost than a more inexpensive though possibly less effective alternative, physicians almost always provide the more expensive treatment. Schwartz, *supra*, at 1359. Practicing defensive medicine insures the patient is thoroughly treated and helps shield physicians from medical malpractice suits. *Id.* at 1361. See also Kenneth R. Pedroza, Note, *Cutting Fat or Cutting Corners, Health Care Delivery and its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 404 (1996) (discussing defensive medicine). Neither physicians nor patients are concerned about costs under this system because a third party payer who is uninvolved in the decision making about the treatment assumes the costs. Schwartz, *supra*, at 1359.

19. Ross, *supra* note 16, at 42. In the mid-1800s hospitals were only for the poor who could not afford house calls. *Id.* It was not until the late 1880s that hospital stays became an accepted method of health care delivery. *Id.* In 1873, 178 hospitals existed in the United States with a total of 35,064 beds. *Id.* In 1909, the number of hospitals reached 4359 totaling 421,065 beds and by 1929, 6665 hospitals existed totaling 907,133 beds. *Id.*

20. *Id.*

21. Christine C. Dodd, Comment, *The Exclusion of Non-Physician Health-Care Providers from Integrated Delivery Systems: Group Boycott or Legitimate Business Practice?*, 64 U. CIN. L. REV. 983, 983 (1996).

22. Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 291 (1995). In 1927, the Community Hospital of Elk City, Oklahoma first introduced the concept of an HMO as a medical cooperative. *Id.* In the mid-1930s, a corporation called Kaiser-Permanete developed a system whereby its employees received all medical services through their employer. JOHN F. MCCALLY, CAPITATION FOR PHYSICIANS UNDERSTANDING AND NEGOTIATING CONTRACTS TO MAXIMIZE REIMBURSEMENT AND MANAGE FINANCIAL RISK 1 (1996). Kaiser hired a group of physicians and paid them five cents per month for each Kaiser employee. *Id.* The physicians were hired by Kaiser to provide medical care in a cost-efficient manner. Thomas J. Maxwell, *A View from a Doctor's Office*, 13 DEL. L. 33, 34 (1995).

23. Morreim, *supra* note 12, at 80. As health insurance became more popular, the price of insurance increased and the number of uninsured people grew. Pedroza, *supra* note 18, at 404. The workforce provided health insurance as an employee benefit leaving many unemployed, elderly and poor people without a means of paying for medical services. COLODIA OWENS, MANAGED CARE ORGANIZATIONS PRACTICAL IMPLICATIONS FOR MEDICAL PRACTICES AND OTHER PROVIDERS 2 (1996). Therefore, in an effort to help the unemployed with medical costs, the federal government created Medicare and

Although health insurance companies became responsible for indemnifying the expense of patients' medical care, the method of reimbursement remained fee-for-service.²⁴ Physicians exerted exclusive control over the diagnosis and treatment of patients and had complete discretion to choose the method and cost of treatment.²⁵ The physician submitted a bill for services to the health insurance company and received payment without question. The insurance company insulated both physician and patient, providing no incentive for the physician or patient to maintain costs.²⁶ Both physicians and patients, under the fee-for-service system, benefited from increased services and treatment.²⁷ Patients received any and all treatment available that promised any benefit, regardless of how incremental the benefit was to the patient.²⁸ Increased medical services and treatment provided physicians with more profits and a shield against medical malpractice lawsuits.²⁹ Therefore, the fee-for-service system encouraged physicians to over utilize treatment. Physicians handsomely profited from excessive services rendered to patients and had no incentive to contain costs.³⁰

Eventually, escalating health care costs and innovative medical technology forced insurers, policymakers and employers to consider a new method for the delivery of health care.³¹ In 1973,

Medicaid in 1966. *Id.*

Medicare provides health services to the elderly, while Medicaid provides health services to the poor. Ross, *supra* note 16, at 43. Blue Cross was given the administrative responsibility of determining reimbursement for physicians. *Id.* Under Medicare, physicians are reimbursed for "customary, prevailing [and] reasonable charges" and individual states determine Medicare's reimbursement schemes. 42 U.S.C. § 1395(1)(a) (1994). These reimbursement schemes assure physicians that reasonable costs of medically necessary services are compensated. Ross, *supra* note 16, at 43.

24. MCCALLY, *supra* note 22, at 2.

25. McGraw, *supra* note 3, at 1822. See also MCCALLY, *supra* note 22, at 2 (detailing a physician's freedom under a fee-for-service reimbursement system).

26. McGraw, *supra* note 3, at 1822.

27. Pedroza, *supra* note 18, at 401.

28. *Id.*

29. *Id.*

30. Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 400 (1996).

31. Bischof & Nash, *supra* note 5, at 226. Kenneth Pedroza offers reasons for the dramatic rise in health care costs over the years. Pedroza, *supra* note 18, at 401-03. He suggests that reimbursement, defensive medicine, technology and treatment care are factors that have contributed to escalating health care costs. *Id.*

Under a traditional fee-for-service reimbursement system, Medicare or insurance companies reimburse physicians for medical services and treatment. *Id.* at 401. A third party payer reimburses most services and treatment rendered to patients under this system which, therefore, provides incentives for physicians to increase services to patients. *Id.* Any test or

Congress passed the Health Maintenance Act³² to promote the growth of the first MCO, the HMO.³³ The Health Maintenance Act

procedure is not only a benefit for the patient but also a profit for the physician. *Id.* There is no incentive for the physician to contain costs. *Id.* An increase in charges for medical services and an increase in the number of procedures performed per patient means more money for the physician. *Id.* Therefore, Pedroza claims the fee-for-service reimbursement system results in an increase in medical bills. *Id.*

Secondly, Pedroza suggests that defensive medicine is another reason for rising costs in the health care industry. *Id.* A physician under a fee-for-service system may provide excessive tests and perform excessive procedures which have a small benefit to patients but will nonetheless provide greater protection against medical malpractice lawsuits. *Id.* at 401-02. Pedroza states that while it is difficult to determine if defensive medicine has substantially effected escalating health care costs, physicians spend more money when over treating patients as a means of avoiding liability. *Id.* at 402.

A third factor in the rise of medical costs is the increase in innovative medical technology. *Id.* There are incentives for physicians under a fee-for-service system to request more tests and procedures using the latest, most expensive technology because reimbursement is based on the procedure. *Id.* Physicians also use innovative expensive technology because it is more advanced, produces more reliable results and provides greater accuracy. *Id.*

Finally, the type of health treatment physicians provide to patients is another factor that attributes to escalating health care costs. *Id.* at 403. Preventative care is providing medical care to patients in order to keep them healthy. *Id.* The theory behind preventative medicine is that if patients are informed on how to remain healthy and if ailments are caught before they reach advanced stages, physicians can prevent patients from getting sick. *Id.* Treatment care, on the other hand, is treating a patient when symptoms have advanced into a disease or ailment that must be treated. *Id.* Opponents argue that in a fee-for-service system physicians practice treatment care rather than preventative care because treatment care is more profitable. *Id.* Advocates for managed care argue that the use and emphasis of preventative care is one reason managed care lowers health care costs. *Id.*

32. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e-300e-17 (1994) (amended 1976, 1978, 1981, 1986, 1988). The purpose of the Federal HMO Act is to provide financial assistance to HMOs as long as they meet prescribed qualifications. Bearden & Maedgen, *supra* note 22, at 291-92. The federal government approves loans and grants to entrepreneurs interested in creating HMOs that meet federal requirements. Dodd, *supra* note 21, at 984. In order to receive financial assistance from the federal government, an HMO must abide by certain requirements set forth in the Act. Bearden & Maedgen, *supra* note 22, at 291. The rules and regulations provide a structure that the HMO must follow to assure quality health care is being provided. Bahr, *supra* note 2, at 562. The Act also requires HMOs to assume all responsibility for health care services on a prospective basis. Panah, *supra* note 3. However, the Act permits physicians contracted by the HMO to assume financial risk for the rendering of health care services. *Id.*

33. Bishof & Nash, *supra* note 5, at 227. Between 1970 and 1990 enrollment in HMOs escalated from 3.6 million to 35 million. McGraw, *supra* note 3, at 1823. HMOs were implemented as the first system to attain the goal of lowering health care costs, however, new delivery systems such as PPOs and POS plans have since emerged. *Id.* All of these delivery systems attempt to limit medical treatment and are considered MCOs. *Id.* See *supra* note 2 for a definition and discussion of HMOs, PPOs and POS Plans.

marked the beginning of the era of managed care and the concept of providing affordable quality health care to participants enrolled in a managed care plan.³⁴

B. *The Shift Into Managed Care*

The United States introduced the concept of managed care to control the delivery of quality health care and lower health care costs.³⁵ Managed care attempts to provide quality health care in a cost efficient manner.³⁶ MCOs monitor physicians' treatment of patients and implement cost control systems to limit costly medical services.³⁷

Unlike the traditional fee-for-service system that depends upon a contract between the patient and the insurance carrier, MCOs rely upon a contract between the health care provider and the MCO.³⁸ Health care providers contract with MCOs to provide health care to a group of individuals.³⁹ Various types of managed care plans that deliver health care to subscribers include, HMOs, PPOs, and POS Plans.⁴⁰ To achieve the goal of lowering health care costs, MCOs implement various cost-containment mechanisms to limit treatment to patients and provide incentives to encourage physicians to render medical services at lower costs.⁴¹

II. TYPES OF COST-CONTAINMENT MECHANISMS IMPLEMENTED BY MCOs

Managed care plans implement various cost containment mechanisms to achieve their primary purpose of lowering medical costs. Although there are many different types of cost containment mechanisms, the most common are utilization review, capitation and payment incentives.⁴² Section A of this Part describes

34. Bischof & Nash, *supra* note 5, at 227.

35. Stanley, *supra* note 3, at 3-4.

36. *Id.*

37. Bischof & Nash, *supra* note 5, at 230.

38. Freiburg, *supra* note 2, at 585.

39. BENDA & ROZOVSKY, *supra* note 2, at 7.

40. See *supra* note 2 for a definition of HMOs, PPOs, and POS Plans.

41. William A. Chittenden III, *Malpractice Liability and Managed Health-care: History and Prognosis*, 26 TORT & INS. L.J. 451, 476 (1991).

42. McGraw, *supra* note 3, at 1826-28. MCOs formerly used a drastic mechanism known as gag clauses to preclude physicians from criticizing managed care plans. Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM J.L. & MED. 331, 350 (1996). "Gag clauses are provisions in physicians' contracts which prevent them, explicitly or implicitly, from giving patients information about treatment options that may not be covered by their health plan." *AMA Takes Stand Against Health Plan 'Gag' Rules*, WEST'S LEGAL NEWS, July 12, 1996, available in 1996 WL 382081. In effect, a gag clause constrains free and unfettered discussion between a physician and her patient. Julia A. Martin & Lisa K. Bjercknes, *The Legal and Ethical Implications of 'Gag Clauses' in Phy-*

utilization review, Part B explains capitation and Part C details three forms of payment incentives.

A. Utilization Review

Utilization review is a cost containment mechanism implemented by MCOs that attempts to lower health care costs by reducing the number of unnecessary medical procedures, hospital stays and tests for each patient.⁴³ MCOs hire a board of physicians and/or nurses to review each patient's records on a case-by-case basis.⁴⁴ The physician consultant reviews the patient's medical records to determine if the physician's treatment is medically necessary and thus covered by the plan.⁴⁵ Through utilization review,

sician Contracts, 22 AM. J.L. & MED. 433, 434 (1996). It prohibits or restricts a physician from informing his patient of available treatment options, disclosing the nature of the physician's employment agreement with the managed care organization, soliciting patients outside the managed care organization or engaging in the critical debate over health care. *Id.*

The scope and nature of gag clauses vary in nature. Barry M. Manuel, *Physician Liability Under Managed Care*, 182 J. AM. C. SURGEONS 537, 541 (1996). Gag clauses may be oral or written. *Id.* MCOs often incorporate written gag clauses as boilerplate language in a physician contract. *Id.* A common gag clause provides, in pertinent part, that, "the physician agrees not to exert influence on Members to switch their enrollment to another form of healthcare coverage, or to involve Members unnecessarily in Plan administrative or procedural issues, but instead, agrees to seek problem resolution through the Plan grievance procedures." *Id.* Another written gag clause states, "[d]o not discuss proposed treatments with [members] prior to receiving authorization from the plan." Martin & Bjercknes, *supra*, at 444.

No matter how gag clauses are used, they limit the free flow of communication between physician and patient, undermine trust and fidelity that the relationship once had and crystallize all the concerns that consumers have with managed health care. Michael Jonathan Grinfeld, *Tilting at HMOs*, CAL. L., Feb. 1997, at 85. Presently, 16 states have passed legislation prohibiting the use of gag clauses. *Id.* In addition, in December 1996, the Department of Health & Human Services added a new federal regulation stating that any contract that limits a doctor's ability to advise and counsel a Medicare patient violates Medicare rules. *Id.* As public concern grows over the use and impact of gag clauses, federal and state legislation will be enacted prohibiting their use. *Id.*

43. McGraw, *supra* note 3, at 1826-27. Utilization review is an element of the system of Utilization Management. David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and their Physicians*, 275 JAMA 1693, 1694 (1996). Utilization Management "permits the managed care program to coordinate providers and provider services by measuring treatment, identifying inappropriate use of services or facilities and making medical necessity recommendations on which payers rely to make coverage and payment decisions." YOUNGER, *supra* note 2, at 1. Utilization review constitutes the most explicit intrusion into the physician-patient relationship because life and death decisions between physician and patient are trivialized by the utilization review's cost benefit analysis. Mechanic & Schlesinger, *supra*, at 1695.

44. YOUNGER, *supra* note 2, at 2.

45. McGraw, *supra* note 3, at 1826.

MCOs seek to prevent unnecessary medical treatment and deliver more cost-effective alternatives to treatment.⁴⁶ Utilization review can be performed prospectively, concurrently or retrospectively.⁴⁷

A managed care company performs prospective utilization review prior to the administration of treatment.⁴⁸ The reviewer of the claim determines whether the treatment for the patient is medically necessary.⁴⁹ If treatment is not medically necessary, the reviewer refuses to reimburse the cost of the treatment.⁵⁰

Concurrent utilization review occurs during the course of the treatment to determine whether a test, referral or hospitalization is medically necessary.⁵¹ The utilization review consultant monitors the patient throughout treatment to determine the medical necessity of each procedure.⁵²

The final type of utilization review, called retrospective review, occurs after treatment is rendered.⁵³ If the review indicates that a medical service provided to a patient was unnecessary, the managed care company will deny payment or coverage.⁵⁴

Utilization review is not the only cost containment mechanism employed to lower health care costs. MCOs also commonly apply a payment scheme called capitation to minimize medical costs.

B. Capitation

The traditional fee-for-service system is thought to encourage physicians to over utilize medical services, thereby increasing health care costs.⁵⁵ To eliminate excessive use of medical services, MCOs use alternative methods to compensate physicians such as capitation.⁵⁶ Capitation is a form of reimbursement whereby a

46. *Id.*

47. YOUNGER, *supra* note 2, at 1.

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

53. YOUNGER, *supra* note 2, at 1.

54. *Id.*

55. Orentlicher, *supra* note 8, at 158.

56. Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301, 301 (1996). Although many health care markets use capitation as the primary method of reimbursement, capitation has not yet surpassed the traditional fee-for-service reimbursement system. John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 174 (1996). On a national level, capitation is not the dominant method of payment, however, third party payers view it as a way to control escalating medical costs and to shift the financial risk to physicians. *Id.* Managed care entities have begun to dominate health care in the United States, and thus capitation has become a popular method of reimbursement for health care providers. Kinney, *supra*

third party payor compensates a contracting primary care physician at a flat rate for each patient enrolled in the MCO for a specific time period.⁵⁷ Physicians under a capitated arrangement are paid a pre-determined fixed fee based on the number of patient subscribers.⁵⁸ Generally, the MCO will determine the costs of medical care for each patient on a monthly basis.⁵⁹ Physicians receive the same amount of money for each patient enrolled in the MCO on a monthly basis regardless of the services provided to the patient or the cost of the services.⁶⁰ Thus, if a patient requires no medical services during a particular month, the physician still receives her monthly payment. If a patient, however, requires an excessive amount of medical attention beyond projected amounts, the physician receives no additional payment for the service rendered to the patient.⁶¹

Under a capitated system, the financial risk of caring for the enrollees shifts to the primary care physician.⁶² When MCOs contract with physicians under a capitated reimbursement system, the MCO places a financial risk on the physician for medical costs which exceed the capitated rate for each patient.⁶³ The primary care physician has a vested financial interest in the amount of

note 56, at 302.

In the 1990s private payers increasingly contracted with provider entities under capitated arrangements. *Id.* at 301. The providers constitute either a group of physicians working with one hospital or a group of physicians, hospitals and health care professionals. *Id.* The private payers are generally employers or insurers on their behalf. *Id.* States have implemented capitated arrangements for Medicaid and Medicare recipients to control rising costs. *Id.* President Clinton suggested in his health care reform proposal in 1996 that capitation be the primary form of reimbursement in health care plans and in paying for services for Medicaid and Medicare recipients. *Id.*

57. Schwartz, *supra* note 18, at 1364-65. For the purposes of this Comment this definition suffices, nevertheless, capitation is actually much more complex than merely setting a flat rate per patient per month. Blum, *supra* note 56, at 174. The methods used to determine capitated rates per patient are complicated and require trained professionals with a thorough understanding of health care costs. Stanley, *supra* note 3, at 60. Actuarial data along with consideration of patient utilization patterns in specific health care plans and in the marketplace in general are used to calculate capitated rates. *Id.* Historical data or industry wide statistics are used to estimate the utilization and cost of medical services per patient. *Id.* The MCOs profits and administrative costs are also included in the rate. *Id.* Consideration is also given to other factors such as age, gender and the type of group being covered. *Id.* Setting capitation rates and negotiating contracts under a capitated arrangement involve complicated financial analysis which includes knowledge of a physician's average fees, utilization rates and income. Blum, *supra* note 56, at 174.

58. Orentlicher, *supra* note 8, at 158.

59. Stanley, *supra* note 3, at 59.

60. McGraw, *supra* note 3, at 1827.

61. Stanley, *supra* note 3, at 59.

62. McGraw, *supra* note 3, at 1827.

63. Gordon J. Apple, *Who Bears the Risk When Physicians are also Insurers?*, 78 MINN. MED. 23, 23 (1991).

medical care that exceeds the capitated amount.⁶⁴ The result of capitation is that MCOs pay physicians a fixed level of compensation regardless of the amount of medical services they provide to managed health care subscribers. Capitated reimbursement schemes also put physicians at risk for costs that exceed the capitated amount per patient.⁶⁵

While utilization review and capitation are the two most widely used cost containment mechanisms, MCOs commonly implement payment incentives as an extra benefit for physicians that limit various medical services.⁶⁶

C. Payment Incentives

While capitation provides an incentive for primary care physicians to limit their direct medical services and time spent with patients, it may not be the most effective method to reduce the overall costs of medical treatment provided to each patient.⁶⁷ Physicians utilize many different services in the treatment and care of their patients enrolled in an MCO.⁶⁸ For example, a patient may need the expertise of a specialist or require a diagnostic test.⁶⁹ If a physician is being reimbursed for his medical services at a fixed rate per patient regardless of the time spent with the patient or the service provided to the patient, the physician is then motivated to decrease his time spent with the patient and to increase the use of other medical services such as diagnostic tests and referrals to specialists.⁷⁰ While a capitated reimbursement system will decrease the costs of the physician's own services for the MCO, the excessive use of outside services will result in an increase in the overall costs of medical treatment provided to the patient.⁷¹

MCOs, therefore, utilize payment incentives such as risk pools, bonuses and expanded capitation to decrease a primary care physician's use of referrals, diagnostic tests and other services.⁷² These payment incentives not only attempt to encourage physicians to use fewer outside services, they can also reward the physician financially for minimizing the number of referrals, tests and medical services.⁷³ Payment incentives are employed to control the

64. *Id.* at 24.

65. Orentlicher, *supra* note 8, at 160.

66. Zoloth-Dorfman & Rubin, *supra* note 1, at 349.

67. Orentlicher, *supra* note 8, at 159.

68. *Id.*

69. *Id.*

70. *Id.* at 159-60. Physicians may also increase the use of outside medical services to insure proper diagnosis and to decrease the risk of liability for medical malpractice. *Id.* at 160.

71. *Id.* The increased use of medical services outside the MCO threatens the financial stability of the MCO. Bearen & Maedgen, *supra* note 22, at 294.

72. Orentlicher, *supra* note 8, at 160.

73. Noah, *supra* note 2, at 1227.

over utilization of outside medical services and attempt to encourage physicians to provide cost effective case-management techniques.⁷⁴

Under a withhold risk pool, a portion of the physician's capitated payment is withheld and put into a risk pool.⁷⁵ In some instances, the risk pools are divided into hospital risk pools and/or referral risk pools.⁷⁶ Money put into the risk pool is then used to pay for referrals to specialists and hospitalization expenses.⁷⁷ At the end of an accounting period, physicians receive any remaining funds left in the pool.⁷⁸ However, if no money remains in the pool due to a high number of referrals or inpatient stays, the physicians must share in the loss.⁷⁹ Withhold pools attempt to encourage physicians to contain costs by giving physicians a share of the pool if referrals and the use of high technology health services are kept to a minimum.⁸⁰

Bonuses are similar to risk pools.⁸¹ The MCO rewards the primary care physician for referring less patients and requesting fewer diagnostic tests and procedures.⁸² However, instead of withholding a percentage of the physicians' fees, in a bonus arrangement, the MCO sets aside additional funds at the beginning of the year to pay for outside medical services such as referrals and diagnostic tests.⁸³ At the end of the year, the MCO pays any funds remaining to the physicians in the form of a bonus above and beyond each physician's capitated compensation.⁸⁴

Expanded capitation attempts to encourage physicians to minimize costly medical treatment by including ancillary services for each patient in the physician's capitated payment.⁸⁵ The capitated payment for each enrollee includes the primary care physician's own expenses, tests, referrals and other medical services.⁸⁶ Thus, the physician's own income pays for diagnostic tests and referrals to specialists.⁸⁷

While cost containment mechanisms such as utilization review, capitation and payment incentives are the central focus of MCOs, most patients and physicians perceive cost controlling limi-

74. Latham, *supra* note 30, at 402-04.

75. *Id.* See Stanley, *supra* note 3, at 62 (giving an example of a risk pool).

76. Chittenden, *supra* note 41, at 481.

77. Latham, *supra* note 30, at 404.

78. *Id.*

79. Chittenden, *supra* note 41, at 481.

80. Latham, *supra* note 30, at 404.

81. Maxwell, *supra* note 22, at 35.

82. Latham, *supra* note 30, at 403.

83. McGraw, *supra* note 3, at 1828.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

tations as a threat. Cost effective measures encourage physicians to under utilize medical services which thereby strain the physician-patient relationship.⁸⁸ Disgruntled patients who question a physician's motivation when necessary medical treatment is not provided now seek redress in court with a host of legal theories against primary care physicians and their MCOs. Part III examines various theories plaintiffs assert in court against primary care physicians and MCOs for instituting cost containment measures such as utilization review, capitation and payment incentives. Although the theories vary in success, they dictate the future direction of managed care.

III. EXPANDED THEORIES OF LIABILITY FOR PHYSICIANS AND MCOs

The conflict of providing quality health care to a patient while at the same time attempting to contain costs results in expanded liability for physicians and MCOs.⁸⁹ Patients who are in-

88. John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 710 (1997). As the health care industry moves toward managed care and away from traditional medicine, the physician-patient relationship is altered. *Id.* at 706-07. The physician-patient relationship is viewed as a fiduciary relationship whereby the physician owes his patient a fundamental duty to put the patient's medical needs above all other personal interests. Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 23 (1986). A patient places complete trust in his doctor to care for him and provide the best medical treatment possible. AMA Council on Ethical and Judicial Affairs, *Ethics in Managed Care*, 273 JAMA 331 (1995) [hereinafter AMA Council]. A doctor takes a Hippocratic oath to provide the best possible medical care for the sick above all other interests. Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, AM. J.L. & MED., 241, 246 (1995). The relationship between the patient and physician is held in the highest regard, as the most important relationship in medicine. AMA Council, *supra*, at 331. However, managed care introduces a third party into the previously exclusive doctor-patient relationship. As a provider in a MCO, a physician must abide by his ethical duty to the patient to provide the best medical treatment possible, and at the same time adhere to cost containment mechanisms and limitations set forth in their contracts with the MCOs. David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX, 141, 149 (1995). Cost containment mechanisms such as utilization review, capitation and payment incentives limit treatment and encourage health care providers to cut costs. Freiburg, *supra* note 2, at 588. A physician has an ethical and legal duty to put the patients needs first; however, the pressure to contain costs and the incentive to make more money by cutting treatment costs may cloud a physician's judgment about a patient's medical treatment. See Orentlicher, *supra*, at 149. When determining medical treatment for a patient, a doctor should not consider what is best for the managed care plan. Freiburg, *supra* note 2, at 588. Nevertheless, through bonuses and other incentives, the MCOs pressure physicians to do just that or risk personal financial ruin. Orentlicher, *supra*, at 158.

89. Chittenden, *supra* note 41, at 476.

jured because cost containment mechanisms limited their treatment are attempting to attack cost containment mechanisms in court.⁹⁰ Injured patients have claimed that cost containment mechanisms influence a physician's judgment to limit or deny treatment, referrals or other medical services.⁹¹ Patients use common causes of action such as negligence, breach of fiduciary duty, breach of contract and tortious interference with the physician-patient relationship to allege that cost containment mechanisms were the cause of their injury.⁹² When cost containment mechanisms interfere with the physician's medical treatment and result in injury to the patient, courts find it difficult to determine who should be found liable and under what theory of law.⁹³

90. Richard C. Reuben, *With More Patients Suing HMOs for Denial of Treatment Lawyers are Exploring Ground in Going up Against the Managed Care Giants*, 82 ABA J. 55, 55 (Oct. 1996).

91. *Id.*

92. Chittenden, *supra* note 41, at 481.

93. The Employee Retirement Income & Security Act of 1974 (ERISA) preempts a vast majority of private claims against qualified MCOs. ERISA was originally promulgated to provide cost-effective protection over employee pension plans. 29 U.S.C. § 1001 (1994). See Manuel, *supra* note 42, at 545. ERISA provides a cost effective uniform regulation for employee benefit plans so as to "assure American workers that they may look forward, with anticipation, to a retirement with financial security and dignity." H.R. REP. NO. 93-533, at 8 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4646. Lower administrative costs in managing the pension funds arguably provide greater benefits to the plans' beneficiaries. Peter M. Mellette & Jane E. Kurtz, *Corcoran v. United Healthcare, Inc.: Liability of Utilization Review Companies in Light of ERISA*, 26 AM. HOSP. ASS'N. J. HEALTH & HOSP. L. 129 (1993). However, because the final version of the legislation regulated employee pension plans and employee benefit plans, health and benefit plans, including qualified employer managed care, was regulated under ERISA. Manuel, *supra* note 42, at 545. ERISA's inclusion of qualified employer health plans is significant because Congress enacted a preemption clause in ERISA which supersedes state laws which relate to covered plans. 29 U.S.C. § 1144(a) (1994). ERISA, therefore, preempts a broad range of state laws, including certain actions for injuries and wrongful death actions resulting from negligence by a health care plan's physicians or administrators and limits a beneficiaries remedies to contract damages. Jack Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice and Enterprise Liability*, 22 AM. J.L. & MED. 7, 9 (1996). The effect of the broad preemption is to leave some employees without recourse when an administrator or physician in a managed health care organization commits a tort. Mellette & Kurtz, *supra*, at 129.

ERISA's preemption over employee tort actions is significant because ERISA now covers more than 50% of all American workers. Kilcullen, *supra*, at 9. According to one prominent plaintiff's attorney, Mark Heipler, who has successfully challenged the administrative structure of an HMO in relation to a malpractice claim, "ERISA eliminates about 70 percent of all potential HMO cases, leaving only those clients [that are] covered by [either] government-sponsored plans . . ." or individual plans to seek recourse against HMO's. Grinfeld, *supra* note 42, at 48 (citing Mark O. Heipler, an attorney who has represented several patients in suits against HMOs).

The Fifth Circuit initially addressed the broad preemptive interpreta-

tion of ERISA and the judiciary's growing concern for plaintiffs who are left without recourse against managed care in *Corcoran v. United Healthcare Inc.*, 965 F.2d 1321 (5th Cir. 1992). In *Corcoran*, the plaintiff who was a member of a qualified employer health plan under ERISA needed hospitalization during her last month of pregnancy due to a history of miscarriage. *Id.* at 1324. When her obstetrician requested the month-long hospitalization, United Healthcare, the utilization review firm who monitored the plan, denied the request and authorized ten hour a day home nursing care instead. *Id.* Two weeks later, when the home nurse was not on duty, Mrs. Corcoran's baby went into fetal distress and died. *Id.*

The Corcorans filed an action against United Healthcare and Blue Cross & Blue Shield, the managed health care plan. *Id.* at 1324. The case was removed to federal court where the defendants argued that ERISA's preemption clause barred the Corcorans' wrongful death action. *Id.* at 1324-25. The district court judge granted defendants' motion for summary judgment holding that ERISA preempted the Corcorans' action on the basis that the damages claimed for improperly handling a claim were asserted against the administrators of the plan. *Id.* at 1325. On appeal, the Corcorans argued that the state traditionally authorizes their negligence claim and that the claim does not seek to regulate the administration of the plan in violation of ERISA. *Id.* at 1330. In addition, plaintiffs argued that if their claim is preempted, they are left without a remedy. *Id.* at 1338. The appellate court rejected plaintiffs' arguments with regret and noted that although United Healthcare made medical decisions and rendered medical advice through its utilization review, it did so in the context as an administrator in the plan. *Id.* at 1332. In rationalizing its decision, the court broadly interpreted the preemption clause as follows:

By its very nature, a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary, faced with the knowledge of specifically what the plan will and will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits.

Id. at 1332.

Despite the broad preemptive interpretation of ERISA in *Corcoran*, recent cases permit negligence claims against managed care by distinguishing between the administration of the plan, which is preempted by ERISA, and the quality of the plan, which is not preempted. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 357 (3d Cir. 1995) (stating that there is nothing in the legislation history of ERISA that required a medical malpractice action or negligence claim to be heard in federal court); *Roessert v. Health Net*, 929 F. Supp. 343 (N.D. Cal. 1996) (remanding plaintiff's malpractice claim back to state court after the district court judge rejected the defendants' preemption argument).

In light of the recent court decisions which distinguish the scope of ERISA's preemptive power by attacking the quality of the health care plan rather than the administrator of the plan, various groups, including the AMA, seek to sponsor legislation to help control the quality of health care. *See Grinfeld, supra* note 42, at 49, 85 (quoting Carol O'Brien, counsel for the AMA, as saying that the AMA has been "trying to avoid some of the ERISA [preemption] problems by drafting laws that don't look like direct economic hits on the plan, and then by trying to fashion laws that apply to all HMOs").

A. *The Legal Attack on Utilization Review*

As discussed in section A of Part II, the most common type of cost- containment mechanism used to reduce health care costs is utilization review. An MCO typically hires a utilization organization to review physicians' treatment decisions. A utilization reviewer has a strong interest in minimizing the amount of treatment to patients which can create a conflict for a physician who determines that a treatment is medically necessary for his patient. Although the MCO may deny treatment, the physician is responsible for the treatment and care of the patient. Therefore, the question becomes, who is responsible when a physician stops treating a patient because the MCO denies coverage for the treatment and the patient is injured as a result. The following three cases address who is liable when negligent utilization review results in injury to a patient.

1. *Wickline v. State of California*

The first case to challenge the impact of cost-containment mechanisms implemented by MCOs was the highly publicized case of *Wickline v. State of California*.⁹⁴ The cost-containment mechanism that allegedly caused injury to the plaintiff in *Wickline* was prospective utilization review.⁹⁵ *Wickline* is the seminal case to address whether a primary care physician and/or MCO may be held liable for a denial of necessary medical treatment.⁹⁶

Louis Wickline was admitted to the hospital for problems with her back and legs.⁹⁷ She was subsequently diagnosed with Leriche's Syndrome and was forced to undergo surgical treatment.⁹⁸ Louis was eligible for medical benefits under Medi-Cal, a

94. *Wickline v. California*, 228 Cal. Rptr. 661, 661 (Cal. Ct. App. 1986); see also Andrea Jean Lairson, *Reexamining the Physician's Duty of Care in Response to Medicare's Prospective Payment System*, 62 WASH. L. REV. 791, 799 (1987) (discussing the novelty of the issues presented in *Wickline*).

95. *Wickline*, 228 Cal. Rptr. at 662. See also Chittenden, *supra* note 41, at 476 (discussing the facts and holding of *Wickline*). See *supra* notes 48-50 and accompanying text for a discussion on prospective utilization review.

96. *Wickline*, 228 Cal. Rptr. at 662. See also Panah, *supra* note 3 (stating that *Wickline* was the first case to address the issue of liability of third party payors when denied medical treatment results in injury to a patient).

97. *Wickline*, 228 Cal. Rptr. at 663.

98. *Id.* at 663-64. A peripheral vascular surgeon diagnosed Louis with "arteriosclerosis obliterans with occlusion of the abdominal aorta" which is commonly referred to as Leriche's Syndrome. *Id.* at 663. Leriche's Syndrome is caused by the blockage of the terminal aorta. *Id.* Arteriosclerosis, a thickening of the artery walls, caused an obstruction in Louis' aorta above the point where the aorta divides into two separate arteries that descend into each leg. *Id.* Louis' doctors felt surgery was necessary to correct Louis' condition and determined it was necessary to replace part of Louis' artery with a "synthetic (Teflon) graft." *Id.*

California state administered Medicaid program.⁹⁹ Medi-Cal pre-authorized Louis' hospital admission and surgery.¹⁰⁰ After surgery, however, complications arose, and Louis underwent two additional emergency surgeries.¹⁰¹ When the time came for Louis to be discharged, the physician concluded that due to Louis' unstable condition, it was necessary for her to remain in the hospital.¹⁰² However, a Medi-Cal consultant, board certified in surgery, denied the treating physician's request for the additional hospital stay.¹⁰³ Soon after Louis' discharge from the hospital, her leg became infected.¹⁰⁴ Although she was in extreme pain, Louis waited a few days before calling the treating physician.¹⁰⁵ Subsequently, the infection in Louis' leg became untreatable and life threatening.¹⁰⁶

99. *Id.* at 664; Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1304 (1994).

100. *Wickline*, 228 Cal. Rptr. at 664.

101. *Id.*

102. *Id.*; Pedroza, *supra* note 18, at 421. After the "synthetic graft" was inserted into Louis' leg, she began to experience circulatory problems. *Wickline*, 228 Cal. Rptr. at 664. The doctors determined that a clot had formed and immediately took Louis back into surgery. *Id.* After the second surgery, Louis' began experiencing severe pain, spasms in her leg, and hallucinations. *Id.* She was brought into surgery a third time for a lumbar sympathectomy, a procedure performed to stop the spasms in her blood vessels. *Id.* The spasms Louis experienced stopped the blood from flowing from the vessels and therefore caused the clotting. *Id.* After the procedure, Louis' doctors determined that it was "medically necessary" for Louis to remain in the hospital for eight more days. *Id.* The physicians feared infection and clotting and felt that they could save Louis' leg from being amputated if they could watch her closely. *Id.*

103. *Wickline*, 228 Cal. Rptr. at 665. Medi-Cal required the hospital in which Louis received treatment to fill out a "Request for Extension of Stay in Hospital" (request form). *Id.* at 664. The request form required Louis' physician to provide information regarding Louis' "diagnosis, significant history, clinical status and treatment plan" in order to allow a Medi-Cal representative to make a "reasonable professional" decision about the extension. *Id.* at 664-65. A hospital nurse responsible for the request form submitted it to Louis' doctors for their signatures. *Id.* at 665. Louis' physicians testified that the request form was complete and accurate. *Id.*

A Medi-Cal "on-site nurse" reviewed the form and decided not to approve the request. *Id.* While Medi-Cal's "on-site nurse" had authority to approve the request form, she could not deny the request without consulting a Medi-Cal physician consultant. *Id.* After reviewing the request form, the Medi-Cal physician consultant determined that only a four day extension of hospital stay was necessary. *Id.* at 666. The physician consultant based his conclusion on the fact that the form did not mention Louis' temperature, diet or bowel movements, and that it indicated that she could walk without help and was receiving whirlpool treatments. *Id.* The physician consultant therefore determined that Louis' health was progressing and that she was not seriously ill. *Id.*

104. *Id.* at 667.

105. *Id.*

106. *Id.* at 668.

Louis was admitted back into the hospital and her leg was amputated.¹⁰⁷ Louis brought suit against the State of California claiming that Medi-Cal's prospective utilization review process was negligent.¹⁰⁸ She alleged that due to the Medi-Cal consultant's negligent decision to limit her request for additional hospital stay from eight days to four days, the doctors released her prematurely which resulted in the amputation of her leg.¹⁰⁹

A jury found for Louis and awarded her \$500,000.¹¹⁰ The Court of Appeals of California however, reversed the trial court and held that Medi-Cal was not liable for medical malpractice as a matter of law.¹¹¹ According to the court, the Medi-Cal consultant's decision complied with the standards set forth in the California statutes which governed the state's Medi-Cal program.¹¹² The court found that the patient's physician is responsible in determining the medical necessity of a patient's treatment.¹¹³ It was the physician's responsibility, the court concluded, to make an effort to appeal Medi-Cal's decision and to keep Louis in the hospital if, in his medical judgment, it was necessary to do so.¹¹⁴ The court stated that a physician is in a much better position to evaluate and diagnose a patient's condition and therefore has the ultimate responsibility for medical decisions.¹¹⁵

The *Wickline* Court determined that Louis' treating physician and not Medi-Cal made the decision to discharge Louis and, therefore, the physician was responsible for the discharge.¹¹⁶ The court

107. *Id.*

108. *Id.* at 662. See also E. Jane Ross, *Refusing to Pay for Health Care-Part II (of III): Emerging Trends in Third-Party Payer Liability*, *PROGRESS IN CARDIOVASCULAR NURSING*, Spring 1996, 40, 40 (using the *Wickline* case to illustrate emerging trends in third-party payor liability).

109. *Wickline*, 228 Cal. Rptr. at 662; Ross, *supra* note 108, at 40-41.

110. *Wickline*, 228 Cal. Rptr. at 662; Ross, *supra* note 108, at 41.

111. *Wickline*, 228 Cal. Rptr. at 672.

112. *Id.* at 671; Pedroza, *supra* note 18, at 423-24. The chief Medi-Cal physician consultant testified that the standard which governs approval or denial of requests for extension of hospital stay is "medical necessity for the length and level of care requested." *Wickline*, 228 Cal. Rptr. at 670. The medical necessity of the extension is determined by the information provided on the request form. *Id.* The Medi-Cal physician consultant is required to use his "skill, knowledge, training and expertise" when he denies or approves an extended hospital stay. *Id.*

113. *Wickline*, 228 Cal. Rptr. at 670.

114. *Id.* at 671.

115. *Id.* at 670.

116. *Id.* at 671. The court emphasized that while Louis' doctors knew Medi-Cal only approved Louis' hospital extension for four days, none of them contacted Medi-Cal to demand a further extension. *Id.* at 666. Two of Louis' doctors testified that they felt it was medically proper to discharge Louis when they did because her condition had not worsened or become life-threatening. *Id.* The senior doctor responsible for Louis testified that upon discharge, Louis' condition had not deteriorated or changed since Medi-Cal's denial of the

also emphasized that a physician must protest or make efforts to proceed with the treatment denied by a third party payor if in his medical judgment the treatment is necessary.¹¹⁷ A physician cannot escape liability by placing blame on a third party payor for decisions the physician made.¹¹⁸

Although the court found the treating physician responsible for Louis' injuries, the court did not close the door on third party payor liability.¹¹⁹ The court recognized that a prospective utilization review process contains greater risks than a traditional retrospective utilization review process.¹²⁰ If an MCO determines a procedure is not medically necessary in a retrospective utilization review process, the patient's reimbursement is wrongfully withheld.¹²¹ However, if an MCO concludes that a patient's treatment is not medically necessary under a prospective utilization review process, the patient could suffer serious physical injury or death.¹²² The court stated:

Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.¹²³

The court concluded its opinion by admitting that what was really at issue in *Wickline* was the effect of cost containment mechanisms on a physician's medical judgment.¹²⁴ The court stressed that cost containment mechanisms must not be allowed to

eight-day extension. *Id.* He therefore felt that he had no information that would change Medi-Cal's decision to allow Louis to stay in the hospital. *Id.* The doctor also testified that he felt Medi-Cal had authority over him to determine when Louis should be released from the hospital. *Id.*

117. *Wickline*, 228 Cal. Rptr. at 670-71.

118. *Id.* at 671.

119. *See id.* at 670 (stating "[a] patient . . . who is harmed when care should have been provided . . . should recover . . . from all those responsible . . . including, when appropriate, health care payors"). *See also* Pedroza, *supra* note 18, at 422 (quoting the court's dicta that health care payors may be held liable).

120. *See Wickline*, 228 Cal. Rptr. at 672 (noting that errors in the prospective review process can possibly result in a patient's death whereas errors in the retrospective utilization review process will only result in the provider not being paid for his services). *See also* Ross, *supra* note 108, at 41 (noting that the court's recognition of this possibly lethal difference).

121. *See Wickline*, 228 Cal. Rptr. at 663 (stating "[a] mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment").

122. *See id.* (stating that "an erroneous decision in a prospective review process . . . in practical consequences, results in the withholding of necessary care, potentially leading to a patient's disability or death").

123. *Id.* at 670-71.

124. *Id.* at 672.

interfere with a physician's medical judgment.¹²⁵

2. *Wilson v. Blue Cross of Southern California*

MCOs relied on the decision in *Wickline* for many years to protect them from liability for utilization review or cost containment decisions that result in injury to a patient.¹²⁶ However, MCOs became reluctant to use the *Wickline* decision as rational to deny benefits to their enrollees after the California Court of Appeals denied summary judgment motions brought by private insurance companies and a utilization review entity being sued for negligent utilization review.¹²⁷

In *Wilson v. Blue Cross of Southern California*, Howard Wilson was admitted into a hospital for drug dependency, anorexia and depression.¹²⁸ The treating physician, after evaluating Howard, determined that it was medically necessary for Howard to remain in the hospital for three to four weeks for observation and treatment.¹²⁹ Authorization for the hospital stay from Howard's private insurance company was necessary.¹³⁰ The utilization review entity employed by Howard's insurance company determined that he did not meet admission criteria and denied further benefits after his eleventh day in the hospital.¹³¹ Howard was released from the hospital due to his inability to pay his own medical costs.¹³² Twenty days later, Howard committed suicide.¹³³

Howard's parents brought suit against Howard's health insurance companies, the entity that performed utilization review of the medical necessity of hospital stays and the entities' employees for breach of the insurance contract, negligence and wrongful death.¹³⁴ The trial court, relying on *Wickline*, reasoned that Howard's treating physician was responsible for his discharge from the hospital and granted the defendants' summary judgment motions.¹³⁵ The California Court of Appeals, however, holding that

125. *Id.*

126. Pedroza, *supra* note 18, at 422. The court in *Wickline* found that physicians and not MCOs are responsible for any medical decisions made regarding the patient. *Wickline*, 228 Cal. Rptr. at 670.

127. *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876, 885 (Cal. Ct. App. 1990).

128. *Id.* at 877.

129. *Id.*

130. *Id.*

131. *Id.* at 877; Adrienne M. Zibelman, *The Practice Standard of Care and Liability of Managed Care Plans*, 27 HEALTH & HOSP. L. 204 (1994), available in LEXIS, GenMed Library, Med & Health Jnl File.

132. *Wilson*, 271 Cal. Rptr. at 877-78.

133. *Id.* at 878.

134. *Id.* at 880.

135. *Id.*; See also Zibelman, *supra* note 131 (discussing cases in which plaintiffs have sued their health insurance companies for injury resulting from a denial of coverage).

the insurance companies and utilization review organization were not entitled to summary judgment, reversed the trial court and remanded the case.¹³⁶ Ultimately, the utilization review entity settled with Howard's parents and a jury found the insurance company liable for breach of contract.¹³⁷

The court of appeals distinguished *Wickline* on many of the issues raised by plaintiffs and found much of the language in *Wickline* to be dicta.¹³⁸ First, the *Wilson* court stated that Louis Wickline received benefits through a state administered Medicaid program that the California Administrative Code governs whereas Howard Wilson received benefits through a private insurance company.¹³⁹ According to the *Wilson* court, the decision to deny benefits in *Wickline* met the medical standard of care defined in the California Administrative Code and the Welfare and Institutions Code.¹⁴⁰ These Codes allowed a Medi-Cal consultant to review coverage for a patient and to deny coverage when appropriate.¹⁴¹ The decision made by Medi-Cal met the medical standard of care defined in the codes which was the "usual standards of medical practice in the community."¹⁴² The decision to discharge Howard by his private insurance company, however, raised a question of fact for the jury.¹⁴³

Second, the Court of Appeals also distinguished *Wickline* on the basis that the payment of benefits in *Wickline* was not pursuant to a contract but to provisions of a code.¹⁴⁴ This altered normal tort liability rules which provide that all persons are responsible for their own acts and for preventing others from being harmed by their conduct as a result of lack of ordinary care.¹⁴⁵ In *Wickline* there was a public policy exception to general tort liability rules found in the applicable codes which mandated utilization review and allowed Medi-Cal to deny benefits to Louis.¹⁴⁶ However, in *Wilson*, the court stated that there was no public policy exception in the contract between Howard and his insurance company.¹⁴⁷ The court disagreed with the defendants' argument, that the *Wickline* decision can be interpreted to mean that a strong public policy, in favor of utilization review, provides a health insurance

136. *Wilson*, 271 Cal. Rptr. at 885.

137. Frankel, *supra* note 99, at 1308.

138. *Wilson*, 271 Cal. Rptr. at 885.

139. *Id.* at 878-79.

140. *Id.*

141. *Id.* at 879.

142. *Wickline v. State of California*, 228 Cal. Rptr. 661, 670-71 (Cal. Ct. App. 1986).

143. *Wilson*, 271 Cal. Rptr. at 883; Pedroza, *supra* note 18, at 423.

144. *Wilson*, 271 Cal. Rptr. at 879.

145. *Id.*

146. *See id.* at 884 (discussing the *Wickline* opinion).

147. *Id.*

company that denies benefits immunity from general tort liability.¹⁴⁸ Thus, applying general joint tort liability rules in *Wilson*, the court stated that any defendant whose negligent conduct is a substantial factor in bringing about plaintiff's injury is liable.¹⁴⁹ The court in *Wilson* found that there was enough evidence to determine that the utilization review decision to deny benefits to Howard was a substantial factor in Howard's death.¹⁵⁰ In *Wilson*, one of the treating physicians testified that Howard's inability to pay for the treatment was the sole reason for the patient's discharge, and that Howard would probably be alive had he stayed in the hospital.¹⁵¹ The court relied on the treating physician's testimony to hold that there was enough evidence to raise an issue of fact as to whether the defendants' conduct was a substantial factor in Howard's death.¹⁵²

Finally, the court rejected the defendants' main argument that, based on *Wickline*, Howard's treating physician had a responsibility to challenge the utilization review decision and was, therefore, responsible for Howard's discharge and death.¹⁵³ The court found that the language in *Wickline*, stating that the discharge is the sole responsibility of the physician, was dicta and unnecessary for the decision of the case.¹⁵⁴ The court characterized the language as "broadly stated" and emphasized that it did not "correctly state the law relative to causation issues in a tort case."¹⁵⁵ Therefore, the *Wilson* court opened the door for injured plaintiffs to sue their MCOs if denial of benefits is a substantial factor in the patient's injury and reversed the rule that physicians are solely responsible for all discharge decisions.¹⁵⁶

148. *Id.*

149. *Id.* at 883. The elements of joint tort liability are:

The actor's negligent conduct is a legal cause of harm to another [because] (a) his conduct is a substantial factor in bringing about the harm, and (b) there is no rule of law relieving the actor from liability because of the manner in which his negligence has resulted in the harm.

RESTATEMENT (SECOND) OF TORTS § 431 (1965).

150. *Wilson*, 271 Cal. Rptr. at 883.

151. *Id.* at 882-83.

152. *Id.* at 883.

153. *Id.* Although the court stated that the language in *Wickline* requiring a physician to pursue an appeal to a denial of benefits was dicta, they also set forth many other valid reasons for rejecting the defendants' argument. *Id.* at 884-85. The physician's failure to pursue an appeal to the denial of Howard's benefits did not warrant a summary judgment for defendants. *Id.* Howard's physician's were not a party to the lawsuit. *Id.* There was a question of whether Howard's policy with the insurance company allowed utilization review. *Id.* Lastly, the defendants never proved that the request for further hospital stay would have been granted had Howard's physicians appealed. *Id.*

154. *Id.* at 883.

155. *Id.* at 880.

156. See *supra* notes 138-56 and accompanying text for a discussion of the holding in *Wilson*. See also, Ross, *supra* note 108, at 42.

3. *Fox v. Health Net*

In *Fox v. Health Net*,¹⁵⁷ Physicians diagnosed Nelene Fox with breast cancer and recommended a bone marrow transplant.¹⁵⁸ After much delay, Nelene's HMO determined that the transplant was experimental due to her advanced stage of cancer and denied coverage for the transplant.¹⁵⁹ Nelene and her family, through fund-raising efforts, obtained enough money to have the transplant.¹⁶⁰ Unfortunately, Nelene died shortly after the transplant.¹⁶¹ Nelene's husband sued her HMO for breach of contract, bad faith and intentional infliction of emotional distress.¹⁶²

Nelene's husband argued that Health Net denied his wife's transplant because of financial incentives which were implemented to encourage physicians to reduce medical costs.¹⁶³ He claimed that Health Net denied the transplant despite Health Net's written policy which specifically covered bone marrow transplants and a study performed by Health Net which showed that bone marrow transplants were successful in three out of four other HMO's.¹⁶⁴

Under the bad faith claim, Mr. Fox argued that Health Net created financial incentives and bonus schemes which "intend[ed] to or recklessly insure[ed]"¹⁶⁵ that Health Net executives' decisions

157. *Fox v. Health Net*, Case No. 219692 (Cal. Super. Ct. Dec. 28, 1993).

158. Trial Brief at 1, *Fox v. Health Net*, No. 219692 (Cal. Super. Ct. Dec. 28, 1993).

159. Trial Brief at 3, *Fox v. Health Net*, No. 219692 (Cal. Super. Ct. Dec. 28, 1993).

160. Trial Brief at 4-6, *Fox v. Health Net*, No. 219692 (Cal. Super. Ct. Dec. 28, 1993). See also Manuel, *supra*, note 42, at 542 (discussing liability for physicians under managed care).

161. Manuel, *supra* note 42, at 542.

162. Trial Brief at 7, *Fox v. Health Net*, No. 219692 (Cal. Super. Ct. Dec. 28, 1993).

163. *Id.* at 33.

164. Zibelman, *supra* note 131. Two witnesses testified for Mr. Fox that significantly helped his case. Ross, *supra* note 108, at 44. The first witness was a Health Net employee that developed breast cancer. *Id.* She was initially denied coverage for a bone marrow transplant by Health Net, however, Health Net subsequently approved the transplant claiming the procedure was only approved because she had been an employee for so long. *Id.* The witness filed a motion to join in Mr. Fox's suit because she felt Health Net was delaying its approval. *Id.* Soon thereafter Health Net officially approved the transplant. *Id.* The witness also revealed that the money for her transplant came from a pool of funds Health Net reserved for bone marrow transplants. *Id.* There was over four million dollars in Health Net's bone marrow fund when Nelene was denied her transplant. *Id.* The second witness testified that she was granted a bone marrow transplant only because Health Net feared a wrongful death action. *Id.* These two witnesses refuted Health Net's arguments that Health Net did not pay for bone marrow transplants and that the transplants were unsuccessful. *Id.*

165. Trial Brief at 34, *Fox v. Health Net*, No. 219692 (Cal. Super. Ct. Dec. 28, 1993).

to deny or approve treatment were prejudiced by financial decisions.¹⁶⁶ Mr. Fox also presented evidence that two financial incentive plans influenced the Health Net executive's decision to deny Nelene's treatment.¹⁶⁷ The first incentive provided the executive with a bonus equal to 20% of his salary based on the financial condition of Health Net at the end of the year.¹⁶⁸ The second incentive plan provided bonuses to the executive based upon the results of his individual efforts to lower medical costs.¹⁶⁹ Mr. Fox argued that the incentives created a conflict of interest and made it difficult for the reviewer to objectively determine whether to deny or approve treatment.¹⁷⁰ He also argued that the incentive plans encouraged Health Net executives to deny treatment for their own financial gain.¹⁷¹

A jury awarded Mr. Fox 12 million dollars in compensatory damages and 77 million dollars in punitive damages.¹⁷² Health Net subsequently filed a motion for a new trial.¹⁷³ Prior to the court's ruling on Health Net's motion, however, the parties settled for an undisclosed amount.¹⁷⁴

The three cases discussed above are examples of the various theories of liability plaintiffs' use against physicians and MCOs when negligent utilization review results in injury. Capitation and payment incentives are also challenged in court as being the substantial factor in causing plaintiffs injuries.

B. *The Legal Attack on Capitation and Payment Incentives*

As previously discussed in Section B of Part II, capitation reduces health care costs by providing physician's with a set fee per patient per month.¹⁷⁵ Capitation schemes use financial incentives to encourage physicians to minimize medical services and make cost-conscious decisions regarding treatment. Further, under a capitated reimbursement system a physician is burdened with the financial risk for the delivery of care. Therefore, financial incentives create a conflict between the physician's duty to the patient

166. *Id.*

167. Ross, *supra* note 108, at 44. See Trial Brief at 33-34, *Fox v. Health Net* No. 219692 (Cal. Super. Ct. Dec. 28, 1993) (discussing the two financial incentive plans the HMO implemented.)

168. Ross, *supra* note 108, at 44.

169. *Id.* at 44-45.

170. Trial Brief at 33-34, *Fox v. Health Net*, No. 219692 (Cal. Super. Ct. Dec. 28, 1993).

171. *Id.*

172. David Leon Moore, *Ethics Pinched by the System, Lawyer Says*, U.S.A. TODAY, Jan. 22, 1996, at 2D.

173. *Id.*

174. *Id.*

175. See *supra* notes 55-66 and accompanying text for a discussion of capitation.

and the physician's personal financial concerns. If financial incentives are the motivating factor in denying a patient's treatment and the patient is injured as a result, the physician and/or the MCO can be held liable. Therefore, capitated reimbursement systems and the use of financial incentives expand liability for physicians and MCOs. In the following three cases, plaintiffs allege financial incentives implemented by the MCO encouraged their physicians to deny treatment and referrals which resulted in their injury.

1. *Pulvers v. Kaiser Foundation Health Plan*

One of the first cases to challenge financial incentives and risk sharing was *Pulvers v. Kaiser Foundation Health Plan*.¹⁷⁶ Mr. Pulvers allegedly died from the mistreatment of Bowen's Disease.¹⁷⁷ Mr. Pulvers originally sued his health insurance company, Kaiser Health Plan, and his physician for medical malpractice.¹⁷⁸ Subsequently, during the pleading stage of the trial, Mr. Pulvers died and his wife stepped in as plaintiff to the lawsuit.¹⁷⁹ Mrs. Pulvers amended the complaint and added the following additional causes of action: breach of warranty, fraud and wrongful death.¹⁸⁰ At trial, a jury found for Mrs. Pulvers on the fraud count but found for the defendants on the medical malpractice claim.¹⁸¹ The trial court granted a new trial on the wrongful death and fraud issues and granted judgment on the pleadings on the breach of warranty claim.¹⁸² Mrs. Pulvers appealed the decision.¹⁸³ For most of the causes of action pled in the complaint, Mrs. Pulvers alleged that the financial incentive plan implemented by Mr. Pulvers' HMO encouraged physicians to refrain from ordering necessary tests and medical treatment to lower costs for the insurance company.¹⁸⁴ Mrs. Pulvers asserted that the HMO fraudulently led them to believe they would receive "the best quality of care and treatment."¹⁸⁵ However, she argued that the plan implemented financial incentives to encourage its physicians to limit tests and treatment which made it impossible to achieve a high standard of care.¹⁸⁶

The California Court of Appeals rejected Mrs. Pulvers' argu-

176. *Pulvers v. Kaiser Found. Health Plan*, 160 Cal. Rptr. 392 (Cal. Ct. App. 1979).

177. *Id.* at 393.

178. *Id.*

179. *Id.*

180. *Id.* Mr. Pulvers' two children also brought an action against the two defendants for wrongful death. *Id.*

181. *Id.*

182. *Pulvers*, 160 Cal. Rptr. at 393.

183. *Id.*

184. *Id.* at 393-94; Chittenden, *supra* note 41, at 480-81.

185. *Pulvers*, 160 Cal. Rptr. at 394.

186. *Id.*; Chittenden, *supra* note 41, at 480-81.

ment and held that the Federal HMO Act¹⁸⁷ requires financial incentive plans and that professional groups use financial incentives to reduce health care costs.¹⁸⁸ The court further stated, "we can see in the plan no suggestion that individual doctors act negligently or that they refrain from recommending whatever diagnostic procedures or treatments the accepted standards of their profession require."¹⁸⁹ The Court of Appeals thus affirmed the trial court's refusal to allow Mrs. Pulvers to pursue a cause of action against the defendants for not meeting the medical standard of care due to financial incentives implemented by the insurance company.¹⁹⁰

2. *Bush v. Dake*

In 1990, another closely watched case went to trial which again attacked the financial incentives of an HMO, however, it was never officially reported.¹⁹¹ In *Bush v. Dake*, Ms. Bush, an HMO member, alleged that her HMO implemented financial incentives which led to her physician's negligent medical treatment.¹⁹² Ms. Bush argued that her primary care physician failed to perform a pap smear and failed to refer her to an obstetrician which may have lead to an earlier detection of her cervical cancer.¹⁹³ She claimed that the cost containment mechanisms implemented by her HMO were a substantial factor in her physician's failure to provide quality health care to her.¹⁹⁴ Ms. Bush sued the HMO and the physician for negligence, gross negligence, fraud, breach of trust and tortious interference with the physician-patient relationship.¹⁹⁵ Ms. Bush's HMO required her to seek treatment from her primary care physician for any medical problems.¹⁹⁶ A specialist would be recommended for plaintiff only if the primary care physician deemed it necessary.¹⁹⁷ Further, the HMO reimbursed Ms. Bush's primary care physician under a capitated system.¹⁹⁸ The HMO also implemented risk pools for referrals to specialists and patient hospitalization stays.¹⁹⁹ If the primary care

187. 42 U.S.C. § 300e-300e-17 (1997).

188. *Pulvers*, 160 Cal. Rptr. at 394.

189. *Id.*

190. *Id.* at 395.

191. Paul Craig, *Health Maintenance Organizations Gatekeeping Policies: Potential Liability for Deterring Access to Emergency Medical Services*, 23 J. HEALTH & HOSP. L. 135 (1990), available in LEXIS, GenMed Library, Med & Health Jnl File.

192. Panah, *supra* note 3.

193. Craig, *supra* note 190.

194. Chittenden, *supra* note 41, at 481.

195. *Id.*

196. *Id.*

197. *Id.*

198. *Id.*

199. *Id.*

physician's recommendations for referrals and hospital stays were minimal throughout the year, more money was left in the risk pool at the end of the year for distribution.²⁰⁰ Ms. Bush alleged these financial incentives caused her primary care physician to delay a pap smear and referral to a specialist which thereby delayed the timely diagnosis of cervical cancer.²⁰¹ She argued further that the HMO implemented a financial incentive system which tortiously interfered with the patient-physician relationship and violated public policies that existed to protect the patient-physician relationship.²⁰²

Ms. Bush's HMO moved for summary judgment motion arguing that financial incentives were consistent with public policy.²⁰³ They argued that public policy favored lowering health care costs and thus favored financial incentives.²⁰⁴ The HMO also argued that the "incentive to malpractice was illusory" for three reasons.²⁰⁵ First, there is no evidence that financial incentives implemented to control costs are more influential than the fee-for-service system which can influence a physician to over-utilize medical services.²⁰⁶ Second, quality assurance programs implemented by the HMO counterbalance any negative influence financial incentives have on physicians.²⁰⁷ Third, a physician's fear of medical malpractice claims, concern with professional pride, and human compassion insure that a physician will not allow financial incentives to cloud his judgment.²⁰⁸

The Michigan Circuit Court denied the HMO's motion for summary judgment, however, it also found that financial incentives are not against public policy.²⁰⁹ The court held that the question of whether a financial incentive program caused a physician to provide inadequate care, thereby committing malpractice, is a question for the jury.²¹⁰ Therefore, although cost containment mechanisms are not against policy and in fact are required by public policy, a jury can determine that financial incentives effected a physician's medical judgment.²¹¹ The court left the door open for liability against HMOs when it can be proven that

200. Chittenden, *supra* note 41, at 481.

201. Craig, *supra* note 190.

202. Chittenden, *supra* note 41, at 481.

203. *Id.*

204. *Id.* at 482.

205. *Id.*

206. *Id.*

207. *Id.*

208. Chittenden, *supra* note 41, at 482.

209. *Id.*

210. *Id.*

211. *Id.*

financial incentives caused a contracting physician to commit medical malpractice.²¹²

3. *Ching v. Gaines*

In a recent California case, a prominent attorney attempted to blame capitation for his client's death.²¹³ Concerned MCOs watched carefully as the case proceeded to trial.²¹⁴ In *Ching v. Gaines*,²¹⁵ Joyce Ching sought treatment from her primary care physician for pain and discomfort she was having in her stomach and rectum.²¹⁶ After receiving some treatment from the primary care physician, Joyce's pain did not subside.²¹⁷ Joyce requested additional tests and referrals to specialists for months, but her requests were ignored.²¹⁸ Joyce's primary care physician did not refer her to a specialist for her condition for over three months.²¹⁹ Finally, she was referred to a gastroenterologist who diagnosed Joyce with stage four colon cancer that had perforated her bowel wall.²²⁰ The cancer was extensive and inoperable.²²¹ Subsequently, Joyce died.²²²

Joyce's husband sued the physicians and their medical group for medical malpractice, wrongful death and breach of fiduciary duty.²²³ Mr. Ching alleged that Joyce employed a physician to treat and diagnose her condition and that the physicians undertook the duty to do so.²²⁴ The physicians that agreed to treat Joyce had medical expertise and training upon which Joyce relied.²²⁵ Mr. Ching argued that Joyce's reliance on her physicians' medical expertise created a fiduciary relationship between Joyce and her physician.²²⁶ Mr. Ching alleged that as a fiduciary, a physician has various duties which include acting on the patient's behalf to provide the best possible care and treatment, undertaking all necessary actions in the interest of the patient, placing the patient's interests above financial interests or interests of the MCO, and

212. *Id.*

213. Leslie Nicholson, *Physicians Failed to Diagnose, But HMO off the Hook*, 3 MED. MALPRACTICE L. & STRATEGY, 5, 5 (1996).

214. Marie C. Infante, *The Legal Risks of Managed Care, Legally Speaking*, RN, Mar. 1996, at 57.

215. *Ching v. Gaines*, No. CV-137656 (Cal. Sup. Ct., Nov. 15, 1995).

216. Third Amended Complaint at 3, *Ching v. Gaines*, No. CV-137656 (Cal. Sup. Ct. Nov. 15, 1995).

217. *Id.*

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.*

222. Third Amended Complaint at 4, *Ching*, No. CV-137656.

223. *Id.* at 1-5.

224. Third Amended Complaint at 3, *Ching*, No. CV-137656.

225. *Id.*

226. *Id.* at 6.

disclosing all information that affects the patient's condition.²²⁷

Mr. Ching alleged that Joyce's physicians breached their fiduciary duty to her by negligently treating her, failing to refer her to a specialist due to financial gain, and failing to disclose information about the payment incentives.²²⁸ The physicians treating Joyce were part of a capitated MCO, each physician received \$27.94 per month for her treatment.²²⁹ Any costs above the \$27.94 came out of the physicians' pockets.²³⁰ Mr. Ching alleged that Joyce was not immediately referred to a specialist because her physicians were encouraged to limit referrals and tests and because money for referrals came from the physician's own pockets.²³¹ The physicians, therefore, had a financial incentive to restrict patient referrals to specialists which conflicted with their fiduciary duty to Joyce.²³² Mr. Ching also alleged that her physicians had a duty to disclose information about the financial incentives to Joyce because it affected her treatment.²³³ Allowing financial incentives to influence a decision about medical treatment, Mr. Ching alleged, constitutes negligent conduct.²³⁴ The physician's negligent conduct thus directly resulted in Joyce's death.²³⁵

A jury awarded Mr. Ching 3 million dollars, however, a California law reduced the award to \$700,000.²³⁶ However, when calculating damages, the jury was not allowed to consider the breach of fiduciary duty count.²³⁷ On the eve of trial, the judge granted defendant's motion for nonsuit on the breach of fiduciary duty claim.²³⁸ A breach of fiduciary duty claim, the judge held, requires a duty and a breach of that duty.²³⁹ The physicians in the *Ching* case did not have a fiduciary duty to disclose financial incentives to their patient²⁴⁰ Therefore, if the physicians had no duty to disclose information to Joyce, there was no duty to breach. The judge in *Ching* was concerned that if he allowed the breach of fiduciary duty to be tried he would open the door to new law which would require physicians in HMOs to disclose all financial arrangements with patients prior to treatment.²⁴¹ Concerned with the conse-

227. *Id.*

228. *Id.*

229. Moore, *supra* note 172, at 1D.

230. *Id.*

231. *Id.*

232. Nicholson, *supra* note 213, at 5.

233. Third Amended Complaint at 6, *Ching*, No. CV-137656.

234. *Id.*

235. *Id.*

236. Grinfeld, *supra* note 42, at 48.

237. Nicholson, *supra* note 213, at 6.

238. *Id.*

239. Reporter's Partial Transcript of Proceedings Sept. 7, 1995, at 30-35 *Ching*, No. CIV-137656.

240. *Id.*

241. *Id.* at 31, 34.

quences of allowing the breach of fiduciary duty count to be tried, the judge concluded that he was not responsible for making new law which required physicians to disclose financial incentive information to patients.²⁴² He also determined that the defendants would have no defense against this claim.²⁴³

It is apparent from a brief discussion of the cases mentioned above that courts differ in their views as to which party should be held liable when a plaintiff is injured due to a cost controlling measure. Some courts hold physicians solely responsible for any medical decisions while other courts hold MCOs liable for cost containment mechanisms that interfere with a physician's medical judgment. It is also apparent that managed care is successful in lowering health care costs and is here to stay. Therefore, standards must be in place for physicians and MCOs to follow in a managed care setting. In addition, guidelines or rules must be created to dictate the interaction between physicians, patients and MCOs.

IV. PROPOSALS

The purpose of MCOs is to provide its participants with quality health care at a reasonable cost. The system is designed to efficiently allocate quality medical services to a pool of participants. In order to efficiently allocate medical services, MCOs implement several cost containment mechanisms including the aforementioned utilization review, capitation and bonuses to help keep costs of quality health care down. Evidence suggests that MCOs and their cost containment mechanisms help contain the cost of quality medical services.²⁴⁴ However, cost containment measures, as well as resource constraints inherent in the managed care system, create a conflict of interest between physician and patient.²⁴⁵ Financial incentives in the form of cost containment arguably function to limit a patient's treatment options within a given MCO. Whether the MCO or the primary care physician controls cost limitations, the tenuous relationship found between physician and patient under managed care is fraught with conflict and distrust. The prevailing opinion held by the patient is that the physician no longer

242. *Id.*

243. *Id.* at 32.

244. George J. Church, *Backlash Against HMO's*, TIME, April 14, 1997 at 32. Managed care has resulted in a "welcome reduction in the runaway growth of medical costs." *Id.*

245. *Id.* According to David Lawrence, Chairman and CEO of Kaiser-Permanente, California's nonprofit managed care program, "[i]n the fee-for-service days, there was a very perverse system that rewarded doctors for doing way too much medicine; now we have a system [under managed care] creating incentives that do too little." *Id.* at 32. Dr. Alan Fogelman, head of UCLA's Department of Medicine, cryptically notes that "People who are sick will be able to die because it is the best economically." *Id.*

acts as the patient's advocate.²⁴⁶

Although commentators agree that managed care may lessen the impact financial incentives have on primary care physicians, some authors suggest that MCOs require a comprehensive overhaul which includes a prohibition on all cost containment mechanisms.²⁴⁷ Others argue that the ethical obligation and applicable standard of care for physicians in MCOs must be modified to reflect the structural restraints inherent in the particular health care plan.²⁴⁸

246. The portion of premiums allocated for patient care in any managed care plan is called "medical loss ratio." Church, *supra* note 244, at 32. According to the AMA, for-profit HMO's allocate approximately seventy percent for every dollar of premium received from its subscribers; the remaining 30% is allocated for administrative costs and profits. *Id.* at 32-33. Church suggests that non-profit managed plans tend to allocate a larger percentage of premium payments to health care services. *Id.* Alternatively, under the traditional fee-for-service arrangement previously available through Blue Cross & Blue Shield, 96% of each dollar of premium paid for health care services. *Id.* at 33. Unfortunately, under the traditional fee-for-service arrangement, much of the money allocated to health care services may be considered excessive. *Id.* Clearly, non-profit managed care plans that function without needing to feed shareholders' demand for dividends allocate a higher percentage of premiums to health care services. *Id.*

247. David Orentlicher, *supra* note 88, at 169-70. One widely accepted modification to the financial incentives offered to primary care physicians is to expand the physician incentive payments from single physicians to groups of physicians who care for and treat large pools of patients. *Id.* at 168-69. Dr. Orentlicher contends that if MCOs payments are based upon the performance of large groups of physicians rather than single physicians, the impact of the payment incentives and hold-backs would be significantly lessened because a larger cross section of patients would be used to calculate the ratio of referrals and diagnostic tests. *Id.* at 168. Therefore, although the physician may feel the repercussions of excessive referrals, the financial impact on the physician will be spread to the entire physician practice group. *Id.*

See RODWIN, *supra* note 18, at 232-33; Susan M. Wolf, *Health Care Reform and the Future of Physician Ethics*, HASTINGS CTR. REP., Mar.-Apr. 1994, 28, 35-36. Both authors argue that even moderate financial incentives imposed by managed care on primary care physicians can cause patients to question the physician's commitment and responsiveness to the patient's needs. *Id.* If financial incentives are therefore banned, the physician will once again act as the patient's advocate. *Id.*

248. Robert I. Field, Book Review, 17 J. LEGAL MED. 581, 585-586 (1996) (reviewing E. HAAVI MORREIM, *BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS* (1995)). Professor Morreim, a Professor of Human Values and Ethics at the College of Medicine at the University of Tennessee, argues in her book that developments in managed care require the creation of two separate standards of care for a primary care physician. *Id.* The standards are called the "standard of medical expertise" and the "standard of rescue use". *Id.*

The "standard of medical expertise" represents the traditional standard of care wherein a physician's acts or omissions are evaluated on whether the acts comply with what a reasonably well qualified physician would do in like or similar circumstances. *Id.* The second standard, termed the "standard of

While each recommendation has certain appeal, the recommendations ignore the practical reality of managed care. As an alternative, this Comment proposes that although cost containment mechanisms should remain in place, MCOs and primary care physicians must fully disclose each material financial incentive and resource constraint in the managed care system before the patient consents to treatment. The Comment also suggests that the standard of care remain fixed on what a reasonably well-qualified physician would do in like or similar circumstances regardless of the constraints in the health care plan.

A. *Financial Incentives are Necessary To Ensure Efficient Allocation of Quality Health Care*

Managed care, and its use of cost containment mechanisms, such as utilization review, capitation and financial incentives, was created to help stem the rising cost of quality health care.²⁴⁹ Under the fee-for-service arrangement physicians over-utilize medical services and in turn drive up the cost of quality medical care. Although the long term impact of managed care on the health care industry is unknown, the short term effect of managed care is to lower the cost of quality health care.²⁵⁰

resource use," contemplates the services and resources available to the patient that the MCO will reimburse. *Id.* Professor Morreim argues that under the "standard of resource use" the physician has the obligation to inform the patient of all the financial incentives in the health care system and its resource constraints. *Id.* Medical negligence is in turn based upon the resources available to the physician under the particular managed care system. *Id.*

249. Health care spending in the U.S. rose from \$675 billion in 1990 to \$950 billion in 1994. Martin & Bjercknes, *supra* note 42, at 435. (citing from BARBARA H. FRANKLEN ET. AL., U.S. DEPT. OF COMMERCE, BUSINESS FORECASTS FOR 350 INDUSTRIES: U.S. INDUSTRIAL OUTLOOK 1993 42-1 (1993) and Robert Pear, *Health Costs are Growing More Slowly, Report Says*, N.Y. TIMES, May 28, 1996, at A13).

Moreover, total medical expenditures over the years have skyrocketed. In 1960, medical expenditures totaled \$27.1 billion and rose to \$74.4 billion in 1970, \$250.1 billion in 1980 and \$422.6 billion in 1985. Igelhart, *supra* note 4, at 965. Government officials believe that if current growth rates in medical expenditures continue, health care expenditures will account for 16% of the gross national product of the U.S. by the year 2000. Sally T. Sonnefeld, *Projections of National Health Expenditures Through the Year 2000*, 13 HEALTH CARE FIN. REV. 1, 1 (1991).

250. From 1994 to 1995, HMO premium payments have declined. See Eric Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 45, 47 (stating that the Health Care Financing Administration attributed the deceleration of health care to the leveling off of the cost of private health care benefits). See also Arnold Birenbaum, *Managed Care: Will It Be For Everyone?*, USA TODAY, July 1996, at 46 (explaining that HMO's are an alternative form of cost effective health care). Many state run Medicare and Medicaid programs are now shifting into managed care systems to save money and improve the quality of health care. Igelhart, *supra* note 4, at 900.

The prohibition of cost containment mechanisms eliminates the incentive to render only medically necessary services. Without a financial incentive to render only necessary medical service, physicians will ultimately prescribe potentially excessive diagnostic tests and treatments in order to insulate themselves from liability. The excessive diagnostic tests and treatments will lead to additional cost which the managed care plan will pass on to its subscribers. In the end, managed care's sole purpose of providing affordable health care will be lost.

B. Full Disclosure by MCOs and Physicians will Level the Playing Field and Promote Resolution with Patients

The use of cost containment mechanisms make physicians aware of the costs of medical treatment and help to lower costs. However, MCOs must be given some limitations on the use of cost controlling measures so that the quality of health care is not compromised. The MCO and physician must provide full disclosure to the patient about the system's cost containment mechanism. Full disclosure provides patient awareness of the physician's cost limitations and allows the patient to participate in the decision making of his own medical treatment.²⁵¹

New rules governing how managed care organizations structure their physician incentive arrangements support the notion that a physician's payment incentives should be disclosed to the patient.²⁵² However, the Health Care Financing Administration's

251. Professor Morreim also encourages full disclosure of all financial incentives and resource constraints. See Morreim, *supra* note 12, at 80. Professor Morreim believes it is essential to educate each MCO subscriber on the resource limitation inherent in the system in order to hold the participant responsible for cost effective treatment. *Id.* If the patient has a financial interest in his care and treatment, he will listen to treatment alternatives and participate as a partner in his treatment course. *Id.* at 101. However, David Mechanic and Mark Schlesinger suggest that requiring a physician to disclose information about the payment methods may actually reduce the patient's trust in his physician. Mechanic & Schlesinger, *supra* note 43, at 1693-96. They note that currently, the American Medical Association's code of ethics requires that reimbursement schemes must be discussed with new patients. *Id.* However, the authors note that physicians will not disclose payment information to their patients if no enforcement mechanism is in place to deter physicians from disobeying the requirement. *Id.* Further, they argue that if a patient is told about various financial incentives the physician is working under, the patient may have a difficult time understanding how the incentives work or what they mean. *Id.* If the patient comprehends how the incentives work, the patient may develop a great distrust for the physician but have no other option that remain in the physician's care for covered medical treatments. *Id.* If disclosure is necessary, Mechanic and Schlesinger believe that disclosure about the physician's financial incentives occur early in the physician-patient relationship so that the physician, through his care and treatment, may foster trust. *Id.*

252. In May of 1996, the Health Care Financing Administration (HCFA) is-

new rules effect only Medicare and Medicaid patients and only require that physicians disclose merely rudimentary financial incentives to an enrollee who asks for the information.²⁵³

Although the new rules require some disclosure of certain financial incentives, they do not require full disclosure of all cost containment mechanisms a physician considers when treating a patient. Patients have the right to know the financial incentives that may impact the course of their medical care and treatment. Full disclosure allows for patient awareness of the available treatment plans and limitations in the system. In addition, full

sued new rules on how managed care plans structure their physician incentive plans so as to protect Medicare and Medicaid patients. Harris Meyer, *HCFA's New Take on Physician Incentives*, HOSP. & HEALTH NETWORKS, May 5, 1996 at 62, 63. The HCFA rules include a limit on potential financial losses to the physicians if they are at "substantial risk" for referrals. *Id.* "Substantial risk" is defined as putting more than 25% of a physician group's potential payment at risk. *Id.* HCFA further requires that all Medicare and Medicaid prepaid plans must disclose the general features of the physician's incentive arrangement to enrollees who ask. *Id.* If the enrollees do not ask, the physician is under no obligation to disclose. *Id.* See BNA'S HEALTH LAW REPORTER, *New Jersey: Overhaul of HMO Regulations Focuses on Patient Protections*, in NEWS AND DEVELOPMENTS, Feb. 6, 1997. In New Jersey, the number of residents enrolled in HMOs grew from 5000 in 1974 to two million in 1996. *Id.* This dramatic increase in the number of people enrolled in HMOs prompted the Health Department and an advisory committee consisting of physicians, HMOs, nurses, consumers and businesses to create a set of comprehensive rules that govern HMOs. *Id.* The rules, which went into effect on March 15, 1997, focus on protecting patients receiving care under HMO plans. *Id.*

Some of the requirements of the new rules are as follows: a physician and not an administrator, is required to make decisions regarding approval or denial of coverage for a treatment; gag clauses are not allowed and physicians must have freedom to discuss any and all treatment options with their patient; a choice of more than one specialist must be given to patients; patients with a chronic disability must be referred to specialists that are capable of treating them; HMOs are required to provide patients with information about reimbursement systems and financial incentives they implement; patients must be given a phone number to call for information about payment schemes; a quality review organization must review HMOs every three years and make reports to the Health Department; an appeals process must be set up by the HMO with no penalties to patients; the appeal must be reviewed by a physician; an enrollee must have options to appeal to independent utilization review organization; and HMOs are required to submit data to the Health Department which will be used to create "report cards" which resident of New Jersey can use to compare HMOs. *Id.* The New Jersey Department of Health feels these new rules "are the most progressive consumer-oriented HMO regulations in the country." *Id.* They are currently working toward a bill that would extend the rules to non-HMO MCOs. *Id.*

253. HCFA officials contend that their new rules will set the standard for all managed care plans because it will set the standard for physician contracting. Meyer, *supra* note 252, at 63. The purpose for drafting the new rules, according to then Health and Human Services Secretary Donna Shala, was so that "[no] patient should have to wonder if their doctor's decision is based on sound medicine or financial incentives." *Id.* at 62. Obviously, managed care was not happy with the new rules referring to them as "needlessly offensive." *Id.*

disclosure of the system's payment incentives may endear the patient to the physician and foster trust during treatment. Finally, if the patient is aware of the financial incentives, he will better understand the delicate cost considerations related to health care. Therefore, although the trial judge in *Ching* was rightfully apprehensive about recognizing a duty to disclose, legislation or medical ethics committees must impose such a duty on physicians and MCOs to disclose financial incentives to patients. In addition, as suggested by some authors, patient groups must be established to evaluate, critique and educate the public on the quality of each health care organization, so that participants are advised on how well their organization functions.²⁵⁴

C. *The Standard of Care Must Remain to Ensure Quality Medical Care*

Finally, a physician's standard of care should not be modified in any way to reflect the constraints inherent in an MCO.²⁵⁵ The notion of a modifiable standard of care will fail to promote quality medical care and will undoubtedly create mass confusion in the medical and legal communities in determining the appropriate standard of care.

Structural deficiencies in the managed care system make it impossible for the physician to comply with the traditional standard of care. Legislation is necessary that sets forth uniform guidelines for physicians to appeal a denial of service by the managed care system on behalf of the patient. If the physician complies with the guidelines, his actions should exculpate, or act as a complete defense against, a medical malpractice action by the patient and the patient should then have the right to seek damages

254. Robert N. Butler, *Tipping the Scale Back Toward the Patient*, 51 GERIATRICS 8, 8 (1996). Dr. Butler recommends the formation of the American Patients Association (APA) to keep an eye on MCOs and endorse those organizations which meet certain standards of care. *Id.* In addition, the APA would compile patient satisfaction reports and act as a voice for consumers in setting up standards of care. *Id.*

In addition to fully disclosing financial incentives to the patient, a physician, prior to joining an MCO, should also evaluate the quality of other physicians in the group and assess any limitation in the system so as to avoid the risk of medical malpractice claims. Joe Niedzielski, *MCO Doctors Face Medical Malpractice Risks*, NAT. UNDERWRITERS, Nov. 11, 1996 at 9.

255. The traditional theory of medical malpractice is still governed by traditional medicine. Pedroza, *supra* note 18, at 416. The physician is held to the standard of care to "use the knowledge, skill and care ordinarily possessed and employed by members in the profession in good standing." *Id.* Physicians are expected to perform pursuant to the standard of care and to be the sole decision maker in the patient's treatment. *Id.* The legal system continues to assess medical malpractice under the traditional standard of care, which does not take into consideration the constraints of a MCO and the goal to decrease the cost of health care in the U.S. *Id.*

against the MCO. In addition, if the physician complies with the guidelines, the physician should be able to seek damages from the MCO if he is later dropped from the organization in retaliation for his appeal.

CONCLUSION

In light of the cases discussed above, patients should be free to seek damages against MCOs whose system prohibits its participating physicians from complying with the standard of care. With these recommendations, a series of checks and balances is achieved between MCOs, participating physicians and patients. Moreover, financial incentives and resource constraints utilized by MCOs and physicians must be fully disclosed to patients. The arrangement either fosters trust and disclosure or an uneasy peace wherein each party has a cause of action at its disposal to ensure harmony.