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## Softening the ERISA Blow: Minimizing Physician Liability for Patient Injuries Caused by Managed Care Organization Cost Containment Measures

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# SOFTENING THE ERISA BLOW: MINIMIZING PHYSICIAN LIABILITY FOR PATIENT INJURIES CAUSED BY MANAGED CARE ORGANIZATION COST CONTAINMENT MEASURES

## I. INTRODUCTION

Lisa Young goes to the hospital because she fears she is in premature labor at only 25 weeks gestation. In her previous pregnancy she had premature labor that required hospitalization and medication. Lisa's physician examines her, and although Lisa's symptoms do not seem serious, the doctor knows from past experience that she needs to keep Lisa in the hospital for a minimum of three or four days for observation. If her labor progresses quickly like it did the previous time, Lisa's doctor wants to be able to immediately give Lisa intravenous medication to stop the labor. A nurse employed by the managed care organization<sup>1</sup> that covers Lisa Young performs a utilization review (UR)<sup>2</sup> to make sure the three or four day inpatient stay requested by the doctor is really necessary. The nurse thinks it is not and only authorizes an overnight stay for observation.

Lisa's condition does not change the next morning, so Lisa is discharged from the hospital. Even though her doctor thinks she should stay longer, Lisa goes home because she is poor and cannot afford to pay for her care. Her husband drives her home, which is an hour from the hospital.

The following evening, Lisa starts to feel pain in her pelvic area. She wonders if it is the Mexican food her husband brought home. She decides to see how she feels in the morning. By 3:00 a.m., her pain is so intense that she knows something is terribly wrong. Her husband drives her back to the hospital. By the time she gets to the hospital, she is irrevocably in the process of labor. Her baby is born shortly after her arrival. Because the baby is so premature, he will require several months of hospital care. As a result of the premature birth, Lisa's baby develops cerebral palsy.<sup>3</sup> He will require many thousands of dollars of care throughout his life, and

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1. See *Your Guide to Managed Care*, *infra* note 5 (explaining that any entity that utilizes cost containment measures to save money in a health care delivery system is a managed care organization (MCO)). See also 42 U.S.C. § 1396b (m)(1)(a), which also defines "medicaid managed care organization."

2. See Mark K. Wedel, *California's Legal Implications for Utilization Review as a Health Care Cost Containment Measure*, 1 SAN DIEGO JUSTICE J. 415, 415-16 (1993) (explaining that utilization review (UR) is a method of cost control that evaluates the appropriateness, necessity, and quality of health services being rendered. If the proposed treatment is deemed not to be appropriate or necessary, payment for the treatment may be denied.).

will always have major medical problems. If she had been in the hospital for three days, as requested by her doctor, it is probable that her premature labor could have been quickly detected and thus, prevented.

The woman's health coverage is provided through her employer. Because of this, her managed care organization is probably immune from lawsuits under ERISA.<sup>4</sup> Lisa Young is left without a remedy unless she sues her doctor.

With the cost of health care skyrocketing in America today, there must be measures taken to keep costs down, yet the cost containment measures used by managed care organizations are certain to cause patient injuries. This comment will explore how liability of third party payors<sup>5</sup> for injuries to patients caused by cost containment measures affects physicians.

The law needs to change so that injured patients have greater remedies against managed care organizations. This comment will not address in detail the need for legislation; rather, it will examine the problem and suggest ways that lawyers with physician clients can work within the imperfect system, by initially suggesting ways that managed care organizations can be held liable for their actions. In addition, this comment outlines steps physicians can take to minimize their liability. First, this comment will provide background information on managed care and cost containment measures, concentrating primarily on utilization review. Second, it will examine the status of the law concerning physician liability when cost containment measures injure a patient. This section will focus on two cases that illustrate how patients can suffer when managed care organizations employ utilization review to keep costs down, and how physicians are in danger of being held liable for these injuries. It will then show how this problem is further aggravated by ERISA, which is a federal law that gives managed care organizations substantial immunity. Section four will analyze ways that this immunity can be limited or circumscribed including construing ERISA narrowly, using the theories of vicarious and enterprise liability to hold managed care organizations responsible, and labeling utilization review decisions as medical decisions instead of benefit determinations. Section five explains how to minimize physician liability, first by examining what a physician's duty should be in the era of managed care. Finally, this Comment proposes practical strategies physicians can use to limit their liability even if the ERISA preemption cannot be narrowed.

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3. Cerebral Palsy is a term used to describe a disease resulting from prenatal developmental disorders or central nervous system damage which occurs at or shortly around birth. This disease is characterized by impaired voluntary movement. Prematurity, birth trauma, and neonatal asphyxia are factors leading to the disease. Cerebral Palsy is a "lifelong condition". Seizures are common. Physical therapy, occupational therapy, limb braces, orthopedic surgery, and speech therapy are often required. Children with the disease will need lifelong supervision, and will never achieve social independence. ROBERT BERKOW, M.D., *THE MERCK MANUAL OF DIAGNOSIS AND THERAPY* 2263-64 (16th ed. 1992).

4. See Jim M. Perdue & Stephen R. Baxley, *Cutting Costs - Cutting Care: Can Texas Managed Health Care Systems and HMOs be Liable for the Medical Malpractice of Physicians?*, 27 ST. MARY'S L. J. 23, 59-60 (1995) (explaining that ERISA is the Employee Retirement Income Security Act of 1974, a federal law that preempts any state law or cause of action if the cause of action relates to a covered benefit plan). These benefit plans cover many MCOs. The result is that many otherwise strong claims against MCOs by patients are barred from recovery.

5. See *Your Guide to Managed Care*, IDAHO STATESMAN, Sept. 8, 1997, at 5a (defining third party payors as any payor of health care services, other than the patient. It can be any type of MCO, even the federal government).

## II. BACKGROUND

### A. How Health Care is Paid for in America Today

The last decade has seen tremendous changes in the way health care is delivered.<sup>6</sup> Today's health care system is comprised of third-party payors who "influence medical decisions through their implementation of cost containment measures."<sup>7</sup> It is beyond dispute that health care finance is a growing problem today. Advances in every area of medicine have created huge progress in diagnosing, treating, and preventing disease, yet the monetary cost has been high. Health care costs are growing faster than the rate of inflation.<sup>8</sup> In addition, health care expenditures in the United States are consuming a growing percentage of the Gross National Product (GNP).<sup>9</sup> If health care expenditures grow at the same rate they are growing currently, health care costs will be close to a third of America's GNP by the year 2030.<sup>10</sup> Managed care organizations and their cost containment measures are an answer to this health care cost problem.

Any entity that utilizes cost containment measures in a health care delivery system can be categorized as a managed care organization (MCO).<sup>11</sup> MCOs can also be defined as "organizations that employ or contract with physicians to deliver care to defined groups of individuals as an alternative to private fee-for-service medicine."<sup>12</sup> The goal of an MCO is to reduce the cost of health care while maximizing patient well being and treatment.<sup>13</sup> Currently, many people are insured by MCOs.<sup>14</sup> It is estimated that by the year 2000, at least 80% of Americans will receive medical care through MCOs.<sup>15</sup> Government funded healthcare is also within the scope of managed care.<sup>16</sup> Many Medicare and Medicaid beneficiaries are enrolled in MCOs.<sup>17</sup> Managed care is almost certain to affect physicians, since more than 75% of physicians practice medicine in some type of MCO.<sup>18</sup> MCOs

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6. See Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219 (1997).

7. Suzanne M. Grosso, *Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care*, 9 STANFORD L. & POL'Y REV. 433, 434 (1998). See also *Your Guide to Managed Care*, IDAHO STATESMAN, Sept. 8, 1997, at 5a (defining third party payors as any payer of health care services, other than the patient. It can be any type of MCO, even the federal government).

8. See Grosso, *supra* note 7, at 434.

9. See Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297 (1994).

10. See *id.* (citing Victor R. Fuchs, *No Pain, No Gain*, 269 JAMA 631, 631 (1993)).

11. See Grosso, *supra* note 7, at 435.

12. Edward P. Richards & Thomas R. McLean, *Physicians in Managed Care: A Multidimensional Analysis of New Trends in Liability and Business Risk*, 18 J. OF LEGAL MED. 443, 446 (1997).

13. See *id.*

14. See Noah, *supra* note 6, at 12.

15. See *id.*, at 1220. See also Private Sector Advocacy and Support Team, Am. Med. Ass'n, *Managed Care and the Market: A Summary of National Trends Affecting Physicians* 2 (1995).

16. See KENNETH R. WING ET AL., *THE LAW AND AMERICAN HEALTH CARE* 70 (1988).

17. See *id.*

18. See Noah, *supra* note 6, at 1219.

claim that the quality of care will not suffer as a result of cost savings because of the reviews of medical appropriateness and cost-effectiveness they make.<sup>19</sup> This author feels that though reducing cost is important, cost containment measures by their very nature must result in patients being injured because they are denied treatment that they need. These cost containment measures are also burdensome for physicians because they interfere with the fundamental physician-patient relationship.

### *B. Cost Containment Methods*

There are several methods utilized by MCOs to keep costs down. These include pre-authorization of hospitalizations and hospital stays, second opinion requirements, length-of-stay restrictions, and utilization review.<sup>20</sup> MCOs also keep costs down by paying providers less and discouraging physicians from overusing medical testing and referrals to specialists.<sup>21</sup>

Utilization review (UR) is especially burdensome for physicians, as it is the most widely used mechanism to keep costs down in most MCOs.<sup>22</sup> Utilization review is a threat to physician autonomy, because it puts another entity in the middle of the doctor/patient relationship.<sup>23</sup> The purpose of utilization review is to influence treatment decisions, so it must influence or possibly even overrule the physician's treatment plan.<sup>24</sup>

#### 1. The Role of Utilization Review Boards in Today's Health Care Delivery

Utilization review can be defined as "[a] cost-control mechanism by which the appropriateness, necessity and quality of health-care services are monitored . . ."<sup>25</sup> There are two types of utilization review, retrospective and prospective. Retrospective UR looks at what was done after the fact to evaluate the appropriateness of medical care.<sup>26</sup> Prospective (also called concurrent) UR takes place during the patient's treatment.<sup>27</sup> The potential liability is much greater in prospective utilization review.<sup>28</sup>

The utilization review business is a billion dollar industry.<sup>29</sup> Some third party

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19. *See id.*

20. *See* Grosso, *supra* note 7, at 434.

21. *See* Richards, *supra* note 12, at 449.

22. *See* Wedel, *supra* note 2, at 414.

23. *See* Grosso, *supra* note 7, at 435.

24. *See* Grosso, *supra* note 7, at 435. *See also* Griner, *infra* note 26, at 884; Noah, *supra* note 6, at 1249; Furrow, *The Ethics of Cost Containment: Bureaucratic Medicine and the Doctor as Patient Advocate*, 3 NOTRE DAME J. L. ETHICS & PUB. POL'Y 187 (1988).

25. *Your Guide to Managed Care*, *supra* note 5.

26. *See* David D. Griner, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861 at 884-85 (1991).

27. *See id.*

28. *See id.* at 885.

29. *See* Paul J. Kenkel, *Review Firms Under Review*, MODERN HEALTHCARE, Sept. 10, 1990, at 98.

payors do their own utilization review, while many others hire outside firms.<sup>30</sup> Businesses that perform this service are often paid according to how much money they save MCOs by reducing or denying medical claims.<sup>31</sup> There are hundreds of firms that provide these review services.<sup>32</sup> In fact, one woman who works in utilization review says that each person working in utilization review must “prove her worth by submitting statistics on how much money she’s saved . . . .”<sup>33</sup>

It is interesting to study who is conducting utilization reviews. A House Select Committee on Aging study shows that “everyone from physicians to records technicians are conducting reviews.”<sup>34</sup> Nurses make up the bulk of utilization reviewers<sup>35</sup>, along with medical records staff.<sup>36</sup> One staff member explains that she reviews up to sixty charts per day, only spending an average of seven to fifteen minutes on each one.<sup>37</sup> Some people familiar with the system of utilization review suggest that only physicians in the relevant specialty should have the final say in denial of patient benefits.<sup>38</sup>

Because of the potential for abuse, many states are beginning to regulate utilization review companies.<sup>39</sup> The American Medical Association is very active in the area of pushing for utilization review reform.<sup>40</sup> They suggest development of stringent licensing standards, publication of utilization review criteria, and prohibitions against compensating reviewers based on money they save by denying treatment.<sup>41</sup>

### III. PHYSICIAN LIABILITY: THE STATUS OF THE LAW

#### A. Cases

The following two cases illustrate how cost containment measures can result in tragic patient injuries. They also show that it is possible for the patient’s physician to be held liable for the resulting injury.

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30. See Grosso, *supra* note 7, at 435.

31. See Kenkel, *supra* note 29, at 98.

32. See *id.*

33. Donna Zoldi, *What’s it Like in Utilization Review? Quality Assurance and Utilization Review Specialists*, RN, Feb. 1992, at 41.

34. Dan Wise, *Utilization Review: Is it Cost Effective?*, HEALTH LINE, Jan. 21, 1993.

35. See Zoldi, *supra* note 33, at 41 (estimating that about 80% of utilization review staffers are nurses). See generally Wise, *supra* note 34.

36. See Dan Rode, *Is it Time to Combine Utilization Review and Admitting? Patient Care Policies of Hospitals*, HEALTHCARE FINANCIAL MANAGEMENT, Oct. 1992, at 77. See also Zoldi, *supra* note 33, at 41; See also *Wickline v. Wilson*, 192 Cal. App. 3d 1630 (1986), holding limited by *Wilson v. Blue Cross of Southern Ca.*, 222 Cal. App. 3d 660 (1990).

37. See Zoldi, *supra* note 33, at 41.

38. See Noah, *supra* note 6, at 1260.

39. See Kenkel, *supra* note 29, at 98.

40. See Mary R. Kohler, *When the Whole Exceeds the Sum of its Parts: Why Existing Utilization Management Practices Don’t Measure Up*, 53 U. PITT. L. REV. 1061, 1080 (1992).

41. See *id.*

### 1. *Wickline v. State of California*<sup>42</sup>

*Wickline v. State of California*<sup>43</sup> is a case that deals with the legal responsibility of third party payors for injuries caused to a patient because of the third party payor's cost containment measures.<sup>44</sup> Although the plaintiff-patient only brought suit against the third party payor, this case is also important to physicians because the court seems to place a large burden on the physician.

#### a. Facts of the *Wickline* Case<sup>45</sup>

*Wickline*, a woman in her mid-40s, was being treated for back and leg pain by her family practice physician, Dr. Daniels.<sup>46</sup> After several methods of treatment failed, Dr. Daniels admitted *Wickline* to Van Nuys Community Hospital. Dr. Polonsky, a peripheral vascular surgeon,<sup>47</sup> examined *Wickline* and diagnosed her with Leriche's syndrome.<sup>48</sup> Dr. Polonsky determined that *Wickline*'s disease was so far advanced that it was necessary to replace a portion of her artery with a Teflon graft<sup>49</sup>. *Wickline* was eligible for medical benefits under Medi-Cal, California's medical assistance program for the poor.<sup>50</sup> Medi-Cal authorized the surgery and ten days of hospitalization.<sup>51</sup> *Wickline* was admitted to Van Nuys Community Hospital by Dr. Daniel on January 6, 1977, and the next day Dr. Polonsky performed the surgery, replacing part of *Wickline*'s aorta with the Teflon graft.<sup>52</sup> He described her operation as "very major surgery."<sup>53</sup> *Wickline* developed circulatory problems later in the day, so Dr. Polonsky took *Wickline* back to surgery to remove a clot in the Teflon graft.<sup>54</sup> Dr. Polonsky was assisted by Dr. Kovner, chief of surgery at Van Nuys, during all of *Wickline*'s surgeries.<sup>55</sup> *Wickline*'s recovery following the two surgeries was categorized as "stormy."<sup>56</sup>

*Wickline* was scheduled to be discharged on January 16, just four days after

42. 192 Cal. App. 3d at 1630.

43. *See id.*

44. *See id.*

45. *See id.* at 1632-42 (presenting facts of the case).

46. *See id.* at 1634. The Court noted that Lois *Wickline* was a woman of limited education.

47. *See id.* at 1634. Peripheral vascular surgery is surgery on any vessel of the body except the heart.

48. *Wickline*, 192 Cal. App. 3d at 1634. Leriche's Syndrome is where there is blockage of the abdominal aorta. The aorta is the main artery of the body, which carries blood from the heart to all of the organs of the body.

49. *See id.* at 1635.

50. *See id.*

51. *See id.*

52. *See id.*

53. *Id.*

54. *See Wickline*, 192 Cal. App. 3d at 1635.

55. *See id.* at 1636.

56. *Id.* at 1635. *Wickline* had a great deal of pain, spasms, and hallucinations. As a result, she received a lumbar sympathectomy on January 12. A lumbar sympathectomy is a major operation in which nerves are removed from either side of the spinal column in an attempt to stop the spasms. This was necessary to prevent clots from forming when the spasms kept blood from moving freely through the graft.

her most recent surgery.<sup>57</sup> Dr. Polonsky decided that it was "medically necessary"<sup>58</sup> for Wickline to stay in the hospital an additional eight days past her original discharge date of January 16.<sup>59</sup> Drs. Daniels and Kovner agreed with Polonsky.<sup>60</sup> Dr. Polonsky cited danger of infection and/or clotting as the reason for keeping Wickline longer.<sup>61</sup> He wanted to keep Wickline in the hospital to observe her and be instantly available to treat an emergency so that he could save both of Wickline's legs.<sup>62</sup>

Dr. Polonsky requested that a nurse fill out a Medi-Cal form requesting an extension of Wickline's hospital stay.<sup>63</sup> Dr. Daniels signed the form and all three doctors testified that the form was filled out properly.<sup>64</sup>

The nurse responsible for the utilization review of Wickline's form felt she could not approve eight days of hospitalization, so she phoned the Medi-Cal consultant physician on duty, Dr. Glassman, a board certified general surgeon.<sup>65</sup> Dr. Glassman rejected the eight day extension, instead granting only four days.<sup>66</sup> He assumed Wickline was progressing satisfactorily and "was not seriously or critically ill."<sup>67</sup> Dr. Glassman never consulted with a peripheral vascular surgeon<sup>68</sup> even though Medi-Cal made them available to their consultants.<sup>69</sup> Dr. Glassman based his decision primarily on Wickline's apparently normal bowel function, temperature, and diet, which were irrelevant to Wickline's primary condition.<sup>70</sup> He ignored symptoms a reasonably prudent physician would consider important to evaluate Wickline's condition.<sup>71</sup>

Wickline was released from the hospital on January 21 after her four day extension.<sup>72</sup> All three of Wickline's physicians knew the request for an eight day extension was denied, and were aware that they could call Dr. Glassman (the Medi-Cal consultant) to appeal his decision.<sup>73</sup> None of the three physicians did so.<sup>74</sup> Wickline's condition on the date of discharge had neither improved nor deteriorated

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57. *See id.* at 1636.

58. *Id.*

59. *See id.*

60. *See Wickline*, 192 Cal. App. 3d at 1636.

61. *See id.*

62. *See id.*

63. *See id.*

64. *See id.* at 1637. The Medi-Cal form was "Request for Extension of Stay in Hospital", commonly called "MC-180". The hospital must fill out the form with information provided by the physician. The form is then submitted to Medi-Cal's representative for authorization. The nurse who reviewed the MC-180 had the authority to approve the request without further authorization. She had to contact a Medi-Cal consultant physician if she felt that the request should be rejected or modified. It was the consulting physician's duty to ultimately make the decision.

65. *See id.*

66. *See id.*

67. *Wickline*, 192 Cal. App. 3d at 1638.

68. *See id.* at 1634 (explaining that peripheral vascular surgery is surgery on any vessel of the body except the heart).

69. *See id.* at 1639.

70. *See id.*

71. *See Wickline*, 192 Cal. App. 3d at 1639.

72. *See id.*

73. *See id.*

74. *See id.*



since the date of the request for extension.<sup>75</sup> Dr. Polonsky noted on Wickline's discharge summary that it did not appear that her leg was in any danger.<sup>76</sup>

At trial, Dr. Polonsky testified that he felt that the Medi-Cal consultant placed the State's interests above the welfare of the patient, that Medi-Cal had the power to tell him when the patient must be discharged, and these factors resulted in his decision not to appeal Medi-Cal's denial of Wickline's eight day hospital extension.<sup>77</sup> However, Dr. Polonsky did note that he would have made an effort to keep Wickline in the hospital if he thought her condition was deteriorating.<sup>78</sup> All medical experts at trial testified that Dr. Polonsky met the standard of care in the medical community when he discharged Wickline.<sup>79</sup>

Dr. Kovner spoke to Wickline's husband prior to her discharge and explained to him how to care for Wickline at home.<sup>80</sup> On the first and second day after Wickline's discharge from the hospital, she began to feel pain in her leg and the leg began to lose color and look like marble.<sup>81</sup> Wickline did not call any of her physicians because she assumed this was a normal part of recovery.<sup>82</sup> By the third day her leg started to turn gray and the pain increased.<sup>83</sup> She testified that she called one of her doctors who prescribed her pain medication.<sup>84</sup> During the next few days, Wickline's leg turned blue and the pain became excruciating.<sup>85</sup> Wickline's husband phoned Dr. Kovner, who ordered her back to the hospital.<sup>86</sup> Dr. Polonsky examined Wickline and determined she had an infection in the graft site that caused clotting in her leg. As a result, she had no circulation in her leg.<sup>87</sup> Attempts to save Wickline's leg through non-surgical methods proved impossible.<sup>88</sup> Dr. Polonsky amputated Wickline's leg below the knee in order to save her life.<sup>89</sup> This was not enough to improve Wickline's condition, so she was taken back to surgery where doctors amputated her leg above the knee.<sup>90</sup>

In Dr. Polonsky's opinion, had Wickline been in the hospital for the entire eight days he requested, her leg could have been saved.<sup>91</sup> He would have noticed the changes in Wickline's leg immediately and performed surgery to remove the

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75. *See id.*

76. *See id.*

77. *See Wickline*, 192 Cal. App. 3d at 1640.

78. *See id.*

79. *See id.* It is important to note that Lois Wickline protested her discharge from the hospital

80. *See id.* The care Dr. Kovner suggested to Mr. Wickline consisted of topical antibiotic powder, medicine, warm baths, and rest.

81. *See id.*

82. *See id.*

83. *See Wickline*, 192 Cal. App. 3d at 1640.

84. *See id.*

85. *See id.* at 1641.

86. *See id.* The date was January 30, nine days after discharge.

87. *See id.*

88. *See id.* Dr. Polonsky was not able to remove the clot because the infection would have spread through Wickline's body creating more clots or blood poisoning, both can cause death. The use of anti-clotting medications, antibiotics, strict bed rest, pain medicine, and whirlpool baths were not successful.

89. *See Wickline*, 192 Cal. App. 3d at 1641.

90. *See id.*

91. *See id.* at 1641-42.

clot, exactly as he had done in Wickline's second surgery.<sup>92</sup> Her infection could have been controlled with IV antibiotics.<sup>93</sup> Dr. Polinsky also testified that the rejection of the eight day extension did not conform to current medical standards.<sup>94</sup>

#### b. The Wickline Court's Analysis of the Case

The importance of *Wickline* is that it enunciated that third party payors can be held liable when their actions cause negligence. The California Supreme Court explicitly lays this out:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the derivation of such care, including, when appropriate, health care payors. 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 mechanism as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.<sup>95</sup>

However, the court did not intend to allow the physician to abdicate any responsibility for patient care to the insurance company:

[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.<sup>96</sup>

The court explained even though Dr. Polonsky was intimidated by Medi-Cal, he was not powerless to act if he felt it was in his patient's best interest to stay an extra eight days instead of four.<sup>97</sup> However, all three of Wickline's physicians agreed that Dr. Polonsky's decision to discharge Wickline was within the standard of care at the time.<sup>98</sup> Because of this, the court held there could be no viable cause of action against Medi-Cal.<sup>99</sup> The court did not address what Dr. Polonsky should have done if the appeal was denied, however, though it is implied that Polonsky

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92. *See id.* at 1642.

93. *See id.*

94. *See id.*

95. *Wickline*, 192 Cal. App. 3d at 1645.

96. *Id.* at 1645 (emphasis added).

97. *See id.* at 1645-46.

98. *See id.* at 1646.

99. *See id.*

should have left the patient in the hospital.<sup>100</sup>

The court then examined the statutory and administrative rules that authorized denial of Medi-Cal benefits.<sup>101</sup> It determined that California's legislative intent in the creation of Medi-Cal was to provide medical care to the indigent "whenever possible and feasible," and "to the extent possible."<sup>102</sup> The court ultimately held that "the Medi-Cal Consultant's decision, vis-a-vis the request to extend Wickline's hospital stay, was in accord with then existing statutory law."<sup>103</sup>

## 2. *Wilson v. Blue Cross*<sup>104</sup>

The facts in *Wilson* are more to the point. Howard Wilson Jr. was admitted to College Hospital in Los Angeles on March 1, 1983 for major depression, drug addiction, and anorexia.<sup>105</sup> His physician felt that he needed to be treated in the hospital for three to four weeks.<sup>106</sup> After eleven days Western Medical declared it would not pay for anymore inpatient hospital care.<sup>107</sup> Western Medical is the company that provided review decisions for Wilson's insurance company, Blue Cross.<sup>108</sup> Neither Wilson nor any of his family could afford to pay for any further treatment, so Wilson was discharged.<sup>109</sup> He committed suicide on March 31.<sup>110</sup>

The issue in the *Wilson* case is whether the conduct of Western Medical was a substantial causal factor in his death.<sup>111</sup> The representative of Wilson's estate brought a wrongful death action against Western Medical and Blue Cross but not Wilson's physician.<sup>112</sup> The trial court granted Western Medical's motion for summary judgment.<sup>113</sup> However, the Court of Appeals in California found there was substantial evidence that Western Medical's refusal to approve hospitalization beyond ten days was a substantial factor in the death of Wilson.<sup>114</sup> Wilson's treating physician said there was a reasonable medical probability that Wilson would not have killed himself if he had stayed in the hospital for the full recom-

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100. See Richards, *supra* note 12, at 454.

101. See Wickline, 192 Cal. App. 3d at 1646.

102. *Id.*

103. *Id.* at 1647.

104. *Wilson v. Blue Cross of Southern California*, 222 Cal. App. 3d 660 (1990).

105. See *id.* at 669.

106. See *id.*

107. See *id.*

108. See *id.* at 667.

109. See *id.*

110. See *Wilson*, 222 Cal. App. 3d at 663-64.

111. *Id.* at 664. See also William A. Helvison, *California's Wickline Decision Revisited*, PHYSICIAN EXECUTIVE, Nov. 1990, at 40 (explaining that the utilization review company for the insurer refused to certify the hospitalization beyond 10 days).

112. See *Wilson*, 222 Cal. App. 3d at 667.

113. See *id.* at 672.

114. See *id.* Note that Western Medical is the name of the utilization review company hired by Wilson's Insurer. They used the concurrent utilization review process without knowing whether Wilson's Insurance Policy through Blue Cross allowed for review. In addition, Western Medical was not aware that Wilson's policy allowed a patient's treating physician to decide how long to keep a patient in the hospital as long as inpatient care did not exceed 30 days.

mended period of three to four weeks.<sup>115</sup>

Western Medical adopted *Wickline's* argument that physicians should be liable for failure to appeal, so they (Western Medical) should not be liable.<sup>116</sup> The court's response significantly narrows *Wickline*. The *Wilson* court stated that the discussion in *Wickline* about a physician's duty was merely dicta and had no bearing on the *Wilson* case.<sup>117</sup> The failure of Wilson's physician to appeal Western Medical's decision did not warrant the trial court's grant of summary judgment in favor of the defendants.<sup>118</sup>

In reviewing the *Wickline* decision, the *Wilson* court pointed out that statements concerning the physician's duty to appeal MCO decisions were "broadly stated"<sup>119</sup> and "unnecessary to the decision."<sup>120</sup> Most importantly, the *Wilson* court acknowledges the unfairness of providers being solely responsible for injuries resulting from an MCO's cost containment measures.<sup>121</sup>

### B. Managed Care Immunity under ERISA

Another significant factor affecting patients' rights and physicians' liability in the age of managed care is the Employee Retirement Income Security Act (ERISA).<sup>122</sup> ERISA is a federal statute that contains a broad preemption clause covering all state laws that "relate to" any employer-sponsored health care benefit plans, even those managed by an MCO.<sup>123</sup> ERISA is one of the broadest preemptions in federal law.<sup>124</sup> ERISA is the governing law when state law differs from ERISA.<sup>125</sup> A large majority of MCOs are protected under ERISA.<sup>126</sup> In fact, these federally regulated plans account for a majority of private insurance.<sup>127</sup> Approximately 60 percent of people with health insurance today are covered by ERISA plans.<sup>128</sup> The remedies available under ERISA are much more limited than those available under state law.<sup>129</sup>

One of the goals of ERISA is to encourage employers to provide health and pension plans for employees.<sup>130</sup> Employers who did so would be rewarded by

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115. See *id.* at 669-70.

116. See *Wickline*, 192 Cal. App. 3d at 1645.

117. See *Wilson*, 222 Cal. App. 3d at 673-74.

118. See *id.* at 674.

119. Peter Kazon, *Court Narrows Landmark Liability Ruling; Third Party Payor Liable for Premature Release From the Hospital*, MEDICAL ECONOMICS BUSINESS & HEALTH, Dec. 1990, at 58.

120. *Id.*

121. See Grosso, *supra* note 7, at 440.

122. 29 U.S.C.A. §§ 1001-1191 (West 1997).

123. *Id.*

124. See Wayne Blackmon, M.D., J.D., *The Emerging Convergence of the Doctrine of Informed Consent and Judicial Reinterpretation of the Employee Retirement Income Security Act*, 19 J. OF LEGAL MEDICINE 377, 383.

125. See *id.* at 382.

126. See Noah, *supra* note 6, at 1243.

127. See Blackmon, *supra* note 124, at 381.

128. See *Patients' Right to Sue HMO's Over Care Upheld in Texas*, PHYSICIAN'S FINANCIAL NEWS, Oct. 1998, at 3.

129. See Allen D. Allred and Karen A. Carr, *Enterprise Liability Puts MCOs at Risk*, NAT'L L.J., Sept. 8, 1997, at B9.

130. See generally Wing, *supra* note 16, at 765.

enjoying limited liability.<sup>131</sup> It was also created to end appalling abuses of employee pension plans by employers.<sup>132</sup> In these respects, it is a very useful law. However, ERISA was passed a quarter of a century ago when it was impossible to foresee how involved managed care would become.<sup>133</sup> ERISA is out of date in regard to health plans and has become “a shield for unacceptable behavior”<sup>134</sup> even though unacceptable behavior is what ERISA was created to prevent.

The problem with ERISA is that people who are injured through the negligent actions of managed care organizations protected by ERISA have a very limited legal remedy against the MCO, even when state law would otherwise provide a remedy.<sup>135</sup> An ERISA plan enrollee that is injured as a result of cost containment measures can only recover the cost of the treatment that was not offered.<sup>136</sup> This is brought as a breach of contract instead of malpractice of the plan and is often a negligible amount.<sup>137</sup> This is an egregious inequity.<sup>138</sup>

There are other unfortunate consequences of ERISA as well. The statute does not take into account the tremendous changes that have taken place in America’s health care system since ERISA’s enactment in 1974, especially the power MCOs have to affect patient care.<sup>139</sup> In addition, the law removes the incentive for ERISA plans to provide high quality care.<sup>140</sup> The protection also provides an “unlevel playing field”<sup>141</sup> in which ERISA protected MCOs are subject to far different standards than non-ERISA MCOs.<sup>142</sup> Finally, ERISA wastes judicial resources by forcing courts to decide the scope of the preemption instead of concentrating on the merits of the case.<sup>143</sup>

#### IV. ANALYSIS OF ISSUES IMPORTANT TO THE TOPIC

##### A. *Third Party Payor Responsibility for Physician Malpractice*

Third party payors should be liable for malpractice if their intrusion into a patient’s treatment plan causes injury to the patient. This is important to physicians

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131. See 29 U.S.C.A. §§ 1001-1191 (West 1997).

132. See *A Crack in ERISA*, AMERICAN MEDICAL NEWS, Oct. 26, 1998, at 21.

133. See *id.*

134. *Id.*

135. See *Prepared Testimony of Russ Newman, Executive Director For Professional Practice on Behalf of The American Psychological Association Before the House Education and Workforce Committee Subcommittee on Employer-Employee Relations*, FEDERAL NEWS SERVICE, Oct. 23, 1997 [hereinafter *Prepared Testimony of Russ Newman*].

136. See *Prepared Statement of Thomas R. Reardon, M.D., Chair, American Medical Association’s Board of Trustees Before the Senate Labor and Human Resources Committee*, FEDERAL NEWS SERVICE, March 24, 1998 [hereinafter *statement of Thomas R. Reardon, M.D.*].

137. See *A Crack in ERISA*, *supra* note 132, at 21.

138. See *id.*

139. See *id.*

140. See *id.*

141. *Id.*

142. See *id.*

143. See *A Crack in ERISA*, *supra* note 132, at 21.

because when MCOs are immune from liability, the doctor is often the only entity to sue, even when the doctor is not to blame.<sup>144</sup> “The patient who is injured when care which should have been provided is not provided will recover from someone . . . the physician becomes the insurer.”<sup>145</sup> It is important to patients that MCOs be liable for their actions because institutions provide a more stable and dependable source of relief.<sup>146</sup> Physicians are more likely to utilize bankruptcy protection or not carry malpractice insurance.<sup>147</sup>

There are several ways that courts can get around the ERISA preemption to decide the merits of the patient’s claim. First, courts can adopt a narrower interpretation of the ERISA preemption. In addition, courts can use the theories of vicarious and enterprise liability to narrow the scope of ERISA. Finally, courts can hold plan administrators liable for MCO decisions, as well as hold that utilization review is a medical decision.

### 1. Narrow Reading of ERISA

Courts are beginning to adopt a more narrow interpretation of the ERISA preemption.<sup>148</sup> The United States Supreme Court, which has traditionally given ERISA a very broad interpretation, is now beginning to narrow the statute’s scope, especially in the areas of tort law, health, and public safety.<sup>149</sup> The courts are beginning to adopt an approach that is closer to ERISA’s original purpose, which is to protect employees and members, not corporations.<sup>150</sup> The purpose of ERISA was not to keep health care costs down; instead, Congress was trying to protect pension plans.<sup>151</sup>

A Texas state law<sup>152</sup> that went into effect in September 1997 was the first in the country to allow patients to bring a malpractice suit against an MCO for the health care quality decisions they make.<sup>153</sup> This law allows patients to sue MCOs and collect damages if it can be proven that the MCO failed to provide quality care.<sup>154</sup> The law was recently challenged for the first time by an MCO in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*<sup>155</sup> and upheld in part by a U.S. District Judge.<sup>156</sup> The challenger argued that the law conflicts with ERISA,

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144. See Amicus Curiae Brief on Behalf of the California Medical Association in Support of Respondent Lois J. Wickline at 4-5, *Wickline v. State*, 228 Cal. Rptr. 661 (Ct. App. 1986) (No. B010156), noted in Frankel, *supra* note 9, at 1317.

145. *Id.*

146. See Noah, *supra* note 6, at 1232.

147. See *id.*

148. See George Parker Young, *Don't Pre-empt the HMO Liability Bill*, TEXAS LAWYER, Sept. 22, 1997, at 26. See also 514 U.S. 645 (1995) (making clear that ERISA should be subject to a narrow preemption interpretation)

149. See George Parker Young, *Don't Pre-empt the HMO Liability Bill*, TEXAS LAWYER, Sept. 22, 1997, at 26. See also 514 U.S. 645 (1995) (making clear that ERISA should be subject to a narrow preemption interpretation)

150. See Young, *supra* note 149.

151. See *id.*

152. Senate Bill 386.

153. See *Patients' Right to Sue Upheld*, *supra* note 128, at 3.

154. See Senate Bill 386, *supra* note 152.

155. 12 F.Supp.2d 597 (1998).

156. See *Patients' Right to Sue Upheld*, *supra* note 128, at 3.

but the Judge in the case said that a lawsuit is not preempted by ERISA if it challenges the quality of care received, which differs from a benefit determination.<sup>157</sup> The judge said that further cases would be examined on a case-by-case basis.<sup>158</sup> Though this law represents a very important step in minimizing ERISA, there is still much more to be done. First, this law upheld a patient's right to sue an MCO for negligence, but this remedy is available only after harm has occurred. It offers no injunctive relief.<sup>159</sup> In addition, this represents only one state's law. More than two dozen states have attempted to move forward with a law similar to the Texas law and have failed.<sup>160</sup>

An important proposed federal bill is the Patient Access to Responsible Care Act (PARCA).<sup>161</sup> PARCA is sponsored by House and Senate Republicans and has bipartisan support.<sup>162</sup> The motivation behind PARCA is to curtail the unfair results of ERISA's preemption.<sup>163</sup> Drafters of PARCA take into account the fact that ERISA was intended to deal with retrospectively denied payment, instead of prospective denials of treatment which lead to patient injuries.<sup>164</sup> PARCA's most consequential provision takes away ERISA's broad preemption provision.<sup>165</sup> PARCA does not create a cause of action, rather it gives states the power to enact legislation to create liability for MCOs that is not shielded by the ERISA preemption.<sup>166</sup> PARCA also creates rules requirements for MCOs that protect patients and ensure quality care, such as prohibiting inducements to providers for limiting treatment, and issuing guidelines for utilization review.<sup>167</sup> If PARCA is enacted, it will provide the protection patients need and take the sole liability burden of patient cost containment injuries away from physicians.

## 2. Vicarious Liability

Because MCOs either employ or contract with physicians, an injured patient may attempt to hold the MCO vicariously liable for his or her injury.<sup>168</sup> MCOs can be exposed to vicarious liability claims under the theories of respondeat superior

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157. *See id.*

158. *See id.*

159. *See id.*

160. *See A Crack in ERISA*, *supra* note 132, at 21.

161. H.R. 1415, 105<sup>th</sup> Cong. (1997).

162. *See Greg Otterson, Medical Malpractice for Texas HMOs: The End of a "Charmed Life?"*, 39 S. TEX. L. REV. 799, 840 (1998).

163. *See id.*

164. *See id.* at 841.

165. *See id.*

166. *See id.* at 841.

167. *See id.* at 842-43.

168. *See Sharon M. Glenn, Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability*, 29 WAKE FOREST L. REV. 305, 314 (1994). *See also Raglin v. HMO Illinois, Inc.* 595 N.E.2d 153, 156 (1992) (recognizing that a potential exists for MCOs to be liable for medical malpractice based on vicarious liability on the basis of respondeat superior or ostensible agency); Wing, *supra* note 16, at 761 (recognizing that since 1995, the Third, Sixth, Seventh and Tenth Circuits have ruled that the possibility exists that claims against MCOs might not be preempted when brought under the theory of vicarious liability).

and ostensible agency.<sup>169</sup>

Respondeat superior may be used to hold an MCO liable for the negligence of its physicians if they are employees of the MCO.<sup>170</sup> The theory of respondeat superior holds that an employer may be held liable for the negligence of its employee as long as the employee was acting within the scope of employment.<sup>171</sup> This theory focuses on whether the MCO has control or direction over the physician.<sup>172</sup>

Ostensible agency<sup>173</sup> may be used if respondeat superior does not apply. Ostensible agency (apparent authority) may be used to hold an MCO liable for a patient's injury if the MCO's behavior makes it reasonably apparent that the utilization reviewer is acting as an agent of the MCO.<sup>174</sup> If the MCO "holds out or represents that an independent contractor is an employee,"<sup>175</sup> it can be held liable under this theory.<sup>176</sup> The patient must detrimentally rely upon this assumption that the physician is an employee.<sup>177</sup> Courts generally rely on the type of marketing materials used to determine whether the MCO held the physician out as its own.<sup>178</sup> MCOs have minimized their risk in this area, however, by having patients sign notices saying that they (the patients) understand that the physicians are independent contractors.<sup>179</sup>

Texas case law provides a good example of three elements that must be proven in order to find MCOs liable under the theory of ostensible agency.<sup>180</sup> First, the patient must reasonably believe in the physician's authority.<sup>181</sup> Next, the MCO must have taken some action or omission that furthered this belief.<sup>182</sup> Third, the

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169. See Glenn, *supra* note 168, at 314-15.

170. See Ila S. Rothschild et al., *Recent Developments In Managed Care*, 32 TORT & INS. L.J. 463 (1997).

171. See RESTATEMENT (SECOND) OF AGENCY § 219 (1957).

172. Ila S. Rothschild et al., *Recent Developments In Managed Care*, 32 TORT & INS. L.J. 463 (1997). See also *Schleier v. Kaiser Foundation Health Care Plan*, 876 F.2d 174 (D.C. Cir. 1989); *Pacificare of Oklahoma Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995). But see, *Chase v. Independent Practice Ass'n., Inc.*, 583 N.E.2d. 251 (1991) (holding that the independent practice agency which contracted with MCO to arrange for health services for MCO members was not vicariously liable for alleged negligence of physician who provided services to MCO member, where IPA did not employ physicians directly, but instead contracted with another IPA for it to provide physicians because IPA did not have right to hire and fire individual physicians, nor to set their salaries, work schedules, or terms of employment, and IPA did not control actual medical decisions made by physicians or IPA which provided physicians).

173. Ostensible Agency is a concept of agency which focuses solely on appearances. When the principal's actions create the impression that she has authority to act, there is ostensible agency. RESTATEMENT (SECOND) OF AGENCY § 219 (1957).

174. See Peter H. Minaly, *Health Care Utilization Review: Potential Exposures to Negligence Liability*, 52 OHIO ST. L.J. 1289, 1302 (1991). See also RESTATEMENT (SECOND) OF AGENCY §§ 8, 27 app. (1958).

175. Rothschild, *supra* note 170 at 463.

176. See *id.*

177. See *id.*

178. See *id.* See also *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229, at 1235 (Pa. Super. Ct. 1988).

179. See Rothschild, *supra* note 170 (explaining steps MCOs can take to protect themselves from ostensible authority claims).

180. See Perdue, *supra* note 4, at 33.

181. See generally *Nicholson v. Memorial Hosp. Sys.*, 722 S.W. 2d. 746, 750 (Tex. App. 1986); *Brownsville Medical Ctr. v. Gracia*, 704 S.W. 2d. 68, 74 (Tex. App. 1985); *Boyd v. Albert Einstein Medical Ctr.*, 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988.)

182. See *Nicholson*, 722 S.W. 2d., at 750.



patient must have justifiably relied on the belief.<sup>183</sup>

The Superior Court of Pennsylvania decided what determines whether a physician is an ostensible agent in *Boyd v. Albert Einstein Medical Center*.<sup>184</sup> In *Boyd*, the court held that to determine whether the treating physician is an ostensible agent of the MCO, the court must consider whether the “patient looks to institution, rather than individual physician, for care, and whether HMO ‘holds out’ physician as its employee.”<sup>185</sup>

Courts are currently split on whether ERISA preempts vicarious liability claims.<sup>186</sup> Federal district courts have been divided on whether ERISA preempts a claim that an MCO is vicariously liable for the actions of one of its physicians.<sup>187</sup> However, in 1995 the Tenth Circuit of the United States Court of Appeals decided in an issue of first impression “whether ERISA preempts a claim that an HMO is vicariously liable for alleged malpractice of one of its physicians.”<sup>188</sup> In *Pacificare*, the court held that ERISA does not preempt the medical malpractice claim. They decided that the medical malpractice claim was based on state law, but does not “relate to” the Pacificare plan sufficiently as to warrant preemption.<sup>189</sup> The court identified four categories of laws which relate to an employee benefit plan:

First, laws that regulate the type of benefits or terms of ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan.<sup>190</sup>

The court reasoned that the claim that an MCO be vicariously liable for the actions of its physicians does not involve “the administration of benefits or the level or

183. *See id.*

184. 547 A.2d 1229 (1998).

185. *Id.* at 1234.

186. *See* Noah, *supra* note 6, at 1244.

187. *See Pacificare of Oklahoma v. Burrage*, 59 F.3d 151, 153. *See also Pomeroy v. Johns Hopkins Medical Servs., Inc.*, 868 F. Supp. 110, 113-14 (D.Md. 1994) (holding ERISA preempts medical malpractice claim against MCO based on vicarious liability); *Visconti ex rel. Visconti v. U.S. Health Care*, 857 F.Supp. 1097, 1102-05 (E.D.Pa. 1994) (same); *Dukes v. U.S. Health Care Sys. of Pa., Inc.*, 848 F.Supp. 39, 42-43 (E.D.Pa. 1994) (same); *Nealy v. U.S. Healthcare HMO*, 844 F.Supp. 966, 972-73 (S.D.N.Y. 1994) (same); *Ricci v. Goberman*, 840 F.Supp. 316, 317 (D.N.J. 1993) (same). *But see, Jackson v. Roseman*, 878 F.Supp. 820, 826 (D.Md. 1995) (holding ERISA does not preempt medical malpractice claim against MCO based on a vicarious liability or ostensible agency theory); *Haas v. Group Health Plan, Inc.*, 875 F.Supp. 544, 548 (S.D.Ill. 1994) (same); *Dearmas v. Av-Med, Inc.*, 865 F.Supp. 816, 818 (S.D.Fla. 1994) (same); *Kearney v. U.S. Healthcare, Inc.*, 859 F.Supp. 182, 186-88 (E.D.Pa. 1994) (same); *Burke v. Smithkline Bio-Science Labs.*, 858 F.Supp. 1181, 1184 (M.D.Fla. 1994) (same); *Paterno v. Albuerno*, 855 F.Supp. 1263, 1263-64 (S.D.Fla. 1994) (same); *Smith v. HMO Great Lakes*, 852 F.Supp. 669, 671-72 (N.D.Ill. 1994) (same); *Elsesser v. Hospital of Philadelphia College of Osteopathic Medicine*, 802 F.Supp. 1286, 1290 (E.D.Pa. 1992) (same); *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983, 988 (E.D.Pa. 1990) (same).

188. *Burrage*, 59 F.3d at 153.

189. *Id.* at 153-54.

190. *Id.* at 154.

quality of benefits promised by the plan.”<sup>191</sup> Instead, the claim alleges negligent care by the physician and an agency relationship between the MCO and the physician.<sup>192</sup> The *Pacificare* court stated that “just as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent.”<sup>193</sup>

### 3. Enterprise Liability

One way to narrow the scope of ERISA is to establish enterprise liability.<sup>194</sup> This would keep health care costs to a minimum while maximizing quality.<sup>195</sup> Enterprise liability identifies who has the most control over the cause of the negligence and makes this party liable for the injury under theories of malpractice.<sup>196</sup> Physicians would be treated as part of a “single enterprise” that would be liable for negligence.<sup>197</sup> This is especially appealing to physicians because they would not have to maintain their own malpractice insurance, and there would be less of a need for physicians to practice defensive medicine.<sup>198</sup> Enterprise liability benefits the patient as well, because it is easier to recover for injuries.<sup>199</sup> This is a much more equitable malpractice system. It does not hold physicians solely responsible for patient injuries when the physician is not solely responsible for patient treatment decisions.<sup>200</sup> Enterprise liability encourages cost containment, but not to the point that patient care deteriorates.<sup>201</sup>

### 4. Utilization Review as a Medical Decision

Historically, prohibitions on the corporate practice of medicine<sup>202</sup> have given physicians a monopoly on the practice of medicine.<sup>203</sup> The negative implication of this is that physicians bear sole responsibility for negligent medical decisions.<sup>204</sup>

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191. *Id.* at 155.

192. *See id.*

193. *Id.*

194. *See generally* Grosso, *supra* note 7, at 450.

195. *See id.*

196. *See id.* at 437.

197. *See* Allred, *supra* note 129, at B9.

198. *See id.* *See also* Frankel, *supra* note 9, at 1298 (explaining that physicians are paying more than 5 billion dollars per year on malpractice insurance). This does not include the hidden costs of practicing defensive medicine. Defensive medicine is where tests and procedures are done primarily in anticipation of litigation. This is estimated to cost as much as 15 billion dollars per year). *Id.*

199. *See* Allred, *supra* note 129, at B9.

200. *See* Grosso, *supra* note 7, at 450.

201. *See id.* at 450.

202. *See generally* Mars, *The Corporate Practice of Medicine: A Call for Action*, 7 HEALTHMATRIX 241 (1997) (explaining that the basic idea behind the prohibition of the corporate practice of medicine is that the primary interest of physicians is the well being of their patients, while the primary interest of corporations is the satisfaction of their shareholders. Allowing the corporate practice of medicine may jeopardize the quality and delivery of health care. *Id.*

203. *See* J. Scott Andreson, *Is Utilization Review the Practice of Medicine? Implications for Managed Care Administrators*, 19 J. OF LEGAL MEDICINE 431, 446 (1998).

204. *See id.*

However, the prevalence of MCOs has brought about an erosion of physicians having sole medical decision making power.<sup>205</sup> If prospective utilization review can be classified as a medical decision, it is possible for liability to shift to MCOs in some cases.<sup>206</sup> The following three cases clearly clarify this issue:

a. *Corcoran v. United Health Care*<sup>207</sup>

In *Corcoran*, the plaintiff needed to be monitored because of a history of high risk pregnancy.<sup>208</sup> The plaintiff's physician felt that hospital monitoring was necessary, but utilization review did not approve this hospitalization. UR approved home health nursing. Corcoran could not afford to pay the hospitalization herself, so she accepted the home care. Within two weeks of the UR decision not to pay for hospitalization, Corcoran's fetus went into distress while the home health nurse was not present. The fetus subsequently died. On appeal, the fifth circuit stated the central issue is how to characterize the actions of utilization review.<sup>209</sup> The defendant claimed that they merely applied criteria to determine benefits, while Corcoran, the plaintiff, maintained that the utilization review decision was a medical one.<sup>210</sup> The court held that the utilization review decisions were medical decisions.<sup>211</sup> The court ultimately decided in favor of the defendants, however, when it concluded that the utilization review decisions were medical ones but were made in the context of determining benefits under the health plan.<sup>212</sup> As a result, ERISA preempted recovery for Corcoran.<sup>213</sup>

b. *Long v. Great West Life & Annuity Ins. Co.*<sup>214</sup>

In *Long*, the plaintiff suffered from herniated vertebral discs.<sup>215</sup> The condition caused Long a great deal of pain.<sup>216</sup> He visited several physicians who authorized surgery.<sup>217</sup> Long's insurance company utilization review board would not authorize the surgery, so Long paid a penalty so that he could proceed with the surgery

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205. *See id.*

206. *See id.*

207. 965 F.2d 1321 (5th Cir. 1992).

208. *See id.* at 1322-24.

209. *See id.* at 1329-30.

210. *See id.* at 1326.

211. *See id.* at 1331.

212. *See id.*

213. *See id.*

214. *Long v. Great West Life & Annuity Ins. Co.*, 957 P.2d 823 (Wyo. 1998).

215. *See id.* at 826.

216. *See id.* at 837.

217. *See id.*

without the necessary pre-authorization.<sup>218</sup> Subsequently, Long sued Great-Life.<sup>219</sup> The *Long* court held that utilization review was a medical decision, and thus Long could seek a judicial remedy for the insurance company's conduct.<sup>220</sup>

c. *Murphy v. Board of Medical Examiners of the State of Arizona*<sup>221</sup>

Dr. Murphy is a physician who conducted utilization reviews for Blue Cross.<sup>222</sup> He denied a patient a gallbladder surgery, claiming that it was not medically necessary.<sup>223</sup> However, the patient's surgeon felt the surgery was medically necessary, so he proceeded to operate on the patient despite the MCO's refusal to pay for the procedure.<sup>224</sup> Pathology on the patient's gallbladder revealed that the surgery was medically necessary.<sup>225</sup> Blue Cross eventually paid for the surgery, but the patient's surgeon made a complaint to the Board of Medical Examiners (BOMEX) criticizing Dr. Murphy's decision that the gallbladder surgery was not medically necessary.<sup>226</sup> Dr. Murphy claimed that the BOMEX had no jurisdiction over him because he was not practicing medicine.<sup>227</sup> The court held that the utilization review decisions "unequivocally" were medical decisions.<sup>228</sup> Moreover, the court stated that the decisions Dr. Murphy made were "appropriate for the symptoms and diagnosis of the [c]ondition."<sup>229</sup>

There are several other results of utilization review being classified as the practice of medicine that are worth noting. First, all states require a person to be licensed to practice medicine. If states defined UR as the practice of medicine, states would require the decision makers in the utilization review process to have medical licenses.<sup>230</sup> In addition, an unlicensed administrator could be subject to criminal proceedings since it is a criminal offense in all states to practice medicine without a license.<sup>231</sup> Even if administrators are licensed to practice medicine, they could be still be subject to criminal charges if they are not licensed in the state in which they are performing the utilization review.<sup>232</sup> As noted in *Murphy*,<sup>233</sup> liability is not limited to criminal actions.<sup>234</sup> The particular state medical board of the state in which the utilization review is taking place may also be given the authority to

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218. *See id.*

219. *See id.*

220. *Long v. Great West Life & Annuity Ins. Co.*, 957 P.2d 823, 852 (Wyo. 1998).

221. 949 P.2d 530 (1997).

222. *See id.* at 532.

223. *See id.*

224. *See id.* at 533.

225. *See id.*

226. *See id.*

227. *See Murphy v. Bd. of Med. Exam'rs of the State of Ariz.*, 949 P.2d 530, 533 (1997).

228. *Id.* at 536.

229. *Id.*

230. *See ANDERSON, supra* note 203, at 452.

231. *See id.*

232. *See id.*

233. 949 P.2d at 530.

234. *See ANDERSON, supra* note 203, at 453.

oversee decisions made by utilization review administrators.<sup>235</sup>

## V. MINIMIZING PHYSICIAN LIABILITY

In light of MCOs, *Wickline*, *Wilson*, and all the other complex issues involved, many physicians are unclear on their responsibility as decision makers for their patient's treatment, especially when it is contradicted by a third party payor.<sup>236</sup> This section outlines ideas about what physicians owe their patients in the era of managed care as well as strategies physicians can use to minimize their liability.

### A. What Should a Physician's Duty Be?

Most people agree that physicians should take sensible measures to prevent their patients from being injured by cost-conscious treatment decisions.<sup>237</sup> Medicine has an "egalitarian ethic which imposes on a physician a duty to care for his patient regardless of the patient's ability to pay."<sup>238</sup> The duty of care can never depend on whether payment will be made.<sup>239</sup> If this situation were allowed to happen, a two-tiered duty of care would develop.<sup>240</sup> One court eloquently explained why the duty of care should not be tied to cost:

Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care. He may decline to respond to the call of a patient unable to compensate him; but if he undertake the treatment of such a patient, he cannot defeat a suit for malpractice, nor mitigate a recovery against him, upon the principle that the skill and care required of a physician are proportioned to his expectation of pecuniary recompense.<sup>241</sup>

Some courts have even held that failure to perform all available diagnostic tests constitutes negligence, though others reject this claim of due care in diagnosis.<sup>242</sup> "If financial pressures cause a physician to deviate from the required standard of care, then the patient's health is threatened."<sup>243</sup> Physicians must ignore the pressures of MCOs when it comes to making treatment decisions so that the quality of care is not diminished, for it is the physician who is in the best position

235. *See id.*

236. *See* Andrea Jean Lairsen, *Reexamining the Physician's Duty of Care In Response to Medicare's Prospective Payment System*, 62 WASH. L. REV. 791, 804 (1987).

237. *Id.* at 792.

238. Kohler, *supra* note 40, at 1078.

239. *See* Lairsen, *supra* note 236, at 805.

240. *See id.* at 806.

241. *Becker v. Janinski*, 15 N.Y.S. 675, 677 (NY 1891), *noted in* Frankel, *supra* note 9, at 1316.

242. *See* Frankel, *supra* note 9, at 1316. *See also* *Forrestal v. Magendantz*, 848 F.2d 303, 310 (1st Cir. 1988); *Clark v. United States*, 402 F.2d 950, 952 (4th Cir. 1968); *Wilkinson v. Vesey*, 295 A.2d 676, 683 (R.I. 1972); *Smith v. Yohe*, 194 A.2d 167, 173 (Pa. 1963) (supporting the claim of due care in diagnosis). *But see* *Durr v. McElrath*, 382 S. E. 2d 20, 22 (S.C. Ct. App. 1989) (rejecting duty to perform all available tests).

243. Lairsen, *supra* note 236, at 805.

to care for the patient. The physician is “educated to care for the patient . . . , knows the patient, has treated the patient, and can assess the patient’s needs. Patients entrust themselves to their physicians . . . .”<sup>244</sup>

One related issue is whether a physician has a responsibility to disclose cost containment measures that impact his or her patient’s care. An MCO should “publicly disclose its cost-benefit standards” so that consumers can make informed choices on which health care plan to use.<sup>245</sup> Patients are entitled to make informed judgments about their treatment.<sup>246</sup> The American Medical Association (AMA) strongly believes that physicians have a “legal and ethical duty to provide patients with all the information they require . . . patients should no longer fear that third-party payors could interfere with crucial medical information.”<sup>247</sup> This includes disclosing utilization review policies and procedures.<sup>248</sup>

Physicians should be aware that some MCOs include gag clauses in their contracts.<sup>249</sup> Gag clauses are contractual provisions intended to preclude physicians from disclosing medically significant information to patients or from revealing to the patient that the MCO might not be treating him or her fairly.<sup>250</sup> The AMA insists that physicians should not tolerate these gag clauses under any circumstances.<sup>251</sup> The following is an example of a gag clause:

Physician shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in U.S. Healthcare or the quality of U.S. Healthcare coverage. Physician shall keep the Proprietary Information payment rates, utilization-review procedures, etc. and this Agreement strictly confidential.<sup>252</sup>

This leads to the question of whether a physician should have a duty to disclose personal interests unrelated to the patient’s health that may affect the physician’s medical judgment.<sup>253</sup> The reason that lack of disclosure leads to liability is that the patient cannot trust the physician if the patient is unaware of the physician’s hidden economic interest.<sup>254</sup> This is difficult to determine in today’s health care setting because many things are affected by what a physician can afford to do as well as what the patient can afford.<sup>255</sup> The traditional standard of disclosure

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244. *Id.* at 807.

245. John C. Goodman, *A Plan to Empower Patients*, WALL ST. J., May 2, 1995, at A18. See also Jennifer A. Hradil, *Patchwork Patient Protection: Must We Choose a Single Pattern?*, 27 SETON HALL L. REV. 203, 223 (1996).

246. See Hradil, *supra* note 245, at 225.

247. Statement of Thomas R. Reardon, M.D., *supra* note 136.

248. See *id.*

249. See *id.*

250. See RICHARDS, *supra* note 12, at 455.

251. See *id.*

252. *Id.*, (quoted in Woodhandler & Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706, 1706 (1995)).

253. See BLACKMON, *supra* note 124, at 388.

254. See *id.*

255. See *id.*

was informing a patient in a manner consistent with how other physicians would disclose.<sup>256</sup>

Two cases clarify what a physician's duty to disclose information should be in today's health care system.<sup>257</sup> In *Canterbury v. Spence*,<sup>258</sup> a new standard was expressed which was based on the individual patient's informational needs instead of what other physicians would disclose.<sup>259</sup> In *Moore v. Regents of the University of California*,<sup>260</sup> informed consent was expanded to require the disclosure of conflicts of interest.<sup>261</sup> The court stated that the physician must disclose personal interests unrelated to the patient's health that may affect the physician's medical judgment whether those personal interests pertain to research or economics.<sup>262</sup> These two cases suggest that "a physician would be liable for failing to obtain an adequate informed consent if the physician failed to explain to a patient that the physician's financial compensation may be based on incentives to deny or restrict care."<sup>263</sup>

Another important issue in this area is the idea of physicians as fiduciaries. Almost all states have case law holding that the physician-patient relationship is a fiduciary one.<sup>264</sup> In managed care plans, physicians who are not cost-effective (as deemed by the MCO) are no longer able to treat MCO patients.<sup>265</sup> This puts the physician in a legal quandary.<sup>266</sup> MCOs also provide incentives to physicians to limit care. These things can lead to a breach of a physician's fiduciary duty to the patient.<sup>267</sup> Breach of fiduciary duty is a cause of action on its own and can also give rise to criminal actions for fraud.<sup>268</sup> In the traditional physician-patient relationship, physicians should be "financially disinterested decision makers, influenced only by the patient's best interests."

MCOs protected by ERISA create two conflicts between the physician's fiduciary duty to the patient and the physician's obligation to the MCO.<sup>269</sup> First, physicians as fiduciaries are bound to order medically necessary care.<sup>270</sup> An ERISA plan may exclude coverage for this care.<sup>271</sup> Second, physicians may be impelled to conceal important information about treatment from their patients so that the

256. *See id.*

257. *See id.* at 387.

258. *See Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

259. *See* BLACKMON, *supra* note 124, at 388.

260. 793 P.2d 479 (1990).

261. *See* BLACKMON, *supra* note 124, at 387.

262. *See Moore*, 793 P.2d at 483.

263. BLACKMON, *supra* note 124, at 387.

264. *See* RICHARDS, *supra* note 12, at 451.

265. *See id.* at 450.

266. *See id.*

267. *See id.*

268. *See id.* *See e.g., Moore*, 793 P.2d at 483 (holding that a physician has a fiduciary duty to disclose economic interests unrelated to patient's health that may affect physician's professional judgment). *See also Carpenter v. United States*, 484 U.S. 19 (1987) (holding that breach of physician's fiduciary duty can support criminal actions for fraud).

269. *See* RICHARDS, *supra* note 12, at 452.

270. *See id.*

271. *See id.*

patients will not request the treatment.<sup>272</sup>

### *B. What Strategies Can Physicians Use to Minimize Their Liability?*

1. First and foremost, physicians must remember that their primary responsibility is to their patients.<sup>273</sup> It is important to recognize that only a patient's own doctor can evaluate the emotional aspects of a patient's recovery.<sup>274</sup> Physicians have to balance both physical and emotional aspects of a patient when deciding to release a patient from the hospital.<sup>275</sup> No policy can replace this interaction between doctor and patient.<sup>276</sup>

2. Second, physicians should understand that they are in the best position to help their patients if they understand and follow all of the MCO policies and procedures. Physicians should know how utilization review works, be familiar with coverage and eligibility procedures, and know how to expedite review and appeal.<sup>277</sup>

3. A physician should gather information about the utilization review process as it applies to each individual patient. It is important to know why the treatment was denied and what factors were used to make the decision. The utilization reviewer will not always provide the physician with this information unless the physician requests it. This information is helpful to the physician when he or she is appealing the denial.

4. The physician must also gather information about each individual patient, such as how far each lives from the doctor, hospital, or emergency room.<sup>278</sup> A discrete inquiry also should be made as to whether the patient is below average intelligence and whether he or she will comply with discharge instructions or will notice when something that is not a normal part of recovery occurs. The utilization review staffer making the decision about a patient's treatment will not know this information, but it is highly relevant to the determination of treatment.

5. Physicians should appeal each and every denial of treatment that is contrary to what the physician feels is in the best interest of the patient. Remember that the physician is the patient's advocate. The physician should endeavor to pursue and exhaust all pathways to acquiring MCO authorization for the necessary treatment.<sup>279</sup> For an effective appeal, the physician should be armed with "all pertinent records as well as an adamant, persistent, and well-justified articulation of the necessity of the denied treatment."<sup>280</sup>

6. Throughout the process, physicians should keep their patients informed

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272. See *id.*

273. See Cheryl Gutman, *Patients Should Come First In Managed Care Situations*, UROLOGYTIMES, Jan. 1998, at 15.

274. See Ginger Rugai, *HMOs Put Wealth Above Our Health With 'Drive-Through' Mastectomies*, CHICAGO TRIBUNE, Dec. 1, 1996, at 8.

275. See *id.*

276. See *id.*

277. See Fiona G. McCord, *Power Practice -- Trends in Health Care Law; Between a Rock and a Hard Place*, TEXAS LAWYER, Aug. 1997, at 33.

278. See Naomi Pfeiffer, *Hospital Admissions or Discharge Up to Doctor, Not Budget*, MEDICAL ECONOMICS DRUG TOPICS, Jul. 21, 1997, at 48.

279. See McCord, *supra* note 277, at 33.

280. See Gutman, *supra* note 273, at 15.



about what is going on with the process as well as all treatment options so that the patient can make an educated choice about what to do next.<sup>281</sup> If the MCO ultimately refuses to authorize treatment, the physician should inform the patient of treatment alternatives so the patient can decide how he or she wants to proceed.<sup>282</sup> The patient may either decide to forego the treatment or undergo the suggested treatment without the MCO funding it.<sup>283</sup> As stated previously in section Five A., physicians should avoid gag orders whenever possible so that they are free to discuss all relevant facts with their patients. According to Memphis physician Thomas E. Wallace, M.D., J.D., “[w]hen doctor and patient are communicating well and the patient knows the doctor is an advocate, lawsuits are greatly reduced.”<sup>284</sup>

7. If the physician’s treatment of choice is denied, he or she should explore alternatives. For example, if the MCO will only pay for four inpatient days instead of eight there may be other alternatives, such as home health care or more frequent follow up office visits. In the *Wickline* case, Wickline’s physician could have recommended sending her home with a visiting nurse, instead of discharging her solely to her husband’s care.<sup>285</sup>

8. Regardless of the mode of treatment, the physician should provide patients with “clear, written instructions outlining the treatment, what is involved, after-treatment precautions and care and access to follow-up emergency care.”<sup>286</sup> For example, in the *Wickline* situation, the physician might have given Wickline and her husband written instructions and told them to be watching for specific symptoms. In particular, he should have explained how important it was to seek emergency care if those or other symptoms presented themselves.

9. One of the most vitally important steps a physician can take to protect him or herself is to document everything. This includes writing down the treatment plan the physician feels is medically indicated, how he or she has explained the indicated treatment to the patient, all actions taken to help the patient obtain authorization, how the physician appealed denials, and if the treatment was denied, how the physician explained to the patient that the treatment is still indicated. Every objection the physician has to treatment denials must be meticulously documented.<sup>287</sup> It is important to remember that good medical care will not necessarily save physicians from a lawsuit.<sup>288</sup> There is a great deal of information that is collected that is never documented. Physicians may take all the necessary steps or make correct decisions about patient care but they are still at risk for liability if their actions are not clearly justified by documentation.<sup>289</sup> Plaintiff’s

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281. See McCord, *supra* note 277, at 33.

282. See *id.*

283. See *id.*

284. Pfeiffer, *supra* note 278, at 33.

285. See Kohler, *supra* note 40, at 1073. Note, however, that managed care organizations are becoming more reluctant to pay for home health care.

286. Pfeiffer, *supra* note 278, at 33.

287. See Patricia Thomas, *Physicians Out on a Liability Limb*, MEDICAL WORLD NEWS, Jun. 12, 1989, at 62.

288. See Janet Dyer, *Documentation: The Linchpin of any Malpractice Defense* MEDICAL ECONOMICS, Oct. 1998, at 18.

289. See *id.*

lawyers want winnable cases. Perfect records may make them move on to the next case.<sup>290</sup>

10. Physicians should also reconsider their malpractice coverage. A St. Louis attorney, Morris Stokes, whose specialty is representing physicians and their insurance company gives the following advice:

If I was a doctor signing up with a group plan, I would want a 'hold harmless' agreement from the corporation for any liability arising out of my medical practice, including decisions about cost containment. Then I would want them to insure that with a very, very solid company with huge limits.<sup>291</sup>

Remember that the interests of physicians and MCOs are often adverse.<sup>292</sup> Physicians might consider negotiating with the MCO to provide malpractice coverage.<sup>293</sup> If the MCO agrees to provide the physician with malpractice coverage, the physician should be the primary insured on the policy.<sup>294</sup> This gives the physician more control over whether the claim is defended or settled, and if the claim is settled, the terms of the settlement.<sup>295</sup> The physician also should hire his or her own attorney to monitor and make sure the defense attorney is acting in the physician's best interest instead of in the interest of the MCO.<sup>296</sup>

11. Finally, an experienced physician writing to new doctors gives this advice, which is valuable to all practicing physicians:

[S]hould anyone call you a health-care provider and suggest that your patients are customers in a business, I offer this suggestion: Stand tall, look them in the eye, and say, "I am a doctor and I take care of patients as well as their diseases. Therefore, I intend to establish a trusting relationship with my patients. I understand that medical care costs money and I do not intend to waste a penny, but *I am a doctor and not a businessperson*. The service I give to my patients comes first."<sup>297</sup>

## VI. CONCLUSION

There is no doubt that health care costs are skyrocketing. Expensive new technology, an aging population, and insurance companies' high overhead costs have caused health care spending to escalate. Managed care organizations and their cost containment methods were created to alleviate this difficulty, which in turn, have caused enormous problems of their own. ERISA's protection of MCOs further

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290. *See id.*

291. Thomas, *supra* note 12, at 472.

292. *See* RICHARDS, *supra* note 12, at 452.

293. *See id.*

294. *See id.*

295. *See id.*

296. *See id.*

297. J. Willis Hurst, M.D., *Thoughts About Becoming an Intern on a Medical Service*, RESIDENT AND STAFF PHYSICIAN, Aug. 1998, at 73 (emphasis in the original).

aggravates these problems. Legislation is needed to correct these problems, but until this comes to pass, physicians and their lawyers must be aware of the issues involved and utilize strategies that minimize physician liability. Only when the physician is protected can good patient care be insured.

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