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LIABILITY IMPLICATIONS OF UTILIZATION REVIEW AS A COST CONTAINMENT MECHANISM

Health care costs have escalated dramatically over the last several decades with a three-fold increase in per capita costs since 1950. The Congressional Budget Office estimates health care expenditures will increase from $190 billion in 1991 to $300 billion in 1995, supplanting defense as the largest component of the federal budget. The increased cost of health care has had a wide and potentially devastating economic impact: seventeen percent of the American population has no health insurance coverage; the federal Medicare program faces bankruptcy before the year 2000; state Medicaid programs are in financial distress; and American business, underwriter of one-third of the nation's health care costs through employee benefit programs, faces tougher international competition because of the rapidly expanding health care component of labor costs.

Rising health care costs have been attributed to numerous factors, including overall price inflation, expensive technological advances, the rapid growth of hospital facilities, the increased needs of an older and more acutely ill population, and the practice of "defensive" medicine (spurred by an increase in malpractice liability). Significantly, third party payers have

3. Flanigan, supra note 2.
4. Morreim, supra note 1, at 1720.
5. Id.
6. Id. at 1720-21.
8. The term “third party payers” refers to the entities which pay for health care services rendered to members (beneficiaries) of a health care plan or policy. Third party payers include insurance companies, charities, publicly financed programs such as Medicare and Medicaid, and employers who provide health insurance to their employees on a self-insured basis—i.e., where the employer acts as an insurer by paying the medical expenses of its covered employees instead of purchasing an insurance plan to pay the expenses. Paul E. Kalb, Controlling Health
encouraged maximum use of high-priced technologies and facilities by the
time of their reimbursement system—paying in retrospect for each service
as rendered—thereby raising the revenues of health care providers as the
prescribed use of services increased.9 As one commentator has stated,
"Thus insulated from the economic costs of their decisions and inspired by
the societal value that each patient should receive the best health care avail-
able, physicians and other providers have had powerful incentives to deliver
all indicated care, and virtually no incentives to hold back."10 The creation
of commercial enterprises to manage and administer the delivery of health
care has further contributed to the escalation of health care costs; in fact,
many of these enterprises profit from a continued escalation of costs which
enhances the need for their services.11

By the early 1980s, the fiscal impossibility of continuing to underwrite
expanding health care costs in a system with few valid restraints mandated
some form of cost control. The government and third party payers re-
sponded with new methods of financing health care designed to control the
use of hospital facilities and expensive technologies—primarily by initiating
prospective payment plans that cap reimbursement fees or require prior au-
thorization for elective procedures and by guarantying reimbursement only
as approved.12 In addition, new systems for the delivery of health care fo-
cusing on utilization control rapidly proliferated—the most common exam-
ple of which is the Health Maintenance Organization (HMO).13

Utilization review (UR) is a cost containment and quality assurance strat-
ey implemented to enforce the above cost control efforts.14 It is the process
by which health care services are examined to ensure that the services pro-
vided are both necessary and cost-efficient.15 Insurance coverage is denied if
these criteria are not satisfied and, due to prohibitive costs, individuals are

9. Morreim, supra note 1, at 1720.
10. Id.
11. Evans, supra note 2, at 115. For example, competitive efforts to obtain the most cost-
effective health care plans and meet administrative requirements have, under various govern-
ment plans, increased the use of management consultants, accountants, and public relations
specialists. Id.
12. See Morreim, supra note 1, at 1721.
13. Id.
14. Eleanor D. Kinney & Marilyn M. Wilder, Medical Standard Setting in the Current
15. Id.
not likely to seek care at their own expense. Thus, because an improper UR denial may prevent the delivery of appropriate care and result in patient injury, UR may create liability in the attempt to constrain costs.

Although survival of the current health care system depends on the success of cost control strategies, medical malpractice cases increasingly reflect tension between the quality and economics of care. Despite limited experience adjudicating liability for UR and other cost containment programs, courts have recently held third party payers and others involved in the UR process potentially liable in cases in which a negligent UR decision leads to patient injury. Although stringent standards may deter negligence in the application of UR, overly stringent standards are likely to frustrate legitimate cost control efforts. Since medical malpractice is determined according to standards of the medical community, standards that conform to reasonable financial considerations should be encouraged by the health care community, lawmakers, and courts. Such standards support valid cost control efforts, including UR, and simultaneously protect patients against arbitrary or negligent medical decisions.

This Comment begins with a discussion of the nature of health care cost control strategies. Next, it presents an overview of cost containment programs undertaken by the government, employers and insurers, hospitals, and other health care providers. This overview illustrates the relevance of utilization management in cost containment and provides a synopsis of some of the cost control measures at issue in medical litigation. A discussion of UR as a mechanism for cost containment follows, with particular emphasis on how it applies to the Medicare/Medicaid diagnosis related group (DRG) system of reimbursement and the HMO-type provider organization. Finally, this Comment addresses the liability implications of the UR process by analyzing current case law and the ramifications of a cost control defense. The focus of this Comment is on prospective review of health care costs. Since


19. Marcotte, supra note 17 (quoting Barry Furrow, Address at the A.B.A. Medical Malpractice National Institute, Reno, Nev. (Mar. 1988)).


this form of UR is more effective at containing costs than is retrospective review, it is more likely to impact the quality of patient care and lead to potential liability.

I. The Nature of Cost Control Strategies

Cost control can operate from two perspectives: externally, by a reduction in the amount of care consumed; or internally, by a reduction in the cost of items or services provided. In other words, cost is decreased by either using fewer health care services or by making health care less expensive. Utilization management or control, the efficient use of available health care resources, is the basis for cost control efforts from both perspectives; UR is the primary mechanism involved. Basically, UR is a process under which the use of health care services for a specific patient is compared to an established norm for the use of similar services for comparable patients. Insurers set reimbursement limits accordingly by denying payments for

22. See George A. Gregory, Who Should Receive Intensive Care?, 11 CRITICAL CARE MED. 767, 768 (1983). External controls generally reduce the consumption of services by an explicit denial of care or the withholding of reimbursement. Internal controls reduce costs while providing the same overall services, although the level of quality may be reduced. See Schwartz, supra note 18. For example, in order to obtain an internal cost reduction, an employer may contract with a less expensive insurance carrier for the administration of its insurance program, yet provide the same general health services to employees. Similarly, a provider (i.e., hospital, HMO, physician) may obtain less expensive supplies or employ fewer or less expensive personnel to provide the same general patient services. See id. (describing analogous cost reductions as “silent rationing”). Whether the provider retains the savings or passes them on to the consumer (the patient/payer), the effect is still that of reducing the overall costs of health care. See also Mark A. Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. PA. L. REV. 431, 436-37 (1988) (discussing the internalization of health care costs in the HMO-type provider). Note, however, that the distinction between internal and external forces on health care economics exists from other perspectives. For example, external forces may refer to forces entirely outside the health care system. See generally Evans, supra note 2, at 104-06 (describing the true expansionary forces in health care costs as internal to the health care system rather than external to the system).

23. See Gregory, supra note 22, at 768; Schwartz, supra note 18 (discussing cost reductions in terms of explicit rationing and implicit or “silent” rationing of services). The division of cost containment methods has also been described in terms of three, rather than two categories of health care rationing which affect access to medical services: market rationing, influenced by the consumer’s ability to pay directly or through insurance coverage; explicit rationing, influenced by the decisions of health care administrators as to who and what will be covered under various health care plans; and implicit rationing, influenced by health care providers who are encouraged to conservatively use available medical resources. Sara T. Fry, Rationing Health Care: The Ethics of Cost Containment, 1 NURSING ECON. 165, 165-67 (1983). Although both providers and payers may seek more health care activity, the providers would like to charge a higher cost for health care services, while the payers would like to pay a lower cost for services. Evans, supra note 2, at 124.

questionable services or capping fee payments at specified levels or both. Providers such as hospitals and HMOs use similar comparisons to lessen the expense of care they provide by reducing the amount of care delivered to no more than the established norm.

UR is now an integral part of the government health care reimbursement system through Medicare and Medicaid and is increasingly being implemented by private third party payers, purchasers, and various health care organizers to control costs. Originally, UR was the process under which the payer/insurer reviewed medical charges incurred by a covered patient and denied reimbursement for charges deemed unreasonable or unnecessary. As health care costs have escalated, UR has evolved into a broader and more pervasive process. Thus, the term utilization “review” has become somewhat of a misnomer. As currently used, UR encompasses not just an examination of services already provided (retrospective review), but also includes the streamlining of prospective services to provide coverage for only the most cost-efficient and necessary care (prospective review). Since UR may limit or ration the amount of health care provided, especially through prospective denials of coverage, it has an inherent potential to create liability when patient injury results.

II. COST CONTAINMENT PROGRAMS

UR is not the sole mechanism in the effort to control health care costs. From a broader perspective, utilization management and control concepts
pervade the realm of cost containment measures. Significant efforts to hold down costs through utilization control have been undertaken by: 1) the federal and state governments, which pay approximately forty percent of all health care expenditures;23 2) businesses, which ultimately pay the majority of reimbursed employee health care expenditures for covered employees, either through self-insured programs or insurance premiums;34 3) insurance companies;35 and 4) the health care industry itself, through hospital programs36 and the development of alternative delivery systems which provide complete health care services for set enrollment fees.37 An overview of cost containment programs demonstrates an emphasis on controlling utilization to contain costs.

A. Legislative Programs38

The most comprehensive governmental program instituted to control escalating health care costs is the DRG method of reimbursement used under Medicare and some state Medicaid programs.39 DRGs, enacted by Con-

33. Kalb, supra note 8, at 1111.
34. Id. at 1111 n.10 (noting that employers pay approximately 75% of all private health insurance premiums). For a discussion of employer responsibility for costs, see infra notes 78-79 and accompanying text.
35. See Kinney & Wilder, supra note 14, at 437.
36. See id. at 438.
38. This Comment does not address regulatory efforts to control health care costs that are not related to the UR process, such as the power of some state commissions to set hospital rates. See, e.g., Blue Cross v. Franklin Square Hosp., 352 A.2d 798 (Md. 1976) (discussing the power of the Maryland Health Services Cost Review Commission, now codified at Md. HEALTH-GEN. CODE ANN. §§ 19-201 to 19-222 (1990 & Supp. 1991), to review and set hospital rates), appealed after remand Health Serv. Cost Review Comm'n v. Franklin Square Hosp., 372 A.2d 1051 (Md. 1977); Health Serv. Cost Review Comm'n v. Holy Cross Hosp., 431 A.2d 641 (Md. 1981) (holding the power of the Maryland state commission to regulate total hospital costs did not include the authority to approve and set the professional component of hospital-based physicians' fees).

In addition, a number of state legislatures have made significant efforts to reduce medical costs by statutorily capping malpractice awards. In some states these caps have been upheld by the courts, but in others they have been declared unconstitutional. Judy Tyrrell, Case Comment, Interpretation of Virginia's Medical Malpractice Act: Boyd v. Bulala, 12 GEO. MASON U. L. REV. 361, 361 (1990). Malpractice caps, along with other tort reforms, are an attempt to cut down the utilization of health care resources which go toward the payment of higher insurance premiums, litigation costs, and award payments. See Charles P. Bailey, An Alternative Approach to the Malpractice Crisis, LEGAL ASPECTS MED. PRAC., Dec. 1988, at 1, 10. Other tort reforms include reductions in the time permitted for filing tort claims, reductions in attorney contingency fees, the use of screening panels to review cases prior to trial, changes in the rules for joint and several liability, and provisions for structured awards. Id.

39. Giordani, supra note 7, at 1010; see also Hall, supra note 22, at 436 n.15 (noting that eleven states employ DRG systems to determine Medicaid reimbursements, but pointing out
gress as part of the Social Security Amendments of 1983, limit reimbursements to specified amounts according to diagnostic categories. This type of prospective fee payment system, in which hospitals receive a predetermined fee for patient care, is dependent upon a patient's diagnosis but is unrelated to the actual cost of care. Hospitals are prohibited from billing the patient for excess cost and must absorb the cost of overruns.

Other regulatory efforts limit or define the services that providers may offer. For example, regulations may limit the number of hospital beds available or the acquisition of certain high-technology equipment to that which is based on substantiated community need. Providers are thereby discouraged from prescribing unnecessary care in order to recoup expenses.

that many states have opted instead to structure their Medicaid programs as HMOs. A number of states have implemented even more rigorous "all payer" cost control systems which apply DRGs or other forms of prospective reimbursement to all hospital patients. In addition, some private payers have adopted the DRG method of reimbursement at their own initiative. Giordani, supra note 7, at 1010.


41. JOSEPH AND ROSE KENNEDY INSTITUTE OF ETHICS, SCOPE NOTE NO. 4, DIAGNOSIS RELATED GROUPS (DRGs) AND THE PROSPECTIVE PAYMENT SYSTEM: FORECASTING SOCIAL IMPLICATIONS 1 (1984). DRGs categorize all illnesses within approximately 400 listings. Id.

42. Morreim, supra note 1, at 1010. DRG systems are aimed at institutions. Reimbursement for individual physicians has not been subject to DRG limitations. See Hall, supra note 22, at 434 (noting no direct limits on physician reimbursement in spite of estimates which place 70 to 90% of health care expenditures under the control of individual physicians). But see 42 U.S.C.A. § 1395w-4 (West 1992) (codifying broad Congressional changes to the Medicare physicians' reimbursement system under the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2169 (1989), amended by the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990), in which a resource-based relative value scale was scheduled to be implemented for the reimbursement of physicians' fees effective January 1, 1992).

43. Giordani, supra note 7, at 1010 n.22. This creates incentives to cut costs by undertreating patients. Id. at 1011. Accordingly, critics allege that the DRG system of reimbursement reduces access to needed care and lowers the quality of care provided, particularly to the elderly and indigent recipients of Medicare and Medicaid benefits. Id. at 1010-11.


45. Giordani, supra note 7, at 1014; Vita et al., supra note 44, at 93. Numerous states require health planning agency approval of proposed hospital capital expansions in the form of certificates of need (CONS), which are dependent upon a showing that the proposed expansions will satisfy a community need. Id. Similar approval for capital expenditures was required by the federal government until 1987. Id. at 93 n.59 (citing § 221 of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1386 (42 U.S.C. §§ 701, 1395, 1396, as amended by Pub. L. No. 92-603, 86 Stat. 1329, 1386 (adding § 1122 to Title XI of the Social Security Act))).
for beds or equipment that the community is unable to support.46

B. Employer/Insurer Programs

There are a number of methods by which employers and insurers, as third party payers, discourage the utilization of health care. First, they have instituted requirements that the insured bear a larger portion of health care costs47 and have increased enforcement of both coordination of benefit provisions and policy subrogation rights.48 Second, employers obtain the most economical coverage plans by encouraging competition among health care providers and insurers.49 Third, most insurance policies limit coverage to nonexperimental care that is "reasonably" or "medically" necessary.50 In addition, some benefit plans provide for voluntary or mandatory second surgical opinions to reduce the incidence of unnecessary surgical procedures,51 and many require preadmission review for coverage of hospital charges.52 However, expensive and wasteful technologies—including those that are unsafe, ineffective, or more expensive than existing alternative treatments—are

46. See Giordani, supra note 7, at 1014 (describing the placing of limit controls on providers as a form of cost containment).

47. This burden on the employee/insured takes the form of higher deductibles, copayments, and coinsurance amounts. The number of employees receiving "first-dollar" medical coverage declined substantially during the 1980s. Macaulay, supra note 8, at 96.

48. Id. at 97. Coordination of benefit provisions establish a priority system of payment if multiple insurance carriers are involved to prevent the insured from receiving more than 100% reimbursement. Subrogation rights allow the payer to be reimbursed where the employee/insured recovers from a third party. Id.

49. Morreim, supra note 1, at 1721.

50. Kalb, supra note 8, at 1114-15. Thus, coverage may depend on what constitutes "experimental" therapy. For example, a federal district court recently declared that breast cancer treatment with high dose chemotherapy and autologous bone marrow transplant was within plan coverage, despite the insurer's prospective determination that the therapy was noncompensable experimental therapy. Pirozzi v. Blue Cross-Blue Shield, 741 F. Supp. 586, 594 (E.D. Va. 1990) (noting, however, that this was a narrow decision based on the specific plan involved and the expert medical testimony presented). The court pointed out that the insurer's determination would probably have survived an arbitrary and capricious standard of review; however, because the terms of the plan did not give the utilization reviewer discretion to deny experimental therapies, the decision was subject to the court's de novo review. Id. at 595 n.20. But see Adams v. Blue Cross/Blue Shield, 757 F. Supp. 661 (D. Md. 1991). In Adams, the court held that an insurer's decision to deny coverage for autologous bone marrow transplant therapy was arbitrary and capricious since the company had not deferred to the consensus opinion of Maryland oncologists to determine the accepted standard of medical practice. Id. at 676. The court noted that the contract had no language allowing the plan administrator to unilaterally review medical data and decide if a procedure fell within the accepted standard of practice. Id. For a discussion of "medical necessity" language typical to health insurance contracts, see Sarchett v. Blue Shield, 729 P.2d 267, 270-73 (Cal. 1987).

51. Macaulay, supra note 8, at 98.

52. Morreim, supra note 1, at 1721.
often covered as a result of liberal judicial construction of policy terms.\textsuperscript{53} Because advanced medical technologies—including drugs, equipment, and medical-surgical procedures—may account for up to fifty percent of health care inflation, one commentator has proposed a plan whereby private insurers offer a multi-tiered system of health insurance with a series of increasingly expensive policies providing coverage for more complex and innovative technology options.\textsuperscript{54}

\textbf{C. Hospital Programs\textsuperscript{55}}

Attempts to control inpatient costs have intensified because hospitals are required to absorb costs not covered under DRG forms of reimbursement.\textsuperscript{56} A stronger emphasis on UR is key to this effort and has led to pressure on staff physicians to adhere to DRG guidelines with penalties for those who prescribe unnecessary treatment or prolonged hospital stays.\textsuperscript{57} Hospitals and other health care institutions have also stepped-up risk management programs in an attempt to identify and reduce potential liability hazards and thereby minimize necessary expenditures for malpractice liability.\textsuperscript{58} In addi-

\textsuperscript{53} Kalb, \textit{supra} note 8, at 1112-15.  
\textsuperscript{54} Id. at 1112, 1121-24.  
\textsuperscript{55} This Comment does not address the trend among hospitals to close their less profitable or unprofitable health care services and promote new and more profitable services as sources of revenue. See James W. Summers, \textit{Closing Unprofitable Services: Ethical Issues and Management Responses}, \textit{Hosp. \& Health Serv. Admin.}, Sept./Oct. 1985, at 8 (discussing the integration of ethical and management considerations in hospital service closures).  
\textsuperscript{56} Giordani, \textit{supra} note 7, at 1010 n.22; cf. Summers, \textit{supra} note 55, at 9 (discussing the closure of unprofitable hospital services because of prospective pricing and the increased pressure to reduce costs).  
\textsuperscript{57} See, \textit{e.g.}, \textit{Joseph and Rose Kennedy Institute of Ethics, supra} note 41, at 3; Morreim, \textit{supra} note 1, at 1747; Morreim, \textit{supra} note 16, at 21.  
\textsuperscript{58} See Allen K. Hutkin, \textit{Resolving the Medical Malpractice Crisis: Alternatives to Litigation}, 4 \textit{J.L. \& Health} 21, 45-46 (1990) (indicating that risk management programs have broadened in scope as more hospitals have become partially or totally self-insured). Since 1988, the Joint Commission on Accreditation of Hospitals has required hospitals to maintain risk management programs. Id. at 45. Moreover, courts now recognize the responsibility of hospitals to use care in the selection and monitoring of their employees and medical staff. Stewart R. Reuter, \textit{Vicarious Liability: When Are You a “Second Defendant”?}, \textit{Legal Aspects Med. Prac.}, Nov. 1987, at 6, 7. Commentators have noted that with liability risks inherent to the UR process, it behooves hospitals to monitor UR programs on their premises. Marcotte, \textit{supra} note 17 (citing Los Angeles attorney Michael D. Roth). Such monitoring would probably be part of the risk management program, although it could be related to a quality assurance program. See Richard L. Griffith \& Jordan M. Parker, \textit{With Malice Toward None: The Metamorphosis of Statutory and Common Law Protections for Physicians and Hospitals in Negligent Credentialing Litigation}, 22 \textit{Tex. Tech. L. Rev.} 157, 158 n.3 (1991) (“Quality assurance analyzes patient care problems in the context of what \textit{should} occur in the hospital. Risk Management analyzes patient care problems in the context of what \textit{should not} occur in the hospital.”); see also Bailey, \textit{supra} note 38, at 11 (addressing risk management programs for physicians).
tion, hospitals have sought to offset the burden of increased costs by reducing their labor costs, especially in the area of nursing, by assigning higher patient-to-nurse ratios based on the patient classification systems which dictate staffing patterns. It has been noted that "[a]lready, a number of hospital organizations have begun to decrease their nursing complement, asking those remaining nurses to cover a wider variety of service areas." Moreover, as the economic pressures of DRGs continue to mount, hospitals increasingly substitute less trained personnel for registered nurses despite growing concerns about lower quality care. A decrease is also expected in the number of allied health care workers as well as a gradual reduction in the number of staff physicians. Standing in opposition to this reduction is the interesting prediction that the number of management, administrative, and consultant personnel will increase under the DRG program.

D. Alternative Health Care Delivery Systems

Responses to the economic crisis in health care have spawned a variety of alternative delivery systems based on cost containment through utilization control. Alternative delivery systems include HMOs, Independent Practice Associations (IPAs), and Preferred Provider Organizations (PPOs). Providers—including physicians, nurses, and other medical personnel—are employed by or contract with these health care entities to provide a full range of health care services to member patients for prepaid or fixed enrollment fees. Alternative delivery systems employ strict protocols and pro-

59. See Eric D. Joseph et al., A DRG and Prospective Pricing Action Plan for Nursing 66 (1983) (describing the nature of patient classification systems used to forecast staffing patterns); James T. Ziegenfuss, Jr., DRGs and Hospital Impact 156-57 (1985) ("Nursing reductions will be used to hold down and fight the cost pressures that have now been faced by almost all hospitals. This is not a future possibility, but a strategy already underway . . . .").

60. Ziegenfuss, supra note 59, at 156. Ziegenfuss notes the development of a major problem, however: "As length of stay is shortened, intensity of care will increase, requiring at least the same, and perhaps greater, nursing support." Id. at 157. (The liability implications of hospital staff reductions based on financial incentives are outside the scope of this Comment.)

61. Id. at 156.
62. Id. at 156-57.
63. Id. at 157.

64. See Morreim, supra note 1, at 1721; Hall, supra note 22, at 435-38; Giordani, supra note 7, at 1012-13.


66. Kanute, supra note 65, at 841. "Alternative health care delivery system" is a phrase used to describe a provider system that differs from the traditional medical "fee-for-service" system. Alternative delivery systems utilize fixed prepaid fees for the delivery of all necessary health care, as opposed to the typical fee-for-service system in which patients pay separate fees
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perspective review for non-emergency hospitalizations and medical/surgical treatments to maximize the efficient use of resources. The distinction between these models is the relationship of the organization to its affiliated physicians.

The HMO can be subdivided into two categories: the staff-type and the group-type. The staff-type HMO employs individual physicians as staff members who provide services in HMO-owned facilities. In contrast, the group-type HMO contracts with a physician-group to provide services to HMO patients, frequently but not always in HMO facilities. The second model of alternative delivery system, the IPA, is actually a third type of HMO. Under this model, the HMO contracts with an IPA, which in turn contracts with individual physicians to provide medical services in individual office facilities to the affiliated HMO patients. HMOs and IPAs encourage an economic utilization of health care dollars from the employer's perspective by providing services for a fixed fee based on enrollment, and from the HMO or IPA perspective by providing financial incentives to staff and participating physicians to contain costs.

The third model of alternative delivery system, the PPO, consists of insurers, hospitals, or physician-groups who contract with employers to provide discounted services to enrolled members. The members are encouraged to utilize the preferred provider network by a system of reimbursement that pays a higher percentage of the fees charged by listed providers than charged to independent providers for each service rendered. Id. at 841 n.1. Services typically covered in an HMO (or alternative delivery system) agreement are those that provide general, emergency, and preventive care—including inpatient and outpatient hospital and physician services. Id. at 842 n.5.

For a discussion of clinical practice protocols and UR protocols, see infra notes 92-95 and accompanying text. The prospective payment concept of DRGs, HMOs and other alternative delivery systems has revolutionized the delivery of health care. Hall, supra note 22, at 437-38. Almost 60% of privately insured Americans participate in some form of prospective review plan. Id. at 437 n.18.

Kanute, supra note 65, at 842.

Id. at 842-43.

Id.

Id. at 843. The use of physician-owned facilities may come about when a medical group, already practicing in its own facilities, decides to affiliate with an HMO. Id. at 843 n.15.

Id. at 843.

Id. at 843-44.

See id. at 841-42. Alternative delivery systems seek primarily to attract employers faced with escalating costs of third party insurance plans who are therefore willing to switch to an alternative system to decrease the cost of employee health care benefits. See Giordani, supra note 7, at 1012.

Giordani, supra note 7, at 1013-14.

Id. at 1013.
by non-listed providers. Since employers ultimately absorb all reimbursed employee health care expenses, whether through the experience-ratings process of a fully insured plan or through a self-insured plan, they benefit from the discounted rates if the rates reduce overall costs, depending on the structure of the PPO option. The incentive for providers to participate is to maintain their share of patients in an increasingly competitive market.

III. Utilization Review—Mechanism for Cost Containment

The primary efforts to hold down health care costs are aimed at controlling the use of services. The goal of UR is to control the amount of health care delivered and ultimately the cost of care by establishing guidelines and procedures to eliminate unnecessary and inappropriate treatment. This is a form of health care rationing that limits reimbursable care to that determined medically necessary according to protocols. UR is undertaken by hospitals, insurance companies, government providers, and HMOs as a means of cost containment. Moreover, utilization concepts were the basis for the development of HMO-type provider systems—illustrated by the fact that the HMO structure is based on maximizing the efficient use of health care dollars by providing substantial incentives to physicians to curb the use of unnecessary services.

UR is tied to quality control through a balancing process which strives to control overutilization and simultaneously ensure the delivery of quality care. 

77. See Macaulay, supra note 8, at 99.
78. Under the experience ratings process, the employer receives a credit or dividend for the amount of premium paid over that paid out for claims and expenses and a debit for any amount by which claims and expenses exceed the premium. This debit or deficit is reflected in higher premiums at renewal; even if the policy is not renewed, the employer may be liable for the deficit by agreement. Id. at 93.
79. For example, a PPO plan might offer an employee the option of care from a listed provider (who discounts the cost to the PPO) at 100% reimbursement or care from a non-listed provider (who charges full cost to the PPO) at 80% reimbursement. Id. at 99. Thus, depending on the discount and reimbursement percentages, an employer may realize a cost savings from the PPO plan. Contra Giordani, supra note 7, at 1013 n.64 (citing a PPO study which concluded costs had increased under a PPO option).
80. Macaulay, supra note 8, at 99.
83. For a discussion of clinical practice protocols and UR protocols, see infra notes 92-95 and accompanying text.
84. See Blum, supra note 29, at 192-94.
85. Saue, supra note 27, at 239 ("Such methods as preadmission certification, concurrent review, and second surgical opinion programs were initially promoted by... (HMOs) and... (PPOs) whose financial health depended on successful utilization management.").
86. Morreim, supra note 16, at 21; Giordani, supra note 7, at 1013.
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...care. UR increases the potential for malpractice liability if efforts to decrease utilization and contain costs conflict with the ability to provide adequate health care according to established medical standards. Therefore, from the liability standpoint, UR programs are implicated when care-providers, in an attempt to stay within coverage guidelines, fail to provide proper care and negligently cause injury to their patients. At issue is whether the provider (hospital or physician) or the third party payer (insurer, government, or HMO/alternative delivery system—both provider and payer) is liable when the quality of care falls below an adequate standard due to utilization control and cost containment efforts.

Two types of protocols are used as a basis for cost effective payment decisions. First, clinical practice protocols, generally set by physicians as a guideline to patient care management, define a recommended standard of care specific to a disease or procedure. Second, UR protocols combine quality control with cost containment strategy to establish guidelines for appropriate care while preventing overutilization. UR is achieved from either one of two perspectives: retrospective review, wherein health care...
costs are reimbursed on a reasonable basis criterion after treatment is rendered; and prospective review, wherein health care costs are reimbursed only for pre-approved treatment. The latter form of review, far more effective as a cost containment measure, is more likely to impact the quality of care and raise potential liability issues.

A. DRGs—Prospective Payment System of Cost Containment

Although cost efficiency is the primary objective of the DRG system, many believe it lowers the quality of health care by promoting rationing. The prospective nature of DRG payments imposes incentives for providers to undertreat patients, thereby cutting losses where reimbursement fails to meet the cost of care and increasing profits where reimbursement exceeds the cost of care. This creates the potential for malpractice claims based on inadequate diagnostic or therapeutic measures or on injury due to premature discharge.

Professional Standards Review Organizations (PSROs) were created by Congress in the early 1970s, primarily as UR organizations, to control run-
away costs of the Medicare program. The PSRO program failed to meet expectations and was replaced in 1982, a year prior to the implementation of DRGs, by the Medicare Utilization and Quality Control Peer Review Organization (PRO) Program. Since the implementation of DRGs, the focus of UR has shifted from the control of overutilization to overall monitoring of cost and quality, including the monitoring of attempts by hospitals to undertreat or prematurely discharge Medicare patients or to assign improper DRGs.

PROs were originally designed to be physician-sponsored organizations through which the work of private doctors was to be reviewed by their peers. However, where physician-sponsored contractors prove ineffective, various for-profit entities may serve as PROs, including insurance companies and Medicare fiscal intermediaries. PROs are not limited to performing Medicare review and have been encouraged by law to conduct review for other public and private entities. Although PROs have traditionally focused their review on inpatient care, many have begun to review the care provided by HMOs and other competitive medical plans involving Medicare risk-sharing contracts. Hospitals, insurers, and other health-related entities rely on internal UR mechanisms (which may be carried out by independent reviewers or by in-house reviewers) for cost and quality control, although internal mechanisms, as well as government PROs, have built-in incentives to limit patient care.

Although individual reviewers of a PRO are granted immunity from civil liability, they are only granted such immunity when acting with due care. However, as one commentator has noted, "Based on provisions in the PRO statute, . . . it appears that a successful challenge for negligence may be quite difficult outside of the administrative structure." A successful challenge would require extremely offensive conduct by the PRO reviewer and would

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102. *Id.* at 3.
103. *Id.* at 5.
104. *Id.* at 3.
105. *Id.* at 6-7.
106. See Kapp, *supra* note 82, at 248.
108. *Id.* at 196.
probably be handled through the administrative process.\(^{109}\) Physicians and providers who act in reliance on the PRO review or in compliance with the medical norms outlined by the review are likewise immune from civil suit, provided they exercise due care in treatment.\(^{110}\) However, until 1990 PROs were not granted immunity as corporate entities and could conceivably be sued under several theories of liability, including vicarious liability for the negligent conduct of employees, corporate negligence for errors in organization or administration, or as a third party in a suit against a fiscal intermediary whose negligent acts were related to the PRO review.\(^{111}\)

States generally do not provide for review entities such as the federally mandated PROs to review services under state Medicaid programs, but instead provide that reviews be conducted under the auspices of various state agencies.\(^{112}\) In these circumstances, tort liability for Medicaid reviewers at the state level may be challenged according to state agency law, under which the agency may be granted immunity from suit, or may be challenged according to PRO procedures if the review was conducted under a PRO contractual agreement.\(^{113}\)

B. HMOs—Health Care Delivery Based on Utilization Control

HMOs and related alternative delivery systems (hereinafter collectively referred to as HMOs) were established in response to the need to control escalating health care costs.\(^{114}\) Federal legislation\(^{115}\) and state enabling statutes authorize and regulate their operation.\(^{116}\) While hospital liability for negligence is fairly well established, HMO liability is unclear.\(^{117}\) Some states’ laws shield HMOs against malpractice liability for the actions of any

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109. Id.
110. Id. (citing 42 U.S.C. § 1320c-6(c) (1982)). But see Morreim, supra note 1, at 1752. Referring to liability of the treating physician, Morreim states, "PRO regulations require that physicians continue to exercise 'due care.' Without such a requirement, patients would have virtually no civil protection against medical incompetence or carelessness, since physicians and review organizations would be free to endorse virtually any standard of care they wished." Id. (citing 42 U.S.C. § 1320c-6(c)(2) (1982)). Morreim believes that adding the due care requirement "essentially reinstates the common law standards of liability, because the physician who adheres to the relevant formalized norm could still be found liable if the patient needed more elaborate care." Id. at 1752.
111. See Blum, supra note 29, at 196-97.
112. Id. at 197.
113. Id.
114. Giordani, supra note 7, at 1012.
117. Id. at 841. See generally Linda F. Rice, HMOs: Emerging Areas of Liability, 11 Whittier L. Rev. 33 (1989) (discussing the relaxation of judicial and legislative doctrine which previously protected HMOs from malpractice liability).
individual or entity rendering services to members under the auspices of the HMO.118 Other states have permitted the injured party to sue the HMO, as well as the physician, under various theories advanced to hold the HMO liable for the negligence of its affiliated physicians.119 These theories include those traditionally applied to hospitals: respondeat superior, ostensible agency, corporate negligence, and breach of contract.120 In addition, HMOs face increasing liability under the theory of negligent selection or supervision of a physician or physician-group.121 However, because HMOs “arguably


119. Cases Indicating HMO May Be Liable for Doc’s Malpractice Are Starting to Stack up, MANAGED CARE OUTLOOK, Oct. 1990, at 2, 2 (citing Dan Mulholland, Address at Managed Care Law: New Risks, New Solutions, Group Health Association of America meeting) [hereinafter HMO Cases]; see also Kanute, supra note 65, at 863-73.

120. Kanute, supra note 65, at 841; HMO Cases, supra note 119, at 2-3; see, e.g., Schleier v. Kaiser Found. Health Plan, 876 F.2d 174, 177-78 (D.C. Cir. 1989) (invoking the doctrines of ostensible or apparent agency and respondeat superior to hold an HMO liable for breach of contractual duty to provide adequate medical care when an independent consulting physician hired by the HMO was negligent); Sloan v. Metro Health Council, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987) (holding that failure to incorporate under the state’s Professional Corporation Act—which did not shield medical corporations from the liability of their physician-employees—would not protect an HMO from a vicarious liability suit under the doctrine of respondeat superior for an alleged failure to diagnose); Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1235 (Pa. Super. Ct. 1988) (applying the doctrine of ostensible agency to an arrangement in which a patient selected his physician from an HMO provided list, therefore looking to the HMO as an institution for medical care, rather than the physician); Depenbrok v. Kaiser Found. Health Plan, 144 Cal. Rptr. 724, 726 (Ct. App. 1978) (recognizing a breach of warranty cause of action against an HMO when a physician promised a particular result); Stelmach v. Physicians Multispecialty Group, No. 53906, 1989 Mo. App. LEXIS 852, at *26-27 (Mo. Ct. App. June 13, 1989) (holding that a physician group did not avoid liability for breach of a medical services contract to provide quality services when it hired an independent contracting physician). But see Williams v. Good Health Plus, Inc., 743 S.W.2d 373, 377-79 (Tex. Ct. App. 1987) (holding that an HMO was not liable for malpractice because it did not practice medicine and its associated physicians were independent contractors; further holding that the plaintiff-patient could not invoke the doctrine of ostensible agency because that theory had not been pleaded at trial level); Mitts v. H.I.P. of Greater New York, 478 N.Y.S.2d 910, 911 (App. Div. 1984) (holding that a health insurance plan was not liable for the medical negligence of its independent contractor physicians); Propst v. Health Maintenance Plan, 582 N.E.2d 1142, 1143 (Ohio. Ct. App. 1990) (holding that an HMO corporation was not in the practice of medicine and was not liable for the medical malpractice of its physicians).

121. Rice, supra note 117, at 34. More creative approaches include allegations of violations under the Racketeer Influenced and Corrupt Organizations (RICO) Act, codified at 18 U.S.C.A. §§ 1961-68 (West 1984 & Supp. 1991), which generally involve fraud and focus on the promotional aspects of HMO facilities. Id. at 35. These allegations raise issues of whether HMOs are obligated to disclose information regarding financial ties with their affiliated physi-
achieve savings by encouraging [the] underuse of services," a more interesting and alarming prospect is the potential for liability based on the inherent cost containment structure of the HMO system.

By providing treatment as well as performing the insurance functions involved in the delivery of health care, "HMOs internalize in the provider the costs of medical care." Because of this dual structure, the key concept behind the organization of HMOs is the control of utilization. If utilization increases, fixed enrollment fees provide less profit; if utilization decreases, fixed enrollment fees provide greater profit. The primary HMO strategy to reduce the number and cost of hospital days—which consume the largest portion of health care dollars—is to require pre-admission and concurrent review for full reimbursement of non-emergency hospital expenses. These procedures provide a strong basis for structural liability when patients who receive an adverse prospective payment decision subse-

122. Giordani, supra note 7, at 1013.
123. Rice, supra note 117 at 34 ("There is now case law which suggests that where cost containment features interfere with the quality of the medical care rendered, a patient may have recourse against the HMO, despite the fact that it has complied with the quality assurance and other regulatory provisions.").

An example of cost containment efforts likely to raise liability issues is the attempt by HMOs to control the costs of emergency room care. M. Carroll Thomas, Did HMO Cost Controls Kill This Baby?, MED. ECON., June 8, 1987, at 54. Because HMOs provide care on a capitated or fixed enrollment fee basis, they tend to have stringent controls on coverage for care provided outside the HMO, particularly in situations where patients seek routine care in hospital emergency rooms. If the HMO has a "gatekeeper" physician on call to direct patient care, that physician, who is under pressure to control costs, has the responsibility to assess patient status and confirm or deny coverage for services outside the HMO. A misdiagnosis may lead to injury and liability when care is denied Medicaid-HMO patients, who by definition do not have independent funds to obtain medical treatment. See id. at 54-58 (discussing the potential liability related to HMO cost control policies in a tragic situation in which a five-month-old child died at home within hours of an HMO-physician's alleged refusal to confirm policy coverage which would have allowed the child to be seen at its affiliated hospital emergency room).

125. See Giordani, supra note 7, at 1012-14.
126. Id. at 1013 n.55. HMOs are paid on a capitation basis in which "the enrollee's use of the services provided has no influence whatever on the fixed sum paid." Id. The author notes that "if the enrollee requires care costing more than the premium paid covers, the HMO loses money. Conversely, if the enrollee requires less service than the premiums cover, the HMO makes a profit." Id. (citing Perkins, The Effects of Health Care Cost Containment on the Poor: An Overview, 19 CLEARINGHOUSE REV. 831, 843 (1985); Futtow, Medical Malpractice and Cost Containment: Tightening the Screws, 36 CASE W. RES. 985, 986 (1986)).
127. Macaulay, supra note 8, at 100.
quently allege that they did not receive proper medical care.\textsuperscript{128}

The practice of providing financial incentives to member or contracting physicians to decrease patient use of services is another cost control strategy that increases the potential for HMO structural liability.\textsuperscript{129} As one commentator has stated, "These incentives are far more powerful than mere incremental income for performing extra services, well-known under fee-for-service. Now, an HMO physician may see wide fluctuations in his income as a direct result of his medical decisions."\textsuperscript{130} For example, physicians may receive large bonuses for reducing hospital stays or performing outpatient surgery instead of inpatient surgery; on the other hand, they may face a loss of employment or hospital privileges if uncompensated patient expenses are too high.\textsuperscript{131} Such a system makes it possible for physicians to find themselves weighing their own interests against those of their patients.\textsuperscript{132} It has been suggested, therefore, that these arrangements may violate public policy by disrupting the patient-doctor relationship.\textsuperscript{133} According to one commentator, "If the physician's primary interest is no longer the patient, but is divided between the patient and the HMO, there is a tension between the three parties."\textsuperscript{134} If this tension results in patient injury, the likely forum for the resolution of the conflict is the courtroom.\textsuperscript{135}

IV. LIABILITY IMPLICATIONS OF UTILIZATION MANAGEMENT AND REVIEW

A. Judicial Theories of Liability

\textit{Wickline v. California,}\textsuperscript{136} a 1986 California case, was the first appellate decision on the issue of tort liability of a third party payer whose prospective review decision denying continuation of hospital coverage allegedly interfered with medical judgment and negligently caused harm to the patient.\textsuperscript{137} The third party payer was the State of California through its state Medicaid

\begin{itemize}
\item \textsuperscript{128} Id.
\item \textsuperscript{129} See Saue, supra note 27, at 243. See generally Morreim, supra note 16 (discussing the implications of cost containment strategies on physicians' decisions regarding patient care).
\item \textsuperscript{130} Morreim, supra note 16, at 21.
\item \textsuperscript{131} Id.; see also Giordani, supra note 7, at 1013 (discussing examples of financial incentives which may include bonuses paid to physicians from unspent premium dollars that had been allocated for specialist-consultant or inpatient hospital fees).
\item \textsuperscript{132} Morreim, supra note 16, at 21.
\item \textsuperscript{133} Rice, supra note 117, at 35.
\item \textsuperscript{134} Id. at 35-36.
\item \textsuperscript{135} Id. at 36.
\item \textsuperscript{136} Wickline v. California, 228 Cal. Rptr. 661, reprinted at 239 Cal. Rptr. 810 (Ct. App. 1986), \textit{review dismissed}, 741 P.2d 613 (Cal. 1987).
\item \textsuperscript{137} Macaulay, supra note 8, at 100; accord Wickline, 239 Cal. Rptr. at 811.
\end{itemize}
program known as "Medi-Cal." At issue was whether Medi-Cal, as a health care payer, could be brought within the medical malpractice chain of causation. In this landmark case, the California Court of Appeal, Second District, recognized both the public interest in cost containment and the high stakes in prospective UR, in which an erroneous decision withholding care may lead to disability or death. After balancing broad standards, the court refused to hold Medi-Cal liable for patient injury under California's codified negligence liability rules. In dicta, however, the Wickline court did not foreclose the possibility of third party payer liability when a "defect" in the cost containment mechanism might be the cause of harm.

The facts of the Wickline case are straightforward. Lois Wickline, a Medi-Cal patient, underwent peripheral vascular surgery for an obstruction of the terminal aorta, a condition known as Leriche's Syndrome. She received pre-approval authorization from Medi-Cal for the surgery and a ten-day hospitalization. When post-operative complications required two more surgeries, Wickline's surgeon requested authorization from Medi-Cal for an additional eight days of hospitalization which he deemed "medically necessary." The Medi-Cal reviewer only authorized a four-day extension. Although all three of Wickline's attending physicians knew they could request a further extension from Medi-Cal by telephone, no such request was made. Wickline was released on the fourth additional day. Her condition worsened following discharge and, by the time of re-admittance, required amputation of her leg. Wickline's surgeon testified that, in

138. Wickline, 239 Cal. Rptr. at 811.
139. Id. at 811-12.
140. Id. at 818. In examining the state negligence liability standard, the Wickline court reviewed Rowland v. Christian, 443 P.2d 561 (Cal. 1968). In Rowland, the Supreme Court of California, citing section 1714 of the California Civil Code, set forth the applicable negligence liability rule: all persons must use ordinary care to prevent injury to others as a result of their conduct; and, in the absence of any statutory exception to that fundamental principle, no exception should be made unless clearly supported by public policy. Wickline, 239 Cal. Rptr. at 818 (citing Rowland, 443 P.2d at 563-64). In balancing whether a departure from the fundamental principle was warranted, the Wickline court considered a number of broad criteria, including: foreseeability of harm to the patient, certainty of injury, connection between the defendant's conduct and the injury, moral blame for the defendant's conduct, extent of the defendant's burden, policy of preventing future harm, and community consequences of imposing a duty of care with resultant liability for breach. Id. (citing Rowland, 443 P.2d at 564).
141. Wickline, 239 Cal. Rptr. at 819.
142. Id. at 812.
143. Id.
144. Id. at 812-13.
145. Id. at 814.
146. Id. at 815.
147. Id.
148. Id. at 816.
Liability Implications of Review

his opinion, the requested eight-day extension would have saved her leg, but that she was not in critical or deteriorating condition when she was initially released from the hospital. In fact, all medical testimony indicated Wickline's discharge fell within medical standards.

In essence, the Wickline court found that the state's review of the request for an extended hospitalization had been performed according to Medi-Cal's statutory guidelines which include provisions for prospective review of non-emergency hospitalizations. The court indicated Medi-Cal was not a party to the actual discharge decision which, even if negligently made, was ultimately the responsibility of Wickline's physician.

In deciding Wickline, the court recognized the public interest in cost containment and ultimately found Medi-Cal non-liable as a third party payer. The opinion nonetheless stirred controversy throughout the health care community by forecasting potential liability for parties involved in cost control programs. The court warned that if a party who has a duty to provide patient care fails to provide that care, the injured patient should recover from all responsible parties, even from third party payers if appropriate. The court indicated that payers could be held legally accountable when an inappropriate medical decision results 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." However, in absolving Medi-Cal from liability, the court stated that Wickline's physician should have appealed Medi-Cal's decision to limit the hospitalization if in his judgment the authorization was not appropriate under the circumstances. According to the court's decision, "the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise," is ultimately responsible for the care of his patient. The court indicated that a physician "cannot point to the health care payor as the liability scapegoat when the consequences of his

149. Id. at 815, 817.
150. Id. at 816.
151. Id. at 820 (citing CAL. WELF. & INST. CODE §§ 14132-33 and CAL. ADMIN. CODE tit. 22, § 51327(a)(2)). Coverage authorization is based on a determination of "medical necessity" according to community medical practice standards. Id. at 818-20.
152. Id. at 819-20.
153. Id. at 820.
154. Id. at 819; see also, Saue, supra note 27, at 241; Marcotte, supra note 17.
155. Wickline, 239 Cal. Rptr. at 819.
156. Id.
157. Id.
158. Id.
own determinative medical decisions go sour." Because Wickline's physician had not appealed Medi-Cal's determination, the court ruled that Medi-Cal had not made a decision to override the medical judgment of the attending physician; therefore, the state was not liable.

The Wickline court concluded with a comment on the effect of cost containment programs on professional medical judgment: "While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgement." Thus, while supporting Medi-Cal's UR decision in Wickline's case, the opinion revealed judicial hostility to arguments that cost constraints should preclude physician or payer liability for erroneous UR decisions—leaving open questions regarding the parameters under which liability might be found.

Four years later, in Wilson v. Blue Cross, the same court that authored Wickline addressed the confusion created by that controversial opinion. In Wilson, the California Court of Appeal, Second District, identified a large portion of its Wickline decision as dicta and limited application of the Wickline holding to its facts, in particular to the context of Medi-Cal patients. Consequently, the Wilson court set forth a broader basis of liability for UR in the private sector by finding a patient's private insurance company, its UR contractor, and the individual reviewing physician all potentially liable for allegedly causing injury to the patient by negligently refusing to confirm coverage for an extended hospital stay.

The Wilson case was filed on behalf of the estate of a patient who committed suicide after learning that his private insurer, through its utilization reviewer, had denied authorization for continued hospitalization prescribed by his physician for severe depression. The company based its denial on a lack of medical necessity. The patient, unable to pay for additional treatment on his own, had reportedly made progress until he was prematurely discharged due to the denial of benefits. The alleged negligence occurred

159. Id.
160. Id. at 819-20.
161. Id. at 820.
162. Marcotte, supra note 17 (quoting Barry Furrow, Address at the A.B.A. Medical Malpractice National Institute, Reno, Nev. (Mar. 1988)).
164. Id. at 878.
165. Id. at 882-85.
166. Id. at 877-78.
167. Id. at 882.
168. Id.
when the California reviewer applied concurrent UR, but was unaware that
the patient's Blue Cross plan was based outside of California and did not
provide for such a review process. The court held that the plaintiffs had
established a prima facie case for tortious breach of contract.

In deciding Wilson, the court carefully re-examined Wickline and repudi-
ated a large portion of that holding. The court distinguished three key
elements of the Wickline decision. First, the UR discharge decision in Wick-
line was within the medical standard of care—in essence Medi-Cal's stan-
dard was that of the community. Second, the funding process in Wickline
was pursuant to statutory regulations rather than a private insurance con-
tract, thus altering the normal criteria for tort liability. The Wilson court
identified this rationale, along with the fact that the discharge decision fell
within the standard of care, as the legitimate basis for the Wickline deci-
sion. Finally, the Wickline case was not one in which a cost limitation
program, the UR decision, was allowed to corrupt the judgment of a pa-
tient's private physician. Finding none of the Wickline criteria applicable
to the Wilson case, the court refused to uphold summary judgment motions
by the defendants.

In Wilson, the court identified as dicta the Wickline language which at-
tributes to the physician both the ultimate responsibility for protesting a UR
decision he believes erroneous and the sole liability for the actual dis-
charge. The Wilson court refused to invoke these theories to protect the
insurer, the UR contractor, or the UR physician from potential liability for
two reasons: first, they were premised on dicta; and second, they miscon-
strued the test for joint tort liability. However, the court adhered to some
controversial portions of Wickline by relating UR decisions to the general
rule of civil tort liability. Under the general rule, an injured person is enti-
tled to recover from all parties who are legally responsible for causing in-
jury. The Wilson court repudiated any public policy defense that favors

169. Id. at 881, 883.
170. Id. at 885.
171. Id. at 878-80. The court stated, "We realize that the trial court's decision . . . was
heavily influenced by portions of the Wickline decision which quite frankly contained over-
broad language and constituted dicta. However, it would be inappropriate for this court to
allow errors in one of its own prior decisions to remain uncorrected in this case." Id. at 885.
172. Id. at 879.
173. Id.
174. Id. at 880.
175. Id. at 879.
176. Id.
177. Id. at 880, 884.
178. Id. at 883.
179. Id. at 884. The court indicated that any one of the parties causing injury could be
the use of concurrent UR as a process which alters the normal rules of tort liability, especially in the context of a private insurance policy.\[180\]

Wickline was the first reported examination of the clash between a treating physician's medical judgment and the requirements of a third party program, but not the first to address the potential structural liability of cost containment programs.\[181\] In Pulvers v. Kaiser Foundation Health Plan,\[182\] a 1979 California appeals court rejected allegations of fraud against an HMO accused of deceiving a member into believing he would receive the highest quality care and treatment, when in fact, HMO program incentives encouraged the treating physicians to conserve care.\[183\] The court noted that the use of this type of incentive plan to conserve costs was recommended by professional organizations as well as the federal government; furthermore, there was no conclusive evidence of treatment outside the accepted standard of care.\[184\]

More recently, however, other courts have espoused a stricter view on the liability of cost containment programs. For example, in Bush v. Dake,\[185\] a 1989 Michigan county circuit court dismissed a structural liability claim against an HMO based on its statutorily authorized utilization control process, but refused to dismiss a claim alleging that the use of the control system had denied the patient access to adequate care and was a negligent cause of injury.\[186\] Refusing to second guess legislative policy, the court emphasized that state legislators had approved the existence of HMOs, as well as their use of provider incentives, risk sharing, and UR as mechanisms for cost

held jointly liable if his negligent conduct was a legal cause of harm, that is, if his conduct was a substantial factor in causing the injury and there was no law relieving him of liability. \textit{Id.} at 883 (citing \textit{Restatement (Second) of Torts} § 431).

\[180\] \textit{Id.} at 884.

\[181\] Saue, \textit{supra} note 27, at 241-42.


\[183\] \textit{Id.} at 393-94. The Pulvers family sued an HMO for malpractice in wrongfully delaying chemotherapy for Mr. Pulver's leukemia, allegedly shortening his life. \textit{Id.} at 393, 395.

\[184\] \textit{Id.} at 393-94.

\[185\] Bush v. Dake, No. 86-25767 NM-2, slip op. (Cir. Ct. for Saginaw County, Mich. Apr. 27, 1989). In \textit{Bush}, the plaintiff was insured under an HMO plan through her husband's employer. \textit{Id.} at 1. Under that plan, the HMO contracted with a physician-group to provide primary patient care on a monthly capitation fee basis. \textit{Id.} at 2. A monetary pool was maintained out of which the physicians would receive extra profits if the fund was not expended on referral fees. \textit{Id.} When the plaintiff complained of vaginal bleeding, the physicians allegedly delayed referral and the ultimate diagnosis of cervical cancer. \textit{Id.} They failed to perform pap smears which would have revealed the condition at an earlier stage. \textit{Id.} at 3. Under the HMO regulations, only the primary physician, who was not entitled to additional pay above the capitation fee, could perform pap smears. \textit{Id.} The plaintiff argued that the HMO should be found structurally liable on public policy grounds for providing disincentives to treat, as well as negligent and fraudulent for using the system in her case. \textit{Id.} at 1.

\[186\] \textit{Id.} at 3-4.
However, the court refused to dismiss the issue of whether the operation of the HMO system in Bush had "in and of itself proximately contributed to the malpractice, . . . [or to] . . . the improper treatment and delay in diagnosis of [the plaintiff-patient's] cancerous condition."\textsuperscript{188}

\section*{B. Cost Control Defense}

In response to current economic constraints, some medical-legal commentators have proposed a cost control defense to charges of medical negligence.\textsuperscript{189} Soon after the implementation of DRGs, one commentator stated that "in the wake of the DRG system and related developments, . . . the medical profession will [quite likely] accommodate the profession-dominated standards of malpractice laws to the economizing values of rationing decisions, by implicitly altering substantive norms of medical conduct."\textsuperscript{190}

Under the current legal system, the medical profession determines the standard of care for medical negligence.\textsuperscript{191} As long as a physician's actions, or those of other health care providers, fall within the parameters of acceptable quality, liability will not be imposed.\textsuperscript{192} However, if a provider is sued for medical malpractice, defenses can take one of two forms: an ordinary defense, wherein a defendant denies the validity of the charge that care deviated from an acceptable standard; or an affirmative defense, wherein—in the cost control context—a defendant alleges cost considerations as a justification for providing care outside the parameters of the current standard of care.\textsuperscript{193} An explicit affirmative defense based upon cost control objectives would likely fail today in spite of the economic condition of the health care environment.\textsuperscript{194} It has been stated that because current professional norms do not openly embrace health care rationing, "the physician who independently rations care for particular patients and then expressly cites the necessity to ration as an excuse for treating the patient in a less than preferable manner is taking a course that is fraught with legal jeopardy."\textsuperscript{195} However,

\begin{thebibliography}{195}
\bibitem{187} Id. at 3.
\bibitem{188} Id. at 4.
\bibitem{189} \textit{E.g.,} Kapp, \textit{supra} note 82, at 249-51. \textit{See generally} Giordani, \textit{supra} note 7, at 1022-32.
\bibitem{190} Kapp, \textit{supra} note 82, at 250.
\bibitem{191} Id. at 249.
\bibitem{192} Id.
\bibitem{193} Id.
\bibitem{194} Id.
\bibitem{195} Id. at 250. Some commentators predict that health care in the United States, necessitated by the economic and legal impact of DRGs, will follow the pattern of implicit rationing that has become part of the British system of socialized medicine. \textit{Id.} Under the British system, the standards of care are more reflective of economic realities and the scarcity of resources. \textit{Id.} The British have lowered the standards of medical practice to account for age,
as health care standards evolve toward an accommodation of the economic values inherent in rationing decisions, the nature of an affirmative cost control defense would change to an ordinary defense because there would be no deviation from the accepted standard of care.196

Although cost containment mechanisms have found support in some case law, the trend in malpractice actions has been to strengthen liability principles against parties who erroneously base medical decisions on economic criteria. In this vein, the California Court of Appeal, First District, has indicated that although the California Department of Health Services has a valid interest in guarding public funds against unnecessary medical expenditures, “cost-consciousness must not take precedent over the legitimate medical needs of . . . [a Medicaid] recipient for continued services.”197

On the other hand, the financial condition of the health care system demands that due consideration be given to reasonable and legitimate cost control efforts when assigning liability. Proponents continue to argue persuasively for a cost-based defense, stating that in order “[t]o facilitate the

Evidence indicates that forms of rationing already exist in the United States, despite moral or legal reluctance to the concept. See, e.g., Schwartz, supra note 18 (discussing two forms of rationing, including the overt denial of care and the less visible form of silent rationing which involves trade-offs of quality for cost, for example, through slowdowns in research and development or denials of care as “experimental”); Victor Cohn, Rationing Medical Care: It's Here and This Is Just the Beginning, WASH. POST, July 31, 1990, Health Magazine, at 10, 10-11 (describing silent rationing as a mechanism by which the indigent are subjected to a decrease in covered services and supplies and long delays in treatment); see also supra note 23 (discussing forms of health care rationing).

The Oregon state legislature recently enacted an aggressive rationing program which seeks, through a ranked list of medical priorities, to provide a higher level of basic care to a greater number of Medicaid recipients at the cost of eliminating more advanced and expensive treatments that are ranked lower in priority. Cohn, supra, at 10-13; Flanigan, supra note 2; Not Enough for All: Oregon Experiments with Rationing Health Care, NEWSWEEK, May 14, 1990, at 53, 55. Implementation of the Oregon plan awaits federal approval. Alan K. Ota & Roberta Ulrich, Economy Ranks As Foremost Issue That Congress Faces, OREGONIAN, January 19, 1992, at C10. Meanwhile, in spite of criticism that the program favors the rich by creating a two-tier health care system, several other states have expressed interest in the plan and a few have drafted similar legislation. Oregon: A Trade-Off on Health Costs, U.S. NEWS & WORLD REP., July 8, 1991, at 6.

196. Kapp, supra note 82, at 250.
197. Frank v. Kizer, 261 Cal. Rptr. 882, 887 (Ct. App. 1989). In Frank, the court mandated that Medi-Cal adhere to the federally regulated notice guidelines to terminate or suspend benefits. In addressing Medi-Cal’s cost control arguments against full compliance, the court cited Wickline v. California, 228 Cal. Rptr. 661, 663, reprinted at 239 Cal. Rptr. 810, 812 (Ct. App. 1986), review dismissed, 741 P.2d 613 (Cal. 1987), stating that “[a]lthough the reviewing court exonerated the Department, . . . [Wickline] presents a graphic example of harm to the recipient when the fiscal ‘bottom-line’ takes precedence over the medical needs of the recipient.” Id.
adoption of more cost-effective norms of medical practice, the courts, in defining the standard of due care, must recognize cost as a valid defense against malpractice actions...”

V. CONCLUSION

The economic nature of the health care system has created tension between providers who seek to deliver the highest quality care, avoid liability, and enhance their financial profits, and purchaser-payers of health care who seek the provision of quality care with a controlled escalation of costs. Theoretically, the system demands an ongoing balance in the use of health care services. If overutilization occurs, providers either do not get reimbursed or, if they do, overall medical costs rise unnecessarily. If underutilization occurs, individuals may be deprived of needed services and the responsible health care providers, primarily physicians and hospitals, are potentially liable for malpractice. Attaining a balance in health care utilization presents a formidable goal. Medical decision-making, historically dependent on scientific and human variables, is now influenced by economic variables as well.

In the past, health care reimbursements flowed freely. Many providers overprescribed treatments to ensure their patients every advantage, decrease the likelihood of malpractice suits, and simply because the funds were available. However, because of the financial crisis in the health care system, various cost containment programs, including UR, now place pressure on providers to make more conservative decisions which may be implicated as a cause of patient injury.

Although the courts have limited experience with UR and related prospective payment systems, cases to date may predict future liability parameters as prospective UR becomes more entrenched and more of these cases are litigated. The Wilson and Bush decisions exemplify the courts' willingness to hold HMOs, third party payers, and utilization reviewers potentially liable if harm is negligently inflicted as a result of cost containment measures or UR procedures. Although some jurisdictions may grant immunity based on statutory or public policy considerations in support of cost control efforts, there are indications that such parties may be held liable under general tort principles for the negligent infliction of injury or under contract principles for bad faith breach of a medical care contract.

198. Giordani, supra note 7, at 1029 (quoting P. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 143 (1985)); see also Morreim, supra note 1, at 1757-58 (proposing a rebuttable presumption in which it is presumed that all patients are owed the same basic quality of care regardless of economic circumstances, but in which a physician can rebut the presumption by describing how the diminution of care arose of necessity and not of negligence).
Cost containment mechanisms are based on objective criteria, whereas individual claims are based on subjective criteria—this dichotomy creates conflicts regarding limitation setting. The attending physician is in the best position to evaluate whether utilization constraints are appropriate in a given case. Liability is appropriately assessed against third party payers (including HMOs as payers) and fourth party utilization reviewers when injury results from a denial of care because the attending physician has no reasonable access to appeal a decision denying coverage or when injury results from arbitrary or capricious denials of coverage. Likewise, providers are justifiably liable when injury results from inappropriate attention to economic criteria in the making of health care decisions. This does not mean, however, that legitimate cost control programs, including UR, should not receive reasonable protection from liability.

The statistical data on health care costs and the failure of attempts to control their rapid escalation attest to the economic crisis faced by providers, payers, and recipients of health care services. The vast majority of cost containment programs today—including DRG programs; alternative delivery systems; and hospital, employer, and insurer programs—are based on the economic realization that it is not feasible to provide every conceivable treatment for every patient at any cost. Public interest in the control of health care costs dictates that reasonable financial considerations be factored into the standards of care that physicians and other providers are expected to deliver and against which liability is measured for all participants in the delivery of health care. The difficulty with this approach is that while providers maintain a fairly close nexus to the patient, third party payers and fourth party reviewers are one and two steps removed. For that reason, it may be appropriate to more closely scrutinize their actions. However, third and fourth party liability for utilization decisions should be limited to situations in which their decisions fall outside reasonable parameters that include economic considerations.

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