Preferred Provider Organizations: Balancing Quality Assurance and Utilization Review

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COMMENTS

PREFERRED PROVIDER ORGANIZATIONS: BALANCING QUALITY ASSURANCE AND UTILIZATION REVIEW

As the result of escalating health care costs, health care financing has changed dramatically in the past few years.\(^1\) One of the most innovative developments in this area has been the establishment of preferred provider organizations ("PPOs").\(^2\) PPOs are difficult to define because there are no well established guidelines governing their formation; consequently, as a group, PPOs may be characterized more in terms of their diversity than their similarity.\(^3\) In general, however, PPOs are arrangements through which consumers are given financial incentives to utilize certain hospitals and physicians, or "preferred providers."\(^4\) While the consumer receives a discount for utilizing the preferred provider, the provider is guaranteed increased patient volume and efficient processing of claims.\(^5\) Because PPOs are primarily cost-containment mechanisms, many physicians are concerned that the quality of medical care may suffer at the expense of cost control.\(^6\) There are others in the health care industry, however, who argue that there is little basis for such concern.\(^7\) The purpose of this comment is to define the

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3. Id.
4. NATIONAL HEALTH LAWYERS ASSOCIATION, *INTRODUCTION TO ALTERNATIVE DELIVERY MECHANISMS; HMOs, PPOs & CMPs* 11 (1986).
5. Id.
6. D.H. COWAN, *PREFERRED PROVIDER ORGANIZATIONS* 34 (1984). This concern has been voiced by others in the health care industry as well. In May, 1985, The Physician's Insurance Company of Michigan ("PICOM") informed its insured physicians that it intended to change its underwriting guidelines with respect to physicians participating in HMOs or PPOs in order to raise liability premiums for these physicians. PICOM finally withdrew the guidelines at the request of the State's Special Deputy Commissioner of Insurance, but did not rule out the eventual implementation of the guidelines in the event that statistical data begins to reinforce its misgivings concerning HMOs and PPOs. Champney, *Quality of Care and Malpractice Exposure: An Examination of One Challenge to HMOs*, 7 GROUP HEALTH A. AM. J. 34 (1986).
7. Cowan, *supra* note 6, at 35. For example, the policy director for AARP, John Rother, stated in 1985 that cost control made "hospitals more efficient . . . eliminate[d] unnecessary
general characteristics of PPOs, to discuss the factors which have facilitated their development, to discuss the federal and state regulatory environments in which they operate, and, finally, to examine the ability of PPOs to contain costs while ensuring adequate quality of care for patients.

PPO'S DEFINED

Since the structure of a PPO is determined largely by local market conditions, there is no single definition which precisely describes such entities. In general, however, a PPO usually is described as an organization or arrangement through which a group of hospitals and physicians, as well as other health providers, agree to furnish services to a defined group of subscribers on a discounted fee-for-service basis. Most PPOs consist of the following components: a provider panel of preferred hospitals and physicians, negotiated fee schedules, utilization review, freedom of choice for the consumer, with monetary incentives to utilize preferred providers, and efficient processing of provider claims. This structure, or arrangement, is designed to control costs in two ways; first, by establishing rigorous utilization review mechanisms, PPOs are able to determine the most efficient providers of care; second, by giving the consumer a monetary incentive to utilize PPO providers, the PPO ensures that, in most cases, the more efficient providers are selected. Usually the purchasers, rather than the PPO or the providers,
Preferred Provider Organizations

assume the risk for excessive utilization.\textsuperscript{13}

PPOs are usually classified in terms of sponsorship categories.\textsuperscript{14} The following are the six categories used in a 1986 national survey of PPOs ("1986 Rice National Survey"): (1) hospital sponsors, which include corporate hospital chains and joint sponsorships by hospitals and physicians; (2) physician sponsors, which include medical groups; (3) insurer sponsors, that is, commercial insurers; (4) Blue Cross/Blue Shield sponsors; (5) investor sponsors; and (6) other sponsors, such as union trusts and Health Maintenance Organizations ("HMOs").\textsuperscript{15} Although the numbers of sponsors within a particular category are changing rapidly as more organizations enter the PPO market, hospital and Blue Cross/Blue Shield sponsored PPOs had the greatest number of enrollees in the 1986 Rice National Survey.\textsuperscript{16} Between 1985 and 1986, however, enrollment in Blue Cross/Blue Shield sponsored PPOs quadrupled, and enrollment in insurer sponsored PPOs doubled, compared to fifty percent increases for hospital and physician sponsored PPOs.\textsuperscript{17} Researchers predict that because commercial insurer sponsored PPOs are still in the initial stages of development, this category may experience the greatest growth in the near future.\textsuperscript{18} Since commercial insurers arguably possess superior administrative resources, negotiating experience, and knowledge of historical cost data and group benefits,\textsuperscript{19} they may have a competitive edge over other types of sponsors.\textsuperscript{20}

Regardless of sponsorship type, the potential for enrollment growth in PPOs is enormous. Presently, sixty-five percent of PPO enrollment is concentrated in three states: California (thirty-nine percent), Colorado (seventeen percent), and Florida (nine percent).\textsuperscript{21} As restrictive provisions in state legislation, such as freedom of choice and antidiscrimination statutes,\textsuperscript{22}

\textsuperscript{13} Gabel, supra note 1, at 307.
\textsuperscript{14} Rice, supra note 9, at 9-10; Rice, The State of PPOs: Results From a National Survey, 4 HEALTH AFF. 25, 25-40 (1985).
\textsuperscript{15} Rice, supra note 9, at 9-10.
\textsuperscript{16} Id. at 13.
\textsuperscript{17} Id.
\textsuperscript{18} Id. at 15-17.
\textsuperscript{19} de Lissovoy, supra note 9, at 10.
\textsuperscript{20} In addition, commercial insurers and investors may be more successful than hospital or physician sponsored PPOs in controlling costs because there is no conflict of interest in terms of filling hospitals beds and increasing patient volume. Interview with Jon Gabel, Health Insurance Association of America in Washington, D.C. (Jan. 5, 1987) [hereinafter interview with Jon Gabel]. Whether commercial insurers will be able to operate competitively to contain costs without sacrificing quality of care, a concern of many physicians, remains to be seen. See de Lissovoy, supra note 9, at 8.
\textsuperscript{21} Rice, supra note 9, at 12-13.
\textsuperscript{22} Rolph, State Laws and Regulations Governing Preferred Provider Organizations, 1986 THE RAND CORPORATION 1. Although 49 of the 51 jurisdictions (the 50 states and Puerto
which prevent selective contracting with providers or employers, are repealed, PPO growth will continue.  

FACTORS FACILITATING PPO GROWTH

Several factors have contributed to the emergence of PPOs. A primary factor has been the enormous increase in health care costs in the past few years. By 1985, health care costs had increased so significantly that they represented approximately eleven percent of the gross national product. A second factor contributing to the development of PPOs and other cost containment mechanisms has been the decline in patient volume for physicians and hospitals. This decline is attributable to a growing supply of new physicians each year, along with an increasing reluctance of patients to seek medical assistance for nonemergency problems, possibly due to the shift of additional liability for costs, in the form of premiums and co-payments to the patient. Another reason for the decline in patient volume has been a reduction in the number of individuals who are insured through private health insurance due to increased levels of unemployment. The loss of health care benefits by the unemployed has forced these people and their families to forego necessary and nonemergency medical care. The growing supply of physicians and decreased patient volume have created increased financial pressures and growing competition among physicians and other providers. In addition, state and federal budget reductions, and an inability to shift costs to private payers have also created a need for new methods

Rico) have statutes which could present obstacles to the establishment of PPOs, most jurisdictions either have interpreted their statutes to allow the formation of PPOs, or have adopted legislation overriding restrictive provisions. It appears that most state legislators desire to encourage PPO growth. Id. at 32.

23. Rice, supra note 9, at 13. The 1986 survey indicated that eligibility had nearly tripled since the 1985 survey, and that expansion into densely populated areas, such as New York, is almost certain. Id. at 37.

24. Gabel, supra note 1, at 305.


26. Cowan, supra note 6, at 17.

27. Id. at 28.

28. In 1985, occupancy rates in community hospitals decreased below 65% and the number of physicians per capita was predicted to increase 30% between 1981 and 1990. Gabel, supra note 1, at 320.

29. Cowan, supra note 6, at 28.


of health care financing.\textsuperscript{32} Perhaps the primary reason for the emergence of PPOs in the health care marketplace is the increasing sophistication, and consequent increase in demands and expectations, of corporate consumers of health care services.\textsuperscript{33} This "purchaser’s revolution" is an aggressive response to increases in the cost of health care\textsuperscript{34} which has resulted in increased deductibles and copayments, as well as mandatory second opinions for surgery.\textsuperscript{35} In fact, this "purchaser’s revolution" has sparked concern among health care providers that there has been a shift from a scientific to a business orientation in health care; and that the demands of corporate consumers for the restructuring of health care financing are attempts to "relate the price of the product to the cost of production," as in any other form of business.\textsuperscript{36}

**Potential Problem for PPOs**

As discussed above, PPOs have developed in response to changing conditions in the health care marketplace. Because of escalating costs, an increasing ratio of physicians to patients, and the demands of corporate buyers of health care services, the primary purpose, and the greatest strength, of PPOs is cost containment.\textsuperscript{37} There are, however, several potential problems which might thwart the unhampered growth and efficient operation of PPOs which must be considered.

The first potential problem which PPOs face is inconsistent regulation; because PPOs are subject to rules which govern their sponsoring entities, PPOs operating within a particular jurisdiction may be subject to quite different regulatory requirements.\textsuperscript{38} In addition, regulation of PPOs varies from state to state, thus potentially posing substantial problems for sponsors
desiring to implement multi-state PPOs. Furthermore, where state regulation of insurance is particularly stringent, an employer may choose to self-insure; as a result, the self-insured plan is exempt from state regulation, and is subject to limited federal regulation under the Employee Retirement Income Security Act ("ERISA"). In the past, this disparity of treatment led some in the private sector and in the government to suggest that PPOs should be subject to uniform federal regulation. Federal regulation, however, would have posed at least two problems. First, it would have necessitated a substantial alteration in the division of federal and state power with respect to insurance regulation. Second, since PPOs are not independent entities, but creations of sponsoring bodies, PPOs would have been regulated by federal law, while their sponsoring bodies would have continued to be regulated by state law, an arrangement which would not have been practicable. Despite an awareness of such impracticabilities, proposals for uniform federal regulation reflected concern that state laws were restricting the development of PPOs. Since many states have begun to take measures to allow PPO formation, however, interest in federal legislation has waned. The most recent development with respect to PPO legislation has been the drafting and adoption of model PPO provisions (the "Model Act") by the State and Federal Health Insurance Legislative Policy (B) Task Force ("Task Force") on December 6, 1986. The purpose of the model legislation is to provide guidelines to state policy makers for establishing minimum standards for preferred provider arrangements.

A second potential problem for PPOs is the possibility of attack under the

39. Id. at 70.
41. H.R. 2956, 98th Cong., 2d Sess. (1983); Rolph, supra note 22, at 70.
42. Rolph, supra note 22, at 70.
43. Id.
44. Id.
45. Preferred Provider Arrangements Model Act (State and Federal Health Insurance Legislative Policy (B) Task Force 1986).
46. Id. § 2. The establishment of minimum standards was not intended to suggest that sponsors of PPOs would be acting unlawfully in states where PPO legislation has not been enacted. Id.
47. The members of the Task Force were not unanimous in their adoption of the Model Act. There was concern that § 6 of the Model Act established a higher standard of care for PPO doctors than for others, and that the "Emergency Care" definition in § 3 was ambiguous. Another concern was that the need for the Model Act is uncertain. Minutes from the meeting of the State and Federal Health Insurance Legislative Policy (B) Task Force, Orlando, Florida (Dec. 8, 1986).
antitrust laws. Although the most common antitrust issue facing PPOs has been illegal price fixing, other antitrust issues could include monopolization, exclusive dealing, and geographic allocation of markets. To complicate matters, PPOs have faced antitrust challenges not only by the federal government, but also by providers excluded from the PPOs. Within the past few years, the Department of Justice and the Federal Trade Commission have ameliorated this situation by indicating that within certain reasonable boundaries, PPOs may have a procompetitive effect and should not be discouraged. For this reason, antitrust issues, although still a concern for sponsors structuring new PPOs, are no longer a formidable obstacle to the operation of well established PPOs.

A third problem facing PPOs is their vulnerability to certain types of liability, such as vicarious medical malpractice liability and liability for physical injury resulting from the determination of a utilization review panel. With respect to vicarious medical malpractice liability, a PPO could become the defendant in this type of litigation if a member of the preferred provider panel were to commit malpractice because the PPO could be the "deep pocket" target of the lawsuit. In order to find such liability, PPOs must


49. Rolph, supra note 22, at 57. A comprehensive discussion of these antitrust issues is beyond the scope of this comment. It should be noted, however, that price fixing, monopolization, exclusive dealing and geographic allocation of markets are restricted by the Sherman Act, 15 U.S.C. §§ 1-7 (1982 & Supp. 1 1983). Section 1 of the Act states that "every contract, combination . . . or conspiracy . . . in restraint of trade" is illegal. Section 2 provides that "[e]very person who shall monopolize . . . any part of the trade or commerce among the several States . . . shall be deemed guilty . . . ."

50. Id. at 59. See Ball Memorial Hosp. v. Mutual Hosp. Ins., 784 F.2d 1325 (7th Cir. 1986).

51. Rolph, supra note 22, at 59.

52. Id. at 60.


54. Rolph, supra note 22, at 64; Rich, supra note 53, at 90. "Vicarious liability" is defined in Black's Law Dictionary as "indirect legal responsibility." BLACK'S LAW DICTIONARY 1404 (5th ed. 1979). "Malpractice" is defined as "[p]rofessional misconduct or unreasonable lack of skill." In order to recover for medical malpractice, it is necessary to show that (1) the phys-
screen carefully the credentials of potential providers, and monitor the performance of participating providers.\textsuperscript{55}

An equal, if not greater, threat to the successful operation of PPOs is liability resulting from utilization review determinations.\textsuperscript{56} Many physicians strongly oppose the use of utilization review or "cost efficient" medicine which, in effect, determines the medical necessity of their decisions, as harmful, if not antithetical, to a high standard of medical care.\textsuperscript{57} Utilization review, however, is the primary mechanism through which PPOs control costs.\textsuperscript{58} Therefore, it is unlikely that PPOs will respond to concerns of physicians by eliminating utilization review.\textsuperscript{59} PPOs must respond to these concerns in some fashion, however, or the quality of care offered by preferred providers may suffer.\textsuperscript{60} Furthermore, if a patient is discharged prematurely based on the decision of a utilization review panel, and the patient suffers an injury as the result, the PPO could be subject to liability.\textsuperscript{61}

Utilization Review Methods

The manner in which a utilization review panel performs its functions is critical since such methods could expose a PPO to liability or, if structured carefully, insulate it from liability.\textsuperscript{62} In general, PPOs incorporate one or more of the following components in their utilization review programs: (1) pre-admission review, which determines the medical necessity of a scheduled inpatient admission, and generally applies to expensive procedures and/or procedures provided on an outpatient basis; (2) admission review and certification, which determines the medical necessity of unscheduled inpatient admissions or other admissions not covered by pre-admission review; (3) the plaintiff suffered an injury; and (4) the physician's violation of the duty, or applicable standards of care, caused the injury. \textit{Id.} at 864. Vicarious medical malpractice liability, therefore can be described as indirect legal responsibility for the professional misconduct or lack of skill of a physician who caused an injury in violation of a duty owed to a patient.

55. Rolph, \textit{supra} note 22, at 64.
56. \textit{Id.} Rich \textit{supra} note 53, at 91; Rice, \textit{supra} note 9, at 36.
58. Boland, \textit{supra} note 8, at 3; Aquilina, \textit{supra} note 33, at 106; Cowan, \textit{supra} note 6, at 31; Gabel, \textit{supra} note 1, at 312.
59. \textit{See} Cowan, \textit{supra} note 6, at 34-35.
(3) concurrent review or length of stay certification, which determines the medical necessity of a continued hospital stay; (4) second opinions for elective surgery programs; (5) gatekeeping, which determines, in a variety of ways, whether or not a patient should be seen; (6) retrospective claims review, which determines retroactive disallowances of payments for utilization abuses; (7) physician profiling, which monitors physician performance; and (8) terminating physicians. Almost all PPOs use pre-admission certifications, and most use concurrent review, unless the hospital is being paid based upon diagnosis related to groups ("DRGs").

Second opinion surgery and gatekeeping programs are used much less often, and the use of retrospective claims review is declining, possibly because it is not as effective as prospective or concurrent review. Physician profiling is becoming an increasingly important component of utilization review programs, perhaps because of the threat to PPOs of vicarious medical malpractice liability. Termination of physicians on a formal basis has been used by several PPOs, and some predict additional terminations as soon as their physician profiling systems locate utilization abuses.

Utilization review may be conducted by the provider, the PPO, or an independent third party. Unfortunately, each of these types of review panels has inherent weaknesses which could be difficult to overcome. Provider sponsored utilization review panels have been criticized because of their conflicting interests: the obligation to prevent over-utilization and the desire to fill hospital beds. Since hospitals enter PPOs primarily to remedy a decline in patient volume, they may not be inclined to conduct stringent utilization review, thus further reducing their numbers of patients. Some describe provider utilization review panels as "foxes guarding the henhouse," and

63. Lemkin, supra note 53, at 51-52; Aronson, supra note 62, at 3; Rice, supra note 9, at 32-35.

64. Rice, supra note 9, at 32. "DRGs" can be defined as "a classification system which groups patients according to principal diagnosis, presence of a surgical procedure, age, presence or absence of significant comorbidities or complications, and other relevant criteria." See Comment, Diagnosis Related Groups and the Price of Cost Containment, 2 J. CONTEMP. HEALTH L. & POL'Y 305, 306 (1986).

65. One exception to the less frequent use of second opinion programs appears to be use by commercial insurers. In 1985, these sponsors required second opinions in twice as many programs as any other sponsor. de Lissovoy, supra note 9, at 11.

66. Rice, supra note 9, at 32.

67. Id. at 35.

68. Rolph, supra note 22, at 64.

69. Rice, supra note 9, at 35.

70. Lemkin, supra note 53, at 50.

71. Id.

72. de Lissovoy, supra note 9, at 9.
doubt the ability of providers to perform utilization review effectively.\footnote{73} For this reason, review panels established by the PPOs themselves and independent third party utilization review firms are becoming, and will continue to become, the primary organizations responsible for monitoring utilization and containing costs.\footnote{74}

Because outside utilization panels are concerned primarily with ensuring less expensive care, many physicians and health care specialists argue that there is a danger that quality may suffer.\footnote{75} Unquestionably, proper utilization review can cut costs while protecting the interests of the patient by eliminating unnecessary procedures, medications and hospitalizations.\footnote{76} However, utilization review which focuses principally on increased savings and productivity, and induces physicians to make decisions based on economic pressure, for example, through loss of business or termination, exposes the patient to injury and, consequently, the PPO to unlimited liability.\footnote{77} With such utilization review:

\begin{quote}
[t]he transaction between physician and patient becomes a commodity transaction. The physician becomes an independent entrepreneur or the hired agent of entrepreneurs and investors who themselves have no connection with the traditions of medical ethics. The physician begins to practice the ethics of the market place, to think of his relationship with the patient, not as a covenant or trust, but as a business and a contract relationship . . . . Medical knowledge becomes proprietary; the doctor's private property to be sold to whom he chooses at whatever price and conditions he chooses.\footnote{78}
\end{quote}

This concern about liability resulting from economic rationing of care is not unfounded; in the past several years providers have been held liable for

\begin{itemize}
\item \footnote{73} Id.; Lemkin, \textit{supra} note 53, at 50. There are, however, some potential advantages for a PPO which contracts with a hospital for utilization review; the review structure may already be in place; the hospital already has a comprehensive database listing all patients; and the hospital's ethical and legal obligations assure that standards for review will be uniformly applied to all patients. Kloss, \textit{Quality Review and Utilization Management}, in \textit{The New Healthcare Market - A Guide To PPOs For Purchasers, Payors and Providers} 680, 684-85 (P. Boland ed. 1985).
\item \footnote{74} Interview with Jon Gabel, \textit{supra} note 20.
\item \footnote{75} Lemkin, \textit{supra} note 53, at 50; Cowan, \textit{supra} note 6, at 34.
\item \footnote{76} See Pellegrino, \textit{Rationing Health Care: The Ethics of Medical Gatekeeping}, 2 \textit{J. CONTEMP. HEALTH L. & POL'Y} 23, 30 (1986). Many unnecessary tests and hospitalizations are being ordered by physicians who fear malpractice suits. The practice of such "defensive medicine" to protect against litigation cannot justify the additional costs and risk to the patient. \textit{Id.} at 40.
\item \footnote{77} \textit{Id.} at 32.
\item \footnote{78} \textit{Id.} at 32-33.
\end{itemize}
premature discharge, admissions delays and transfers for financial reasons.\textsuperscript{79} Moreover, in a recent California case, \textit{Wickline v. State}, a third-party payor was sued for the first time for personal injury due to a utilization review determination.\textsuperscript{80}

\textbf{THE WICKLINE CASE}

\textit{Wickline} represents the first attempt to impose liability for malpractice upon a third-party payor for its decisions under a cost-containment, or utilization review, program.\textsuperscript{81} The issue in the case was whether the third-party payor had a legal responsibility for injury when its utilization review program influenced or overruled the treating physician's judgment.\textsuperscript{82} The California Court of Appeals recognized the seriousness of this issue, especially in cases of prospective, as opposed to retrospective, utilization review.\textsuperscript{83} When retrospective review is used, erroneous decisions result in wrongfully withholding reimbursement; when prospective review is used, pressures on quality care created by cost control strategies could result in permanent disability or death.\textsuperscript{84}

The facts in \textit{Wickline} are fairly straightforward. On January 6, 1977, the plaintiff, a woman in her mid-forties, was admitted to a hospital for surgical treatment of Leriche’s Syndrome, a condition caused by obstruction of the terminal aorta immediately above the point at which the aorta divides into two common iliac arteries descending into the legs.\textsuperscript{85} Because the disease was in an advanced state, Dr. Polonsky, a specialist in peripheral vascular surgery, determined that a piece of the plaintiff’s artery should be removed from the right leg, and a synthetic graft should be inserted in its place.\textsuperscript{86} Following the plaintiff’s surgery, she experienced several complications: several hours after surgery, a clot formed in the graft and was removed in a second operation; several days later, she began having spasms in the vessels in her lower leg, requiring Dr. Polonsky to perform a right lumbar sympathectomy, a procedure in which a section of a chain of nerves located on the right side of the spine was removed, in an attempt to stop the spasms.\textsuperscript{87} Several days after the lumbar sympathectomy, Dr. Polonsky decided that it was medically necessary for the plaintiff to remain in the hospital for another

\textsuperscript{79} Stromberg, \textit{supra} note 60, at 4.
\textsuperscript{80} 228 Cal. Rptr. at 661.
\textsuperscript{81} \textit{Id}. at 663.
\textsuperscript{82} \textit{Id}. at 662.
\textsuperscript{83} \textit{Id}. at 663.
\textsuperscript{84} \textit{Id}.
\textsuperscript{85} \textit{Id}. at 663-64.
\textsuperscript{86} \textit{Id}. at 664.
\textsuperscript{87} \textit{Id}.
eight days for observation; his reasons for extending the plaintiff's hospital stay were the fear of clotting and/or infection, and the possibility that an unexpected emergency might occur. 88

In order to extend the patient's hospital stay, Dr. Polonsky was required to submit his request to a representative of the third-party payor, Medi-Cal, for approval. 89 The Medi-Cal representative physician, Dr. Glassman, denied Dr. Polonsky's request for an eight-day extension and authorized an extension for only four days. 90 The representative testified that his decision was based on factors such as the plaintiff's temperature, diet and digestion, and the fact that the plaintiff was able to walk with assistance. 91 Based on these factors, the representative assumed that the plaintiff's condition was not critical and that she was making satisfactory progress. 92 Although Dr. Polonsky could have attempted to appeal Medi-Cal's decision to limit his request, he did not do so. 93 Dr. Polonsky testified that he had two reasons for acquiescing: first, although he believed that the patient was seriously ill and still in danger, her condition had not deteriorated and no new symptoms had developed; second Dr. Polonsky felt that Medi-Cal had the authority to override his decisions, as a treating physician, in determining when to discharge a patient from the hospital. 94

In the first days after her discharge from the hospital, the plaintiff began to experience pain and noticed loss of color from her leg. 95 Nine days after her discharge, when her leg became bluish and nothing could be done to alleviate the pain, the plaintiff was readmitted to the hospital. 96 Upon examination, Dr. Polonsky discovered that the plaintiff had developed an infec-

88. Id. at 665.
89. Id. at 664. Dr. Polonsky was required to furnish the hospital with a diagnosis, history, status and treatment plan for the plaintiff. The hospital, in turn, was obligated to use the information in completing Medi-Cal's "MC-180" form and to submit the form to Medi-Cal's representative for review. Based on the MC-180, the Medi-Cal representative was responsible for determining the medical necessity of the request. Id. at 665.
90. Id. at 666.
91. Id.
92. Id. The Court stated that it was reasonable to conclude, based upon the record, that Dr. Glassman did not obtain an opinion from a specialist in peripheral vascular surgery before deciding to discharge Mrs. Wickline.
93. Id. at 667.
94. Id. Dr. Polonsky's understanding that Medi-Cal was authorized to override his medical judgment is indicative of the concern that utilization review panels may pressure physicians to make decisions based on economic factors such as fear of termination of preferred provider status or staff privileges rather than based on medical ethics. See Pellegrino, supra note 76. It should be noted, however, that all of the medical witnesses who testified at trial agreed that Dr. Polonsky acted within the standards of the medical community in discharging Mrs. Wickline when he did. 228 Cal. Rptr. at 667.
95. Id.
96. Id.
tion at the site of the graft, that she had developed clots in the right leg, and that there was no circulation in the leg. Because of the infection, Dr. Polonsky could not remove the clot surgically. Attempts to save the leg through other methods, such as the use of antibiotics, anticoagulants, and warm water whirlpool baths, were unsuccessful. Finally, in two operations on February 8, 1977 and February 17, 1977, Dr. Polonsky amputated the plaintiff’s leg.

In the resulting lawsuit, the plaintiff sued Medi-Cal for negligently causing her to be discharged prematurely from the hospital. The trial court awarded judgment to the plaintiff, but on appeal, the judgment was reversed. The court of appeals held that the third-party payor was not liable for damages emphasizing that the reason that Medi-Cal was not liable was because Dr. Polonsky accepted the Medi-Cal determination without protest; he did not attempt to appeal the Medi-Cal decision and therefore could not blame Medi-Cal for his own mistake. If Dr. Polonsky had appealed the Medi-Cal decision, and his appeal had been denied, Medi-Cal would have been liable. In its opinion the court stated that:

[t]he 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 deprivation of such care, including, when appropriate, the health care payers. Third-party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.

Based on the language above, it would appear that if a utilization review panel arbitrarily denies appeals by a health care provider for medical or hospital care, such action could expose the third-party payor to unlimited mal-
practice liability.\textsuperscript{108} Therefore, in order to protect patients against injury and to provide safeguards against litigation, third party payers such as PPOs must establish quality assurance mechanisms to balance the cost containment goals of utilization review.\textsuperscript{109}

**QUALITY ASSURANCE**

**A. In General**

Ensuring that patients receive adequate medical care was a concern of physicians long before the development of PPOs.\textsuperscript{110} Traditionally, physicians have reviewed the competence of their peers through state agencies and local medical societies.\textsuperscript{111} In addition, hospitals are responsible for monitoring the performance of their medical staffs in order to maintain their accreditation\textsuperscript{112} and to minimize the risk of liability.\textsuperscript{113} In 1972, Congress established Professional Standards Review Organizations ("PSROs"), review organizations composed of physicians, which were established in order to monitor quality of care and utilization review of services provided under Medicare.\textsuperscript{114} In 1982, Congress reorganized the PSRO program, replacing PSROs with utilization and quality control Peer Review Organizations ("PROs"),\textsuperscript{115} which have been more successful in pinpointing abuses.\textsuperscript{116} There is some concern, however, that PROs focus primarily on cost containment, and are not particularly effective in preventing poor quality of care.\textsuperscript{117} One possible explanation for this weakness may be that quality care is difficult to define or to measure.\textsuperscript{118}

**B. Standards for Quality Care**

Although no single definition or measure of quality has proved acceptable

\textsuperscript{108} Id. See Horowitz, supra note 36, at 46-47.
\textsuperscript{109} Id.
\textsuperscript{110} Forbes, supra note 12, at 38-40; Stromberg, supra note 60, at 3-4.
\textsuperscript{111} Donabedian, Twenty Years of Research on the Quality of Medical Care, 8 EVALUATION & HEALTH PROF. 243 (1985); See, Comment supra note 64, at 317-18.
\textsuperscript{112} Id.
\textsuperscript{113} Id.
\textsuperscript{114} Id.
\textsuperscript{115} Id.
\textsuperscript{116} See Pellegrino, supra note 76, at 36.
\textsuperscript{117} Id.
\textsuperscript{118} Cowan, supra note 6, at 35.
Preferred Provider Organizations

to the health care community, the definition formulated by the Council on Medical Service for the American Medical Association ("AMA") provides a general indication of the aspirations of the medical community. The Council has defined high quality care as that which "consistently contributes to improvement or maintenance of the quality and/or duration of life." The Council has also established eight "essential elements of quality" which should be included in any program designed to ensure adequate medical care. These factors are as follows: (1) the production of optimum improvement in the patient's physical condition and comfort; (2) the promotion of prevention and early detection of disease; (3) the timely discontinuation of unnecessary care; (4) the cooperation and participation of the patient in the care process; (5) the skilled use of necessary professional and technological resources; (6) concern for the patient's welfare; (7) efficient use of resources; and (8) sufficient documentation of medical records to ensure continued care and for evaluation of the care by peer review.

Recently, as conditions have changed in the marketplace, and cost containment forms of health care financing have emerged, concerns regarding quality of care have grown. Because quality is so difficult to define, various standards have emerged as measurements. One set of standards which has developed in the past few years has been that established for HMOs. HMOs, which are subject to more regulation than PPOs, have been required to administer comprehensive quality assurance programs in order to meet statutory and regulatory requirements.

The National Committee for Quality Assurance ("NCQA"), incorporated

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119. Id.

120. Council on Medical Service, supra note 111, at 1032. The most striking characteristic of this definition is its lack of specificity. It is arguable that, in order to propose a definition at all, the Council was obligated to use only the most general terms. Another definition of quality which illustrates, if nothing else, the inability to define the term precisely, is the "component of the difference between efficacy and effectiveness that can be attributed to care providers, taking into account the environment in which they work." Horowitz, supra note 36, at 3.

121. Council on Medical Service, supra note 111, at 1032.

122. Id. In addition, the Council has prepared guidelines designed to facilitate adherence to these goals which focus on the type of review mechanisms necessary to assure high quality care. These guidelines are similar to those structured by the National Committee for Quality Assurance ("NCQA") for HMOs, which will be discussed infra.

123. See supra text accompanying notes 24-36; Quality of Care Proposals Need Support, 17 MOD. HEALTHCARE 5 (1987).

124. Board of Trustees Report, AMA Initiative on Quality of Medical Care and Professional Self Regulation, 256 J. A.M.A. 1036 (1986).

125. See Waxman, supra note 9, at 93.

126. Section 1031(c)(7) of the Public Health Service Act requires that each qualified HMO shall "... have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program
in 1979, with the support of the Group Health Association of America ("GHAA") and the American Medical Care and Review Association ("AMCRA"), is responsible for monitoring the quality assurance programs of HMOs, and, in this capacity, has formulated standards by which it measures an HMO program.127 These standards, which are designed to accommodate various organizational structures, are as follows:

1. Organizational arrangements appropriate to the HMO's goals, including:
   (a) a quality assurance committee,
   (b) accountability to the HMO,
   (c) participation from providers with sufficient support staff,
   (d) supervision by an HMO physician,
   (e) regularly scheduled meetings,
   (f') records reflecting actions of the committee.

2. Defined methods for identification and selection of administrative and clinical problems;

3. Established methods for problem evaluation;

4. Development of appropriate recommendations;

5. Adequate follow-up on recommendations; and

6. Periodic evaluation of effectiveness of the program.128

Another method which has been suggested for monitoring and assessing quality of care is the use of audit reports, in which medical records are examined by independent physician auditors following the patient's discharge.129 Audits, in which physician auditors are instructed to limit findings to egregious defects in care, presumably provide "performance snapshots" of a provider's quality of care.130 The proponents of auditing suggest that the results of quality care audits could be provided to potential customers as an additional source of information to use in choosing a health provider or plan.131

A more recent development in the area of quality assurance standards has been a proposal by the AMA that the Joint Commission on Accreditation of

(A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;"

The regulations regarding quality assurance in HMOs are set forth, in part, at 42 C.F.R. § 110.108(h).

127. NATIONAL COMMITTEE FOR QUALITY ASSURANCE, Policy Statement (February, 1986).

128. Id. at 13-15.

129. Milstein, Auditing Quality of Care: An Employer Based Approach, 3 BUS. & HEALTH 10 (1986).

130. Id.

131. Id. at 12.
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Hospitals ("JCAH") should receive a "sole source contract" to develop standards of care for the health care industry as a whole. The AMA suggested that because the JCAH is an independent organization with no vested interests, it would be an ideal coordinator for the program to determine which statistics most accurately measure quality.

C. Quality Assurance in PPOs

Very little information is available with respect to quality assurance in PPOs for several reasons. One explanation is that because of their recent development and the desire of sponsors to obtain a competitive share of the market, the goals of PPOs are first, to contract with preferred providers, and second, to establish utilization review mechanisms which control costs; quality assurance programs are a secondary consideration and, therefore, not discussed widely. A second explanation is that because there are so few providers participating in PPOs, it is difficult to make comparisons, an essential element of a quality assurance program. A third explanation is that because PPOs are relative newcomers in the health care marketplace, there is a desire to encourage their growth. As PPOs become well established and begin to hold a substantial share of the market, they will be scrutinized more carefully by the government, consumers and competitors.

This apparent desire to encourage growth of PPOs, rather than to subject them initially to extensive regulation is reflected by the absence of quality assurance provisions in state law. Of the twenty-two states which have enacted enabling statutes for PPOs, only fourteen have included provisions to protect consumers. Of those fourteen, only two states, Utah and Michigan, have strong quality assurance provisions which require PPOs to establish programs to review care or services. Many state regulators have stated that they are reluctant to create specific regulatory controls prospectively, and that they prefer to grapple with problems as they develop.

133. Id.
134. Interview with Jon Gabel, supra note 20.
135. Telephone interview with S. Edward Pickens, Director of Special Projects, American Medical Care Review Association (Jan. 8, 1987).
136. Id.
138. Id.
139. See Rolph, supra note 22, at 49.
140. Id.
141. Id. at 51.
142. Id. at 69.
CONCLUSION

The emergence and continued growth of PPOs appears to provide a much needed solution to the dilemma of soaring costs, an overabundance of physicians, and a dearth of patients. By creating monetary incentives for consumers to utilize preferred providers, by guaranteeing patient volume to hospitals and physician providers, and by containing costs through utilization review, PPOs seem to provide a palatable financing product for both consumers and health care providers. As PPOs continue to grow and spread throughout the nation, such problems as inconsistent regulations and antitrust violations probably will be resolved quickly.

The most distressing problem facing PPOs today is an apparent inability to balance cost containment and quality of care. Granted, cost containment is the raison d'etre for PPOs. Without comprehensive utilization review, PPOs could not contain costs and, therefore, would not be able to compete effectively in the marketplace. Cost containment, however, cannot be used as an excuse for sacrificing quality of care, for if quality suffers, so do patients.

For this reason, it is critical that utilization review mechanisms be structured so that costs are contained while quality of care is ensured. This not only protects patients, but may protect the PPO from liability as well. As PPOs expand and acquire a greater share of the market, the potential for problems with utilization review will increase. If utilization review determinations are made arbitrarily or solely with regard to cost, it is clear that cases such as Wickline will continue to develop.

The absence of well defined standards for quality assurance programs within the industry and state regulations could pose a serious problem for the continued growth of PPOs. First of all, PPOs should be governed by the same ethical considerations which govern their providers. In fact, PPOs should not be allowed to operate unless they are willing to assure quality care for patients. Second, from a purely practical, business-oriented standpoint, PPOs will function more effectively by taking preventative measures to insulate themselves from malpractice liability by ensuring high quality care. Although there is some concern that imposing quality assurance controls on PPOs may hamper their growth, it is apparent that there are several options open to the industry in establishing standards for quality. First, since quality of care is admittedly difficult to define or measure, the health care community does not have rigid standards demanding absolute compliance. This appears to give PPOs substantial flexibility in setting national, geographic or structure oriented standards. Second, since the NCQA's HMO standards were designed specifically to accommodate various organi-
zational structures, PPOs already have a workable prototype upon which to devise their own programs. Third, a less structured alternative might be auditing quality of care. In this case, however, some mechanism would need to be established in order to implement changes based on the results of the audits. A fourth alternative would be to adopt the JCAH standards when they are published. Whatever the choice, however, PPOs must assume some responsibility for quality assurance in order to protect both patients and themselves.

Cost containment and quality assurance are both necessary and beneficial goals of PPOs. They should not be viewed, however, as conflicting goals, one of which must be sacrificed for the other. PPO sponsors should strive to balance the two in creating a superior form of health care financing.

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