THE LEGAL IMPLICATIONS OF HMO COST CONTAINMENT MEASURES

*Linda V. Tiano**

I. Introduction

Health maintenance organizations (HMOs) have been viewed as one possible solution to the rising costs of health care. An HMO combines comprehensive medical insurance with a strictly managed health care plan. An HMO either employs or contracts with all necessary medical providers, including physicians, hospitals, nursing homes, and home health agencies.[1] Additionally, HMOs generally utilize comprehensive utilization review programs, which seek to verify in advance the medical necessity of hospital admissions and specific medical procedures. For example, HMOs may require pre-admission approval of hospital admissions, and prior approval of referrals to specialist physicians. Further, most HMOs require that members obtain routine care from a primary care physician, such as a family practitioner, internist, or pediatrician, and may utilize financial incentives to discourage unnecessary treatment and referrals.

By intruding into the traditional physician-patient relationship, these cost containment efforts raise a variety of potential liability issues.[2] The purpose of this article is to address these

---

* B.A., University of Cincinnati, 1978, Summa Cum Laude; J.D., Boston University School of Law, 1981, Cum Laude; Partner, Epstein, Becker & Green, P.C.

[1] An HMO that employs physicians and offers clinic-type settings to its members is a staff model HMO. A group model HMO contracts with a separate independent medical group, which is typically a multi-specialty practice that offers all types of medical services in a single location. The group may or may not see non-HMO patients. To the consumer, there may be little difference between the staff and group model. An HMO that contracts with physicians who are independent contractors, practicing in their own offices and seeing non-HMO as well as HMO patients, is an Independent Practice Association (IPA). Some IPA model HMOs contract with an independent or individual practice association, that is, a physician organization, which in turn contracts with physicians; others contract directly with the physicians. *See* M. MACDONALD, K. MEYER & B. ESSIG, HEALTH CARE LAW: A PRACTICAL GUIDE § 7.03[5](a) (1989).

[2] *See generally* Byrnes, *Corporation's Institution of Health Care Utilization Review*, 33 MED. TRIAL TECH. Q. 478 (1987); Carabillo, *The Manageable Risks of Managed Care*, 3 HEALTH COST MGMT. 1 (1986); Eisenberg & Rosoff, *Physician Responsibility for the Cost*

issues and to provide suggestions to HMOs that wish to maximize cost containment efforts, while minimizing liability exposure.

II. Liability in Connection with Utilization Review

Utilization review is used in one form or another by all HMOs, as well as government payors such as Medicare, some private insurers, and some self-insured employers. Some payors perform the review in-house, whereas others contract with independent entities to perform all or part of the review. Many physicians criticize the intrusion of utilization review programs, while most payors claim they reduce health care costs.

Under traditional indemnity plans, utilization review occurs retrospectively, that is, claims for payment are reviewed after the treatment is rendered. Recently, prospective and concurrent review programs have become more prevalent, especially with HMOs. A prospective review program requires the physician to obtain prior certification from the HMO before providing treatment. In concurrent review, the HMO monitors a patient's treatment (usually the length of a hospital stay) and specifies the last day for which payment is authorized.

Because these programs can directly affect the medical care of the patient, they increase the potential for harm, and consequently, the potential for liability arising out of the utilization review program. Prospective and concurrent utilization review decisions also pose dilemmas for the treating physicians and hospitals. If a treatment plan is disapproved, is the physician free to abandon the plan? To what extent is the physician or hospital obligated to provide the treatment despite the risk of non-payment? How vigorously must the physician pursue any appeal rights to contest the utilization review decision?

The patient is also left in a quandary. The patient faces conflicting judgments by two medical professionals: the treating physician and the utilization review consultant. Should the patient

---

of Unnecessary Medical Services, 299 NEW ENG. J. MED. 76 (1978); Hershey, *Fourth-Party Audit Organizations: Practical and Legal Considerations*, 14 L. MED. & HEALTH CARE 54 (1986); Jespersen & Kendall, *Utilization Review: Avoiding Liability While Controlling Health Costs*, 4 HEALTHSPAN 3 (1987); Note, *Provider Liability Under Public Law 98-21: The Medicare Prospective Payment System in Light of Wickline v. State*, 34 BUFFALO L. REV. 1011 (1985).

rely on the treating physician's opinion, go forward with treatment and accept the resulting benefits and penalties, or should he limit treatment to that which the payor will cover? Who is ultimately responsible for such decisions, and where should liability fall if the decision results in injury to the patient?

More recently, it appears that some hospitals will not admit a patient for major surgery, such as a transplant, unless the patient's insurer confirms coverage or the patient pays in advance, the anticipated cost of the hospitalization, which is often $100,000 or more. The result is, in many cases, that the patient is unable to obtain treatment in the absence of coverage.

There are two leading court decisions regarding liability for utilization review decisions, *Sarchett v. Blue Shield*[3] and *Wickline v. State*.[4] *Sarchett*, a retrospective review case, upheld the fundamental right of an insurer to challenge the treating physician's determination of medical necessity.[5] *Wickline*, a case involving concurrent review, addressed the reviewer's potential liability to the patient for harm resulting from prospective or concurrent review decisions.[6]

A. *The Sarchett Decision*

The most important aspect of the California Supreme Court's decision in *Sarchett*, is that it affirms an insurer's right to disagree with the treating physician's determination of medical necessity.[7] The decision also made clear that if coverage is denied, the insurer must inform the insured of any contractual rights to reconsideration or independent review, such as arbitration.[8]

The plaintiff, John Sarchett, was ordered by his family physician to be hospitalized for a three day period.[9] Blue Shield reviewed the hospital records and determined that the

---

[3] 43 Cal. 3d 1, 729 P.2d 267, 233 Cal. Rptr. 76 (1987) (en banc).

[4] 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

[5] *Sarchett*, 43 Cal. 3d at 10, 729 P.2d at 273, 233 Cal. Rptr. at 82.

[6] *Wickline*, 192 Cal. App. 3d at 1632-33, 239 Cal. Rptr. at 811.

[7] *Sarchett*, 43 Cal. 3d at 10, 729 P.2d at 273, 233 Cal. Rptr. at 82.

[8] *Id.* at 15, 729 P.2d at 276-77, 233 Cal. Rptr. at 85-86.

[9] *Id.* at 4, 729 P.2d at 268, 233 Cal. Rptr. at 77.

hospitalization appeared to be for diagnostic purposes only.[10] It denied coverage based upon two policy exclusions: first, an exclusion for hospitalization that is primarily diagnostic, and second, an exclusion for non-medically necessary services.[11]

The California Supreme Court upheld Blue Shield's right to challenge the medical necessity of hospitalization, even though the patient had relied on the recommendation of the treating physician.[12] The court squarely rejected the plaintiff's argument that the treating physician is the final arbiter of medical necessity.[13] Retrospective review was found to be an implied right of the insurance relationship, even though the policy does not expressly state that the insurer may conduct retrospective review.[14]

The *Sarchett* court also commented favorably on the increasing practice of health care payors to require pre-authorization for elective procedures.[15] However, for fear that payors may become too aggressive in coverage decisions, the decision included a reminder that any doubts and uncertainties in an insurance policy will be construed in favor of coverage for the insured.[16] As a result, the court predicted that the decision of a treating physician will rarely be reversed as being unreasonable or contrary to good medical practice.[17]

---

[10] *Id.*, 729 P.2d at 269, 233 Cal. Rptr. at 77-78.

[11] *Id.*

[12] *Id.* at 10, 729 P.2d at 273, 233 Cal. Rptr. at 82.

[13] *Id.* at 10-12, 729 P.2d at 274-75, 233 Cal. Rptr. at 82-83.

[14] *Id.* at 10, 729 P.2d at 273, 233 Cal. Rptr. at 82. For a contrary decision, see Van Vactor v. Blue Cross Ass'n, 50 Ill. App. 3d 709, 365 N.E.2d 638 (App. Ct. 1977), which found "no justification for the denial of benefits *solely* on the ground that the insurer disagrees with the honest judgment of the treating physician." *Id.* at 714, 365 N.E.2d at 642. The court concluded that decisions of medical necessity are "vested solely and exclusively in the judgment and discretion of the treating physician." *Id.* at 720, 365 N.E.2d at 647.

[15] *Sarchett*, 43 Cal. 3d at 12-13, 729 P.2d at 275, 233 Cal. Rptr. at 84.

[16] *Id.*

[17] *Id.* The court also concluded that Blue Shield acted in bad faith when it failed to inform the insured of his right to impartial review and arbitration as provided in the policy. *Id.* at 14-15, 729 P.2d at 276-77, 233 Cal. Rptr. at 85-86. Although this aspect of the case turned on the particular conduct of Blue Shield, which went beyond a simple failure to inform of appeal rights, the decision emphasized the duty of the insurer to protect the rights of the insured at least equally with its own. *Id.* at 14-15, 729 P.2d at 276-77, 233 Cal. Rptr. at 85-86. Thus, even if the insurance policy contains clear and conspicuous language regarding remedial rights, the insurer should take affirmative steps to inform the insured of his rights if a denial of coverage is disputed. *See id.*

B. *The Wickline Decision*

Although the decision in *Wickline v. State*[18] was only an intermediate appellate ruling in California, it is expected to be a seminal decision in the area of utilization review liability. Mrs. Wickline was being treated for problems associated with her back and legs, for which her physicians recommended surgery.[19] Her hospitalization and treatment were covered by Medi-Cal, California's Medicaid program. Medi-Cal would assign an approved length of stay following pre-certification for hospital admission.[20] Any extension of the approved length of stay had to be authorized.[21] Medi-Cal approved Mrs. Wickline's surgery and authorized a ten day length of stay, with payment approved until January 17, 1977.[22]

Mrs. Wickline suffered complications after the original surgery, thereby requiring two additional surgeries to be performed.[23] Her treating physician determined that she should remain in the hospital eight days beyond her scheduled discharge date and filled out a Medi-Cal form requesting an extension.[24] The Medi-Cal on-site nurse reviewer, after consulting with a Medi-Cal physician adviser, approved only a four day extension.[25] Although there were appropriate spaces on the form for the on-site nurse's recommendation and the reason for disapproval by the consultant physician, both were left blank.[26]

The attending surgeon discharged Mrs. Wickline to her home when the four day extension period expired.[27] All three of her treating physicians were aware that there was a process whereby the Medi-Cal decision could be appealed, but none of them appealed.[28] Nine days after discharge, Mrs. Wickline was

---

18 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (Ct. App.), *cert. granted,* 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded,* 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

19 *Id.* at 1634, 239 Cal. Rptr. at 812.

20 *Id.*

21 *Id.* at 1635, 239 Cal. Rptr. at 813.

22 *Id.*, 239 Cal. Rptr. at 812.

23 *Id.*

24 *Id.* at 1636, 239 Cal. Rptr. at 813.

25 *Id.* at 1638, 239 Cal. Rptr. at 814.

26 *Id.*

27 *Id.* at 1639, 239 Cal. Rptr. at 815.

28 *Id.*

readmitted to the hospital with severe pain and discoloration of her right leg, which eventually had to be amputated above the knee.[29] Mrs. Wickline brought an action alleging that her injuries were caused by Medi-Cal's negligence in failing to authorize the full eight day extension.[30] A jury verdict was entered in her favor.[31]

The court of appeals reversed the jury verdict, reasoning that although the state's pre-authorization program played a role in the decision to discharge Mrs. Wickline, this role was not determinative.[32] The decision to discharge was made by the attending physicians.[33] The court held that Medi-Cal was not a party to the medical decision and could not be held liable if that decision was negligently made.[34] In refusing to find liability for the review decision, the court placed responsibility for the hospital discharge on the attending physicians and impliedly criticized them for not appealing the Medi-Cal denial decision if they disagreed with it.[35]

Nevertheless, the court clearly stated that third party payors could be held liable for "defects in the design or implementation of cost containment mechanisms" that result in the denial of medically necessary services.[36] The decision recognizes that negligent utilization review decisions may result in denial of needed treatment, thereby causing injury to the patient. It thus sets the stage for further development of the allocation of responsibilities in this area.

C. *Application of Wickline Liability*

1. Negligence

Negligence is likely to be the principal cause of action against an HMO in cases based upon a utilization review decision. To establish negligence, the plaintiff (patient) must show that the defendant (HMO) owed the plaintiff a duty of reasonable

---

29 *Id.* at 1641, 239 Cal. Rptr. at 816-17.
30 *Id.* at 1633, 239 Cal. Rptr. at 811.
31 *Id.* at 1632, 239 Cal. Rptr. at 811.
32 *Id.* at 1646, 239 Cal. Rptr. at 819.
33 *Id.* at 1645-46, 239 Cal. Rptr. at 819.
34 *Id.* at 1646, 239 Cal. Rptr. at 819.
35 *See id.* at 1645-46, 239 Cal. Rptr. at 819.
36 *Id.* at 1645, 239 Cal. Rptr. at 819.

care, that the defendant breached the duty, and that the breach proximately caused the plaintiff's injury.[37]

Whether a duty of care extends from an HMO to the patient depends on a variety of factors. These factors include:

> [T]he foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved.[38]

Wickline clearly recognized that a duty of care exists with respect to utilization review decisions. In this regard, the court stated:

> The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment 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.[39]

---

[37] *See* Sanbutch Properties, Inc. v. United States, 343 F. Supp. 611 (N.D. Cal. 1972); Thinguldstad v. United States, 343 F. Supp. 511 (S.D. Ohio 1972); Sides v. Richard Mach. Works, Inc., 406 F.2d 445 (4th Cir. 1969); General Elec. Co. v. Rees, 217 F.2d 595 (9th Cir. 1954); Daley v. Sears, Roebuck & Co., 90 F. Supp. 561 (N.D. Ohio 1949), *aff'd*, 182 F.2d 347 (6th Cir. 1950); Shuttleworth v. Crown Can Co., 165 F.2d 974 (7th Cir. 1948); Muller Fuel Oil Co. v. Insurance Co. of North America, 95 N.J. Super. 564, 232 A.2d 168 (App. Div. 1967); Nieves v. Manhattan and Bronx Surface Transit Operating Auth., 31 A.D.2d 359, 297 N.Y.S.2d 743, *appeal denied mem.*, 24 N.Y.2d 741, 250 N.E.2d 257, 302 N.Y.S.2d 1026 (1969); Mennella v. Schork, 49 Misc. 2d 449, 267 N.Y.S.2d 428 (Dist. Ct. 1966); Cowan v. State, 2 Misc. 2d 764, 154 N.Y.S.2d 72 (Ct. Cl. 1956); Aiken v. Shell Oil Co., 219 Or. 523, 348 P.2d 51 (1959); Lewis v. Scott, 54 Wash. 2d 851, 341 P.2d 488 (1959).

[38] Rowland v. Christian, 69 Cal. 2d 108, 113, 70 Cal. Rptr. 97, 100, 443 P.2d 561, 564 (1968) (en banc); *see also* Palsgraf v. Long Island R.R. Co., 248 N.Y. 339, 162 N.E. 99 (1928).

[39] Wickline v. State, 192 Cal. App. 3d 1630, 1645, 239 Cal. Rptr. 810, 819 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

The next issue in a negligence action is to define the standard of care.[40] There are two sub-issues involved. First, the HMO may be liable if a defect in its procedures resulted in harm to the patient. Second, even if the organization's procedures were adequate, the duty of care may be breached if the decision regarding medical necessity did not meet proper standards.

The standard of care for the procedural aspects of a utilization review decision is likely to be based upon the standards followed by HMOs generally, that is, the standard of care in the community of organizations in the same business.[41] Overall, utilization review procedures must be sufficient to obtain enough information to make an informed decision and to enable a timely dialogue and/or appeal if the treating physician or patient disagrees with a review decision.

In *Wickline*, the physician consultant reviewed only the Medi-Cal form completed by the treating physician.[42] He did not review the patient's chart or consult with the treating physician or a specialist consultant before rejecting the requested hospital extension.[43] The plaintiff attempted to show that these procedures were insufficient. The *Wickline* decision did not criticize the review procedure, thereby impliedly accepting the argument that the reviewer was entitled to rely on the information on the Medi-Cal form and that the burden was on the attending physician to justify the request by including all pertinent information on the form.[44] Nevertheless, the defendant's incomplete recordkeeping, including the failure to document any reasons whatsoever for the denial, undoubtedly played a persuasive

---

[40] Every person or entity is expected to exercise the care that the ordinary, reasonable person of common skill and prudence would use under the circumstances of the case. The standard of care is heightened if the person causing the injury enjoys some specialized skill or knowledge. Professionals, such as doctors and lawyers, are expected to use the skill and care common to their professions, not merely that of the ordinary person. W. PROSSER & W. KEETON, THE LAW OF TORTS 185-86 (5th ed. 1984).

[41] The court has upon occasion required more than the industry standard based upon a determination that the industry standard itself is too lenient. For example, in Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974) (en banc), the court held that even though the standard practice of ophthalmologists is not to require routine pressure tests to patients under forty, the test was simple and harmless, and providing the test was a reasonable standard that should have been followed as a matter of law. *Id.* at 519, 519 P.2d at 983.

[42] *Wickline*, 192 Cal. App. 3d at 1637, 239 Cal. Rptr. at 814.

[43] *Id.*

[44] *Id.* at 1638, 1644, 239 Cal. Rptr. at 814, 818.

role in the trial court's decision.[45]

The procedural safeguards for utilization review are increasingly the subject of articles and seminars. The industry appears to have developed minimum standards that are consistently suggested for organizations performing reviews for use by plaintiff's attorneys in utilization review cases.[46] These standards include: (1) review decisions should be made by qualified medical professionals, and any denial decisions should be made only by licensed physicians; (2) reviewers should consult with specialist physicians as appropriate; (3) efforts should be made to obtain all necessary information, for example by reviewing the patient's charts and consulting with treating physicians as appropriate; (4) the reasons for decisions should be clearly documented; (5) there should be a well-publicized and readily available appeal mechanism; and (6) decisions and appeals should be made in a timely manner as required by the exigencies of the situation.[47]

Further, on January 22, 1990, The National Utilization Review Committee, working with the support of the American Managed Care and Review Association (AMCRA), proposed national utilization review standards, to be used for voluntary accreditation purposes. These standards include: (1) standardization of information collection; (2) notification of determinations within two working days; (3) an appeals process, including provision for expedited appeals; (4) provisions for maintaining the confidentiality of medical records; (5) reviewers should be, at a minimum, registered nurses and physicians, and a physician must review any case where a decision is made not to approve a procedure; (6) a physician should be reasonably available to telephonically discuss a denial with a physician of record on appeal; (7) a physician in the same or similar general specialty as typically manages the medical condition, procedure, or treatment should be reasonably available to review the case upon appeal; (8) there should be free telephone access to review staff from at least 8:30 a.m. to 4:30 p.m. in the provider's time zone each regular business day, and telephonic and on-site information gathering should be during the provider's regular business hours; and

---

45 *See id.* at 1638, 239 Cal. Rptr. at 814.

46 Jesperson & Kendall, *Utilization Review: Avoiding Liability While Controlling Health Costs*, 4 HEALTHSPAN 3 (1987).

47 *Id.* at 7.

(9) reviewers should carry picture identification cards.[48] Finally, the HMO should be careful to follow its own procedures.[49] The failure to follow one's own procedures exposes the entity to potential liability regardless of whether the particular review decision was correct.[50]

The standard of care for the substantive decision on medical necessity in a utilization review liability case is likely to be the same as for physicians generally. By using the expertise of physicians, HMOs hold themselves out as having special skill in the evaluation of medical treatment. The HMO, through its individual physician and nurse reviewers, will likely be held to a professional standard of care. In other words, the HMO should authorize treatment if a physician applying the community standard of care would recommend this procedure as medically necessary.

The third issue in a negligence action against an HMO is whether the denial of coverage proximately caused the patient's injury. Causation was the decisive issue in *Wickline*, and is likely to be the single largest hurdle in most utilization review liability cases.

In *Wickline*, the treating physician failed to take any steps to contest the initial denial.[51] In fact, he signed the hospital discharge order and testified at trial that Mrs. Wickline's condition at the time of discharge was neither critical nor deteriorating.[52] The fact that the physician may have been intimidated by the Medi-Cal program did not mean that he was incapable of contesting the decision if he disagreed with it.[53] Thus, the court concluded that Medi-Cal did not participate in the medical decision to discharge Mrs. Wickline from the hospital and could not be held responsible for that decision.[54]

An alternative basis for the *Wickline* decision might have been that, wholly aside from the hospital discharge, the Medi-Cal decision was too remote from the infection and gangrene that eventually de-

---

48 Annual Health Policy Conference, The Managed Care Industry Beyond State Licensed HMOs: National Utilization Review Standards (Apr. 10, 1990).

49 Jesperson & Kendall, *Utilization Review: Avoiding Liability While Controlling Health Costs*, 4 HEALTHSPAN 3, 7 (1987).

50 *Id.*

51 Wickline v. State, 192 Cal. App. 3d 1630, 1645, 239 Cal. Rptr. 810, 819 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

52 *Id.* at 1639, 239 Cal. Rptr. at 815.

53 *Id.* at 1645, 239 Cal. Rptr. at 819.

54 *Id.* at 1646, 239 Cal. Rptr. at 819.

veloped. In other words, the same harm would have befallen Mrs. Wickline even if she had remained in the hospital for the additional four days. One of the doctors testified that he examined her in his office a week after the discharge, three days beyond the extension Medi-Cal had denied, and that he did not note any material or substantial change in her condition.[55]

While *Wickline* provides an excellent description of the facts, its legal analysis is not as crisp. The holding could have been reached on any number of points, but the court's case law analysis is limited to a general recitation of overall negligence principles.[56] The court does not specifically discuss proximate cause, superseding intervening cause, or how the principles of comparative fault may apply. The court simply concludes as a factual matter that the Medi-Cal decision had nothing to do with the hospital discharge.[57]

There remains an infinite variety of fact situations where the causation issue is yet to be explored. For instance, what if Mrs. Wickline's infection had set in only one or two days after discharge instead of ten days? At that time, she still would have been in the hospital if Medi-Cal had not denied the extension. Based upon the court's analysis, Medi-Cal still may have been absolved of liability because Medi-Cal did not participate in the discharge decision.

2. Breach of Contract

An HMO may be liable under contract theories as well as under negligence theories. A contract typically exists between the patient and a third party payor such as an HMO to pay for medically necessary services. Hence, an improper review decision that results in nonpayment is a direct breach of contract.

The measure of damages for breach of contract is all damages reasonably foreseeable from the breach.[58] In prior or concurrent review, since it is foreseeable that denying authorization will result in the patient foregoing medical services, the defendant is potentially liable for the injury to or the death of the patient.

The critical issue in recovering damages in a contract action

---

55 *Id.* at 1642, 239 Cal. Rptr. at 817.
56 *Id.* at 1643-44, 239 Cal. Rptr. at 818.
57 *See id.* at 1646, 239 Cal. Rptr. at 819-20.
58 RESTATEMENT (SECOND) OF CONTRACTS § 351 (1979).

will be causation. In order to recover anything other than nominal damages, the plaintiff must show that the harm to the plaintiff arose in the usual course of events, from the breach, or that the harm could "reasonably be supposed to have been in the contemplation of both parties, at the time they made the contract."[59] Thus, in the final analysis, the pivotal issue in a contract claim is likely to be the same as in a negligence claim.

3. Insurance Bad Faith

Many states recognize tort liability against an insurance company for breach of the implied covenant of good faith and fair dealing. This cause of action exposes the defendant to punitive damages which ordinarily would not be available in a simple negligence or breach of contract case.[60] Insurance bad faith theories are also useful to the plaintiff because they inquire directly into the process used to reach a coverage decision and not merely the correctness of the decision itself.[61] Similarly, the failure to provide adequate appeal rights may itself be the basis for bad faith liability.[62]

4. Infliction of Emotional Distress

An HMO may potentially be exposed to claims for infliction of emotional distress. In states where the intentional tort is recognized, proof of the following is required: (1) extreme and outrageous conduct; (2) intent to cause severe emotional distress to the insured or reckless disregard of the probability that such distress would result; and (3) severe emotional distress suffered by

---

59 Hadley v. Baxendale, 9 Ex. 341, 354, 156 Eng. Rep. 145, 151 (1854).

60 Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 401-02, 89 Cal. Rptr. 78, 93-94 (Ct. App. 1970).

61 *See, e.g.*, Taylor v. Prudential Ins. Co., 775 F.2d 1457 (11th Cir. 1985) (reversing summary judgment for the insurer on the issue of bad faith where the insurer relied on a Medicare determination of no medical necessity without making its own investigation); Mordecai v. Blue Cross-Blue Shield, 474 So. 2d 95 (Ala. 1985) (bad faith allegations arising from failure to consider portions of nurse's notes and to consult with treating nurses and physicians); Egan v. Mutual of Omaha Ins. Co., 24 Cal. 3d 809, 598 P.2d 452, 157 Cal. Rptr. 482 (1979), *appeal dismissed*, 445 U.S. 912 (1980) (bad faith failure to properly investigate claim).

62 Sarchett v. Blue Shield, 43 Cal. 3d 1, 729 P.2d 267, 233 Cal. Rptr. 76 (1987) (en banc); Davis v. Blue Cross, 25 Cal. 3d 418, 600 P.2d 1060, 158 Cal. Rptr. 828 (1979) (en banc) (bad faith upheld where insurer failed to inform insured of rights to appeal an arbitration decision).

the plaintiff as a proximate result of the defendant's conduct.[63] The intentional tort has been interpreted to require proof that the defendant's acts were "so extreme as to exceed all bounds of that usually tolerated in civilized community."[64]

Since such extreme misconduct is not likely to arise in the context of HMO cost containment activities, the more likely cause of action against an HMO would be negligent infliction of emotional distress. The negligence tort requires a showing of: (1) negligent conduct by the HMO; (2) severe emotional distress suffered by the patient; and (3) proximate causation.[65]

III. Liability for Malpractice

As previously mentioned, HMOs employ or contract with physicians either directly or indirectly. In this manner, HMOs are frequently able to negotiate lower fees than they would have to pay in the absence of the contractual arrangements. Maintaining a limited group of providers who must abide by established rules and protocols facilitates the implementation of controls that will limit excessive and unnecessary care. This, however, creates the potential for the HMO becoming directly responsible for damages caused, not directly by its own acts, but by the negligence of the contracted physicians.

Traditionally, entities have been liable for the acts of their own employees or agents, based upon the theory of respondeat superior.[66] This theory assumes that the employer is directing the actions of its employees and accordingly, the employer is responsible for the consequences of those actions. Hence, staff model HMOs are unquestionably responsible for the actions of

---

[63] Fletcher v. Western Nat'l Life Ins. Co., 10 Cal. App. 3d 376, 394, 89 Cal. Rptr. 78, 88 (Ct. App. 1970).

[64] Schlauch v. Hartford Acc. and Indem. Co., 146 Cal. App. 3d 926, 936, 194 Cal. Rptr. 658, 665 (Ct. App. 1983), *quoting* Ricard v. Pacific Indem. Co., 132 Cal. App. 3d 886, 894, 183 Cal. Rptr. 502, 507 (Ct. App. 1982).

[65] *See, e.g.*, C.O. So Relle v. Western Union Telegraph Co., 55 Tex. 308 (1881); Johnson v. State, 37 N.Y.2d 378, 334 N.E.2d 590, 372 N.Y.S.2d 638 (1975); Allen v. Jones, 104 Cal. App. 3d 207, 163 Cal. Rptr. 445 (Ct. App. 1980).

[66] *See, e.g.*, Sztorc v. Northwest Hosp., 146 Ill. App. 3d 275, 496 N.E.2d 1200 (App. Ct. 1986); Davidson v. Conole, 79 A.D.2d 43, 436 N.Y.S.2d 109 (1981); Hoover v. University of Chicago Hosps., 51 Ill. App. 3d 263, 366 N.E.2d 925 (App. Ct. 1977); Beeck v. Tucson General Hosp., 18 Ariz. App. 165, 500 P.2d 1153 (Ct. App. 1972).

their employed physicians.[67]

Until recently, it was assumed that Independent Practice Association (IPA) model HMOs were not subject to liability for malpractice committed by its participating physicians since those physicians are clearly independent contractors. However, recent cases have set forth several possible bases for finding an HMO liable for malpractice committed by a contracting physician.

A. *Credentialling of Physicians*

The first theory under which an HMO may be held directly responsible for the negligence of a contracted physician is based upon the theory of corporate negligence. The HMO, as a corporation, may be negligent in contracting with the physician, or in failing to terminate the contract. The theory assumes that this failure then becomes the direct cause of the harm to the patient, even though the actual negligent act is committed by the physician.

In order to be negligent, there must first be a duty. It is well established that hospitals have a duty to their patients to properly credential and supervise physicians.[68] In *Johnson v. Misericordia Community Hospital*,[69] the court noted that a duty is owed "to refrain from any act which will cause foreseeable harm to others even though the nature of that harm and the identity of the harmed person . . . is unknown at the time of the act."[70] In addition, the court noted that the failure by a hospital to investigate a medical staff applicant's qualifications gives rise to a foreseeable risk of unreasonable harm and therefore a duty is imposed to exercise care in selection of medical staff.[71]

This theory could easily be extended to HMOs. In fact, in

---

67 Sloan v. Metropolitan Health Counsel, 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987).

68 Blanton v. Moses H. Cone Mem. Hosp., Inc., 319 N.C. 372, 375, 354 S.E.2d 455, 457 (1987); Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 723-37, 301 N.W.2d 156, 164-71 (1981); Cronic v. Doud, 168 Ill. App. 3d 665, 668, 523 N.E.2d 176, 178 (App. Ct. 1988), *appeal denied mem.*, 122 Ill. 2d 572, 530 N.E.2d 242 (1988); Elam v. College Park Hosp., 132 Cal. App. 3d 332, 340-47, 183 Cal. Rptr. 156, 161-65 (Ct. App. 1982).

69 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

70 *Id.* at 723, 301 N.W.2d at 164.

71 *Id.* at 744-45, 301 N.W.2d at 174-75.

Harrell v. Total Health Care, Inc.,[72] this duty was explicitly expanded to HMOs. The court in *Harrell* indicated that by listing physicians and requiring patients to utilize only those physicians to obtain coverage, "there is an unreasonable risk of harm to subscribers if the physicians listed . . . are unqualified or incompetent."[73]

It is not clear what the appropriate standard of care is for HMO credentialling. In *Harrell*, the court indicated that there must be a "reasonable investigation of physicians to ascertain their reputation in the medical community for competence."[74] The court noted, however, that what constitutes a reasonable investigation is a matter for jury determination on a case by case basis.[75]

It is likely that some effort is required beyond review of the application form completed by the physician. In *Harrell*, the court criticized the fact that the credentialling consisted merely of a review to determine if the applicant was licensed, had admitting privileges at a hospital, and could dispense narcotics.[76] The court noted that no personal interview was conducted, no check was made of references, and no inquiry was made about standing in the medical community.[77] If appropriate answers were given to the questions on the application, the physician was allowed to participate.[78] Hence, at a minimum, HMOs should verify the accuracy of the information contained in the application and may wish to require references.

Regarding the issue of whether the breach of duty caused the patient's injury, the hospital cases suggest that if an appropriate credentialling would have uncovered information about a physician that is likely to have resulted in the hospital taking action against the physician, and the physician subsequently causes harm to a patient, the hospital (or HMO) may be the cause of the harm to the patient.[79]

---

[72] No. WD 39809, slip op. (Mo. Ct. App. W. Dist., Apr. 25, 1989) *aff'd*, 781 S.W.2d 58 (1989).

[73] *Id.* at 10.

[74] *Id.*

[75] *Id.*

[76] *Id.* at 5.

[77] *Id.*

[78] *Id.*

[79] *See supra* note 67. *See also* Bell v. Sharp Cabrillo Hosp., 212 Cal. App. 3d 1034,

B. *Risk Sharing Arrangements*

Most HMOs have agreements with their participating physicians that include risk sharing mechanisms. For example, an HMO may capitate its primary care physicians. This means that the HMO may pay each primary care physician a flat fee each month for each member assigned to the physician, regardless of the amount of care utilized. Some HMOs utilize withhold mechanisms, whereby a portion of the amount otherwise payable to a physician (typically ten to twenty-five percent), either on a capitated or fee-for-service basis, is put aside in a reserve fund to be used in the event of budget overruns for specified services such as specialist services and hospital services.

In *Bush v. Dake*,[80] the plaintiff, an HMO enrollee, alleged that such a physician compensation system is itself negligent and caused her injury.[81] The court held that, if proven, such allegations were sufficient to state a cause of action.[82] In this case, the patient consulted her primary care physician with complaints of vaginal bleeding.[83] After several months of treatment, she was referred to a specialist, who performed some tests, and advised the patient to return in a month if the symptoms persisted.[84] The symptoms persisted, but her primary care physician refused to authorize a second referral to the specialist.[85] Neither physician performed a pap smear.[86] Three months later, she was hospitalized on an emergency basis, and diagnosed as having cervical cancer.[87] She claimed that a pap smear would have revealed the condition earlier.[88] She also claimed that, pursuant to the physician compensation system, only the primary care physician could perform pap smears, and he did not receive additional reim-

260 Cal. Rptr. 886 (Ct. App. 1989); Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (Ct. App. 1967).

80 Bush v. Dake, No. 86-25767-NM (Mich. Cir. Ct., Saginaw Cty., Apr. 27, 1989). This case was recently dismissed without opinion.

81 *Id.* at 3.

82 *Id.* at 4.

83 *Id.* at 2.

84 *Id.*

85 *Id.*

86 *See id.* at 2-3.

87 *Id.* at 2.

88 *Id.* at 3.

bursement for doing so.[89] Accordingly, she claimed that the physician compensation system provided the physicians with financial disincentives to properly treat, refer, and hospitalize patients, and that this contributed to her improper treatment and delay of diagnosis.[90]

As with the other types of actions previously discussed, causation will clearly be the key factor in this case, and in other similar cases. As in *Wickline*, it may be difficult to distinguish between the results of the physician's breach of duty and the HMO's. However, in *Bush v. Dake*, HMO liability appears less likely because it would necessitate a finding that the disincentive was the direct cause of the injury, or at least caused the physician's behavior. As noted in *Wickline*, the physician in a managed care setting retains the independent duty to properly treat his patients.[91]

C. *Vicarious Liability*

An HMO may be found vicariously liable for the torts of participating physicians based upon traditional principles of agency. Although a staff model HMO is liable for the acts of its employees,[92] it is frequently suggested that an IPA model HMO may avoid vicarious liability because the participating physicians are independent contractors. The independent contractor theory, however, is riddled with exceptions[93] and is increasingly being eroded to the point of nonexistence.

---

89 *Id.*

90 *Id. See also* Teti v. U.S. Healthcare, Inc., No. 88-9808 (E.D. Pa. Nov. 21, 1989) (WESTLAW, DCTU database), wherein a plaintiff alleged various causes of action based primarily upon the HMO's failure to disclose to HMO members the nature of the risk arrangements with physicians, and that the HMO misled members into inaccurately believing that the HMO does not restrict access to care. This case was brought in federal court, based upon the allegations of RICO claims. The court dismissed the lawsuit due to the insufficiency of the RICO claims. *Id.*

91 Wickline v. State, 192 Cal. App. 3d 1630, 1645-46, 239 Cal. Rptr. 810, 819 (Ct. App.), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560 (1986), *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

92 *See supra* note 66.

93 Where the plaintiff can show that one party retains control over the enterprise, benefits from it, selects the independent contractor and is free to require indemnity and insurance from the contractor, that party may be found vicariously liable for the torts of its independent contractor. Also, where the plaintiff can demonstrate a special relationship giving rise to an affirmative duty of care owed by the defendant, vicarious liability may result. *See* 6 B. WITKIN, SUMMARY OF CALIFORNIA LAW § 997 (1988). An HMO is likely to be found to have a special relationship

The erosion of the theory is primarily based upon the doctrine of ostensible agency. Ostensible agency exists when one either intentionally or negligently allows another to believe that an agency relationship exists.[94]

The theory of ostensible agency has been utilized to hold that an HMO may be responsible for the negligence of independent contractor physicians. For example, in *Boyd v. Albert Einstein Medical Center*,[95] a woman who was an HMO member called her primary care physician complaining of chest pains and other symptoms.[96] Her physician referred her to an emergency room, and arranged for a specialist to meet her there.[97] After an examination, the specialist ordered tests to be performed at his office, in accordance with HMO policy, and then sent her home.[98] Later in the day when the patient called with further symptoms, the physician prescribed pain medication over the telephone.[99] The patient died at home that afternoon.[100]

The court held that there was an issue of material fact regarding whether the physician, notwithstanding the fact that he was an independent contractor, was the ostensible agent of the HMO.[101] The court indicated that the factors to be considered were whether the patient looks to the HMO, rather than the physician, for care, and whether the HMO holds the physician out as its employee.[102] The factors suggesting that the physician may be the ostensible agent of the HMO were: (1) the HMO provided a limited list of physicians from which to chose; (2) approval was required to see a specialist; (3) the HMO exercised substantial

---

with its enrollees, thus increasing the likelihood of liability for the acts of independent contractor physicians.

94 *See* RESTATEMENT (SECOND) OF AGENCY, §§ 8, 159 (1958) (apparent authority of agent); Quintal v. Laurel Grove Hosp., 62 Cal. 2d 154, 397 P.2d 161, 41 Cal. Rptr. 577 (1964) (en banc) (whether physician was ostensible agent of hospital is a jury question); Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 N.Y.S.2d 527 (App. Div. 1976) (emergency room physicians may be named agents of the hospital despite independent contractor language in their contracts).

95 377 Pa. Super. 609, 547 A.2d 1229 (1988).

96 *Id.* at 612, 547 A.2d at 1230.

97 *Id.*

98 *Id.*

99 *Id.* at 612-13, 547 A.2d at 1230.

100 *Id.* at 613, 547 A.2d at 1230.

101 *Id.* at 621, 547 A.2d at 1235.

102 *Id.* at 619-20, 547 A.2d at 1234.

control over the care rendered; and (4) the primary care physicians were paid on a capitation basis with a withhold.[103]

Similarly, in *Schleier v. Kaiser Foundation Health Plan*,[104] an HMO enrollee with stomach, chest, and shoulder pains was referred to a hospital and later admitted to the hospital's coronary care unit.[105] Although Kaiser was a staff model HMO and employed many physicians, the patient was referred to a specialist who was an independent contractor.[106] After examining the patient and performing tests, the specialist concluded that there was no coronary heart disease.[107] Subsequently, the patient experienced night sweats.[108] He called a Kaiser physician, but was advised that the symptoms were not cardiac related.[109] Some time later, he experienced heavy sweating and exhaustion, followed by vomiting.[110] When the patient called Kaiser, a nurse advised him not to be concerned.[111] Later that day when the patient's condition further deteriorated his wife called an ambulance.[112] He died en route to the hospital.[113]

The court in this case concluded, *inter alia*, that an HMO could be responsible for the acts of the independent contractor specialist, and held that the key issue was not whether the physician was an independent contractor, but whether there was a master-servant relationship between the HMO and the physician.[114] The court cited five factors that it considered determinative of whether a master-servant relationship exists: "(1) the selection and engagement of the servant, (2) the payment of wages, (3) the power to discharge, (4) the power to control the servant's conduct, (5) and whether the work is part of the regular business of the employer."[115] The court held that there was suffi-

---

103 *Id.* at 621, 547 A.2d at 1235.
104 876 F.2d 174 (D.C. Cir. 1989).
105 *Id.* at 176.
106 *Id.*
107 *Id.*
108 *Id.*
109 *Id.*
110 *Id.*
111 *Id.*
112 *Id.*
113 *Id.*
114 *Id.* at 177-78.
115 *Id.* at 177. The court also upheld a finding that the HMO was liable for the negligence of its own employees, i.e., the Kaiser physician and nurse. *Id.* at 177-78.

cient evidence of a master-servant relationship between Kaiser and the specialist to hold Kaiser responsible for the specialist's negligence.[116]

IV. Provider Actions

The HMO's liability is not limited to potential claims by the patient. Physicians or other providers who are harmed by HMO decisions may also bring suit. Typically, these actions would be for defamation, interference with the physician's contractual relationship with the patient,[117] or antitrust.

A. *Defamation and Interference with Contractual Relations*

In *Slaughter v. Friedman*,[118] Slaughter was an oral surgeon who brought an action against a dental insurance company and its dental director for defamation and intentional interference with prospective advantage.[119] In denying claims for Slaughter's services, the insurer enclosed a letter to the patients that described Slaughter's work as unnecessary, claimed that Slaughter had been overcharging, and stated that the insurance company would report him to a dental association for disciplinary proceedings.[120] The letters also advised the patients to make no further payments to Slaughter.[121] The California Supreme Court upheld Slaughter's right to sue for defamation.[122]

Whenever an HMO informs a patient that the treating physician rendered, or proposes to render, treatment which is not medically necessary, a potential defamation claim exists. The

---

116 *Id.*

117 *See, e.g.*, Slaughter v. Friedman, 32 Cal. 3d 149, 649 P.2d 886, 185 Cal. Rptr. 244 (1982) (en banc) (suit for defamation and for interference with prospective economic advantage); Teale v. American Mfgs. Mut. Ins. Co., 687 S.W.2d 218 (Mo. Ct. App. 1984) (action alleging tortious interference of business relationship); Moore & Assocs. v. Metropolitan Life Ins. Co., 604 S.W.2d 487 (Tex. Civ. App. 1980) (claim stated for tortious interference with doctor-patient relationship by association of anesthesiologists against group medical insurer for insurer's letters to former patients advising that claims would not be paid in full because the association's charges were excessive).

118 32 Cal. 3d 149, 649 P.2d 886, 185 Cal. Rptr. 244 (1982) (en banc).

119 *Id.* at 153, 649 P.2d at 888, 185 Cal. Rptr. at 246.

120 *Id.*

121 *Id.*

122 *Id.* at 155, 649 P.2d at 889, 185 Cal. Rptr. at 247. The interference claim was not before the court.

HMO's decision carries a stamp of authenticity and may cause a patient to question the doctor's medical judgment and capability. In addition, a finding that services were not medically necessary may justify the patient's decision not to pay for the services.

In a defamation action, the HMO could raise the defense of qualified privilege. Qualified privilege applies to communications between persons with a mutual interest in the subject matter.[123] The privilege is not absolute, however, and may be defeated by showing that the communication was made with malice.[124] In the *Slaughter* case, the court found that the pleadings sufficiently raised the issue of malice to allow the complaint to stand.[125] The court noted that the defendants were only required "to inform dental patients of the basis for rejection of their claims; they were not required additionally to defame plaintiff with accusations regarding his dental practices."[126] For these reasons, an HMO should be careful to limit its communications simply to the basis for its denial decisions and should avoid unnecessary embellishments or inflammatory language.

B. *Antitrust*

A full discussion of potential antitrust liabilities is beyond the scope of this article, although a few points are worth noting.

Antitrust is a relatively lesser threat than the other potential liabilities reviewed above; however, when an HMO excludes a physician because of high utilization, there is some potential for antitrust liability. As a general rule, the conduct will not be per se illegal but will be tested under the rule of reason. Under the rule of reason test, the challenged activity will be upheld where legitimate, pro-competitive interests outweigh the potential anti-competitive effects.[127] As long as the defendant succeeds in persuading the court to apply the rule of reason test, the beneficial

123 *See, e.g.*, CAL. CIV. CODE § 47(3) (West 1982); N.Y. EDUC. LAW § 6527(3) (McKinney 1985 & Supp. 1990).

124 *See, e.g.*, CAL. CIV. CODE § 47(3) (West 1982); N.Y. EDUC. LAW § 6527(3) (McKinney 1985 & Supp. 1990).

125 *Slaughter*, 32 Cal. 3d 157, 649 P.2d at 890, 185 Cal. Rptr. at 248.

126 *Id.* at 158, 649 P.2d at 891, 185 Cal. Rptr. at 249.

127 *See* Chicago Board of Trade v. United States, 246 U.S. 231 (1918); Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982) (under rule of reason analysis, hospital permitted to grant exclusive privileges where policy is grounded in ensuring quality patient care and necessary hospital services).

effects of limiting the provider panel to cost effective physicians are likely to prevail over the interest of a single physician in remaining on the panel, at least where the defendant's market share is within reasonable bounds.[128]

One difficulty in defending a provider exclusion case involves the inevitable problem of proving that a physician is a high utilizer. The excluded physician often attempts to show that he was singled out because of some personal animus by his competitors on the review committee. Often the defendant's records are not as precise as the attorney would hope and the statistics are not consistent or are incomplete. Other physicians who have not been excluded may have equally poor or worse utilization records, thereby raising the question of unequal treatment. The excluded physician may have an outstanding reputation for quality, or may claim that his patients tend to be unhealthier than the average population. All of these problems make the defense of the antitrust case more difficult; however, there is nothing inherently illegal in excluding a provider based on utilization data.

Moreover, as long as the HMO acts in good faith, without malice, and provides due process protection for the excluded physician, the HMO may be entitled to an exemption from liability pursuant to various state statutes[129] as well as the Health Care Quality Improvement Act (HCQIA).[130]

V. Conclusions and Recommendations

The use of cost containment devices by HMOs appears to be resulting in the potential increase of an HMO's liabilities. An HMO may be liable for damages to a patient that are the direct

---

128 *See* Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985) (unless an organization possesses market power or controls access to an element essential for competition, expulsion for failure to follow reasonable rules is not per se illegal); *see generally* Antitrust Section of the Connecticut Bar Association and the Connecticut Health Lawyers Association, "Antitrust in the Health Care Field: Distinguishing Resistance From Adaptation," *Antitrust and Health Care Seminar*, Mar. 11, 1988 (remarks of Charles F. Rule, Assistant Attorney General, Antitrust Division, United States Department of Justice).

129 *See, e.g.*, N.Y. EDUC. LAW § 6527(3) (McKinney 1985 & Supp. 1990).

130 42 U.S.C. §§ 11101-11152 (Supp. 1989). This Act provides that a qualified entity, which includes a hospital and an HMO, that complies with the Act's reporting requirements and utilizes procedures that comply with the Act's due process requirements, is exempt from most liability arising out of utilization review activities that result in the exclusion of a provider. *Id.*

result of a coverage decision; the HMO may be responsible for injuries to a patient inflicted by an HMO participating physician who the HMO failed to properly evaluate; the HMO may be directly responsible for the malpractice of a contracting physician who is the HMO's ostensible agent; and the HMO may be liable for damages suffered by a physician who is wrongfully excluded from HMO participation as a result of utilization review activities.

Despite the potential liabilities, however, there is no reason for HMOs to abandon cost containment measures. Based upon the current trends in the law, abandonment may increase the risk of liability. There are many steps an HMO can take to protect itself against such potential liabilities.

First, HMOs should check the sufficiency of their current malpractice coverage. Many HMO malpractice policies only cover liability arising out of utilization review decisions. Thus, while cases such as *Wickline* would be covered, the ostensible agent cases might not. Further, HMOs may want to consider increasing the amount of coverage carried.

Additionally, HMOs that do not currently have strong quality assurance programs should establish and implement such programs to ensure that, despite cost containment measures, quality medical care is being rendered. For example, a strenuous credentialling process should be adopted, and providers should be subject to periodic re-credentialling. HMOs should ensure that all information suggesting potential problems with a physician are referred to the proper personnel, that information is investigated, and if necessary, that appropriate action is taken.

All procedures utilized to sanction and terminate providers should include proper protection for the provider, so as to qualify for available exemptions. Such protections should include, at a minimum, the right to have no competitors of the provider participate in the decision-making process; the right to have a hearing; the right to be represented at the hearing; and the right to present evidence and to cross-examine witnesses.

Further, the HMO's utilization review procedures should be examined to ensure that they meet community standards, and that appropriate checks are in place to ensure that potentially controversial denials of care are not made without proper authority from the HMO. Also, where physician risk sharing mech-

anisms that may impact the physician's medical decision-making are employed, a strenuous quality assurance program should be developed to ascertain whether physicians are making medical decisions based upon cost factors.

HMOs should be cautious of representations made in member manuals, advertising materials, and other public documents. The HMO should ensure that such documents reflect the proper relationship between the HMO and its providers, as well as stress that the responsibility for treatment lies with the provider, regardless of HMO coverage decisions. The documents should not make representations regarding the high quality of care made available by the HMO.

Finally, more comprehensive state and federal legislation may help to ensure that valid cost containment efforts are not sabotaged by liability concerns. The HCQIA will be helpful in deterring some physician lawsuits regarding appropriate quality assurance/utilization review decisions. However, this may be inadequate. Many organizations may choose not to comply with the HCQIA reporting requirements or may not be covered under the Act. Despite statements in general support of cost containment measures, very little state legislation has been enacted to protect entities that utilize such measures. More states should adopt legislation immunizing HMOs and other organizations from liability in connection with good faith peer review activities. Further, legislation may be appropriate to clarify that an HMO, or any insurer, who makes coverage decisions, does not replace the physician as the medical provider. Physicians and hospitals should continue to treat patients as they believe medically appropriate and should contest coverage decisions they believe are inappropriate.

In conclusion, HMOs and the cost containment devices utilized by them, constitute valid and appropriate efforts to control the skyrocketing cost of health care. It is not surprising that some additional risk of liability may be imposed upon HMOs as a result of these efforts. However, legislation limiting the liability of HMOs that engage in reasonable cost containment measures will help to ensure the development and proper use of such measures.