MEDICAL UTILIZATION REVIEW: THE NEW FRONTIER FOR MEDICAL MALPRACTICE CLAIMS?

TABLE OF CONTENTS

I. INTRODUCTION

Between 1965 and 1987, the cost of providing health care services in the United States rose from $42 billion to more than $500 billion.[1] Historically, the majority of these costs have been funded through federal and state governments.[2] However, to offset strict governmental limitations on price increases, as well as "charity" care provided to a growing uninsured population, health care providers are rapidly shifting costs to the private sector.[3] In 1987, more than one-fourth of the United States health care budget was paid through private sector insurance plans.[4] No relief is in sight. Experts predict corporations will continue to face dramatic increases in employee health insurance premiums for several years.[5]

In hopes of containing medical costs, private employers and insurance companies are moving away from traditional fee-for-service insurance plans[6] to more aggressive "managed care" programs.[7] "Managed care" is a comprehensive term used to describe a variety of mechanisms, ranging from reduced-price purchasing agreements with health care providers[8] to preauthorization of facility admissions or surgical procedures.[9] The latter mechanism, known as prospective or concurrent utilization review ("UR"), is becoming increasingly popular among private insurance companies and employers. In fact, a recent national poll found

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1. Annetta Miller, *Can You Afford to Get Sick?*, NEWSWEEK, Jan. 30, 1989, at 44, 45 (citing HEALTH CARE FINANCING ADMINISTRATION, REPORT ON TOTAL UNITED STATES HEALTH CARE EXPENDITURES (citation omitted)). The actual cost in 1991 was projected to reach $700 billion. *See* Thomas Bodenheimer, *The Way to Real Health Security*, THE NATION, Dec. 16, 1991, at 775.

2. Annetta Miller, *Can You Afford to Get Sick?*, NEWSWEEK, Jan. 30, 1989, at 50 (citing UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES AND HEALTH CARE FINANCING ADMIN. (citation omitted)).

3. *Id.* at 45-48.

4. *Id.* at 50.

5. *Id.* at 45.

6. Timothy S. Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 527 (1988).

7. *See* Jacqueline M. Saue, *Legal Issues Related to Case Management*, QUALITY REV. BULL., Aug. 1988, at 239.

8. Provider purchasing agreements are the trademark of preferred provider organizations ("PPOs"). For a discussion of the use of utilization review in PPOs, see Cathy L. Burgess, Note, *Preferred Provider Organizations: Balancing Quality Assurance and Utilization Review*, 4 J. CONTEMP. HEALTH L. & POL'Y 275 (1988).

9. Saue, *supra* note 7, at 239. Utilization review ("UR") has been defined as the "evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities." UTILIZATION REVIEW ACCREDITATION COMMISSION, STANDARDS SUBCOMMITTEE OF THE AMERICAN MEDICAL CARE REVIEW ASSOCIATION, URAC National Utilization Review Standards Nov. 1990, at 15 [hereinafter URAC STANDARDS]. Concurrent and prospective reviews are forms of UR. *Id.*

seventy-four percent of major United States employers currently subscribe to a UR program.[10]

It is misleading to categorize UR as a strict cost-reduction mechanism. In reality, an effective UR program evaluates the quality as well as the cost of medical care.[11] Some experts suggest UR may improve the quality of medical care by eliminating unnecessary procedures, hospitalizations, and the accompanying risks.[12]

Nevertheless, due to the degree of intervention necessarily required through UR, it is vital that health care purchasers exercise care in selecting and overseeing a UR program. Utilization review "places a private payor (or its representative) in a position where it could be substituting its own judgment for that of the medical professionals directly providing the care."[13] If a payor becomes involved to the extent it changes the course of medical treatment, the payor may be exposing itself to liability for any injury the patient suffers as a result of this change.

Consider the situation in which a UR entity denies payment for a proposed hospital admission, continued stay, or surgical procedure: Without an alternative means to pay for the care, the patient/insured declines treatment, or is *refused* treatment by the health care provider. If the patient then suffers adverse consequences, she may file a medical malpractice action on the basis that negligent UR caused her injuries by preventing her from receiving necessary care. Rather than suing the doctor or hospital, who in her mind were not responsible for her inability to receive treatment, she sues the insurance company, UR operator, and possibly, her employer. Actual employees of the insurer or employer may not have *performed* the UR. However, the acts of the UR operator could be *imputed* to the insurer or employer under agency and tort principals.[14]

This Note explores the liability risks to private insurers and employers stemming from the use of prospective UR. Part two outlines the definition and scope of UR as performed in the United States today. Part three examines the two leading UR malpractice cases and possible implications to UR subscribers. Part four discusses the various theories under which a UR operator's actions may be imputed to an employer or insurer. Part five looks at the effects of the Employment Retirement Income Security

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10. MEDICAL UTILIZATION REV., May 24, 1990, at 3 (citing 1990 William Mercer poll (citations omitted)).

11. *See, e.g.*, Gerry Kinworthy & Nancy Gospo, *Development of an Effective Utilization Management Program at Celtic Life Insurance Program,* QUALITY REV. BULL., April 1990, at 138.

12. *See infra* text accompanying notes 188-91.

13. James M. Matthews, *Common Issues Affecting Group Health Care Plans, in* 1990 HEALTH LAW HANDBOOK 139, 140 (1990).

14. *See generally* Maureen E. Corcoran, *Managing the Risks of Managed Care, in* MANAGED HEALTH CARE 1989, at 7 (PLI Commercial Law Practice Handbook Series No. 516, 1989).

Act of 1974 ("ERISA") in minimizing UR litigation. And finally, part six discusses the public policy reasons for and against UR, as well as legislative and private sector efforts to minimize UR liability.

II. UTILIZATION REVIEW: DEFINITIONS AND STRUCTURES

A. *Utilization Review Defined*

Medical utilization review has been defined as a comprehensive evaluation of the efficiency, appropriateness, and medical necessity of health care.[15] The process for conducting UR varies widely, depending on when the review is conducted (before, during, or after the treatment process), the care setting involved, and the needs and desires of the health care purchaser.[16]

Generally, in concurrent or prospective UR, the attending physician or hospital requests preauthorization by contacting the UR entity either in writing or via the telephone. UR personnel compare the patient characteristics received from the provider with pre-established criteria for the particular diagnosis or procedure at issue. If the patient information fails to meet the criteria, the case may be forwarded to a UR physician consultant or staff physician for a final determination based on the UR physician's medical expertise.[17]

It is important to note a UR entity merely approves or denies *payment* for the proposed care.[18] Ultimately, the attending physician and patient have final authority in deciding whether to proceed with the treatment.[19] As

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15. Josephine Gittler, *Hospital Cost Containment in Iowa: A Guide for State Public Policymakers*, 69 IOWA L. REV. 1263, 1321 (1984) (citing GOVERNOR'S COMMISSION ON HEALTH CARE COSTS, FINAL REPORT 34 (1984)). It is important to note that although this discussion focuses on *prospective* review, many other forms of UR exist. In addition to pre-certification for a hospitalization or procedure, UR may also be conducted concurrently, to evaluate the necessity of *continued* hospitalization, to ensure the patient is being cared for at the appropriate level of care (e.g., acute care, skilled nursing care, intermediate nursing care, etc.), and to ensure adequate discharge planning has been performed. Some programs, such as the Medicare Peer Review Organization program, call for review on a retrospective basis. Case management of large illness or disabilities is also a common UR alternative. Corcoran, *supra* note 14, at 36-37.

16. Joseph B. Stamm, *Private Utilization Review and Quality Assurance*, 63 BULL. N.Y. ACAD. MED. 87, 89-91 (1987).

17. URAC STANDARDS, *supra* note 9, at 6-7. It is important to note review procedures, as well as personnel qualifications, differ among various UR operators. *See* Zusman, *infra* note 87, at 143. In addition, most UR plans contain a mechanism for appeal when the provider or patient disagrees with a decision. *See* Corcoran, *supra* note 14, at 38-40.

18. *See, e.g.*, Kinworthy & Gospo, *supra* note 11, at 138.

19. *See* Wickline v. State, 228 Cal. Rptr. 661, 670 (Ct. App. 1986), *appeal dismissed*, 741 P.2d 613 (Cal. 1987); Kinworthy & Gospo, *supra* note 11, at 138.

a practical matter, however, due to the lack of other means by which to pay for the services, most patients are bound by the review decision.[20]

B. *Governmental Use of Utilization Review*

The practice of UR is not limited to the private sector. In fact, the federal Medicare program[21] and state Medicaid programs were required to incorporate UR provisions in the mid 1960s.[22] The current Medicare review system consists of state peer review organizations ("PROs") that were created in 1982.[23] In addition to the acute hospital setting, PRO review is now conducted for skilled nursing care, ambulatory surgery, and home health agency care.[24] Beginning in 1983, PROs began placing greater emphasis on the quality of care provided.[25]

For public policy reasons, Medicare PROs are currently immune from liability based on negligent review decisions.[26] Consequently, government-sponsored UR is not featured within the scope of this discussion.

III. TORT LIABILITY STEMMING FROM ALLEGEDLY NEGLIGENT UTILIZATION REVIEW DECISIONS

A. *Elements in a Typical Malpractice Claim*

To maintain a tort action based on the negligence of a health care provider, a plaintiff must establish the following elements: (1) The existence of a duty to use a certain standard of care in relation to the plaintiff, (2) the breach of that duty, (3) a showing that the breach was the proximate cause of the plaintiff's injuries, and (4) actual damages.[27] The standard of conduct to which a physician is generally held is that which is

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20. *See generally* Maureen E. Corcoran, *Liability for Care in the Managed Care Settinng, in* MANAGED HEALTH CARE 1988: LEGAL & OPERATIONAL ISSUES (PLI Commercial Law Practice Handbook Series, 1988).

21. John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 HOUS. L. REV. 191, 194 (1989); 42 U.S.C. § 1395x(k) (1988) (provisions for UR in the federal Medicare program).

22. Blum, *supra* note 21, at 194; 42 U.S.C. § 1396a(30)(A) (1988) (Medicaid provisions for UR). The UR entity for both the Medicaid and Medicare programs in Iowa is the Iowa Foundation for Medical Care. *See* Gittler, *supra* note 15, at 1321.

23. Peer Review Improvement Act of 1982 of The Tax Equity and Fiscal Responsibility Act of 1982, 42 U.S.C. § 1320c-1 to -12 (1988).

24. *Id.*

25. Timothy S. Jost, *Administrative Law Issues Involving the Medicare Utilization & Quality Control Peer Review Organization (PRO) Program: Analysis and Recommendations*, 50 OHIO ST. L.J. 1, 6 (1989).

26. *See infra* notes 199-206 and accompanying text; *see also* Kwoun v. Southeast Mo. Professional Standards Review Org., 811 F.2d 401 (8th Cir. 1986).

27. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30, at 164-65 (5th ed. 1984).

"customary and usual in the profession."[28] Both the standard of care and proof of negligence must be established through expert testimony, unless the matter is clearly "within the common knowledge of laymen, as where the surgeon saws off the wrong leg, or there is injury to a part of the body not within the operative field."[29]

The key elements in each of the two leading UR cases have been the standard of care used in conducting utilization review and proximate cause.[30] Just as the patient's attending physician must use reasonable care in ascertaining the operative facts necessary to make a diagnosis,[31] a utilization reviewer must abide by a similar standard when determining whether to approve or deny payment.[32] Courts are divided, however, regarding how thorough a reviewer's investigation must be to constitute reasonable care.[33]

B. *Negligence in a Utilization Review Context:* Wickline v. State[34]

Wickline v. State was the first reported case to decide whether a tort action may be maintained based on allegedly negligent prospective UR.[35] In *Wickline*, the California Court of Appeals absolved the State of California from liability as a matter of law, based on a lack of evidence showing the treatment provided was inconsistent with the usual standards of medical practice within the community.[36] *Wickline* admittedly involved government-sponsored, rather than privately funded, UR. However, because *Wickline* was the first case to consider malpractice in a UR context, a brief discussion of the *Wickline* facts and holding is necessary.

Wickline arose from a review decision made by agents of the California Medical Assistance Program ("Medi-Cal").[37] Lois Wickline, a Medi-Cal recipient, required surgery to replace part of an obstructed artery with a synthetic graft.[38] Pursuant to Medi-Cal requirements, Ms. Wickline's physicians sought and obtained preauthorization of the procedure and ten days of hospital care.[39] Post-surgical complications ensued,

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28. *Id.* at 189.
29. *Id.* at 188-89.
30. *See generally* Wilson v. Blue Cross, 271 Cal. Rptr. 876 (Ct. App. 1990); Wickline v. State, 228 Cal. Rptr. 661 (Ct. App. 1986), *appeal dismissed*, 741 P.2d 613 (Cal. 1987).
31. KEETON et al., *supra* note 27, § 32, at 187.
32. *See* Aetna Life Ins. Co. v. Lavoie, 505 So. 2d 1050, 1052-53 (Ala. 1987).
33. *See infra* notes 69-70.
34. Wickline v. State, 228 Cal. Rptr. 661 (Ct. App. 1986), *appeal dismissed*, 741 P.2d 613 (Cal. 1987).
35. *Id.* at 662.
36. *Id.* at 670-71 (quoting CAL. CODE REGS. tit. 22, § 51110 (1977)).
37. *Id.* at 662.
38. *Id.* at 663.
39. *Id.* at 663-64.

and Ms. Wickline's physicians requested an eight-day extension of her hospital stay.[40] However, the Medi-Cal consultant, a general surgeon, approved only four additional days of hospitalization.[41] Because Ms. Wickline's condition had neither "deteriorated nor become critical" after the four-day extension period, her surgeon discharged her even though he disagreed with Medi-Cal's determination.[42]

Shortly after returning home, Ms. Wickline developed a blood clot in her leg (where the graft had been inserted), and returned to the hospital for further treatment.[43] By this time, however, Ms. Wickline's leg had been without circulation for an extended period.[44] Her leg was amputated after repeated attempts to revive circulation failed.[45]

The vascular surgeon later testified that had Ms. Wickline been able to stay in the hospital for eight days as requested, he would have detected the clotting at an earlier date, and likely would have been able to save Ms. Wickline's leg.[46] Ms. Wickline subsequently sued the State of California, claiming negligence on the part of the Medi-Cal physician consultant for proximately causing the loss of her leg.[47] A jury verdict was awarded in Ms. Wickline's favor.[48]

This decision, however, was reversed on appeal.[49] The appellate court centered its decision around three principal factors. First, the Welfare Code governing Medi-Cal *authorized* UR as long as the determination was based on medical necessity.[50] The court found the Medi-Cal consultant's decision was conducted in accordance with this law.[51] Second, the actual decision to discharge was made by Ms. Wickline's surgeon—not by the Medi-Cal consultant.[52] Expert witnesses for both parties agreed the decision to discharge Ms. Wickline was consistent with the standards of medical practice in the community.[53] The court therefore held Medi-Cal's decision did not in any way "corrupt" the medical decision-making

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40. *Id.* at 664.
41. *Id.* at 665.
42. *Id.* at 667.
43. *Id.* at 667-68.
44. *Id.* at 663.
45. *Id.* at 668.
46. *Id.*
47. *Id.* at 662. Interestingly, Wickline did not join the hospital or any of the physicians who treated her even though her vascular surgeon made the ultimate decision to discharge her.
48. *Id.* at 662.
49. *Id.*
50. *Id.* at 671.
51. *Id.* (citing CAL. WELF. & INST. CODE, § 14132 (n.d.)).
52. *Id.* at 666.
53. *Id.*

process.[54] In essence, there was no evidence the Medi-Cal decision proximately caused the amputation of Ms. Wickline's leg.[55]

Despite absolving the state from liability, however, the court was careful to note its decision was not intended to relieve UR operators of all responsibility. The court stated:

> [T]he patient who requires treatment 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.*[56]

Based on the foregoing language, it is likely the court would have reached a different conclusion if it had found evidence of negligence inherent to the Medi-Cal UR process.[57] Unfortunately, the court provided no guidance in determining the appropriate standard of conduct for UR evaluations.[58]

C. *Private Sector Applicability:* Wilson v. Blue Cross[59]

A second California case, *Wilson v. Blue Cross*, provided the backdrop for medical malpractice actions based on *private sector* UR. *Wilson* suggests liability may be imposed for private sector UR if the court finds the UR decision was a "substantial factor" in causing the alleged injury.[60]

1. *Background*

Wilson stems from the suicidal death of a teenager shortly after discharge from a Los Angeles hospital, where he had been treated for major

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54. *Id.* at 672. It is important to recall that an adverse medical review determination is merely a denial of payment , and not a denial of medical care. *See supra* text accompanying notes 18-20.

55. It is not clear how the court would have ruled if Wickline's physician had not found the discharge to be medically appropriate, and nevertheless discharged Wickline due to the lack of funding for continued care. *See infra* text accompanying notes 76-86.

56. Wickline v. State, 228 Cal. Rptr. at 670-71 (emphasis added).

57. An expert for Wickline did in fact argue the UR decision failed to conform to "the usual medical standards," which dictated that a physician either personally examine the patient, review the medical chart, or discuss the case with the patient's personal physician prior to deciding issues of patient care. *Id.* at 669. His argument was not addressed by the court.

58. *Id.*; *see also* Blum, *supra* note 21, at 194 ("there is no consensus on who should perform [UR] functions or how they should be performed").

59. Wilson v. Blue Cross, 271 Cal. Rptr. 876 (Ct. App. 1990).

60. *Id.* at 883.

depression, drug dependence, and anorexia.[61] Ample evidence was presented at trial to show the decedent left the hospital *solely* because his insurer, Blue Cross and Blue Shield of Alabama, denied payment of insurance benefits.[62] The payment denial was based on a review decision made by Western Medical Review Organization ("Western Medical"), an independent California corporation.[63] The decedent's parents sued Blue Cross and Blue Shield of Alabama, Western Medical, and Blue Cross of Southern California, alleging the insurance contract with Alabama Blue Cross did not authorize UR by an "outside entity."[64] Accordingly, the decedent's parents claimed Alabama Blue Cross "tortiously violated" the insurance contract by basing its decision to deny payment on Western Medical's UR determination.[65] The complaint further alleged the contract violation that resulted in the payment denial was the "proximate cause" of the death of the plaintiffs' son.[66]

Based on *Wickline*, the trial court granted summary judgment in favor of the defendants.[67] However, this decision was reversed by the court of appeals, which distinguished the two cases in several areas.[68] First, it was undisputed in *Wickline* that the decision to discharge the plaintiff after the four-day extension was consistent with the recognized standard of care for physicians.[69] In contrast, testimony in *Wilson* suggested the decedent's continued hospitalization was medically necessary, and a Western Medical reviewer was negligent in suggesting further payment be denied.[70]

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61. *Id.* at 877-78.

62. *Id.* at 880 n.2.

63. *Id.* at 881.

64. *Id.* at 880-81. Blue Cross of Southern California was joined in the action due to its status as adjuster for Alabama Blue Cross claims originating in California. *Id.* Blue Cross of Southern California in turn contracted with Western Medical for UR services. *Id.* at 881.

65. *Id.*

66. *Id.*

67. *Id.* at 878.

68. *Id.* at 885.

69. *Id.* at 878-79 (citing Wickline v. State, 239 Cal. Rptr. 810, 816 (Ct. App. 1986)).

The *Wickline* case was originally published in 1986. Wickline v. State, 228 Cal. Rptr. 661 (1986). The Supreme Court of California granted review of the case. Wickline v. State, 231 Cal. Rptr. 560 (Ct. App. 1986). However, pursuant to California rule of court 29.4(c), the supreme court dismissed the review and ordered the lower court to republish the original *Wickline* case. Wickline v. State, 239 Cal. Rptr. 805 (Ct. App. 1987). *Wickline* was republished in 1987. Wickline v. State, 239 Cal. Rptr. 810 (Ct. App. 1986). This information is provided solely for tracking purposes. All citations in this Article will be to the original publication: Wickline v. State, 228 Cal. Rptr. 661 (Ct. App. 1986), *appeal dismissed*, 711 P.2d 613 (Cal. 1987).

70. *Id.* at 883; *see also* Hughes v. Blue Cross, 263 Cal. Rptr. 850 (Ct. App. 1989) (holding that physician reviewer's failure to obtain all relevant information constituted bad faith). A similar conclusion was reached in *Linthicum v. Nationwide Life Insurance Co.*, in which a cancer patient was denied health benefits based on the fact the treatments started before the policy became effective. Linthicum v. Nationwide Life Ins. Co., 723 P.2d 675 (Ariz. 1986). The *Linthicum* court found bad faith on the part of the insurance company that denied the benefits,

Furthermore, UR under the Medi-Cal program is conducted pursuant to the California Administrative Code.[71] For public policy reasons, California legislators identified a need to incorporate cost containment mechanisms within the state-funded medical program.[72] The court in *Wickline* concluded these public policy grounds were sufficient to create an exception to the standard for tort liability set forth in California Civil Code section 1714.[73] However, "[n]o such statutory and regulatory scheme" was present in *Wilson*.[74] The decedent's care was not funded under a state entitlement program, but rather through a privately purchased insurance contract.[75] Moreover, the contract contained no express reference to UR.[76] Consequently, the court found no reason to extend the *Wickline* holding to private sector claims, making special note of the *Wickline* warning that utilization review should not be allowed to corrupt medical judgment.[77]

2. *The "Substantial Factor" Test*

After determining the *Wickline* holding could not be used to grant the defendants immunity as a matter of law, the *Wilson* court addressed various other motions for summary judgment.[78] The most significant motion was based on "the language in *Wickline* which states that the exclusive responsibility for a discharge rests with the physician."[79] Defendants concluded this language meant that "when a treating physician makes a decision to discharge a patient because an insurance company refuses to pay benefits . . . the sole liability rests with the physician."[80]

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due to the fact the insurance company failed to contact the attending physician in regard to the case, and failed to have the case reviewed by its own medical director. *Id.* at 681-82.

71. Wickline v. State, 228 Cal. Rptr. at 671 (citing CAL. WELF. & INST. CODE § 14133 (n.d.)).

72. Wilson v. Blue Cross, 271 Cal. Rptr. at 879; *see also* Sarchett v. Blue Shield, 729 P.2d 267 (Cal. 1987).

73. Wilson v. Blue Cross, 271 Cal. Rptr. at 879 (citing Wickline v. State, 239 Cal. Rptr. at 810).

74. *Id.*

75. *Id.*

76. *Id.* The court later found that although certain contractual language may be construed to authorize review, because the argument was not fully developed at the trial level, it could not serve as the basis for summary judgment in favor of defendants on appeal. *See id.* at 884 n.7. *But see* Franks v. Louisiana Health Serv. & Indemnity Co., 382 So. 2d 1064 (La. Ct. App. 1980) (holding that contract clause was "not ambiguous," and insurer had right to determine medical necessity under the terms of the policy, provided the review was conducted by medical professionals).

77. Wilson v. Blue Cross, 271 Cal. Rptr. at 879 (citing Wickline v. State, 239 Cal. Rptr. 810 (Ct. App. 1986)). Also significant in *Wilson* was the fact the court declined to find public policy considerations (e.g., cost containment) sufficient to absolve the defendants from liability. *Id.* at 884.

78. *Id.* at 879-80.

79. *Id.* at 883 (citing Wickline v. State, 239 Cal. Rptr. at 810).

80. *Id.*

In addressing this argument, the court first noted the referenced language constituted dicta.[81] In addition, the *Wilson* court stated the *Wickline* dicta "misconstrued" the standard for determining joint tort liability.[82] Quoting from the *Restatement (Second) of Torts*, the court determined liability would result if, without a valid legal excuse, an actor's conduct is a "'substantial factor in bringing about the harm.'"[83] The court then concluded that due to testimony stating the decedent was discharged from the hospital solely because his insurance coverage had been denied, a triable issue existed as to whether the UR decision was a "substantial factor" in causing the boy's death.[84] The case was subsequently remanded for determination of liability based on the "substantial factor" test.[85]

D. *Evaluating the Standard of Care Used in Conducting Utilization Review*

Although *Wilson* seems to clarify the causation issue developed in *Wickline*, additional questions remain: How should the negligence or non-negligence of a UR decision be determined? Is compliance with "accepted community standards" sufficient?[86] Without further guidance, it would appear a reviewer must follow the same general steps in conducting an evaluation as an attending physician would follow in making an initial diagnosis. However, because it is virtually impossible for the reviewing physician to conduct a one-on-one evaluation of the patient, this requirement is not practical.[87]

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81. *Id.*
82. *Id.*
83. *Id.* (quoting RESTATEMENT (SECOND) OF TORTS § 431 (1964)).
84. *Id.*
85. *Id.* at 885.
86. *Id.* at 883.
87. Jack Zusman, *Guidelines for the Practice of Utilization Review: Essential But Lacking*, QUALITY REV. BULL., Apr. 1990, at 143. According to the author:

> [T]here are several reasons reviewers should not evaluate or respond to UR cases the way they do to their own patients. Those reasons go beyond the conflict between the objectives of serving the individual patient and minimizing the burden on other parties . . . . [T]he UR situation is markedly different from a physician's relationship with his own patient.
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> First, the information available for UR review is seriously limited. No matter how complete the reviewed record is—and usually it provides far less information than a complete chart—the many clinically relevant facts, impressions, and conjectures engendered through interaction with a live patient are missing.
>
> Second, the patient's socio-cultural, economic, and familial situations that must be major considerations in designing an effective treatment plan for almost any illness or injury are necessarily given little weight in UR (and are often not described in the record). Despite any effort to get beyond abstraction, the UR reviewer deals with a faceless average patient. The clinician deals with the patient in the flesh.

Another California case, *Hughes v. Blue Cross*,[88] may provide additional guidance. In *Hughes*, the court was charged with determining whether an insurance company had breached its implied covenant of good faith and fair dealing when it retrospectively denied payment for acute psychiatric care provided to the plaintiff's son.[89] Consistent with both *Wilson* and *Wickline*, the *Hughes* court found an insurer had a duty to make "reasonable efforts to obtain all medical records relevant to the hospitalization," including, when necessary, contacting the attending physician's office for the needed information.[90] Applying this reasoning to a concurrent or prospective review situation, it would seem logical that a "reasonable effort to obtain all records" might at the very least consist of a telephone call to the attending physician's office.[91] This is especially true if pertinent information is missing from the medical record.[92]

E. *Who Holds the Ultimate Responsibility for Patient Care?*

Wilson also fails to clarify the legal consequences to an attending physician when he or she disagrees with the UR decision. The *Wickline* court clearly stated the ultimate responsibility for patient care rested with the attending physician.[93] At the very least, the attending physician has a duty to appeal the determination if he or she feels the review decision is inconsistent with recognized standards of care.[94] However, the *Wilson* court categorized this *Wickline* language as dicta—irrelevant to the causation issue.[95]

At least one writer suggests that when the patient's insurer requires preauthorization of an admission, procedure, or continued stay, the attend-

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> Finally, and most importantly, the patient's personal desires to have and the physician's wishes to provide something extra in the treatment, such as an additional margin of safety, an added measure of comfort, or a less intensive and slower treatment, must be ignored by the reviewer even though in clinical practice such items usually are given great weight. The reviewer has to draw a sharp line between must-have items and nice-to-have items while the clinician often should not.

Id.

88. Hughes v. Blue Cross, 263 Cal. Rptr. 850 (Ct. App. 1989).

89. *Id.* at 852.

90. *Id.* at 857-58.

91. Wickline v. State, 228 Cal. Rptr. 661, 670 (Ct. App. 1986), *appeal dismissed*, 741 P.2d 613 (Cal. 1987); *see also* FLA. STAT. § 395.0172 (1991) (regulating review entities operating in Florida). The statute requires the reviewing physician to consult with the attending physician before deciding a particular treatment is medically inappropriate. *Id.* at 5(b)2(C).

92. *See generally*, Zusman, *supra* note 87 (medical records available to reviewer likely to be incomplete).

93. Wickline v. State, 228 Cal. Rptr. at 670-71.

94. *Id.*

95. Wilson v. Blue Cross, 271 Cal. Rptr. 876, 879-80 (Ct. App. 1990).

ing physician "shares" liability with the hospital and UR entity.[96] Regardless of the actual *percentage* of liability assigned to the attending physician, however, authorities agree the attending physician must retain a percentage of the risk to ensure the patient receives high quality care.[97]

IV. SPREADING TORT LIABILITY: LINKING EMPLOYERS AND INSURERS WITH THE ACTS OF UTILIZATION REVIEW ENTITIES

A. *Vicarious Liability*

Recent case law, including *Wilson*, suggests vicarious liability theories may be used to extend tort liability for UR decisions beyond the UR entity to the plaintiff's insurer, and perhaps *employer*.[98] As a general rule, principals are exempt from liability for acts or omissions of independent contractors.[99] The *Restatement (Second) of Torts*, however, lists numerous exceptions to the no-liability rule.[100]

In a UR context, the most significant exceptions are negligence in *selecting* an independent contractor,[101] and failure to inspect the work of a contractor.[102] For example, if an employer fails to use reasonable care to investigate the UR firm prior to selection, or fails to monitor decisions made by the UR *after* selection, the employer could be viewed as creating an "unreasonable risk" of harm to its employees and beneficiaries.[103]

B. *Ostensible Agency*

Two *independent* theories also may subject an employer or insurer to liability for negligent UR. First, under the tort principle of "ostensible agency," the employer or insurance company may be held to have assumed *responsibility* for the care provided if it plays an especially active role in

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96. E.H. Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1748-50 (1987).

97. *See generally* Andrea J. Lairson, Comment, *Reexamining the Physician's Duty of Care in Response to Medicare's Prospective Payment System*, 62 WASH. L. REV. 791 (1987); Note, *Rethinking Medical Malpractice in Light of Medicare Cost Cutting*, 98 HARV. L. REV. 1004 (1985).

98. *See generally* Corcoran, *supra* note 14; *see also* Wilson v. Blue Cross, 271 Cal. Rptr. at 881. In naming not only Western Medical, but also both insurance companies and the UR consultant as defendants in her wrongful death claim, the plaintiff claimed "all of the defendants were agents of one another and that they were negligent in selecting one another as their agents." *Id.* In addition to her wrongful death claim, the decedent's mother named all defendants in a cause of action for tortious interference with a contract. *Id.* For a general discussion of possible *contract* claims, see Blum, *supra* note 21, at 209-12.

99. *See* RESTATEMENT (SECOND) OF TORTS § 409 (1965).

100. *Id.* §§ 410-429.

101. *Id.* § 411.

102. *Id.* § 412.

103. Corcoran, *supra* note 14, at 17.

selecting and maintaining a UR program.[104] The *Restatement (Second) of Torts* explains ostensible agency as follows:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as if the employer were supplying them himself or by his servants.[105]

Traditionally, the use of ostensible agency in a health care context has been limited to hospitals[106] and health maintenance organizations ("HMOs").[107] However, as corporations become more sophisticated about methods of cost containment, it may be feasible to hold an employer or insurer liable for the acts of a UR entity. After all, the employer/insurer selected the review entity, and thus assumed the responsibility "for arranging quality as well as cost effective care."[108] To succeed against an employer or insurer on the basis of ostensible agency, a patient will likely need to establish that (1) the patient relied on the employer to arrange for the patient's medical care, and (2) through managed care programs or provider purchasing arrangements, the employer restricted the patient's choice of providers to the extent the provider can be viewed as an agent of the employer/insurer.[109]

An employer/insurer may protect itself by clearly indicating in the insurance policy or employee manual that the UR entity is an independent contractor, acting under its own direction.[110] In addition, an employer/insurer may wish to expressly disclaim any warranties concerning the quality of the UR.[111]

C. *Corporate Negligence*

An employer/insurer who contracts for UR services also may be subject to liability through the doctrine of corporate negligence.[112] In the health care context, this theory is used often to hold a hospital liable for

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104. *Id.* at 8-10; *see also* RESTATEMENT (SECOND) OF TORTS § 429 (1965).

105. RESTATEMENT (SECOND) OF TORTS § 429 (1965).

106. *See* Porter v. Sisters of St. Mary, 756 F.2d 669 (8th Cir. 1985); Garbaccio v. Oglesby, 675 F. Supp. 1342 (M.D. Ga. 1987); Solich v. Wheeling, 543 F. Supp. 576 (W.D. Pa. 1982); Stewart v. Midani, 525 F. Supp. 843 (N.D. Ga. 1981).

107. *See* Independence HMO, Inc. v. Smith, 733 F. Supp. 983 (E.D. Pa. 1990); Boyd v. Albert Einstein Medical Ctr., 547 A.2d 1229 (Pa. Super. Ct. 1988).

108. Corcoran, *supra* note 14, at 18.

109. *Id.* at 21-22.

110. *Id.* at 22.

111. *Id.*

112. *Id.* at 14.

failing to properly investigate an allegedly negligent physician prior to granting staff privileges.[113]

In *Harrell v. Total Health Care, Inc.*,[114] a Missouri Court of Appeals held the doctrine could be appropriately used in the HMO setting.[115] *Harrell* involved an action filed by a patient/beneficiary of the defendant HMO based on the negligence of a physician who contracted to provide services for the HMO.[116] In its holding, the court stated HMOs, like hospitals, have a duty to protect patients from "foreseeable risk of harm."[117] According to the court, the HMO created an unreasonable risk of harm by requiring member employees to use physicians designated by the HMO.[118] The court nevertheless affirmed the trial court's summary judgment order because it found Total Health Care, Inc., who was treating the plaintiff, was exempted as a "health service corporation" under Missouri statute.[119] In states that do not provide such statutory protection, however, the doctrine of corporate negligence remains a threat to unknowing UR users.

Just as an HMO requires its beneficiaries to use designated physicians, employers/insurers who contract for UR services require their employees/beneficiaries to use a particular UR entity. Although a UR entity is not involved in the direct provision of patient care, an adverse UR decision will strongly *influence* the treatment process.[120] It is therefore feasible a future court would find the doctrine of corporate negligence appropriate in the UR setting.

To avoid liability based on corporate negligence, an employer/insurer will undoubtedly need to show it exercised due care both in selecting the UR entity and in continually monitoring the UR entity's performance.[121] The liability issue would likely depend on such factors as the UR entity's operational procedures, the credentials of UR personnel, and the UR entity's history with other employers/insurers.[122]

In short, although few employers or insurance companies can afford *not* to incorporate cost containment into their health insurance programs, it

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113. *See generally* Jack W. Shaw, Jr., Annotation, *Hospital's Liability for Negligence in Selection or Appointment of Staff Physician or Surgeon*, 51 A.L.R.3d 981 (1973).

114. Harrell v. Total Health Care, Inc., No. WD-39809, 1989 WL 153066 (Mo. Ct. App. Apr. 25, 1989), *aff'd*, 781 S.W.2d 58 (Mo. 1989) (stating that in absence of statutory immunity, HMO could be held liable for corporate negligence for negligent UR decision).

115. *Id.* at *6.

116. *Id.* at *1.

117. *Id.* at *4.

118. *Id.* at *5.

119. *Id.* at *8 (referring to Missouri statute section 354.125). The court then transferred the plaintiff's claim that the former statute was unconstitutional to the Missouri Supreme Court. *Id.* at *9.

120. *See* Matthews, *supra* note 13, at 140.

121. Corcoran, *supra* note 14, at 36.

122. *Id.* at 38-40. For other methods of avoiding liability, see Corcoran, *supra* note 14, at 38-42.

is vital they recognize the liability risks that accompany increased intervention. Due care must be taken not only in choosing the UR entity, but also in making sure employees/beneficiaries understand the role of the UR entity and its relationship with the employer/insurer. Clearly, courts are beginning to recognize the degree of influence managed care programs hold over health care delivery, and are beginning to allocate liability accordingly.

V. ERISA AS A DETERRENT TO NEGLIGENT UTILIZATION REVIEW CLAIMS

In light of the above discussion, as well as the widespread use of UR,[123] the number of reported cases involving UR decisions is disproportionately small. ERISA is undoubtedly a major reason for this apparent lack of litigation.[124] ERISA is a far-reaching federal statute that governs both multi-employer pension programs and employee "welfare benefit plans."[125] ERISA defines "welfare benefit plan" to include employer-sponsored medical insurance policies,[126] similar to those that served as the bases for the plaintiffs' claims in both *Wilson* and *Hughes*.

A. *The Legal Implications of ERISA's Preemption Clause*

Although not mentioned in either *Hughes* or *Wilson*, a section of ERISA has served as a significant barrier to similar claims based on state legislation or common law.[127] Specifically, the section provides the statute

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123. *See supra* text accompanying note 10.

124. *See* 29 U.S.C. §§ 1101-1461 (1988). It is likely many cases were dismissed at the district court level on the basis of ERISA. For further discussion of ERISA's effect on suits arising from utilization review, see Matthews, *supra* note 13. *See also* Blum, *supra* note 21, at 200-09.

125. 29 U.S.C.A. §§ 1101-1461 (1985 & Supp. 1991).

126. *See* 29 U.S.C. § 1102(1) (1988). "Welfare benefit plan" is specifically defined as:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits.

Id.

127. *See* Varol v. Blue Cross & Blue Shield, 708 F. Supp. 826 (E.D. Mich. 1989) (holding that state law action filed by psychiatrists against corporate psychiatric-managed care program preempted by ERISA); Thomas v. Gulf Health Plan, Inc., 688 F. Supp. 590 (S.D. Ala. 1988) (holding that ERISA preempted state common law doctrines, including estoppel, as pertaining to health insurer's denial of benefits). *But see* Independence HMO, Inc. v. Smith, 733 F. Supp. 983 (E.D. Pa. 1990) (holding that ERISA did not preempt patient's state court medical malpractice action against HMO).

"shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."[128]

A majority of courts—including the United States Supreme Court in *Pilot Life Insurance v. Dedeaux*[129]—have broadly interpreted this clause to preempt not only statutes that govern benefit plans, but also state common law in actions pertaining to welfare benefit plans.[130] Moreover, the state law need not directly conflict with ERISA in order to be preempted.[131] According to *Shaw v. Delta Airlines*,[132] the mere fact a law referenced an employee benefit plan was sufficient to constitute "relation to" such plans.[133] If claimants could seek state remedies rather than pursue those specifically authorized by the statute, "the intent of Congress to provide comprehensive pre-emption of state law" would be defeated.[134]

It is important to note not all relevant state law is preempted by ERISA.[135] For example, *Shaw* went on to hold a state law that is "too tenuous, remote, or peripheral," will not be preempted under ERISA.[136] In *Firestone Tire & Rubber Co. v. Neusser*,[137] a lower court has since held laws which *indirectly*, as opposed to *directly*, affect benefit plans will also withstand ERISA preemption.[138]

As a practical rule, three factors are relevant in determining whether a state law is preempted by ERISA: (1) "whether [the] state law represents a traditional exercise of authority;"[139] (2) "whether [the] state law affects the relations among the major ERISA entities (the plan sponsor, employer, fiduciary and/or participants);"[140] and (3) "whether the impact of [the] state law on an ERISA plan is incidental in nature."[141]

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128. 29 U.S.C. § 1144(a) (1988).

129. Pilot Life Ins. v. Dedeaux, 481 U.S. 41 (1987). The *Pilot* Court noted the preemption clause is not limited to "'state laws specifically designed to affect employee benefit plans.'" *Id.* at 47-48 (quoting Shaw v. Delta Airlines, 463 U.S. 85, 98 (1983)).

130. *Id.*; *see also* Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 62 (1987); Belasco v. W.K.P. Wilson & Sons, Inc., 833 F.2d 277, 280-81 (11th Cir. 1987).

131. Shaw v. Delta Airlines, 463 U.S. 85, 98 (1983).

132. Shaw v. Delta Airlines, 463 U.S. 88 (1983).

133. *Id.* at 96-97. Lower federal courts have since viewed Shaw expansively. *See, e.g.*, Powell v. Chesapeake & Potomac Tel. Co., 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986).

134. Shaw v. Delta Airlines, Inc., 463 U.S. at 106.

135. *Id.* at 97.

136. *Id.* at 100.

137. Firestone Tire & Rubber Co. v. Neusser, 810 F.2d 550 (6th Cir. 1987).

138. *Id.* at 553.

139. Matthews, *supra* note 13, at 155.

140. *Id.*

141. *Id.*

B. *The Saving Clause and an Exception for the Business of Insurance*

A state law claim based on negligent UR may also escape preemption under ERISA if the UR can be shown to fall within the "business of insurance."[142] A section of ERISA commonly known as the "saving clause"[143] exempts state laws that regulate insurance, banking, or securities from ERISA's preemption clause.[144] To maintain a common-law negligence claim against an insurer, however, a UR plaintiff must establish not only that the UR at issue falls within the practice of insurance, but also that the state law on which the action is based actually *regulates* insurance.[145]

It is also important to note *employers* who maintain ERISA-qualifying plans are generally protected from state-law claims by ERISA's "deemer clause," even if the employer serves as the plan's administrator.[146] Thus, the following discussion applies to insurance companies only.[147]

1. *Does Utilization Review Fall Within the Business of Insurance?*

Unlike the act of claims processing, the basis for the plaintiff's suit in *Pilot Life*, UR performed by an independent organization is not an obvious insurance function. An issue therefore exists as to whether UR can feasibly be viewed as the practice of insurance. In *Union Labor Life Insurance Co. v. Pireno*,[148] the United States Supreme Court addressed whether an insurance company's use of chiropractic peer review to evaluate the medical necessity of chiropractic procedures constituted the practice of insurance.[149] Using criteria developed in *Group Life & Health Insurance Co. v. Royal Drug Co.*,[150] the Court found the peer review was not within the definition of

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142. 29 U.S.C. § 1144(b)(2)(A) (1988).

143. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44-45 (1987).

144. *Id.*

145. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 743 (1985).

146. ERISA's deemer clause provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (1988); *see also* Michael G. Pfefferkorn, Comment, *Federal Preemption of State Mandated Health Insurance Programs Under ERISA—The Hawaii Prepaid Health Care Act in Perspective*, 8 ST. LOUIS U. PUB. L. REV. 339, 344 (1989).

147. For a discussion of potential legal consequences to employers whose benefits plans do *not* qualify as an ERISA plan, see Pfefferkorn, *supra* note 146, at 344-45. For example, many *self-insured* plans may not be covered by ERISA. *See* Matthews, *supra* note 13, at 154.

148. Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982).

149. *Id.* at 122.

150. Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

insurance.[151] In *Pireno*, the Court set forth three factors as relevant in determining if a particular practice is within "the business of insurance": (1) whether the practice "transferred or spread" a risk; (2) whether the practice was an integral part of the contractual relationship; and (3) whether the practice was limited to organizations within the insurance industry.[152]

In applying the first *Royal Drug* criterion, the *Pireno* Court found because the insurance contract had already been made at the time the UR was conducted, the review itself did not help to "transfer" the risk.[153] As the Court explained: "[T]o the extent that the insured pays unreasonable charges for unnecessary treatments, he will not be reimbursed, because the risk of incurring such treatments and charges was never *transferred* to the insurer, but was instead always *retained* by the insured."[154]

The Court's discussion of the second criterion, whether the practice is an integral part of the contractual relationship, focused on the fact the contract between the chiropractic reviewers and the insurance company was separate and distinct from the insurance contract between the insurance company and its policyholders.[155] The decision to pay a claim was made entirely by the insurance company, albeit on the advice of the reviewer.[156] The policyholder cared only that his claim was paid—not *why* his claim was paid.[157] Consequently, the Court held the act of UR was not an integral part of the contract.[158]

Finally, in applying the third criterion, whether the practice is performed exclusively within the insurance industry, the Court stated "it is plain that the challenged peer review practices are not limited to entities within the insurance industry."[159] The Court noted, however, that each factor is merely *relevant* to the determination of whether a practice falls within the business of insurance—no single criterion is controlling.[160]

A court, therefore, may find UR to constitute the business of insurance even though only one or two criteria are satisfied. For example, a strong argument could be made that the UR and insurance functions are intrinsically linked if the insurance company performs the UR.[161] Additionally, Justice Rehnquist argued in his dissent to *Pireno* that peer review was closely linked to claims processing, which in turn is "central to [the] con-

151. Union Labor Life Ins. Co. v. Pireno, 458 U.S. at 129 (citing Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. at 211-15).
152. *Id.* (citing Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. at 211-15).
153. *Id.* at 130.
154. *Id.* at 130-31 (emphasis added).
155. *Id.* at 131-32.
156. *Id.* at 132.
157. *Id.*
158. *Id.*
159. *Id.*
160. *Id.* at 129.
161. Blum, *supra* note 21, at 206.

tractual relationship."[162] Because employers or insurers who use UR may *require* the employee/beneficiary to obtain preauthorization or face a monetary penalty,[163] a court would be hard-pressed to find the UR was not an integral part of the contractual relationship.

2. *When Does a State Law "Regulate Insurance?"*

Even if a court considers UR to fall within the business of insurance, the state-law claim will not withstand ERISA preemption unless the particular statute or common law at issue is shown to "regulate insurance."[164] As discussed earlier, common-law actions are rarely sustained, in deference to the public policy underlying ERISA.[165] In *Pilot Life*, the Court held the plaintiff's suit, based on bad faith claims processing of an insurance claim, was preempted under ERISA even though an insurance action was clearly involved.[166] Crucial to the Court's decision was the fact that "bad faith" is a state common-law cause of action that was not "specifically directed" toward the practice of insurance.[167] Other common-law causes of action, including tortious interference with a contract and breach of contract, have also been preempted under ERISA.[168]

Some states have adopted statutes that grant a private cause of action for bad faith insurance practices.[169] It is relatively clear these laws were intended to "regulate insurance." Consequently, the rate of success in achieving ERISA preemption is far greater than under a common-law cause of action.[170] However, in light of the public policy underlying ERISA, many courts continue to interpret ERISA as preempting state statutes as well as common law.[171]

C. *Statutory Causes of Action Under ERISA*

If a plan participant or beneficiary is unable to maintain an action under state law, he or she is limited to specific causes of action designated

162. Union Labor Life Ins. Co. v. Pireno, 458 U.S. at 136 (Rehnquist, J., dissenting).

163. *See, e.g.*, Kinworthy & Gospo, *supra* note 11, at 138.

164. *See* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

165. *See supra* text accompanying notes 126-40.

166. Pilot Life Ins. v. Dedeaux, 481 U.S. 41, 57 (1987).

167. *Id.* at 50.

168. *See, e.g.*, Cefalu v. B.F. Goodrich Co., 871 F.2d 1290 (5th Cir. 1989) (holding ERISA preempted breach of contract claim); Tomczyk v. Blue Cross & Blue Shield United, 715 F. Supp. 914 (E.D. Wis. 1989) (holding ERISA preempted claims of bad faith, breach of contract, and tortious interference with contract). *But see* Struble v. New Jersey Brewery Employee's Welfare Trust Fund, 732 F.2d 325 (3d Cir. 1984) (holding bad faith claim allowable if plaintiffs can establish breach of fiduciary duties).

169. Matthews, *supra* note 13, at 153.

170. *Id.* at 154.

171. *Id.*

within ERISA.[172] A plaintiff may sue to clarify or enforce any rights under the plan, or to recover a benefit allegedly due under the plan.[173] Under this section, however, a plaintiff may recover merely the amount of coverage specified by the policy, plus a small monetary penalty if the plan administrator fails to "timely provide" needed coverage information or clarification.[174]

In addition, section 409(a) of ERISA enables the plan to recover damages from the plan "fiduciary" for breach of fiduciary duty.[175] A beneficiary may also seek "appropriate relief for a breach of fiduciary duty under section 502(a)(2).[176] These sections viewed together would appear to support a *Wilson*-type claim based on fiduciary negligence. However, in *Massachusetts Mutual Life Insurance Co. v. Russell*,[177] the United States Supreme Court held ERISA barred recovery for "extracontractual damages" such as pain and suffering and emotional distress.[178] Many courts since *Russell* have echoed this view.[179]

Clearly, ERISA currently serves as a major obstacle to plaintiffs filing a common-law negligence claim against an insurer or employer based on a UR denial. However, as more and more insurers incorporate UR in their standard employee health insurance packages, thus establishing UR firmly within "the business of insurance," resourceful plaintiffs may successfully overcome this barrier.

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172. *Id.*; *see also* 29 U.S.C § 1132(a) (1988).

173. 29 U.S.C. § 1132(a)(1)(B) (1988).

174. *Id.* § 1132(a)-(c).

175. *Id.* § 1109. A person becomes a "fiduciary" for purposes of ERISA if he exercises "discretionary authority or discretionary control respecting management of the plan . . . exercise[s] any authority or control respecting disposition of the assets of the plan . . . [or] render[s] investment advice with respect to any money or other property of the plan." 29 C.F.R. § 2509.75-.78 (1991). An insurance company that processes claims under a corporate benefit plan may also be considered a plan fiduciary. Matthews, *supra* note 13, at 159-60.

ERISA section 404(a)(1) requires a plan fiduciary to "discharge his duties with respect to the plan *solely* in the interest of the participants and beneficiaries . . . with the care, skill, prudence, and diligence that a prudent man acting in a like capacity and familiar with like matters would use." 29 U.S.C.A. § 1104(a)(1) (Supp. 1991). Therefore, similar to the corporate negligence theory, if a plan fiduciary fails to exercise "prudence" in selecting and monitoring a utilization review program, he may be found to have breached his fiduciary duties. Matthews, *supra* note 13, at 160-61.

176. 29 U.S.C. § 1132(a)(2) (1988).

177. Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985).

178. *Id.* at 144.

179. *See, e.g.*, U.S. Steel Mining Co. v. District 17, United Mine Workers, 897 F.2d 149 (4th Cir. 1990) (holding that ERISA does not provide remedy in the form of extracontractual damages); Powell v. Chesapeake & Potomac Tel. Co., 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (denying extracontractual damages when plan administrator breaches fiduciary duties under ERISA); Giuntoli v. Garvin Guybutler Corp., 726 F. Supp. 494 (S.D.N.Y. 1989) (holding that punitive damages might be recoverable under New York Human Rights law but were not recoverable under ERISA).

VI. PUBLIC POLICY ISSUES SURROUNDING THE PRACTICE OF UTILIZATION REVIEW: METHODS FOR FURTHER REDUCTION OF TORT LITIGATION

Admittedly, UR could prove detrimental to the quality of patient care if it is not closely controlled. Cost-reduction incentives may cause physicians to eliminate tests and services that might otherwise lead to quicker and more effective diagnosis and recovery.[180] Review determinations based on insufficient information could result in serious harm or even death.[181] Some commentators also fear cost-containment mechanisms will result in a lowering of the standards of care to which physicians and other health care providers are held.[182]

A. *In Support of Utilization Review*

The number of corporations that subscribe to UR programs indicates UR is thought by many to be an effective means of controlling health care expenditures.[183] This view recently drew support from a much-publicized study conducted by researchers from the University of California at Irvine and the University of Michigan.[184] The researchers concluded UR instituted by a large private insurance carrier effectively decreased hospital admissions by 12.3%, and overall hospital expenditures by 11.9%.[185]

Moreover, although cost-containment programs such as UR may reduce the number of services provided, no one has yet proven less medical care is *necessarily* harmful.[186] Renowned health care scholar Avedis Donabedian, M.D., argues that although "[q]uality costs money . . . [m]oney does not necessarily buy improvements in quality [and] . . . [s]ome improvements in quality are not worth the added cost."[187] Some experts also

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180. *See* Note, *supra* note 97, at 1004.

181. *Id.*

182. *See, e.g.*, Edmund D. Pelligrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 42 (1986).

183. *See supra* text accompanying note 10.

184. Paul J. Feldstein et al., *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310 (1988).

185. *Id.* at 1312. The study also uncovered a "savings-to-cost ratio" of eight to one. *Id.* at 1314. In addition, many individual corporations that use UR have documented significant cost savings. *See* Stamm, *supra* note 16, at 91.

186. Melinda Beck et al., *Cost vs. Quality of Care: Tracking the Side Effects*, NEWSWEEK, Jan. 30, 1989, at 48, 48. However, the authors note a recent study published in the New England Journal of Medicine, which found Medicare patients with hip fractures were more likely to end up in a nursing home following the introduction of prospective payment systems. *Id.* (citation omitted in original). Prospective payment systems "allocate fixed prepaid sums to hospitals for patient's care and allow hospitals to profit if overall care costs less." *Id.*

187. Avedis Donabedian, *Five Essential Questions Frame the Management of Quality in Health Care*, HEALTH MGMT. Q. 1987, at 6, 7.

suggest UR may *enhance* the quality of medical care, by minimizing patient exposure to hospital-acquired diseases.[188] As one author points out:

> Not every increase in medical care expenditure immediately benefits any patient. Some are downright harmful. Excessively long hospital stays are not only costly but dangerous. The administration of a test from which one can only expect a tiny yield is unlikely to have very much impact on diagnosis or prognosis, but, undoubtedly, in many instances, carries a risk greater than any benefit that might be received. There are areas, if one focuses at that nexus of the clinical and the financial, where one can identify the many instances in which good medicine is less expensive medicine.[189]

Many UR entities also conduct extensive research into the overall effectiveness and usage rate of a particular procedure or diagnosis in order to develop the criteria or standards used in conducting review.[190] Although physicians may feel constrained by the bureaucracy surrounding UR,[191] it is difficult to ignore the educational aspects of such broad-based research.

Finally, the financial impact of increasing insurance costs are not felt exclusively by corporations and insurance companies. Many employers can no longer afford to pay 100% of employee health care premiums, and are requiring employees to pick up the balance.[192] Others have chosen to increase insurance deductibles, or eliminate entire portions of their benefit package.[193] Although difficult to prove, it is also safe to assume many employers who cannot afford to absorb the costs themselves have transferred the cost to the general population in the form of increased prices. If UR is effective in balancing the quality and cost of health care, all of America can gain by affirmatively supporting its practice.

B. *Utilization Review Certification as Possible Means of Minimizing Utilization Review Malpractice Risks*

The *Wickline* decision suggests UR entities and insurers are most vulnerable when errors are found within the review process itself "which

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188. *See, e.g.*, Evan J. Ellman, *Monitor Mania: Physician Regulation Runs Amok*, 20 LOY. U. CHI. L.J. 721, 733 (1989) (citing Wong & Lincoln, *Ready, Fire! . . . Aim! An Inquiry into Laboratory Test Ordering*, 250 JAMA 2510 (1983)).

189. Bruce C. Vladeck, *Restructuring the Financing of Health Care: More Stringent Regulation of Utilization*, 60 BULL. N.Y. ACAD. MED. 89, 96-97 (1984).

190. *See, e.g.*, Ellman, *supra* note 188, at 768. In addition, the Health Care Financing Administration conducts a "pilot study" of many proposed review requirements prior to implementing the requirements on a national level. *See* Jost, *supra* note 25, at 14.

191. Ellman, *supra* note 188 at, 769.

192. *See* Stamm, *supra* note 16, at 88-89.

193. *Id.* at 89.

somehow remain apart from clinical decision-making."[194] Therefore, if a UR organization abides by procedures meeting recognized standards of quality, the organization can greatly decrease its liability risk.[195]

1. *State Legislation*

Mandatory state certification programs may provide some guidance in developing UR standards. To date, at least nine states maintain legislation regulating UR in their states.[196]

Ironically, the legislation may *protect* certain private review organizations and insurers who conduct review. By showing their procedures are in general compliance with state legislative standards, conscientious review entities may receive favorable consideration from judges or juries called to evaluate their performance. However, due to the lack of litigation in this area, it is yet unclear whether compliance with state certification requirements will release a UR program from liability as a matter of law.

2. *Voluntary Certification*

Concern about quality is not limited to groups *outside* the industry. A voluntary certification program based on performance standards is currently being developed by UR professionals.[197] Standards being considered include provisions for minimum reviewer qualifications, provider appeal mechanisms, and time limitations on notification of review results to providers.[198] As with state regulations, voluntary certification may help to insulate UR entities from liability stemming from allegedly negligent decisions. Employers also are wise to ensure an organization is either certified, or in general compliance with the standards, before contracting for UR services.

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194. Blum, *supra* note 21, at 199.

195. *See* KEETON et al., *supra* note 27, § 30, at 164-65. To prove negligence in a medical malpractice action, a plaintiff is required to show the defendant had a duty to use a certain standard of care in relation to the victim, and that the defendant failed to meet this standard. *Id.*

196. *See* ARK. CODE ANN. §§ 20-9-901 to -914 (Michie Supp. 1991); FLA. STAT. ANN. §§ 395.0172, 407.13 (West Supp. 1991); GA. CODE ANN. §§ 31-7-131 to -133, 33-46-1 to -14 (Harrison 1990 & Supp. 1991); 1990 KY. REV. STAT. & R. SERV. 451 (Baldwin) (codified in scattered sections of Kentucky Revised Statutes Annotated); LA. REV. STAT. ANN. § 22.2021 (West Supp. 1991); ME. REV. STAT. ANN. tit. 24A §§ 2771-2774 (West 1990 & Supp. 1991); MD. HEALTH-GEN. CODE ANN. §§ 19-1301 to -1313 (1990 & Supp. 1990); Miss. Senate Bill 2393 (effective July 1, 1990); S.C. CODE ANN. §§ 38-70-10 to -60 (Law. Co-op Supp. 1990); VA. CODE ANN. §§ 38.2-5300 to -5309 (Michie 1990).

197. *See* URAC STANDARDS, *supra* note 9.

198. *Id.*

C. *Extension of PRO-type Immunity*

As mentioned above, Medicare PROs and their agents enjoy absolute immunity from constitutional and common-law tort claims arising from negligent peer review activities.[199] In granting this immunity, the court in *Kwoun v. Southeast Missouri Professional Standards Review Organization*[200] explained:

> We are not unmindful of the problems that may arise from the extension to medical peer review groups of absolute immunity from both common-law tort claims and constitutional claims. We are convinced, however, that in order for the Medicare program to work effectively, efficiently, and economically, some controls on quality of care must be exercised. We are also convinced that the exercise of controls on quality of care greatly increases the benefits derived from the Medicare program by both the individual Medicare patients and our society as a whole. We are further convinced that the only way to ensure both the effectiveness of the peer review system and the willingness of private doctors to participate in it is to insulate them from damage claims that may result from that work.[201]

As stated in *Kwoun*, to promote efficient, economical, and high quality medical care, certain legal protections—and resulting societal concessions—may be necessary.[202]

It could be argued private sector reviewers warrant partial legislative or judicial immunity for many of the same reasons immunity is granted to PROs. Clearly, other physicians are most competent to evaluate the work of their peers.[203] This is true regardless of whether the care is being purchased through private or public means. As suggested in *Kwoun*, physicians would be reluctant to perform review if they knew they were subjecting themselves to liability.[204] To encourage physician participation in private UR, and thus ensure greater quality of review, some degree of protection must be afforded.[205]

A majority of states currently grant some protection to physicians performing review through a hospital's internal quality assessment

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199. Kwoun v. Southeast Mo. Professional Standards Review Org., 811 F.2d 401 (8th Cir. 1987).

200. Kwoun v. Southeast Mo. Professional Standards Review Org., 811 F.2d 401 (8th Cir. 1987).

201. *Id.* at 409 (citations omitted); *see also* Smith v. North La. Medical Review Ass'n, 735 F.2d 168, 173 (5th Cir. 1984) (stating that PROs perform "critical federal function of monitoring costs of services provided under the Act for which it is paid by the United States").

202. *See* Kwoun v. Southeast Mo. Professional Standards Review Org., 811 F.2d at 409; *see also* 42 U.S.C. § 1395y(g) (1988).

203. Kwoun v. Southeast Mo. Professional Standards Review Org., 811 F.2d at 413.

204. *Id.*

205. *See* Ellman, *supra* note 188, at 763-64.

process.[206] Consequently, clear precedent exists for extending immunity beyond government agencies.

VII. CONCLUSION

The United States is finally learning it lacks the resources to pay for an unlimited amount of health care services. It is therefore vital that cost containment mechanisms be employed to ensure health care dollars are used as efficiently and effectively as possible. Prospective UR is arguably the most valuable of these mechanisms because it enables a third-party payor to ascertain whether a proposed treatment is medically appropriate *before* the care is provided and valuable resources needlessly expended.

This does not mean UR should be *completely* free from liability. Nationwide standards are needed to ensure UR is performed by qualified personnel and review procedures consistent with generally recognized standards of care are used. It is not important whether the national standards are achieved via legislation or voluntary certification, provided UR contractors select only UR entities that comply with the standards.

The extension of medical malpractice litigation to the UR arena could prove devastating to an already threatened health insurance industry. As one writer predicts, "medical malpractice plaintiffs will [then] name both public and private third-party payors whenever possible to ensure the existence of a solvent defendant. This predictable excess of litigation may pose additional administrative problems for third-party payors, and channel scarce health care dollars away from treatment into legal costs."[207] In essence, we would be rewarding insurers who use UR to become more efficient by increasing their risk of malpractice liability. Many insurers may instead choose to relinquish their health care coverage entirely. And unless we are prepared to adopt a national public health care system, this is a chance we cannot afford to take.

Carla Jensen Hamborg

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206. *See* Gregory G. Gosfield, Note, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552, 571-75 (1979); David W. Jorstad, Note, *The Legal Liability of Medical Peer Review Participants for Revocation of Hospital Staff Privileges*, 28 DRAKE L. REV. 692, 693-94 (1978). *But see* Patrick v. Burget, 486 U.S. 94 (1988) (upholding damages in civil litigation when reviewing physician found to violate antitrust laws).

207. Dorsett Marc Lyde, Wickline v. State: *The Emerging Liability of Third Party Health Care Payors*, 21 SOC. SECURITY REP. SERV. 735 (1988), *available in* WESTLAW, database identifier SSRS (query: Lyde & "Wickline v. State"), at Westlaw pages 25-26.