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by

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The Education Committee provides study notes to persons preparing for the examinations of the Society of Actuaries. They are intended to acquaint candidates with some of the theoretical and practical considerations involved in the various subjects. While varying opinions are presented where appropriate, limits on the length of the material and other considerations sometimes prevent the inclusion of all possible opinions. These study notes do not, however, represent any official opinion, interpretations or endorsement of the Society of Actuaries or its Education Committee. The Society is grateful to the authors for their contributions in preparing the study notes.

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CHAPTER 64

Legal Liability Related to Medical Management Activities

James L. Touse

Managed care organizations (plans) are subject to a variety of legal and regulatory obligations related to the development and operation of their medical management programs. This chapter briefly discusses those obligations and plans' legal liability exposure if they fail to satisfy those obligations. The reader is urged to review the other chapters in Part V for additional discussion of related issues.

The terms *medical management program* and *medical management activities* are used to refer to the types of activities that plans utilize to control the cost and quality of health care services provided to their members. Those activities can be broadly categorized as utilization management, quality assurance, and dispute resolution programs. Utilization management activities may include referral management programs; preadmission, concurrent, and retrospective review programs; utilization reporting and evaluation programs; case management programs; and provider incentive arrangements. Quality assurance activities may include provider selection, credentialing, or privileging programs; quality assurance and assessment programs; peer review activities; and the implementation of medical policies, protocols, and practice guidelines. All these subjects are discussed in various chapters in Parts II and III. Although member and provider grievance programs have not traditionally been considered to be medical management activities, they are also discussed in this chapter. Those programs may permit plan management to identify and resolve disputes related to other medical management activities before they escalate into costly and time-consuming legal or regulatory actions against the plan. Member grievance programs and consumer affairs are discussed in Chapter 40.

The statutory and common (that is, case) law related to plans' medical management obligations has dramatically changed during the past 20 years, as managed care has evolved from the health maintenance organization (HMO) movement to the predominant form of health benefits coverage in the United States. That evolution will presumably continue and even escalate as state and federal legislatures, regulators, and courts enact, clarify, and enforce laws and regulations governing plans' medical management activities. At the time this chapter was written, Congress was considering sweeping patient protection legislation, and several states have already enacted laws permitting plans to be held liable for their medical management determina-

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The views presented in this chapter are intended to stimulate consideration and discussion concerning an evolving area of the law and should not be interpreted to constitute legal advice or to describe standards applicable to BCBST or any other managed care organization related to the conduct of its medical management activities.

tions. Those laws, which will be discussed in greater detail in Chapter 69, will certainly affect plans' future medical management obligations, liability exposure, and programs.

Plans must conduct effective medical management programs in order to be successful in an increasingly competitive market. The question confronting plan management and counsel is how to structure and operate effective medical management programs, while avoiding foreseeable liability exposures related to those activities.

If there is any generally accepted rule concerning what plans should do to avoid liability, it is that they must understand their obligations and act in a reasonable manner when making medical management determinations. If an organization acts reasonably, it should minimize its legal liability exposure while still conducting effective medical management activities.

OBLIGATIONS TO CONDUCT MEDICAL MANAGEMENT ACTIVITIES

Plans must implement and operate medical management programs pursuant to applicable laws, accreditation standards, and agreements with customers. Failure to comply with those obligations may, at best, expose a plan to increased regulatory oversight, legal liability, or loss of business. At worst, the plan might be ordered to cease doing business by regulatory agencies or be forced out of business by a loss of customers or a catastrophic liability judgment.

This section discusses state and federal statutes, regulations, and administrative requirements (laws) requiring plans to implement medical management programs. It is clearly beyond the scope of this chapter to evaluate all the laws that are applicable to plans' medical management activities.

Most plans can fairly easily comply with such medical management laws because they establish minimum requirements to obtain and maintain a license or certificate of authority in a state. The term *plan* is used throughout this chapter, but there are many different types of managed care organizations. Those distinctions are most relevant when determining what laws are applicable to a plan's medical management activities.

HMOs are generally required to establish medical management programs pursuant to state HMO licensure laws. As an example, the National Association of Insurance Commissioners (NAIC) Model HMO Act (see Chapter 69), which served as a model for most states' HMO statutes, requires HMOs to conduct medical management activities as a condition of licensure. That model act requires licensed plans to ensure that the health care services provided to enrollees are rendered in accordance with reasonable standards of quality that are consistent with prevailing professionally recognized standards of medical practice.[1] HMOs are also required to establish grievance procedures to address and attempt to resolve member grievances, including grievances related to such organizations' medical management activities,[2] as discussed in greater detail in Chapter 40.

If an HMO is federally qualified, it will also have to comply with the requirements of the federal HMO statute. That statute requires HMOs to have an ongoing quality assurance program that stresses health outcomes and provides for peer review of the services provided to members. It also requires qualified HMOs to have an effective procedure for collecting, evaluating, and then reporting information concerning the utilization of services to the secretary of the Department of Health and Human Services (DHHS).[3] The Health Care Financing Administration also requires Medicare + Choice plans (see also Chapters 55 and 56) to implement quality assessment and performance improvement programs, contract with an approved independent quality review and improvement organization to provide external review of the plan's medical management activities, and implement specified grievance procedures,[4] as conditions of contracting with such plans to serve Medicare beneficiaries.

Regulatory oversight of an HMO's medical management activities varies, depending on the jurisdiction where the HMO is licensed and whether it is federally qualified. The Model HMO Act empowers the state regulatory agency

to fine, suspend, or revoke an HMO's license if it fails to comply with its statutory obligations.[5] The secretary of DHHS may also revoke the federal qualification of any HMO that fails to comply with the assurances given to DHHS concerning its medical management activities.[6]

There are generally fewer regulatory requirements applicable to the medical management activities of other types of managed care organizations, such as preferred provider organizations (PPOs). The NAIC Model PPO Act requires plans to include mechanisms to control utilization and determine if services are medically necessary. It does not require plans to implement other medical management programs, such as quality assurance or grievance procedures.[7]

An increasing number of customer groups contractually require plans to be accredited as a condition of being offered to the groups' employees. One possible explanation for such accreditation requirements is the concern that those groups will be held liable for breaching their fiduciary duties pursuant to the Employee Retirement Income Security Act (ERISA) of 1974, as amended (see Chapter 66 for a full discussion of ERISA),[8] or for negligence if they fail to exercise reasonable care when selecting and supervising the activities of contracting plans.[9]

There are a number of private accreditation organizations, but the most widely accepted HMO accreditation agency is the National Committee for Quality Assurance (NCQA; see Chapter 44). The NCQA accreditation process evaluates an applicant's compliance with specific quality management and improvement, utilization management, credentialing, member rights and responsibilities, preventive health service, and medical records' standards.

Other groups do not require accreditation, but require contracting plans to satisfy specified medical management standards as a condition of being offered to the groups' members. As an example, the Federal Employees Health Benefit Program (FEHBP; see Chapter 54) requires contracting plans to develop and implement a quality assurance program that assesses the utilization of services, credentialing of providers, risk arrangements with providers, and member satisfaction with the plan.

COMMON LAW MEDICAL MANAGEMENT LIABILITY ACTIONS

Creative plaintiffs' attorneys are constantly dreaming up new and novel liability theories in actions against plans. The most recent actions have alleged violations of the Federal Racketeer Influenced and Corrupt Organizations Act ("RICO") on behalf of a class of the defendant plan's members.[10] The Supreme Court of the United States has held that RICO actions are not preempted by state insurance laws, in *Humana, Inc. v. Forsyth*,[11] but, as of the end of 1999, no case had held a plan liable for violating RICO. In fact, in September 1999, the U.S. District Court for the Eastern District of Pennsylvania dismissed a class action civil RICO action against a plan in *Maio v. Aetna, Inc.*[12] The plaintiffs alleged that Aetna had engaged in a fraudulent scheme to induce members to enroll based upon its commitment to provide quality care, when it was really motivated by cost and administrative considerations. The Court concluded the plaintiffs had failed to prove any actual injuries; an actionable fraud claim; or that Aetna could conspire with its subsidiary, as required to establish an actionable RICO claim. While plan counsel and management must be concerned about potential RICO actions, which permit treble damage awards, this chapter will focus on current trends in contract and negligence liability actions against plans. Such actions currently represent the most significant medical management liability exposure for plans.

Most reported liability actions against plans have either alleged that the plan violated its contractual obligations to members or was directly or indirectly negligent when conducting medical management activities. The fundamental difference between a contract and a negligence action is the basis of the alleged duty to the other party and the type of damages arising from the failure to comply with such duties.

A contract action is based upon the duties specified in the agreement between the parties.

Contractual damages are limited to the economic losses caused by the failure to perform those agreed-upon duties.

A negligence action is based upon an alleged failure to exercise the degree of care required by law, which directly or proximately causes injuries to a member. If a plan fails to exercise reasonable care, the injured party may be awarded compensatory damages for past and future expenses arising from or related to that injury.

Damages are generally limited to the amount necessary to compensate the other party for contractual losses or personal injuries. Punitive damages may be awarded in certain circumstances, however, to punish a defendant and create an example for others, if the defendant acted in an intentional, malicious, wanton, willful, reckless, or outrageous manner.

CONTRACT ACTIONS RELATED TO MEDICAL MANAGEMENT ACTIVITIES

Most medical management issues, to date, have involved the denial of claims for services or failure to authorize providers to render services to members (referred to as adverse determinations) when such services allegedly should have been covered pursuant to a plan's certificate of coverage. Those cases have generally considered whether an adverse determination was reasonable based upon the terms of the certificate and factual circumstances of that case. One of the most significant issues in such cases has been the question of whether the member's benefit plan is governed by ERISA.

The media and elected officials have convinced the public that ERISA prevents members from suing their plan if it fails to authorize or pay for covered benefits. In fact, as demonstrated by the number of cases against plans cited in this chapter, ERISA imposes no such limitation on suing a plan. It does, however, limit the damages that can be assessed against a plan to amounts that should have been paid pursuant to the member's certificate of coverage.

Such damages are appropriate in a breach of contract action, but plaintiffs' attorneys and the media argue that such damages are inadequate when a denial of authorization effectively precludes members from receiving desired services. Those arguments ignore the fact that not all treatments are covered by health insurance. They also fail to differentiate between benefit or payment determinations, which are made by plans, and treatment decisions, which are made by providers in consultation with their patients. Providers can always render treatment and then dispute the plan's denial of authorization or refusal to pay claims, if they believe that such services are medically necessary and covered by the member's certificate. Unfortunately, the perception that the remedies available under ERISA are inadequate has caused certain courts and legislators to expand plans' liability for their medical management determinations beyond that specified in the ERISA statute.

ERISA provides that it preempts "any and all State laws insofar as they now or hereafter relate to any employee benefit plan."[13] The Supreme Court has stated that the preemption provision should be liberally construed as follows: "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."[14] ERISA also includes what is referred to as the savings clause, which states that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."[15]

The apparent conflict between the broad preemption of any law related to an ERISA plan and the savings clause was addressed in *Pilot Life Insurance Co. v. Dedeaux*.[16] In that case, the Supreme Court decided that ERISA preempted a bad faith judgment against an insurance company because Mississippi's bad faith law was not specifically directed at regulating the insurer's activities. *Pilot Life* held that ERISA only permits a plan participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."[17]

Although *Pilot Life* held that ERISA preempts bad faith actions, plans must not ignore their po-

tential bad faith liability exposure when conducting medical management activities. ERISA is not applicable to government, church, or nongroup benefit plans.[18] FEHBP imposes limitations similar to those of ERISA, but actions by state or local government employees will probably not be preempted by ERISA. Not all states have adopted a cause of action for bad faith benefit determinations, but as of 1996, that theory of liability had been accepted by 43 states, with 14 of those states imposing some type of cap on punitive damage awards.[19]

Bad Faith Actions

The basis for a bad faith action is an allegation that a plan breached its implied duty of good faith and fair dealing when conducting medical management activities. The consequences of violating that implied duty can be catastrophic.

The two most notable bad faith cases have both been decided by juries in California, *Goodrich v. Aetna,* ("*Goodrich*") and *Fox v. HealthNet* ("*Fox*").[20] As trial court decisions, they have limited precedental value (that is, the requirement that the decision be followed by lower courts in the same jurisdiction). They also have limited precedental value because there was no written decision in either case explaining the legal and factual bases for either jury's decision. Finally, the *Goodrich* case is being appealed and the *Fox* case was settled upon undisclosed terms after the jury issued its decision, so we do not yet know if higher courts will affirm, reverse, or modify those trial court decisions.

It is important to examine those cases, however, to determine what incited the juries to award such extraordinary punitive damages against the defendant plans. Published reports concerning the *Goodrich* case and the pleadings filed in the *Fox* case provide valuable information about the factual circumstances of each case.

In *Goodrich*, a jury in San Bernardino, California, awarded a total of $120,564,363.40 against Aetna U.S. Healthcare of California in January 1999. Of that amount, $747,655.88 was awarded for unpaid medical bills, $3,790,603.52 for wrongful death, and $116,026,104 in punitive damages. The plaintiff's attorney, Michael Bidart, wrote a commentary summarizing the facts of that case from the plaintiff's perspective.[21] Mr. Bidart reported that Mr. Goodrich, a deputy district attorney for San Bernardino County, was diagnosed with a rare form of stomach cancer after collapsing in court on June 5, 1992. Goodrich's primary care physician authorized a referral to the City of Hope Hospital for consultation and assessment to determine if he was an appropriate candidate for high dose chemotherapy and a bone marrow transplant (the "transplant"). Aetna's consulting oncologist agreed that Goodrich should be referred to that hospital on July 21, 1992. The authorization request was then referred from the contracting provider group, Redlands Medical Group, to Aetna's local medical director, who forwarded it to Aetna's home office in Hartford, Connecticut. Aetna ultimately denied authorization on November 18, 1992, because it deemed the procedure to be experimental. Bidart claims that Goodrich's evidence of coverage did not exclude coverage for experimental and investigational procedures. Unfortunately, by the time Aetna issued its decision, the cancer had metastasized, which disqualified Goodrich as a candidate for the proposed transplant.

Goodrich's primary care physician then requested authorization to refer him for potential cryosurgery at St. John's Medical Center on August 26, 1993. That request was again referred from the local medical group, to the local Aetna medical director and to the company's home office. Aetna denied coverage on November 3, 1993, because the medical center was not a participating provider. According to Bidart, the treating oncologist testified that performing the surgery would have extended Goodrich's life by 15 to 20 months and improved the quality of his life during that period.

Finally, on January 11, 1995, Goodrich's primary care physician requested authorization to hospitalize him at St. John's for surgery and chemotherapy. This time, Goodrich's providers did not wait for authorization from Aetna and performed the surgery on January 17. According to Bidart, Aetna denied authorization on January

18 in a letter from a registered nurse that was delivered to Goodrich's wife while he was in the intensive care unit. Goodrich remained hospitalized until his death on March 15, 1995. He died believing that he had left his family owing $750,000 in medical bills, although his wife had secondary coverage that ultimately paid those bills.

Aetna disputes many of the facts cited by Bidart. It has also publicly stated that it will vigorously appeal the jury's verdict. Aetna specifically claims that the trial court excluded critical evidence from the jury's consideration. That evidence included the facts that: (1) Ms. Goodrich's health plan had precertified the out-of-network treatment; (2) there was an addendum to the evidence of coverage that listed covered benefits and the experimental exclusion; (3) Goodrich was not an appropriate candidate for high dose chemotherapy because his cancer had metastasized by the time he was referred for treatment; (4) the services performed by out-of-network providers had been approved if they were performed by participating providers; (5) Goodrich did not take advantage of the case management services available to him; (6) he did not utilize Aetna's internal grievance and appeals procedures; and (7) Aetna's conduct in the case did not contribute to shortening Goodrich's life.[22]

The jury's decision might have been different had they been given the opportunity to consider those facts. It appears, however, that the most significant factor in their decision was Aetna's failure to respond to Goodrich's treating physicians' authorization requests in a timely manner. The jury apparently believed that Goodrich's life could have been saved or the quality of his remaining life improved if Aetna had promptly authorized the proposed treatments. It is unclear from the published reports why the authorization requests were not given expedited consideration. Aetna may ultimately have made the same benefit determinations, but the jury might have concluded that the plan acted in good faith and not awarded punitive damages if Aetna had permitted expedited reconsideration of the initial adverse determination. An expedited reconsideration process would have permitted the treating physicians to attempt to justify their proposed treatments to an objective qualified medical reviewer on an expedited basis, as recommended at the conclusion of this chapter.

In the *Fox* case, a jury in Riverside, California, awarded the family of a schoolteacher, Nelene Fox, $89.3 million based upon the plan's failure to authorize coverage for a bone marrow transplant to treat her metastatic breast cancer.[23] That award included $212,000 plus interest to pay for the cost of the transplant, $12.1 million for breach of the duty of good faith and infliction of emotional distress, and the remainder as punitive damages.

Fox was diagnosed with breast cancer in June 1991. The tumor had metastasized to her bone marrow by December. Her treating oncologist requested that HealthNet's contracting medical group approve a referral to the University of Southern California (USC) for further evaluation, which was denied by the medical group. Fox was evaluated, despite that decision, and USC agreed to perform the bone marrow transplant. HealthNet subsequently received a request to authorize the transplant on June 5, 1992, received requested medical records on June 10, and denied the transplant as investigational on June 12. The Foxes conducted extensive fundraising activities and paid for the transplant after the plan's denial of coverage. The transplant was performed at USC in late August, but Fox died in April 1993.

At trial, the plaintiff's attorney, who was Fox's brother, alleged that HealthNet had breached the covenant of good faith and fair dealing by refusing to cover the transplant procedure. His trial brief alleged that Fox's certificate specifically provided coverage for bone marrow transplants under the following provision: "The member must satisfy the medical criteria developed by HealthNet Participating Medical Group and by the referral facility performing the transplant."[24] The attorney argued that Fox had satisfied those conditions because her treating oncologist had recommended the bone marrow transplant and referred her to USC, which agreed to perform that procedure. The oncologist allegedly changed his mind about the

need for the transplant only after a discussion with the plan's associate medical director, during which "financial issues" were discussed. The trial brief further alleged that the experimental and investigative procedure exclusion of the certificate was ambiguous as evidenced by the facts that: the plan subsequently expanded that exclusion from one sentence to an entire page, the plan's 1990 independent technology assessment concluded that the procedure had gained widespread acceptance, and the plan had paid for bone marrow transplants for two other members in similar circumstances. Finally, the brief alleged that the bonus of the medical director, who made the decision to deny coverage, was based on the plan's medical loss ratio, which provided an incentive for him to deny the transplant.

The lesson of the *Fox* case is that a plan must consider how a jury will view its conduct when it decides to deny coverage for a procedure recommended by a participating provider. In that case, the plaintiff was able to persuade the jury that the plan had acted in bad faith based upon: its interpretation of the coverage and exclusion provisions of an ambiguous provision of the certificate (as evidenced by the revision of the exclusion language), its efforts to get the oncologist to change his mind (as evidenced by the discussion of financial issues after he had written letters supporting the transplant), differentiating in the treatment of members with similar conditions, and paying a reported $5.5 million in bonuses to key executives of the plan at the same time that it was denying coverage for Fox's transplant.

A critical issue in both the *Goodrich* and *Fox* cases was the question of whether the member's certificate clearly excluded coverage of the proposed transplants. Other cases have upheld denials of coverage in similar circumstances when the plan specifically excluded autologous bone marrow transplants for breast cancer; excluded coverage for transplants that were not specifically listed as being covered; or referenced objective sources of information, such as the Medicare coverage manual, to determine whether a procedure was experimental.[25–27]

Even if a plan has a clear exclusion in its certificate, the *Warne v. Lincoln National Administrative Services Corp.* case illustrates the importance of making certain that the plan's promotional materials are consistent with the terms of that certificate.[28] In that case, a jury awarded the plaintiff, who was also covered by a school district plan, $26.8 million for the plan's failure to cover Warne's liver transplant, despite the fact that transplant was clearly excluded by Warne's certificate. Unfortunately, the plan's benefit brochure stated that the cost of organ transplants was a covered benefit. The jury found that the denial of coverage in such circumstances constituted bad faith and awarded the plaintiffs $320,000 for breach of contract, $1.5 million for pain and suffering, and $25 million in punitive damages.

The decision in another bad faith case, *Hughes v. Blue Cross of Northern California*, provides a good example of what a plan should not do when making a medical management decision.[29] In that case, the California Court of Appeals upheld an award of $150,000 in compensatory damages and $700,000 in punitive damages against Blue Cross based upon its denial of claims totaling $17,000 for psychiatric inpatient services. The court stated:

> There was evidence that the denial of respondent's claim was not simply the unfortunate result of poor judgment but the product of the fragmentary medical records, a cursory review of the records, the consultant's disclaimer of any obligation to investigate, the use of a standard of medical necessity at variance with community standards, and the uninformative follow-up letters sent to the treating physician. The jury could reasonably infer that these practices, particularly the reliance on a restrictive standard of medical necessity and the unhelpful letter to the treating physician, were all rooted in established company practice. The evidence hence was sufficient to support a finding that the review process operated *in conscious disregard of the insured's rights.* (emphasis added)[30]

In short, the plan acted in bad faith because it did not conduct a reasonable evaluation, give the treating physician the opportunity to provide additional information, or, most important, balance the member's interests in having services covered against the plan's interests in containing costs when making medical management decisions. Other bad faith cases have held plans liable for failing to contact the member's attending physician concerning the member's condition before denying coverage on the basis of a preexisting condition, failing to obtain pertinent sections of a patient's medical record, not requiring medical review of a claim before determining that services were not medically necessary, or failing to inform members of their right to appeal an adverse determination.[31-33]

Contract Actions Governed by ERISA

The *Hughes* case also illustrates the scope of ERISA's preemption. It was subsequently overturned by the Supreme Court of California, which concluded that California's bad faith common law was preempted by ERISA based on the *Pilot Life* decision.[34] If state law claims are preempted by ERISA, members cannot recover damages for pain and suffering, emotional distress, or punitive damages, in contrast to the plaintiffs in the *Goodrich, Fox*, and *Warne* cases. They may only recover benefits due them under the terms of the plan, enforce their rights under the terms of the plan, or clarify their rights to future benefits under the terms of the plan.

While ERISA may limit the damages that may be awarded, it does not relieve a plan of its responsibility to act in a reasonable manner when making medical management determinations. Plan administrators are prohibited from acting in an arbitrary and capricious manner when making such determinations.

If the plan has been granted discretionary authority to make benefit determinations by the ERISA plan sponsor, the courts generally defer to the administrator's determination unless it is clearly unreasonable. In *Jett v. Blue Cross and Blue Shield of Alabama*, the court stated: "The function of the court is to determine whether there was a reasonable basis for the decision based on the facts known to the administrator at the time that the decision was made."[35]

A decision may be found to be arbitrary and capricious, however, if a plan fails to act in a reasonable manner when making medical management determinations. The following has been held to be arbitrary and capricious conduct: relying on undisclosed medical criteria that are more restrictive than the policies utilized by other insurers, basing an adverse determination on an ambiguous provision of the member's benefit agreement, and failing to comply with the notification and reconsideration procedures mandated by ERISA, which precluded the member from requesting reconsideration of an adverse determination.[36-38]

In *Brown v. Blue Cross and Blue Shield of Alabama,* the Eleventh Circuit Court adopted a higher standard when a plan has an inherent conflict of interest.[39] In that case, the plan offered insured coverage to the plaintiff's employer, so any benefits were paid from the plan's funds. The court stated: "When a plan beneficiary demonstrates a substantial conflict of interest . . . the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary."[40] Not all courts have accepted that higher standard when a plan underwrites coverage for an ERISA group. The Second Circuit Court of Appeals expressly rejected the *Brown* decision, in *Whitney v. Empire Blue Cross & Blue Shield.*[41] That court concluded that an administrator's benefit determination should not be held to be arbitrary and capricious as long as the interpretation is reasonable, in light of competing interpretations, and the evidence does not show that the administrator was, in fact, influenced by its potential conflict of interest.

The question of whether a plan acts in an arbitrary and capricious manner is important because, if a plan acts in an arbitrary and capricious manner, ERISA permits courts to require the plan to pay the member's attorney's fees and legal costs, which can be a significant penalty. As an example,

in *Egert v. Connecticut General Life Insurance Co.*, the insurer utilized inconsistent and undisclosed medical coverage policies to deny coverage for Ms. Egert's infertility treatments.[42] The court ordered the insurer to pay for treatments that had already been rendered and to cover Egert's future infertility treatments. It also awarded her $160,000 in legal fees and costs to "deter plan administrators from developing unreasonable interpretations of ERISA plans as a means of wrongly denying coverage to plan participants."[43]

NEGLIGENCE ACTIONS RELATED TO MEDICAL MANAGEMENT ACTIVITIES

An increasing number of actions have alleged that plans have acted in a negligent manner when performing medical management activities. Negligent conduct is defined as "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm."[44] In other words, plans are required to exercise the level of care that would be exercised by a reasonably prudent managed care organization in similar circumstances to avoid causing foreseeable injuries to their members.

The enactment of plan liability statutes and the trend to consider vicarious liability actions against plans represent the most significant developments affecting plans' liability for their medical management activities during the past several years. Although there have been relatively few cases alleging direct or corporate negligence related to plans' medical management activities, that may change if Congress and/or additional states adopt "patient protection laws" permitting plans to be held liable for their medical management activities. There have also been an increasing number of cases alleging that plans should be held liable for the acts of employed or contracting providers, which is referred to as vicarious liability.

Negligent Design of Medical Management Programs

Wickline v. State of California was the first widely reported case that suggested that a plan might be held liable for the negligent design of its utilization review program.[45] The court stated, in dicta (a statement of opinion that did not support the ultimate decision in that case), that the failure to offer a physician the right to appeal a nonauthorization decision might be negligent. The court ultimately decided, however, that the failure to offer such an appeal procedure did not cause Wickline's injuries, despite the plan's refusal to authorize continued hospitalization, because her attending physician had discharged her without any effort to appeal that decision. The court concluded that the attending physician was solely responsible for the consequences of his decision to discharge Wickline. That is consistent with the generally accepted rule that an attending physician is ultimately responsible for making treatment decisions concerning the care of his or her patients.[46]

In *Wilson v. Blue Cross of Southern California,* however, the court stated that Blue Cross might be held liable for negligence even though the attending physician had not appealed the denial of authorization to continue Wilson's hospitalization.[47] The court noted that the plan only had an informal reconsideration process and concluded that the plan would not have reversed its initial decision even if the attending physician had attempted to appeal that decision. It returned the case to the trial court, which ultimately decided that Blue Cross's failure to authorize continued hospitalization did not directly contribute to Wilson's death.

Despite the trial court's decision, the *Wilson* case has been interpreted to erode the traditional distinction between a physician's obligation to make treatment decisions and a plan's obligation to make benefit determinations. In the future, courts may decide that plans have a duty to exercise reasonable care, even if the attending physician does not appeal an adverse determination, if it is reasonably foreseeable that a denial of authorization will preclude members from receiving necessary covered services.

If members are covered by ERISA plans, the courts have generally held that actions alleging that plans have acted negligently when conducting medical management activities are preempted by ERISA. The Supreme Court has refused to review lower court decisions holding

that ERISA preempts negligence actions against plans for failing to authorize the hospitalization of a mother during a high-risk pregnancy, allegedly resulting in the death of her unborn child, in *Corcoran v. United Healthcare, Inc.*, or for failing to authorize heart surgery for a member in *Kuhl vs. Lincoln National Health Plan of Kansas City,* because such determinations relate to the administration of the ERISA plan.[48,49]

Negligence Actions Related to the Selection and Supervision of Participating Providers

There have been a number of cases in which hospitals have been held to be liable for failing to exercise reasonable care when selecting or supervising their staff physicians (see also Chapter 7 for additional discussion about physician credentialing). The landmark case holding hospitals liable in such circumstances is *Darling v. Charleston Community Memorial Hospital.*[50] In that case, the court concluded that the hospital had an independent duty to oversee the care provided to patients in accordance with applicable licensing regulations, accreditation standards, and the hospital's own bylaws. The court rejected the hospital's argument that it should not be held liable for a physician's negligence, noting "the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient."[51]

Similar issues can be raised concerning a plan's obligation to exercise reasonable care in selecting and supervising its participating providers. The most widely reported case addressing a plan's potential liability for such negligence is *Harrell v. Total Health Care.*[52] In that case, the member's negligence action against the HMO was dismissed based upon a unique Missouri statute that immunized nonprofit HMOs against liability in such circumstances. The Missouri Court of Appeals stated, however, that the HMO might have been held liable, absent such immunity, because it failed to exercise reasonable care when credentialing the participating specialist who caused Harrell's injuries. The court noted that the HMO had solicited applications from specialists by mail and had limited its evaluation of such applications to determining whether the applicant was licensed, could dispense narcotics, and had hospital admitting privileges. It had not conducted personal interviews, checked references, or otherwise investigated the applicant's credentials before accepting that physician as a participant. The court concluded that the failure to conduct a reasonable investigation created a foreseeable risk of harm to members who were required to utilize that specialist.

There is a question of whether ERISA preempts a negligent credentialing action against a plan. In *Altieri v. Cigna Dental Health, Inc.*, the court dismissed a member's claim that the plan was negligent when evaluating a participating dentist's competence during its credentialing process. The court concluded that such claims have a substantial enough effect on a benefit plan to trigger preemption because "plaintiff's negligence, misrepresentation . . . and breach of contract claims have one central feature: the circumstances of [the plaintiff's] medical treatment under his employer's [dental] services plan."[53]

Other cases and the liability statutes discussed below differentiate between a plan's administrative duties under ERISA and its duty of care to members, which is not preempted by ERISA. Plans should, therefore, exercise reasonable care when selecting and supervising participating providers because of the increasing possibility that a state law negligence action will not be preempted by ERISA.

Negligence Actions Related to the Compensation of Participating Providers

An evolving theory of liability contends that implementing provider compensation arrangements that provide incentives to limit the utilization of covered services is either negligent or a breach of a plan's fiduciary obligations pursuant to ERISA. In *Bush v. Dake,* the court decided that a plan might be liable for negligence if it implements an incentive compensation arrangement that encourages participating providers to withhold necessary treatment from members.[54] That

case conflicts with the decision in *Pulvers v. Kaiser Foundation Health Plan*, however, which held that "the use of such incentive plans is not only recommended by professional organizations, but that they are specifically required by section 1301 of the Health Maintenance Act."[55]

The most recent development concerning provider incentive programs is the decision that such programs may constitute a breach of the plan's fiduciary duties pursuant to ERISA. In *Shea v. Esensten*, the plaintiff, Mr. Shea, visited his long-time family physician after experiencing severe chest pains on a business trip.[56] The physician advised that Mr. Shea did not need to see a cardiologist, despite his offer to pay the cardiologist's fee. Several months later, Mr. Shea died of heart failure and his widow brought an action in state court against the physician and the plan. Ms. Shea alleged that the plan's nondisclosure and misrepresentation about its physician incentive arrangement, which created incentives to limit referrals to specialists, had limited Shea's ability to make an informed decision about consulting a cardiologist. The plan removed the case to federal court because Shea was covered by an ERISA benefit plan. Ms. Shea then amended her complaint to allege that the plan's failure to disclose its incentive arrangements breached its fiduciary duties under ERISA. The 8th Circuit Court of Appeals concluded that ERISA preempted Ms. Shea's state law claims, because those claims related to the administration of the ERISA benefit plan, but found that she had stated a potential breach of fiduciary duty claim against the plan. The Court concluded that a fiduciary of an ERISA plan has a duty of loyalty requiring the disclosure of any material facts that might adversely affect a member's interests. The court reasoned that Mr. Shea had a right to know that his physician would be penalized for making too many referrals and could earn a bonus for "skimping on specialized care," which might affect his judgment about the need for a referral to a cardiologist.

The 5th Circuit Court of Appeals reached a different conclusion in *Ehlmann v. Kaiser Health Plan of Texas et al.*[57] That Court concluded that the ERISA statute and regulations do not require plans to disclose provider incentive arrangements, despite numerous other provisions detailing an HMO's disclosure duties, demonstrating that Congress and the Department of Labor did not intend to require such disclosure. The Court distinguished the *Shea* decision, noting that the Court in that case had not addressed the statutory interpretation issue. It also noted that the ERISA plan members, who were the plaintiffs in the *Ehlmann* case, had not specifically inquired about the plan's provider compensation arrangements nor established any special circumstances requiring the disclosure of material information about such arrangements. That distinguished the *Ehlmann* case from the *Shea* case, where Mr. Shea, who had asked to be referred to a cardiologist, was not informed of the plan's incentive arrangement that discouraged such referrals.

The question of whether a plan has a fiduciary duty to disclose its financial arrangements with participating providers to members should be resolved during the 1999–2000 term of the U.S. Supreme Court. The Court has granted *certiorari*, or agreed to review, the *Herdrich vs. Pegram* decision, which held that a plan could be found to have breached its fiduciary duties to members by providing incentives to physicians to limit treatment of their member patients.[58]

In that case, the plaintiff, Ms. Herdrich, was covered by an ERISA plan. Her physician, Dr. Pegram, who was employed by the plan, discovered that Herdrich's appendix was inflamed but required her to wait eight days before having a diagnostic ultrasound at a plan facility located approximately 50 miles from her home. Her appendix ruptured before she received that test, resulting in peritonitis. Herdrich filed suit in state court against Dr. Pegram, her employer, the plan, and the plan's affiliated entities, alleging both medical malpractice and fraud. She subsequently amended her complaint to allege a breach of the defendants' fiduciary duty after the case was removed to federal district court. The district court dismissed the breach of fiduciary duty claim, and she appealed that dismissal to the Seventh Circuit Court of Appeals.

A divided Court of Appeals reversed the district court decision on August 18, 1998. The majority first concluded that the defendants were

fiduciaries under ERISA because they retained discretionary authority to decide disputed claims. As fiduciaries, the defendants were required to act solely in the interests of participants and beneficiaries pursuant to ERISA. The court then noted that clinic physicians, who owned and administered the plan, made all medical management decisions and received bonuses based upon cost savings achieved during the year, which created an incentive to limit treatments to increase their bonuses. The majority of the Court then devoted most of the remainder of their decision to excoriating the "bottom line" orientation of managed care organizations, including their opinion that physicians, "not insurance bureaucrats dictating policies from the boardroom," should make care-related decisions.[59] They concluded that Herdrich's allegation that the defendant's incentive system depleted plan assets to benefit physician-owners was sufficient to submit the issue of whether the defendants breached their fiduciary duty to a trial court.

Irrespective of the ultimate decision in the *Herdrich* case, the lower court's decision and the decisions in the *Bush* and *Shea* cases should concern plan management and counsel. They illustrate that courts believe that physician incentive arrangements create such an inherent conflict of interest that failing to disclose such arrangements is either negligent or breaches a plan's fiduciary obligation to its members. The concern that incentive arrangements might inappropriately influence provider treatment decisions has resulted in 16 states enacting legislation requiring plans to disclose such arrangements in certain circumstances and the requirement that Medicare + Choice plans disclose incentive arrangements that place providers at substantial financial risk.[60]

Liability for the Negligence of Participating Providers

Perhaps the most significant development affecting plans' medical management liability exposure during the past several years has been the trend to hold plans liable for the negligence of their participating providers. A plan, as an employer, may be held liable for the conduct of its employees. The basis for such liability, referred to as respondeat superior, is that the employer is able to control its employees' conduct. It should, therefore, be held responsible if they injure someone when acting within the scope of their duties.

Another legal theory, referred to as the ostensible agent theory, permits a plan also to be held liable for negligence of an independent contractor if a member reasonably believes that the contractor is acting as an employee or agent of the plan. Such actions are referred to as vicarious liability actions because, unlike cases seeking to hold a plan liable for its own negligence, vicarious liability actions seek to hold the plan liable solely because of its relationship with the negligent provider.

The courts have consistently held that actions against plans based upon their administration of an ERISA benefits plan are preempted by ERISA. The question is whether an action based upon the quality of care rendered to a member by an employed or contracting provider involves the administration of an ERISA plan? In *Nealy v. U.S. Healthcare*, the plaintiffs alleged that the plan should be held liable for the failure of a contracting primary care physician to refer Nealy to a cardiologist before he died from a heart attack.[61] The court concluded that the negligence action was preempted by ERISA, because the ERISA plan created the relationship between the plan and Nealy. The court, therefore, decided that the malpractice action, in which the plaintiffs claimed that the plan failed to provide timely and adequate treatment, related to the administration of Nealey's ERISA benefit plan. In response to an allegation that the plaintiffs would be left without an adequate remedy, the court noted that the preemption of the action against the plan did not affect the plaintiff's state law malpractice action against the involved providers.

The Nealy decision appropriately differentiates between administrative medical management determinations and treatment decisions by participating providers. Unfortunately, other courts have not made that distinction and have

decided that such quality of care actions are either not preempted by ERISA or that the ERISA preemption defense is properly addressed in state courts (that is, the case is not removable to the federal courts).

The leading case distinguishing between administrative and quality of care related actions is *Dukes v. U.S. Healthcare, Inc.*[62] In that case, the plaintiffs claimed that the plan should be held vicariously liable for the negligence of its contracting providers, who allegedly failed to order blood tests that would have prevented Duke's death. The court held that the malpractice action should not be removed to the federal courts because it was not a claim for benefits or to clarify the member's right to benefits under the ERISA plan. The court returned the case to the state court to determine whether the plan should be held vicariously liable for the malpractice of its contracting providers. The Supreme Court refused to consider an appeal of that decision.

The issue of whether the federal or state courts are the proper forum to consider allegations concerning the quality of care provided to a member of an ERISA plan was addressed more recently in *Giles v. NYLCare Health Plans, Inc.*[63] In that case, Giles sued the plan for negligence, vicarious liability, breach of contract, misrepresentation, and breach of warranty following her son's death while being treated by the plan's participating providers. When the plan attempted to remove the case to the federal district court, Giles dropped the breach of contract, misrepresentation, and breach of warranty claims and moved to remand, or return, the case to state court. The federal court granted that motion based upon the *Dukes* decision. The Fifth Circuit Court of Appeals affirmed that decision, explaining that there are two types of ERISA preemption: complete and conflict preemption. Completely preempted claims, such as those seeking to enforce the ERISA remedies, may not be remanded to state courts because they involve exclusively federal issues. The court explained that ERISA simply provides a defense to other state law actions that fall outside of ERISA's civil enforcement remedies, such as vicarious liability claims. Such actions must be remanded to the state court for resolution of that preemption defense.

Another federal circuit court has gone even further, in *Pacificare of Oklahoma, Inc. v Burrage*, holding that a vicarious liability claim against a plan based upon the alleged malpractice of its contracting primary care physician was not preempted by ERISA.[64] The court reasoned that the claim did not involve the administration of the benefit plan and was, therefore, "too tenuous, remote or peripheral . . . to warrant a finding that the law 'relates to' the plan."

Even if vicarious liability actions are not preempted by ERISA, the generally accepted common law rule holds that plans should not be held vicariously liable for the negligence of an independent contractor.[65] In *Williams v. Good Health Plus, Inc.,* the court not only refused to hold the plan liable for the actions of its contracting provider but also emphasized that an HMO could not practice medicine pursuant to the Texas Medical Practice Act.[66] It stated that the plan could not, therefore, be held liable for negligence related to the provision of medical services to members.

Other courts are beginning to challenge that rule, however, particularly when members are required to be treated by a designated participating provider. As an example, in *Schleier v. Kaiser Foundation Health Plan,* the court held the plan liable for the malpractice of a contracting cardiologist.[67] It based that decision on the facts that the plan restricted members' access to a limited number of physicians, paid those physicians to provide services that it was obligated to provide pursuant to its member certificate, and had some right to control the contracting physician's behavior. The court concluded that those were all attributes of an employer-employee relationship, so that the plan could be held vicariously liable for the contracting specialist's negligence.

In *Boyd v. Albert Einstein Medical Center,* the court reversed a summary judgment against the plaintiffs because it concluded that there was a question of fact concerning whether the contracting provider was acting as the plan's ostensible agent when he negligently treated Boyd.[68] The court noted that the plan advertised that its partici-

pating providers were competent, required members to utilize network physicians, required primary care physicians to refer members to participating specialists, made capitation payments to primary care physicians, and exercised some control over the physicians' conduct pursuant to the terms of its participation agreement. On that basis, the court concluded that Boyd could reasonably have believed that her primary care physician was acting as an agent of the plan when he instructed her to have diagnostic tests performed at his office instead of at the hospital emergency department. Unfortunately, Boyd died of a heart attack after leaving the emergency department. The court concluded that summary judgement was not appropriate because the trial court might find that the physician was acting as the plan's ostensible agent when he failed to authorize the diagnostic tests that would have disclosed Boyd's heart condition.

Those cases illustrate the danger that courts will increasingly hold plans vicariously liable for the conduct of contracting providers in the future. In fact, that liability exposure may increase as plans implement medical management programs that include practice guidelines, financial incentives to practice cost effectively, and tightly restrict which providers can treat their members. Unfortunately, the very actions that plans take to control the cost and improve the quality of services provided to members may lead to the conclusion that they either control such providers' conduct or are permitting them to act as representatives of the plan.

State and Federal Liability Laws

As of 1999, Texas, California, and Georgia have adopted laws holding plans accountable if they are negligent when conducting medical management activities. On October 7, 1999, the U.S. House of Representatives adopted the Bipartisan Consensus Managed Care Improvement Act of 1999, commonly referred to as the "Patient Protection Act," which also creates a cause of action if a plan is negligent when performing medical management activities. It does not appear likely that version of the Patient Protection Act will be enacted, because of significant disagreements among the House of Representatives, the Senate, and the President. That act and the referenced state liability statutes clearly reflect a trend to hold plans liable for certain medical management activities. Advocates of such legislation, including plaintiffs' attorneys, claim that such laws will prevent "insurance bureaucrats" from becoming involved in treatment decisions. Ironically, such laws may simply increase premium costs, while requiring plans to restrict network participation, require indemnification from participating providers, and require greater oversight of their practices; plans may be held directly liable if they disagree with a provider's treatment recommendations.

It is beyond the scope of this chapter to examine each of those liability statutes in detail, so this section will briefly examine the Texas liability statute. It is appropriate to consider that statute because Texas was the first state to adopt such a statute, which has served as a model for the other states that have either enacted or considered such liability statutes. It is also appropriate to consider that statute because a federal district court has addressed the question of whether the statute is preempted by ERISA.

The Texas Health Care Liability Act (the "Act") was adopted in 1997. It provides that a health insurance carrier, HMO, or other managed care entity has a duty to exercise reasonable care when making health care treatment decisions. The Act further provides that a plan is liable for damages proximately caused by treatment decisions made by its employees, agents, ostensible agents, or representatives acting on its behalf over whom it exercises or has a right to exercise influence or control. The Act provides a defense to a liability action if the plan does not control, influence, or participate in a treatment decision; or deny or delay payment for any treatment prescribed or recommended by a provider. The Act prohibits plans from removing participating providers because the provider advocates for coverage of medically necessary services on behalf of an enrollee. It further prohibits plans from requiring providers to indemnify or hold the plan harmless for their acts or conduct. Fi-

nally, the Act requires members to exhaust the plan's internal appeals process and submit their claim for review by an independent review organization as a precondition to initiating a legal action against the plan in most circumstances.

In *Corporate Health Insurance, Inc. v. The Texas Department of Insurance,* Corporate Health and several Aetna affiliates initiated an action against the Texas Department of Insurance, its commissioner, and the Texas attorney general seeking a declaration that the Act was preempted by ERISA and the FEHBP.[69] On September 18, 1998, the Federal District Court for the Southern District of Texas issued a decision finding that the liability provisions of the Act were not preempted. The court did find that: the provisions prohibiting plans from removing providers for advocating on behalf of their patients, the indemnification prohibition, and the independent review requirement of the Act were preempted by ERISA. The reason that the court held that the liability provisions of the Act were not preempted was because the Act created a standard of care for regulated health insurers and HMOs when making treatment decisions, while specifically excluding ERISA plans from the definition of a managed care entity. The administrative provisions were preempted, however, because they placed restrictions on how managed care entities structure their programs (e.g., prohibiting provider indemnification or hold harmless clauses), which affects ERISA plans that purchase such programs. The Court decided that such interference with the structure and administration of the plans conflicts with Congress's intent to permit uniformity in the administration of ERISA plans.

The court distinguished the *Corcoran* and *Rodriguez v. Pacificare of Texas, Inc.* decisions, in which the 5th Circuit Court of Appeals decided that ERISA preempted claims seeking to hold plans liable for adverse determinations.[70] The district court noted that the *Dukes* decision had subsequently distinguished between an action based on a denial of benefits from one based upon the quality of benefits actually received by a member. The court, therefore, concluded that the Act permitted plaintiffs to seek to hold a plan liable for failing to exercise reasonable care in its capacity as an arranger of health care services, as distinguished from denial of coverage allegations, which would be preempted by ERISA.

The *Complete Health* decision is currently on appeal to the Fifth Circuit Court of Appeals. If the Appeals Court upholds that decision, it is likely that other states will promptly enact MCO liability laws patterned after the Texas Act. Even if reversed, it is apparent that legislators and the courts, under pressure from consumer advocates, plaintiffs' attorneys, and providers, will continue to search for ways to hold plans liable for their medical management decisions.

It also appears likely that Congress will enact some type of "patient protection" legislation within the next several years. President Clinton and all of the candidates running for president in the 2000 election have endorsed holding MCOs liable for their medical management activities in certain circumstances, so it is likely such legislation will be signed into law if enacted by Congress.

RECOMMENDATIONS

The prospect of state and/or federal liability laws being enacted, together with the continuing trend by courts to hold plans liable for their medical management activities, should encourage plan counsel and management to carefully evaluate and oversee the operation of their plans' medical management programs. The objective of such evaluation and oversight should be to ensure that those programs achieve their objectives of providing high quality covered services to members in a timely and cost-effective manner without creating unnecessary liability exposures for the plan. As stated at the beginning of this chapter, the key to achieving those objectives is to act reasonably and in good faith when selecting participating providers; establishing medical management policies, procedures and criteria; drafting contracts and membership materials; making medical management determinations; and resolving disputes with members and providers. More specifically, this recommends

plans should take the following actions to comply with their medical management obligations and to minimize their liability exposure related to their medical management activities:

- Monitor significant court decisions and proposed legislation through trade publications, seminars, and discussions with legal counsel to understand how those developments may affect the plan's medical management obligations.
- State that the plan has discretionary authority to make eligibility and coverage determinations in agreements with insured groups. Reserving such discretionary authority should encourage the courts to defer to the plan's determinations in ERISA cases. If the plan contracts with self-funded or ASO groups, clearly specify who will make and assume liability for such determinations.
- Comply with ERISA's notice and reconsideration requirements. Failure to provide the specific information required by ERISA might be deemed to be arbitrary and capricious, bad faith, or negligent conduct if it deprives members of their right to request reconsideration of an adverse determination.
- Periodically update the plan's certificates to ensure that they clearly express the intended contractual obligations to members. As examples, plans should incorporate specific definitions (for example, of medical necessity, emergency services, experimental or investigational procedures, and custodial care) and specifically explain any exclusions or limitations (for example, of dental, cosmetic, rehabilitation, mental health, and other services) to avoid any ambiguity concerning what services are covered by their certificates. Although there is no generally accepted source of model contract provisions, plans should attempt to use provisions that have been tested and found to be enforceable instead of developing novel contract provisions that courts may find to be ambiguous in future benefit disputes.
- Ensure that marketing brochures accurately describe the benefits, exclusions, and limitations of the certificate to avoid conflicts between those documents.
- If the plan makes exceptions to the exclusions or limitations of the certificate, those extra-contractual benefits should be described in a separate written agreement with the member. That agreement should explain the reason for that exception, state that it is not intended to create a precedent in future cases, and prohibit the member from disclosing any information about that agreement, including its existence, to third parties.
- Make a reasonable effort to ensure that any medical management issues are thoroughly investigated before the plan makes an adverse benefit determination. As an example, it may be advisable to develop a checklist of the type of information that should be obtained before making an adverse determination. That checklist will document that the plan has fully and fairly evaluated the circumstances of each case before making an adverse determination. It might require reviewers to affirm that they review applicable provisions of a member's certificate, review relevant medical policies, contact the member's attending physician(s), obtain pertinent medical information, refer issues requiring specialized knowledge or training to a qualified physician specialist, and generally follow established policies or procedures before making an adverse determination. Many plans further require that a medical director approve any adverse determination that may affect members' access to services (e.g., nonauthorization of services). That procedure helps ensure that relevant medical issues have been appropriately evaluated and identifies whom the attending physician should be directed to contact if he or she disagrees with that determination.
- Ensure that bonuses payable to those plan employees who are responsible for making medical management decisions are not based primarily upon the plan's utilization experience.

- Establish medical policies that are consistent with generally accepted standards of medical practice. As an example, it may be advisable to submit proposed policies and review criteria to a panel of physicians to ensure that they are not overly restrictive or at variance with community standards. After those policies have been approved, they should be distributed to participating providers. Distributing those policies to providers should limit the plan's liability exposure because the plan will not need to make adverse determinations if participating providers understand those policies and do not order services that they know will not be covered by the plan.
- Implement a member complaint and grievance procedure that encourages members to contact the plan concerning anything that causes them to be dissatisfied with their coverage from the plan, including treatment received from participating providers. That procedure should establish specific deadlines for responding to inquiries, complaints, and grievances; ensure that such issues are routed to an individual who is able to evaluate and respond to member concerns; include a mechanism to identify and resolve matters causing member complaints; and provide a multi-level appeal process to disinterested persons, if members are dissatisfied with the plan's response to their concerns. If any disputes cannot be resolved to the member's satisfaction during the plan's internal review process, the plan's certificate should require that those matters be referred to an external organization, such as a specified mediation or arbitration agency. Plans should also consider requiring that the decision of such an external review organization be based upon applicable contract provisions and the information submitted by the parties and that the decision be binding upon both parties, absent a mistake of law or an abuse of discretion. Such an external review process will provide a prompt, thorough, and objective method of resolving member concerns without the delay, expense, adverse publicity, and potential liability exposure involved in litigating such matters.
- Establish a provider appeal procedure similar to that used to resolve member grievances. That procedure should permit providers to request a hearing before an impartial and appropriately qualified physician hearing officer to present and explain their arguments concerning a disputed medical management determination. The plan should also permit physicians and members to request an expedited review if an adverse determination may preclude a member from receiving urgently needed services. The ability to identify and resolve disputes quickly, or at least to demonstrate that the plan fully and fairly considered relevant information before making an adverse determination, should significantly reduce the plan's liability exposure, particularly in bad faith or negligence actions. This recommendation is also discussed in Chapter 18 on managing basic medical-surgical utilization.
- Obtain current technology assessments concerning the status of new, experimental, or investigational procedures. As an alternative the plan should consider contracting with a "centers of excellence" vendor for transplants and other high cost, but relatively low frequency procedures. Such vendors may be better able to select qualified providers, conduct assessments, and negotiate favorable reimbursement arrangements with providers because they can refer a large volume of cases to participating providers. Another advantage of such arrangements is that participating providers have an incentive to select only qualified candidates for such procedures to ensure that their outcome results satisfy the vendor's requirements for continued participation in its program.
- Base provider bonuses upon specific performance measures, such as member satisfaction, compliance with applicable administrative standards, and satisfying quality of care requirements, in addition to the

provider's utilization experience (see Chapters 8–11). If applicable, plans should notify members about their provider incentive compensation arrangements and emphasize that members may appeal any denial of services that they believe may be financially motivated. If members request more detailed information concerning such incentive arrangements, plans should provide an explanation of those arrangements, although such disclosure should not include confidential information concerning amounts paid to specific providers.

- If providers are placed at substantial financial risk, the plan should provide or require those providers to obtain stop-loss coverage to limit their risk once they reach a specified risk threshold. While the Federal Medicare + Choice regulations, which require contracting plans provide such stop-loss coverage to providers, are only applicable to Medicare + Choice plans, it is advisable to extend such coverage to any incentive arrangement that places providers at substantial financial risk.[70] Such stop-loss arrangements should minimize allegations that the plan has created an incentive for providers to deny necessary care to members.
- Clearly explain the independent contractor relationship between the organization and its participating providers in certificates, brochures, and provider participation agreements. Such provisions should emphasize that providers are solely responsible for all treatment decisions and also explain how providers or members can appeal adverse determinations.
- Implement quality assurance programs to evaluate members' access to services, any underutilization of services, and patient complaints to prove that the plan has exercised reasonable care in reviewing the quality of services provided to members. Plans should structure their quality assurance programs in accordance with applicable accreditation standards, even if the plan does not seek accreditation, to demonstrate that those programs comply with generally accepted quality assurance standards.
- Adopt credentialing criteria, including verification of applicants' professional references, malpractice history, insurance coverages, hospital privileges, and licensure. Incomplete applications, unsolicited applications, or applications indicating that a provider does not meet the plan's participation requirements (for example, no staff privileges at a participating hospital) should not be accepted for further review. If applicants satisfy the plan's screening criteria, their application should be submitted to a peer review committee for evaluation of their professional reputation, qualifications, and experience.
- Thoroughly investigate any questions concerning a participating provider's conduct or competence. The plan should terminate the participation of any providers who are unable or unwilling to comply with the organization's medical management requirements. The plan's sanction procedure should also permit immediate termination if a provider's incompetence or misconduct creates a risk of harm to the organization or its members.
- Do not delegate medical management responsibilities to another entity (for example, an independent practice association) unless that entity's medical management programs are comparable with the plan's programs. The plan should retain the right to audit that entity's activities to ensure that it exercises reasonable care when performing delegated management activities. The provider entity should also be required to refer all complaints to the plan so it can promptly address any problems related to that entity's performance of its delegated duties.
- Purchase professional liability coverage to insure the plan and representatives (e.g., directors, officers, employees, and committee members) against liability and defense costs related to the plan's medical management activities. The plan should also require providers to indemnify the plan (that is, hold it harmless) if it is held vicariously liable for the provider's negligence.
- Furnish members and their attending physicians with understandable information

about treatment alternatives, if any, if the plan determines that a proposed treatment is not medically necessary. If the plan denies authorization to render services, its participation agreements should require physicians to explain available treatment alternatives to patients if that physician and the plan's medical director are unable to agree upon an acceptable alternative for the denied services. Available treatment alternatives should also be mentioned in letters to members and their attending physicians to encourage discussion of the risks and advantages of the alternative treatments.

- Refer any questions related to the plan's medical management obligations or compliance with those obligations to the plan's legal counsel. Acting upon the advice of counsel may establish that plan determinations are reasonable and made in good faith. It may also provide protection against the disclosure of privileged attorney-client or attorney work product information if the plan is sued based on those determinations.

CONCLUSION

Plans have a variety of regulatory, contractual, and common law obligations related to the organization and operation of their medical management programs. Although the laws concerning plans' liability for failing to satisfy those obligations are rapidly changing and evolving, the fundamental issue in all the cases discussed in this chapter has been whether an organization acted reasonably when conducting its medical management activities. The ability to make benefit determinations to control the cost of providing covered services to members is one of the fundamental purposes of a medical management program. A plan will not be competitive if it is unable to deny claims for services that are specifically excluded by its certificate or for services that are not medically necessary or appropriately authorized by the plan. Plans should not permit their potential liability exposure to deter them from making appropriate benefit determinations, provided that they can prove that such determinations are reasonable and give the member's interest in obtaining covered services equal weight to the plan's interest in containing costs. If a plan conducts medical management activities in such a fair, reasonable, and well-documented manner, it should be able to achieve its essential medical management objectives without having to be overly concerned about the regulatory or legal liability consequences of those activities.

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SUGGESTED READING

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