

**Health Care Liability Exposure in  
Managed Care Organizations**

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### **Abstract**

This paper establishes criteria to determine the key differences in healthcare liability exposure among the various managed care organizations. A description and assessment of the relative liability exposure for the major types of managed care organizations are then developed using these primary criteria. Underwriting criteria is then discussed which serves to assess the level of liability exposure inherent in managed care organizations that can be partially controlled through aggressive risk management procedures.

### **Biography**

Collin Suttie is an actuary in the Healthcare Division of Employers Reinsurance Corporation in Overland Park, Kansas. His primary responsibilities are in the medical professional department. Prior to this position, he was with Milliman & Robertson specializing in medical professional liability pricing and reserving. He is an Associate of the Casualty Actuarial Society and a member of the American Academy of Actuaries.

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## ***I. Introduction***

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Traditionally, the liability costs associated with the delivery and management of healthcare services has been reasonably identifiable and estimable. Since the mid 1980's, actuaries have been faced with a somewhat predictable loss cost environment with only the occasional tort reform effort adding appreciable "parameter" uncertainty into the reserve and rating calculations. However, the onset of managed care has generated additional liability exposure to healthcare institutions and providers beyond the exposure typically confronted by a stand-alone hospital or fee-for-service physician. This additional exposure is being generated by a variety of causes including, but not limited to:

- the existence of the cost containment elements central to a managed care organization (MCO). Patients, historically accustomed to the ready availability of a wide range of healthcare services, want more access than they need or are being allowed. When this previously unlimited access is denied or limited, allegations of economic-based healthcare decisions can occur which, although somewhat true and justifiable (especially from a societal standpoint), gives plaintiff's lawyers a valuable tool in trying those cases where an adverse health outcome has occurred;
- the provider attempts to maintain professional independence. MCO's have essentially forced a limitation on provider compensation either through capitated rates or salaries. In addition, since the MCO controls the healthcare choices available to a patient, a provider's access to a patient can be limited. These two factors can result in an MCO and provider being in a somewhat adversarial role; and
- the increased competition among the various MCO's and insurers for the patient population that presents the best (cheapest) risk. This competition inevitably results in marketing and promotional schemes that may not clearly differentiate between mere "puffery" and legitimate service differences. Marketing material has been a favorite plaintiff exhibit in many cases alleging malpractice and the failure of the MCO to allow potentially life-saving procedures.

This paper is intended to identify the professional liability exposures associated with the management and delivery of healthcare in the major forms of managed care plans. It is intended to be a reference guide for actuaries who need basic knowledge of the subtle differences in healthcare liability exposure among the various "alphabet entities" that comprise the healthcare delivery and management methods under managed care. Towards that end, this paper first identifies the major sources of healthcare liability faced by MCO's, then discusses some of the exposure elements that impact the various types of MCO's in different ways, and finally provides a one-by-one description of the common managed care arrangements along with an assessment of the relative liability exposure facing each one.

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## ***II. Sources of Liability***

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Strictly speaking, the legal obligations of a managed care organization in the delivery of healthcare services are no different from that of any other healthcare delivery system. However, within the context of a managed care organization, these obligations can be interpreted in new ways. Lawsuits can emanate from a variety of different sources including enrollees (patients), providers, employers, competitors, and the government. Generally, most causes of action relating to healthcare delivery and management in an MCO will fall under one (or more) of the following categories:

- **Negligence caused by the healthcare provider.** Providers are subject to tort actions from a variety of allegations including negligent or inadequate treatment, failure to advocate, failure to obtain informed consent (or, more typically for MCO's -- a failure to obtain informed refusal), and many other breaches of duty already established in case law relating to the conduct of healthcare professionals. In certain instances, the MCO can be held vicariously liable for the actions of the providers it utilizes. Typically, this is true only for staff model HMO's because of the employment relationship that exists. However, ostensible agency liability can be placed on the MCO under certain conditions for negligent acts performed by a contract physician;
- **Negligence caused by the performance of duties related to the management and administration of the MCO.** This is an exposure caused by the negligence the MCO may have with regard to the duty it owes its patients to protect them from harm. This type of exposure can be generated in a variety of ways, including any one of the following:
  - > *Credentialing and Recredentialing Activities.* Failure to properly credential a provider who subsequently is involved in malpractice can lead to negligence allegations on the part of the MCO. Credentialing oversights in MCO's may be more common due to the difficulty of monitoring groups not within the complete control and oversight of the MCO;
  - > *Record Keeping.* A reduced level of control can make confidentiality of patient records more difficult thus increasing the likelihood of suits brought by employees alleging violations of laws prohibiting the release of sensitive information to an employer;
  - > *Utilization Review Activities.* This exposure was essentially non-existent in the past since utilization reviews were usually done retroactively. Although an insurer may have denied paying for a service, at least the service was delivered thereby avoiding suits based on a failure to treat. Managed care organizations rely more heavily on concurrent and prospective reviews, which may result in a denial of treatment and therefore greater exposure to negligence;
  - > *Financial Incentive Programs.* While the argument that quality medical care is substituted for financial incentives is generally groundless, it provides a persuasive argument for plaintiff's attorneys in arguing their cases in front of an already skeptical jury;
  - > *Marketing Activities.* Brochures, advertisements, and other explanatory material may contain misleading statements (or omit important information) which, if a patient relied upon in selecting the MCO, could result in a claim of misrepresentation.

All of these types of corporate negligence exposure can generally be used by patients, providers, employers, or the government to allege the MCO breached its duty to protect against harm. And in the case of marketing activities, an MCO's competitor can also allege injury; or

- **A violation of public policy statutes.** Anti-trust allegations, while not technically a medical professional liability issue, will likely involve a physician's ability to provide healthcare services and is thus included as a liability exposure in this paper. The larger the MCO relative to the community size, the more claims will occur from providers who will have fewer opportunities to practice outside

the organization or network. In addition, suits from competitor MCO's will occur if they believe the exclusivity of the larger MCO have left them without a sufficient pool of practitioners.

Clearly, as a business entity, an MCO has a much broader exposure to liability than those listed above. Perhaps the most obvious is the financial risk that some of these entities assume as capitation and other economic incentives wind their way through the healthcare delivery system. In addition, all of these entities face the same exposure related to all businesses that own and occupy space, own and operate automobiles, employ people, and have directors and officers. While the exposure related to these other activities are all important and relevant concerns to a managed care entity, they are outside the scope of this paper.

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### ***III. Primary Criteria (criteria that differentiates liability exposure among MCO's)***

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Before discussing the exposure differences between various types of MCO's, there is a need to determine the elements of exposure that can cause a different level of potential liability between any two (or more) managed care arrangements. Hampering that determination is the fact that many of the drivers of liability exposure for managed care entities impact all entities in roughly the same way. However, since the purpose of this paper is to identify the differences in liability exposure among the various managed care entities, the following list can be considered to be among the most important criteria that can be used to differentiate the level of healthcare liability exposure among the various different managed care arrangements.

#### ***The MCO-provider employment relationship***

It is necessary to establish how close the relationship is between the MCO and the healthcare provider in order to appropriately assess the degree of direct medical liability exposure that may exist due to physician actions. Employed physicians will present a greater exposure to the MCO than a contracted independent physician due to the doctrine of respondent superior. However, employment is not a necessary condition for vicarious liability to attach to the MCO. A high degree of control over the physicians work actions and environment can be used to show that a near-employment relationship existed. Courts have developed general guidelines in assessing this degree of control which depend on the answer to numerous questions including:

- how much control the MCO has in dictating the work performed as well as the hours of work;
- the method of payment the MCO uses to compensate the physician;
- the physicians ability to accept or reject patients;
- which party maintains the patients records; and
- who owns and/or maintains the office space, equipment, and supplies utilized by the physician.

It is more likely that an employer-employee relationship can be established if the MCO retains the right to hire and fire physicians, sets the compensation and work schedules of the physicians, uses capitation or salary (versus direct fee-for-service) when compensating physicians, or has patients treated at an MCO facility rather than a private office. If the MCO merely exercises administrative control instead of control over medical decisions, courts are less likely to find a vicarious liability connection.

However, even an independent physician can bring about vicarious medical liability exposure to an MCO in certain circumstances. Showing that an ostensible agency relationship exists requires that a patient reasonably believed that the physician worked for the MCO and that this belief was based on representations made by the MCO. This relationship is more easily established if the MCO claims that it credentials or otherwise evaluates its physicians or if the MCO advertised the use of a particular group or physician in its marketing material. Other financial circumstances that can be used to provide an agency link to a contract physician include:

- whether the physician is compensated partially on his/her ability to control utilization;
- whether the physician is subject to discipline for not abiding to an MCO regulation; and
- whether the MCO informed its membership of the independent contractor status of the physician.

Ostensible liability is much more likely to occur in an MCO environment than a fee-for-service environment since it is more unlikely that a patient could draw an employer-employee conclusion from a fee-for-services setting (with the possible exception of emergency room services).

### *The extent of utilization control*

By definition, managed care entities control either the utilization of healthcare services, the cost of healthcare services, or both. Those entities that rely solely, or in part, on controlling the utilization of services are more prone to allegations of inadequate treatment. To a lesser extent, the control of the reimbursements to providers can also serve to create incentives to treat illnesses less aggressively. This behavior can lead to charges of negligence and in extreme cases, result in punitive damages. Thus, the more the MCO controls the service utilization and costs, the greater the potential liability.

### *Supervision of provider activities*

An MCO has a duty, within reason, to supervise the medical care provided to patients. This duty is present regardless of whether the actual healthcare services are performed in an MCO office or a private practitioner office. It can even extend to the services provided by allied health care professionals who are employees of a private practice physician. Liability occurs when the MCO either:

- Fails to detect a providers incompetence; or
- Fails to take corrective action after it learns of (or should have learned of) a potential problem affecting patient safety.

The ability to oversee physician activities and assess competencies will differ slightly among the various managed care arrangements.

### *The extent of members (patients) choice of clinics, hospitals, and/or physicians*

This criterion is designed to assess the degree to which an MCO is exposed to two typical allegations involving healthcare malpractice:

- A failure to provide timely and/or appropriate treatment; and
- Negligent selection of a provider

The more choice a member has in choosing the physician or location for their healthcare services, the less likely a lawsuit alleging untimely or inappropriate treatment. Severe health complications can and have arisen when delays in treatment are caused by the need to transport a patient to a network facility in place of a closer, non-network facility.

There is also potentially corporate negligence on an MCO for negligent acts of physicians because of the independent duty of the MCO to investigate and review the competency of participating physicians (credentialing activities). Recent court decisions are suggesting that it is more likely that a managed care plan that limits a covered persons' choice of provider will have a greater exposure than a plan that incorporates an election to use out-of-network care with only a modest financial disincentive. The degree of choice depends partly on whether or not the MCO is an open or closed panel. Closed panel plans require a covered person to receive care from physicians who provide care on an exclusive basis to that particular MCO. The providers are generally not allowed to see patients from other MCO's. Open panels allow access by any provider who meets the established criteria set by the MCO.

### *The extent of financial controls and incentives*

With regard to healthcare professional liability, the existence of financial controls and incentives can bring about allegations of negligence in cases where denial of care is involved. This increase in exposure can be greatly magnified when punitive damages are considered since behavior like this, if proven, is often viewed as egregious in the minds of the jury. The extent of liability due to the financial incentives is dependent on the type of compensation and reimbursement structure being utilized, which is dependent on the type of managed care arrangement.

### *The extent of ERISA protection*

The Employee Retirement Income Security Act (ERISA) provides for a uniform national administration of pension and health plans. Although not all organizations fall within the domain of ERISA, a large portion of the population is covered under its provisions. The provisions within this Act take precedence over any state laws that relates to employee benefit plans. This is especially relevant in cases of medical negligence involving a managed care plan in that ERISA does not permit extracontractual or punitive damages. Instead, if a medical malpractice allegation is preempted by ERISA, a plaintiff is limited to a recovery of benefits due under the plan and possibly attorney fees.

Courts are beginning to erode the preemption clause, especially in those cases where the quality of care or credentialing activities are the primary negligence issues. In addition, plan providers may not be subject to ERISA preemption, thus increasing the MCO exposure in cases where vicarious liability will be easier to prove. Thus, the type of managed care organization can have an impact on whether a preemption claim will prevail.

### *The infrastructure of the MCO*

This criterion attempts to differentiate MCO's by assessing how seamless the organizational structure is. MCO's that can be shown to be made up of several entities all under a loose operating control may be more open to liability exposure due to:

- A breach in patient confidentiality; or
- A provider's anti-trust allegation because of their de-selection from a plan.

Patient confidentiality is more difficult to assure when patient records are being routinely transferred between various independent entities. Although it's possible to have a central record-keeping unit responsible for limiting records flow between independent practices, that appears to be the exception rather than the rule. Patient record confidentiality is a hot issue now given the discussions taking place in the industry regarding the use of the internet in transferring data. Given this, it may be an area requiring closer scrutiny in the future in assessing total liability exposure.

The anti-trust issue can arise anytime a provider is excluded from participating in an MCO, whether it be the result of a routine credentialing check of a current MCO provider or a new provider application. Generally speaking, these are very fact specific cases that are difficult for the plaintiff to win. In order to show that an anti-trust violation occurred, it must be proven that at least two separate and distinct entities agreed to take action against the plaintiff to his or her detriment. Courts have generally disagreed on whether a hospital and its medical staff are legally distinct entities capable of conspiring. However, in a managed care setting, it may be easier to prove due to the existence of multiple independent physician groups. Managed care organizations that are closely

held together and function as one entity probably would not meet the test of having at least two conspiring entities. However, situations can arise in MCO's with a looser structure whereby several currently credentialed and operating physician practices could be economically hurt by the addition of another similar practice. The actions of the existing practices to exclude the incoming practice could result in anti-trust violations.

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#### ***IV. MCO Liability Exposure***

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An analysis of the various levels of exposure inherent in each type of MCO is difficult to summarize succinctly due to the numerous variables that impact the ultimate exposure level. Further complicating the analysis is the fact that MCO's are no longer distinct, mutually exclusive organizations with easily identifiable characteristics to distinguish themselves from one another. Because of this, one really needs to think of the answers in terms of a matrix consisting of (1) the type of entity, (2) the duties and purpose of the entity, (3) the organizational structure of the entity, (4) the risk management protocols, and (5) the social acceptance and legal environment of managed care in the particular geographic area. All of these factors combine to create a unique exposure environment for any given MCO.

This section of the paper is an attempt to provide the reader with a short description of the most common types of MCO's and an assessment of the *relative* medical liability exposure the entity can be expected to have utilizing the criteria described in the previous section. Of course, this assessment is subject to caveats, proviso's, addendum's, and exceptions too numerous to list here. The reader should be aware that any given MCO may have characteristics uncommon to the general description. These uncommon characteristics could substantially alter the liability exposure of the entity.

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#### ***Health Maintenance Organizations (HMO) – Staff Model***

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***Description:*** HMO's are organized to explicitly merge the delivery, management, and financing of healthcare services under one common controlling entity. An HMO not only insures and delivers healthcare services but is also involved in the utilization and quality management of the services as well as the marketing activities associated with increasing the member base. HMO's provide a predefined set of medical services to their members and typically limit the choice of providers to those identified by the HMO. Any healthcare services obtained outside the HMO network (without proper authorization) will not be covered. Referrals within the system need pre-certification and referrals outside the system are rarely granted unless the physician expertise is unavailable.

Staff model HMOs' are distinguished mainly by the fact that they employ their own physicians and own their own clinics and offices. As such, physicians see only those patients who are members of the HMO. Treatment protocols are prevalent and enforceable due to the employed nature of the healthcare providers. Physicians are typically compensated through a salary and bonus combination with the bonus being based on the performance, profitability, and member satisfaction of the HMO (although other arrangements are possible).

#### ***Assessment***

***Employment Status:*** Due to the employment of physicians, any negligence on the part of the physician will be the responsibility of the HMO due to the doctrine of respondent superior. Thus, a staff model HMO possesses the highest level of exposure to claims of vicarious liability relative to all other MCO arrangements.

***Utilization Control:*** Because of the employed status of the physicians, the control the HMO has over treatment protocols results in an increased exposure to negligence due to failure to treat since the

HMO will have a difficult time persuading a jury that the physician was acting independently and without the guidance of the HMO's utilization management directives.

*Provider Supervision:* The employed status of the physicians should place the MCO in a position to adequately supervise and assess their competence. Assuming that adequate plans are in place to take corrective action when a problem surfaces, the exposure to claims alleging inadequate supervision should be mitigated.

*Subscriber Choice of Physician:* A relatively low level of choice since patients are limited to members of the HMO staff. Healthcare outside the HMO is generally not covered without prior authorization. Thus, exposure to negligent selection claims is higher in this type of managed care arrangement. The larger and more comprehensive the HMO, the lower the exposure.

*Financial Controls and Incentives:* By definition, HMO's are involved in the financing of healthcare services and are therefore the most likely entities to introduce and enforce incentives and controls that constrain the fiscal impact of the delivery of those services. Since staff model HMO's are seamless entities, the exposure the HMO has to denial of care allegations is relatively high compared to other MCO forms.

*ERISA Protection:* May have less ERISA protection due to recent court rulings which state that ERISA does not preempt claims when an HMO is vicariously liable for the malpractice of its providers. In general, the more direct the provider-MCO relationship, the less ERISA protection may be available.

*Organizational Infrastructure:* Staff models are designed to operate as a single entity. They would have little need to transfer patient records to other independent entities and would be unlikely to be considered as more than one entity. Thus, could be expected to have a relatively low level of exposure to confidentiality claims (assuming adequate controls) and anti-trust claims.

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#### ***Health Maintenance Organizations (HMO) – Group/Network Model***

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*Description:* Group/Network model HMO's contract with either large multi-specialty group practices (group model) or several single specialty practices (network model) in order to form a network of providers within a geographical area. Depending on the particular situation, providers may be able to see patients outside of the HMO membership. The biggest operational difference this type of entity has from a staff model is that the physicians are not employees of the HMO but rather are independent contractors who are employees of the group practice that they belong to. Compensation of the physicians can come in a variety of ways ranging from a salary to a capitated fee arrangement. These entities can be structured with the HMO owning the groups, the groups owning the HMO, or the HMO and the groups being separate and independent. Because of this variety, control of treatment protocols is very dependent on the organizational structure of the Group/Network HMO.

#### ***Assessment***

*Employment Status:* Because the HMO is not the direct employer of the physician, the likelihood of negligence claims against the HMO due to a physician's malpractice is reduced. However, depending on the degree of control, the HMO can still be held vicariously liable. Also, under the theory of ostensible agency, the HMO could be held liable for the physician's negligence if it is determined that

the physician held him or herself out to be an agent of the HMO. The ostensible agency exposure is potentially high unless steps are taken to minimize the exposure.

*Utilization Control:* Utilization control will likely be similar to a staff model. However, because some of the financial risk will be shifted to the group practice, the liability to the HMO may be shared or otherwise limited when allegations of inadequate treatment arise.

*Provider Supervision:* Provider supervision will likely be less than a staff model. A group model HMO probably controls the provider's actions easier than a network model HMO since a large multi-specialty group will operate more as a single entity. Relative to staff model HMO's, these entities will have more exposure to claims of inadequate provider supervision because the MCO-provider relationship is not as direct.

*Subscriber Choice of Physician:* Generally, group models have a low level of choice since they are typically a closed panel model. Patients are restricted to providers within the group or face no coverage. Thus, the exposure to claims of negligent provider selection is the same as a staff model. However, network models can be open or closed panel and may provide a slightly higher degree of choice and therefore face slightly less liability exposure to negligent selection allegations.

*Financial Controls and Incentives:* Compensation arrangements to the provider group in this type of HMO are more likely to involve a capitated rate than staff model HMO's. Thus the group or network, not the HMO, is generally more exposed to denial of care claims which could migrate to the HMO who set the terms of the reimbursement arrangement. Vicarious liability is therefore possible but not as likely as a staff model HMO.

*ERISA Protection:* Would likely have more ERISA protection than staff model HMO since the MCO-provider relationship is not quite as direct. However, a group model is just one step removed from a staff model and courts may not view these entities as being substantially different.

*Organizational Infrastructure:* In a group model, the providers would be a part of a single multi-specialty group and could thus control patient records in a manner similar to a staff model HMO. Network models would be less seamless due to the number of different practices involved and thus more exposed than staff or group models to confidentiality claims.

Group models would be less exposed to provider anti-trust claims than network models since the providers belong to one entity. On a relative basis, exposure to provider anti-trust claims would be similar in group and staff models and greater in network models.

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#### *Health Maintenance Organizations (HMO) – IPA/Direct Contract Model*

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*Description:* Independent Practice Association (IPA) HMO's are entities that contract with numerous independent physician practices to service the healthcare needs of members in a particular geographic area. Technically, IPA's contract with associations of providers whereas "direct contract" models contract with individual physicians. In either case, the issues involving liability are essentially identical. Physicians who participate in these arrangements maintain their own practice

and may see patients from other HMO's or non-HMO fee-for-service patients. The HMO typically compensates the IPA on either a fee-for-service or capitated basis (depending primarily on what area of the country the HMO operates) and the IPA pays its members on a capitated, per diem, or fee-for-service basis.

#### ***Assessment***

***Employment Status:*** This model is similar in most respects to a Group model HMO except that it is less likely to result in vicarious claims of negligence. The independence of the individual practices and providers that comprise the network is likely to be more obvious to the ultimate consumer of healthcare services and therefore be more difficult to prove that an ostensible agency relationship exists. However, providers sometimes work out of an HMO facility, thereby increasing the likelihood of an ostensible agency finding.

***Utilization Control:*** Utilization control will be similar to group and staff model HMO's. Because the HMO capitates the IPA, the IPA will likely have full control over utilization practices. This may serve to shield the HMO from liability due to claims of inadequate treatment. However, with a direct contract model, most of financing risk stays with the HMO. Thus, the HMO has more financial concern regarding referrals to out-of-network specialists. This conflict could result in greater liability exposure to inadequate treatment allegations.

***Provider Supervision:*** Because of the relative independence of the IPA's, the HMO is unlikely to have as much supervisory control and assessment capability over the physicians as a staff model. Therefore, they may be relatively more exposed to negligent supervision claims.

***Subscriber Choice of Physician:*** Typically provides a higher degree of choice since they are usually open panel models. Thus, liability exposure to negligent selection claims will be less than that of either a staff or closed panel group model HMO.

***Financial Controls and Incentives:*** Compensation arrangements to the provider group in this type of HMO are more likely to involve a capitated rate than staff model HMO's. Thus the IPA, not the HMO, is generally more exposed to denial of care claims which could migrate to the HMO who set the terms of the reimbursement arrangement. Vicarious liability is therefore possible but not as likely as a staff model HMO and probably less than a group model HMO.

***ERISA Protection:*** Would likely have more ERISA protection than staff and group model HMO's since the MCO-provider relationship neither is, or would appear to be, as direct.

***Organizational Infrastructure:*** Record keeping control could potentially be less than staff models and group models due to the independence of the potentially numerous practice associations affiliated with a single HMO. Thus, allegations relating to confidentiality may be more prevalent in this type of model. In addition, it may be more feasible to show that this arrangement consists of more than one entity and thus be capable of conspiring to prevent an eligible provider from participating. Provider anti-trust exposure is therefore greater in this type of model.

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*Preferred Provider Organizations (PPO) or Preferred Provider Arrangements (PPA)*

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**Description:** PPO's (or PPA's) are organizations set up to allow access by insurers, employers, or administrators to a network of physicians and facilities that provides the healthcare needs of the individuals covered by a health plan. Historically, PPO's provided unrestricted access to providers but have recently begun to implement gatekeeper systems as well as some financial risk taking into their compensation systems. Technically, the PPO itself does not provide the medical services but rather acts as an intermediary in bringing together the supply and demand of healthcare services. The typical health plan that utilizes a PPO allows the participants to go outside the network of providers but builds in a disincentive to do so (such as higher deductibles or co-pays). In essence, PPO's act as the coordinator of healthcare services that contracts with the necessary physicians to offer a full range of healthcare benefits. In return for providing the physicians or facilities with patients, the providers accept discounted rates as well as utilization controls. This type of structure is attractive to many employers who want to give their employees a wide degree of choice in selecting their providers.

**Assessment**

**Employment Status:** PPO's do not employ physicians but rather contract with physicians to provide healthcare services to a covered population at a reduced rate. Although this does not completely shield the PPO from ostensible agency claims, that exposure can be minimized through proper risk management techniques. Exposure to vicarious liability would be similar to an IPA model HMO.

**Utilization Control:** Historically, PPO's have not had the same gatekeeper mentality as HMO's. As originally designed, PPO's provided unrestricted access to physicians within a network. Cost management was achieved through provider discounts rather than capitation or salary. As these organizations evolve, managed care concepts are becoming more prevalent. Thus, some PPO's may operate essentially like HMO's by performing case management, utilization review, and prior authorization functions. One needs to analyze each PPO individually to assess the utilization control issue and the subsequent degree of exposure to negligence. However, even if utilization control is utilized, the exposure to the MCO is minimal and would be similar to an IPA model HMO.

**Provider Supervision:** Similar to a direct contract model HMO in that physicians will be relatively independent and thus more difficult to supervise and assess their competence. This could result in relatively more exposure to negligent supervision claims.

**Subscriber Choice of Physician:** Relative to HMO's and EPO's, PPO's provide a higher degree of choice. Typically, healthcare services provided outside the network of PPO providers entails a higher deductible or co-payment. This arrangement would not likely be viewed by courts as being too restrictive, thus reducing liability associated with negligent selection.

**Financial Controls and Incentives:** Historically, PPO providers were compensated on a discounted fee-for-service arrangement. In that event, denial of care allegations due to financial incentives would be rare. However, as PPO's evolve and become more responsive to employers managed care desires, they will likely have more exposure to denial of care allegations than what they previously faced. On a relative basis, they would have no more exposure than a group model HMO and probably much less.

**ERISA Protection:** Would likely have more ERISA protection than staff and group model HMO's since the MCO-provider relationship neither is, or would appear to be, as direct. Exposure would be similar to an IPA model HMO.

*Organizational Infrastructure:* Record keeping control would be less than staff and group models due to the independence of the potentially numerous providers. Thus, allegations relating to confidentiality would likely be more prevalent in this type of model. In addition, it may be more feasible to show that this arrangement consists of more than one entity and thus be capable of conspiring to prevent an eligible provider from participating. Provider anti-trust exposure is therefore relatively high in this type of model and probably similar to an IPA model HMO.

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### *Exclusive Provider Organizations (EPO)*

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*Description:* EPO's are similar to PPO's in that they are organized to bring together the purchasers and providers of healthcare services. As with PPO's, they technically do not provide the medical services but rather act as an intermediary in joining the two parties. However, they are much more restrictive than PPO's in two key respects. First, members typically are not covered for healthcare services received from non-EPO providers. And second, providers may be prohibited from referring patients to non-EPO providers or facilities. In fact, EPO's could be considered a very restrictive form of an HMO.

#### *Assessment*

*Employment Status:* EPO's do not employ physicians but rather contract with physicians to provide healthcare services to a covered population. Because of the restrictions placed on providers within an EPO, it may be easier for a plaintiff's lawyer to show a lack of independence and thus enable the MCO to be held vicariously liable for provider malpractice. Exposure to vicarious liability is similar to that of group model HMO's, if not higher.

*Utilization Control:* Utilization control would likely be established by the providers contracted by the EPO. However, because of the structure and limitations placed on providers, an EPO has a modest vicarious liability exposure to allegations of inadequate treatment similar to that of a group model HMO.

*Provider Supervision:* Similar exposure as a PPO and direct contract HMO since providers are relatively independent and thus more difficult to supervise and assess their competence.

*Subscriber Choice of Physician:* Very restrictive. Similar to an HMO in that healthcare services provided outside the network are not covered. May even be greater liability exposure than an HMO if the EPO does not provide a comprehensive panel of providers and the EPO restricts a provider's ability to refer outside the system. If the EPO isn't large enough, there is a relatively high exposure to negligence claims on the grounds of a lack of expertise and the inability of the provider to access the quality of care necessary to treat a patient. Would also be higher exposure to negligent selection claims due to the restricted choice..

*Financial Controls and Incentives:* Exposure potential would generally be greater than a PPO since an EPO contract would be more likely to involve capitation or a substantially reduced fee-for-service

reimbursement. Because of the structure and limitations placed on providers, an EPO may be more likely to be held vicariously liable for negligence claims than a PPO.

*ERISA Protection:* On a relative basis, there would be limited protection due to the possibility of the MCO-provider relationship being viewed as close. ERISA protection would fall between a staff model and group model HMO.

*Organizational Infrastructure:* The assessment of exposure to confidentiality and anti-trust claims is very dependent on the structure of the EPO, namely the number and type of providers in the system. The more diverse and numerous the network of providers, the higher the exposure to these claims. Assuming a similar sized network, the exposure would be similar to an IPA model HMO. However, as a general rule, EPO's tend to be fairly small due to the restrictions placed on members and the low reimbursements to providers. Given that, these organizations will likely have less exposure than an IPA model.

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#### *Point of Service Plans (POS)*

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*Description:* POS's are HMO's or PPO's that provide an option to receive care from healthcare providers who are not within the network of designated providers. Payment for services is still made if a patient chooses to receive care outside the network but is done with an increased deductible and/or co-payment.

#### *Assessment*

*Employment Status:* Need to look at exact structure since a wide range of employment relationships are possible. If an HMO is providing the in-plan services, then the potential vicarious liability exposure would be roughly equivalent to the HMO form it most closely resembles. Otherwise, liability potential would be similar to a PPO.

*Utilization Control:* Gatekeeper system is still utilized as in a typical HMO. However, services using nonparticipating physicians may not have these controls. Thus, assessment of potential exposure is dependent on what percentage of the subscribers access providers outside the system. If out-of-plan services are heavily utilized, less exposure to utilization control related allegations.

*Provider Supervision:* Assessment of potential exposure is dependent on what percentage of the subscribers access providers outside the system. If out-of-plan services are heavily utilized, there may be more exposure to negligent supervision claims. However, most of the liability for negligence would remain with the out-of-plan provider.

*Subscriber Choice of Physician:* Relative to other HMO's, EPO's, and PPO's, the ability of patients to select providers is greater (although a higher co-payment is usually required). However, access to specialists will still be limited if in-plan services are desired. Even so, exposure to negligent selection claims should be relatively low.

*Financial Controls and Incentives:* Services provided in-plan would generally be performed by capitated providers. However, the vicarious liability to the MCO is dependent on the relationship between the MCO and the providers. That relationship can vary substantially among POS plans, thus the exposure potential to denial of care claims varies as well. Services out-of-plan would typically be fee-for-service and thus pose very little conflict of interest. In addition, it is unlikely that negligent out-of-plan services would migrate to the MCO.

*ERISA Protection:* Need to look at exact structure since a wide range of MCO-provider relationships are possible. The closer the relationship, the greater the liability exposure.

*Organizational Infrastructure:* Difficulty in coordinating in-plan and out-of-plan services may result in higher exposure to confidentiality issues. Anti-trust exposure is dependent on the structure and would follow the exposure of the HMO it most closely resembles.

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### *Physician-Hospital Organizations (PHO)*

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*Description:* PHO's are separate legal entities owned jointly by a hospital and a group of physicians. One common example is when an IPA and a hospital join together to provide healthcare services to a geographic region. This type of structure can be beneficial for both parties in the event that neither is able to generate enough sustainable business on their own. PHO's were initially designed to ward off aggressive MCO's. However, that strategy may not be working as PHO's did not generally develop the cost effective protocols necessary to compete for cost-conscious employer groups. To survive, they are evolving by implementing managed care capabilities.

#### *Assessment*

*Employment Status:* Although the PHO would not employ the physicians, the ownership the hospital and providers may have of the PHO may expose them to vicarious liability more easily than a PPO. In general, exposure would be similar to that of a group or IPA model HMO.

*Utilization Control:* In many cases, PHO's are formed to resist aggressive managed care initiatives. In these cases, it can be very difficult to place adequate controls on utilization review and quality management, especially when the goal is to keep beds and appointments filled (assuming the plan's financial incentives allow it). Because of this, PHO's tend to have less control over physician practice patterns and therefore less exposure to claims involving denial of care issues.

*Provider Supervision:* Similar exposure to inadequate supervision allegations as a group or IPA model HMO. Providers will be relatively independent and therefore more difficult to assess their competence. Exposure to allegations involving inadequate provider supervision could be more prominent than in MCO's where the relationship is more direct.

*Subscriber Choice of Physician:* Similar to an HMO in that healthcare services provided outside the network are not covered. May even be greater liability exposure than an HMO if the PHO does not provide a comprehensive panel of providers and the PHO restricts a provider's ability to refer outside the system. If the hospital in the system lacks comprehensive facilities, there is a relatively high exposure to negligence claims on the grounds of an inability of the hospital to provide the quality of care necessary to treat a patient. Would also be higher exposure to negligent selection claims due to the restricted choice.

*Financial Controls and Incentives:* Need to assess the compensation/reimbursement arrangements on an individual basis since they can vary significantly among PHO's. The provider group may be capitated which would increase the group's exposure to failure to treat claims that could in turn be shifted to the MCO through various vicarious liability theories. Relative to other MCO's, the exposure is probably low and similar to a PPO.

*ERISA Protection:* Would likely have more ERISA protection than HMO's since the PHO is not the direct employer of the providers.

*Organizational Infrastructure:* Record keeping control would be similar to an IPA model HMO due to the independence of the hospital and provider groups. Thus, exposure to allegations relating to confidentiality would be higher than staff or group model HMO's. However, it may be more feasible to show that this arrangement consists of more than one entity and thus be capable of conspiring to prevent an eligible provider from participating. Provider anti-trust exposure is therefore greater than staff or group model HMO's in this type of model.

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### ***Third Party Administrator (TPA)***

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*Description:* TPA's are typically responsible for the claims processing and records management for an organization providing healthcare to a group of individuals. Although not MCO's themselves, they are used by employers to administer the activities associated with self-funded health benefits or insurance programs that involve managed care. This type of arrangement is sometimes called an Administrative Services Only (ASO) organization.

#### ***Assessment***

*Employment Status:* Not applicable since there is no relationship with providers of healthcare services.

*Utilization Control:* Some TPA's are beginning to provide utilization review services via a group of physicians on retainer or by employing part-time physicians. In either event, the exposure to allegations of improper utilization review against the TPA may be increasing in the future due to the direct relationship between the TPA and physician.

*Provider Supervision:* Not applicable since there is no relationship with providers of healthcare services.

*Subscriber Choice of Physician:* Not applicable since there is no relationship with providers of healthcare services.

*Financial Controls and Incentives:* Generally, the MCO places no financial incentives on the TPA to reduce the utilization of healthcare services.

*ERISA Protection:* Claims involving TPA's would likely be pre-empted by ERISA, thus substantially reducing potential liabilities.

*Organizational Infrastructure:* Confidentiality issues are the main concern with TPA's. Strong controls are needed to reduce liability exposure.

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### *Management Service Organizations (MSO)*

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*Description:* MSO's are formed to provide practice management services to physician groups. The functions they perform vary significantly and can include equipment & supply purchasing, providing and employing office staff (including physicians), adding information systems, credentialing, quality assurance functions, negotiating MCO agreements, and other medical management functions. Any function designed to improve or support the administrative infrastructure of a group of physicians falls within the domain of MSO's. These entities position themselves between the provider and consumer of healthcare services although many of their functions are identical to those performed by an HMO.

#### *Assessment*

*Employment Status:* Very dependent on the structure of the particular contract and services offered. It is possible for an MSO to purchase the furniture, equipment, and supplies of a medical practice and to employ the office staff as well as the healthcare providers. In that arrangement, vicarious liability exposure is high. Other arrangements could be significantly less exposure to the MCO.

*Utilization Control:* Very dependent on the structure of the contract and services offered. Some MSO's conduct medical management and quality assurance, thus exposing themselves to a relatively high potential for denial of treatment claims.

*Provider Supervision:* Very dependent on the structure of the contract and services offered. Some MSO's employ the physicians and thus maintain a high degree of control. Other arrangements may be more similar to an IPA model.

*Subscriber Choice of Physician:* Very dependent on the structure of the contract and the services offered. A wide range of liability exposure is possible and needs to be assessed individually.

*Financial Controls and Incentives:* Very dependent on the structure of the contract and the services offered. May be heavily involved in the financing of the healthcare being provided by the physicians in a group or association, thus exposing themselves to a higher number of denial of care claims.

*ERISA Protection:* An MSO may not have strong ERISA protection due to the potential for a strong MSO-provider relationship. Again, it is very dependent on the particular situation.

*Organizational Infrastructure:* Would probably maintain strong record keeping controls since one of their functions is typically to manage the provider practice and therefore would have access to strong management skills and operations. Generally speaking, will have less exposure to confidentiality claims.

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## ***V. Secondary Criteria (underwriting criteria)***

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In addition to the list of primary (differentiating) criteria, there are numerous underwriting criteria that do not serve to differentiate liability exposure between various types of managed care entities but rather serve to distinguish the level of exposure within in any given MCO. An exhaustive list of all the underwriting concerns would be too numerous to list here, but among the most important are:

### ***The credentialing and recredentialing procedures utilized by the MCO***

In some instances, the credentialing duties of an MCO are delegated to other entities. For example, an HMO may delegate credentialing duties to an IPA or medical group who may in turn rely upon the credentialing done by a local hospital or medical society. While tort laws do not make this delegation illegal, the MCO does not escape the duty. However, the further removed an MCO is from the actual credentialing process, the less likely they will have to bear the full impact of a liability suit, thus lessening their exposure to claims involving negligent credentialing. It should be noted that the fact that a duty to apply appropriate credentialing criteria exists does not necessarily imply that the MCO will be responsible for a bad outcome resulting from the actions of an MCO provider. Liability also requires proof that adequate criteria or monitoring would have indicated that the provider was likely to engage in harmful activity.

In addition, the frequency of credentialing activities can have an impact on the ultimate liabilities of an MCO. It is important to maintain periodic credentialing activities on all providers within a system in order to stay up to date. The more frequent the activities, the less exposure to negligent credentialing can be expected.

### ***The adequacy of the contract physician's professional liability limits***

In the event a contract physician carries low limits of professional liability coverage and is involved in a bad outcome, it is more likely that plaintiff's lawyers will name the MCO in the suit in an attempt to access deeper pockets. This could happen even in cases where the relationship between the MCO and physician is clearly contractual. However, trials by jury can have notoriously unpredictable results and it is clearly in the best interest of the MCO to be named in as few suits as possible.

### ***"Any Willing Provider" statutes***

"Any Willing Provider" statutes generally require MCO's to accept any physician that meets broad acceptability criteria. These provisions can legislatively limit an MCO's ability to exclude physicians which they feel do not meet their own quality standards. The existence of these statutes may serve to partially shield the MCO from the liability associated with negligent selection.

### ***The size of the MCO***

Although somewhat dependent on the type of MCO, the larger the MCO relative to the community size, the more claims will occur from providers who will have fewer opportunities to practice outside

the organization or network. Also, suits from competitor MCO's will occur if they believe the exclusivity of the larger MCO has left them without a sufficient pool of providers.

#### ***The location of the MCO***

The legal and social environment in the locality that a claim is made can have a dramatic effect on the outcome of jury trials and therefore has an influence on the outcome of negotiated settlements. Information on loss cost differences by state and territory for both physician and hospital professional liability can be obtained and used as a reasonable proxy for determining the likely liability loss cost differences that could be expected for managed care entities.

#### ***The financial risk associated with the delivery and management of the healthcare services***

If a perception can be created in a juror's mind that the MCO sacrificed quality healthcare for an economic savings, the potential exposure can be enormous, especially when punitive damages are considered. The likelihood of punitive damages will increase if a plaintiff can prove that financial considerations replaced proper patient considerations especially when life saving procedures are the issue. Thus there is a need to determine the structure of the financial incentives of the MCO and whether that arrangement could call into question a physician's duty to the patient.

#### ***The appeal process in place for providers to challenge a utilization review decision***

Physicians have a non-delegable responsibility for patient care and cannot rely upon a utilization review decision that they disagree with and hope to avoid liability in the event of a bad outcome. If a physician does not appeal a utilization review decision, then the MCO is probably shielded from liability (unless the physician is an employee). However, if an appeal process is in place, it may result in more liability to the MCO if the physician is then forced to comply with the decision and a bad outcome results. This is also an area where the potential for punitive damages is increased unless proper procedures are in place.

#### ***How the utilization review activities are handled***

Utilization review activities have been one of the most fertile grounds for finding liability against an MCO. Generally, managed care entities use prospective and concurrent utilization review in assessing patient needs. These types of utilization review are far more likely to create legal liability than a retrospective review. Under retrospective reviews, the medical procedures have already been performed, thus no negligence with regard to a failure to perform a certain procedure can be alleged. The only issue is whether the patient gets the procedure paid for, thus dramatically reducing the potential medical professional liability.

MCO's handle this activity in many different ways. Some organizations are more likely to handle these review activities in-house, thus generating more exposure than if they outsourced the service to independent contractors.

*The regulatory environment*

Increased exposure to tort claims have occurred to MCO's that are not typically covered under state laws pertaining to insurance or HMO's. Most MCO's other than HMO's are not regulated by state statutes and thus do not face laws designed specifically for them. As a consequence, they may be more exposed to tort claims since the absence of state mandated procedures for remediation of malpractice claims may leave a plaintiff no choice but to bring a tort action to compensate for the injury. This is an issue which could be a primary criterion. However, the monetary damages likely to be circumvented by HMO regulations would tend to be low severity and thus not have a substantial impact on MCO loss costs.

For a more complete discussion of the various underwriting criteria being utilized to differentiate risks, refer to the bibliography section of this paper.

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## ***VI. Concluding Remarks***

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The assessment of the liability exposure to claims relating to the delivery and management of managed care operations primarily involves what would traditionally be considered underwriting criteria. This is due to the broad and overlapping ways a managed care plan can organize itself. Presumably, this overlap will continue for as long as the evolution of the healthcare industry continues. Until a system of classification can be developed which will allow for a significant database of claims activity by MCO type, loss costs allocated using the current definitions will simply have too much variation to be credible. Actuaries involved in assessing the healthcare liability exposure of managed care entities will need to continue to assess the exposure on an individual basis and allow for a wide latitude in judgement.

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