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**THE DENIAL OF BENEFITS QUANDARY  
AND MANAGED CARE:  
MCGRAW v. PRUDENTIAL  
INSURANCE COMPANY**

*Jennifer M. Jendusa\**

**INTRODUCTION**

*“Getting really sick is what worries most Americans. They know how hard it can be to cut through the managed-care red tape for a pair of eyeglasses or a simple ear infection. What would happen, they wonder, if they or one of their loved ones became desperately ill and needed serious – and expensive – medical attention? Who would prevail if their medical needs ran smack into gatekeepers of an HMO focused primarily on reducing costs?”<sup>1</sup>*

Health insurance may not be mandatory in the United States, but given the high cost of health care it does appear to be a necessity. People need to be prepared in the event that they need costly, life-saving medical attention. Furthermore, health insurance has become an increasing necessity due to the high costs of health care treatments. While a variety of insurance plans are available, the forms most prevalent today are cost-containing managed-care entities, or Health Maintenance Organizations (HMOs) and

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<sup>1</sup>Christine Gorman, *Playing the HMO Game: Denied Viagra and Inflamed by Horror Stories, Consumers Put Health Reform Back on the Front Burner*, TIME, July 13, 1998, at 22, 24.

Preferred Provider Organizations (PPOs).<sup>2</sup> Cost-containing efforts of HMOs and PPOs have come under increased scrutiny for denying coverage to claims that would provide necessary treatment to an ailing patient. This situation begs the question whether insurance companies, designed to provide individuals with the resources necessary in case of emergencies, can refuse to pay for the treatment required. Although such a scenario appears counterintuitive, the fact is that managed-care insurance entities have increasingly faced scrutiny for denying benefits. The following examples consider whether assessments that determine the prescribed treatment is not medically necessary in a given case are actually an economic decision to contain costs.

Thirteen year-old Matthew Cerniglia developed a rare and aggressive form of cancer, and doctors estimated that he had a 20% chance of survival.<sup>3</sup> Matthew was administered a course of chemotherapy, which was initially paid for by the Cerniglia's HMO.<sup>4</sup> When the chemotherapy was deemed unhelpful in Matthew's situation and a bone-marrow transplant was recommended, the insurance company refused to cover the procedure.<sup>5</sup> According to the HMO, the new bone-marrow transplant treatment was not on the list of approved therapies that would receive coverage, nor was the procedure "medically necessary."<sup>6</sup> Consequently, Matthew's family was left with the arduous task of trying to accumulate \$100,000 to pay the bills already incurred, as well as the large sum that the transplant would require.<sup>7</sup>

Mary Halm of Ohio suffered from an extreme case of endometriosis which caused her excruciating pain much of the time.<sup>8</sup> Her HMO paid for several operations, but the procedures failed to remove all of the uterine tissue causing her pain.<sup>9</sup> After learning about a specialist in Atlanta, Mary attempted to procure coverage to seek the additional expertise of this new

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<sup>2</sup>See Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 20 (1994).

<sup>3</sup>See Gorman, *supra* note 1, at 24.

<sup>4</sup>See *id.*

<sup>5</sup>See *id.*

<sup>6</sup>See *id.* In the insurance industry, medical necessity refers to treatments and procedures an insurance company deems necessary and appropriate as the sole or most effective means of improving an individuals health. See *id.*

<sup>7</sup>See *id.*

<sup>8</sup>See Gorman, *supra* note 1, at 25.

<sup>9</sup>See *id.*

physician.<sup>10</sup> The HMO refused to cover the specialist in Atlanta, claiming that plenty of qualified specialists resided in her area (although the insurance company could not name any).<sup>11</sup> After appealing the denial of benefits for nine months, Mary borrowed the necessary money, and underwent the operation.<sup>12</sup>

These stories are a small sampling of anecdotal evidence describing how patients have been left to suffer pain, or even face imminent death, because of the decisions of insurance companies to deny payments of medical benefits. Not always receiving a clear explanation for the denial, consumers are becoming increasingly frustrated at what appears in many cases to be cost-containment decisions that supersede a patient's well-being.<sup>13</sup> Must consumers live in fear that managed care entities will primarily focus on financial considerations and not examine what is truly in the best interest of the patient?

This article will examine the history of health care and the evolution of the managed care system in the insurance industry.<sup>14</sup> It will evaluate the managed care system in light of the process of utilization review and recent case law in this area.<sup>15</sup> A recent case *McGraw v. Prudential Insurance Company of America*,<sup>16</sup> which involves denial of benefits on the basis that the prescribed treatment was not medically necessary under the definitions of the insurance plan<sup>17</sup> will be examined. Attempts to assure quality care in the medical setting<sup>18</sup> will be analyzed, as well as the ramifications of the court's holding on the future of health care and utilization review.<sup>19</sup>

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<sup>10</sup>See *id.*

<sup>11</sup>See *id.*

<sup>12</sup>See *id.*

<sup>13</sup>See Randall, *supra* note 2, at 3-4 ("But managed care, like other programs in the past, has become so focused on the problem of cost that it may very well be losing sight of what should be the overriding purpose of health care — the well being of the patient. . . . The patient's well-being is not directly aided by cost-containment . . .").

<sup>14</sup>See *infra* pp. 118-128 and accompanying text.

<sup>15</sup>See *infra* pp. 121-128 and accompanying text.

<sup>16</sup>*McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253 (10th Cir. 1998).

<sup>17</sup>See *infra* pp. 128-137 and accompanying text.

<sup>18</sup>See *infra* pp. 137-139 and accompanying text.

<sup>19</sup>See *infra* pp. 137-139 and accompanying text.

## BACKGROUND

### The History of the Health Care System and the Evolution of Managed Care

America's health care system has undergone vast changes over the last 100 years, with each change resulting in both positive and negative ramifications to the individuals and health care entities involved.<sup>20</sup> In general, the historical changes can be classified as movement from a home-based system to a hospital-based enterprise, transition from a nursing care-based system to a technology-based system, and modification from a patient interest driven enterprise to a provider interest driven enterprise.<sup>21</sup> Presently, change in the health care arena is not unusual. Specifically, the health care industry has faced a significant and ongoing transformation resulting from the evolution from a provider-driven system to a third-party payer-driven system.<sup>22</sup>

Early medicine (dating as far back as the 1600s if not earlier) was quite rudimentary, as limited technological resources, treatment alternatives, and medications restricted physicians' options.<sup>23</sup> Physicians offered ill patients little more than house calls, observation and simple surgical procedures.<sup>24</sup> This was due partly to the lack of financial resources available to the individual patients to compensate physicians, as well as a lack of professional resources available to the treating doctors.<sup>25</sup> Additionally, lack of treatment facilities thwarted the ability to offer necessary and quality patient care.<sup>26</sup> From the 1700s to mid-1800s, only the poorest and lowest class individuals went to the hospital, which was

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<sup>20</sup>See Randall, *supra* note 2, at 9.

<sup>21</sup>See *id.* The negative features resulting from the changes in health care possibly could have been avoided if attention was paid to "the down side of changes occurring in the health care system." *Id.*

<sup>22</sup>See *id.* at 10. "As the new system is being designed and implemented, it is important to understand how the current systemic problems developed. Only then can actions be taken to avoid analogous pitfalls in this new third-party payer-driven system." *Id.*

<sup>23</sup>See Allison Faber Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 211 (1997).

<sup>24</sup>See *id.* Reimbursement methods for medical assistance were also quite rudimentary. After providing the necessary treatment to the patient, the physician set a fee that the patient was capable of paying out-of-pocket. "This simple reimbursement method was, and still is, referred to as fee-for-service." *Id.*

<sup>25</sup>See *id.*

<sup>26</sup>See *id.*

an unsophisticated and small section of a jail or almshouse.<sup>27</sup> Those who could pay the expense of personal treatment instead opted to stay in the comfort of their home for treatment.<sup>28</sup> The first community-owned hospitals serving both the poor and paying patients were created in the late 1700s at the urging of European-trained doctors, although hospital stays and treatment plans did not become widely accepted until the late 1800s.<sup>29</sup>

In the early 1900s, with the availability, acceptance, and familiarity of hospital care increasing, patients chose to seek treatment at hospitals rather than receive treatment at home.<sup>30</sup> This all began to change with the onset of the Great Depression.<sup>31</sup> As a result of the economic disparity felt by American society during the Depression, patients were unable to pay for basic health care, let alone complex and expensive hospital bills.<sup>32</sup> Consequently, the economic stability of hospitals and medical institutions wavered greatly from the lack of patient use.<sup>33</sup> Hit hard by this economic downfall, the American Hospital Association and insurance companies created private health insurance options to assure stable revenues and provide affordable health care to citizens struggling financially.<sup>34</sup>

The Blue Cross insurance plans created during the Depression only guaranteed payment of hospital costs in an "environment of limited technology and patient self-rationing."<sup>35</sup> However, given the economic status of the country, response was enormous.<sup>36</sup> The limited coverage of the Blue Cross plans was applauded by physicians in the American Medical Association (AMA) who believed that insurance should be paid

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<sup>27</sup>See Randall, *supra* note 2, at 10.

<sup>28</sup>See *id.*

<sup>29</sup>See *id.* at 10-11. "As late as 1873, there were only 178 hospitals with a total of 35,064 beds in the entire United States. Only thirty-six years later, in 1909, the number had grown to 4,359 hospitals with 421,065 beds, and by 1929 to 6,665 hospitals with 907,133 beds" See *id.* at 11.

<sup>30</sup>See Walsh, *supra* note 23, at 212.

<sup>31</sup>See Randall, *supra* note 2, at 11.

<sup>32</sup>See *id.*

<sup>33</sup>"As early as 1930, average hospital receipts fell from \$236.12 per patient in the 1920s to \$59.26, bed occupancy dropped from 71.28% to 64.12%, and hospital deficits rose dramatically" See *id.* at 11. See also Walsh, *supra* note 23, at 212.

<sup>34</sup>See Randall, *supra* note 2, at 11; Walsh, *supra* note 23, at 212.

<sup>35</sup>Randall, *supra* note 2, at 11. Given the overall poor economic status of American society, the extreme popularity of the plans was predictable. "The plans, however, covered only hospital costs. Physicians, through the American Medical Association (AMA), sought to keep coverage limited." *Id.*

<sup>36</sup>See *id.*

only to the patients.<sup>37</sup> Physicians feared that third-party intermediaries would play too significant a role in determining medical treatment, perhaps at the expense of patient well-being.<sup>38</sup> The AMA specifically feared that third-party payers dealing directly with physicians would eventually require that medical decisions be made on the basis of the third-parties' interest and not that of the patient.<sup>39</sup> Such fears and reservations were not seriously considered at the time, although history would prove the observations to be highly insightful. Despite the warnings, some states adopted the popular Blue Shield medical service benefits.<sup>40</sup>

After World War II, commercial insurance emerged as wage and price freezes and tax exemptions prompted employers to offer health insurance programs to workers.<sup>41</sup> With the coming of commercial insurance opportunities came tremendous growth in the health insurance industry and the integration of health insurance into employee benefits programs.<sup>42</sup> As the health care industry grew, modernized, and transformed into an institution in its own right, demand for services increased along with demand for coverage.<sup>43</sup> To supply the needed insurance benefits, new insurance companies sprang up in competition with the Blue Cross and Blue Shield plans, and the field became increasingly competitive.<sup>44</sup> The result of the increased number of individuals covered by insurance was a disparity between those who had private insurance and those who did not.<sup>45</sup>

The method of reimbursement of health insurance companies was fee-for-service.<sup>46</sup> This entailed physicians providing patient treatment and diagnoses exclusively, with total discretion to utilize whatever resources

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<sup>37</sup>See *id.*

<sup>38</sup>See *id.*

<sup>39</sup>See *id.* "The current interest in managed care plans, which emphasize controlling physicians' behavior, indicates that physicians' historical fears of third-party payer control of medical practice decision making were well founded." *Id.* at 12.

<sup>40</sup>See *id.* at 11-12. "Like Blue Cross, Blue Shield proved extremely popular. Over the last sixty years, the Blue Cross and Blue Shield plans have become the largest providers of private medical insurance." *Id.* at 12.

<sup>41</sup>See Randall, *supra* note 2, at 12; Walsh, *supra* note 23, at 212.

<sup>42</sup>See Randall, *supra* note 2, at 12; Walsh, *supra* note 23, at 212

<sup>43</sup>See Randall, *supra* note 2, at 12.

<sup>44</sup>See *id.* Unlike the early Blue Cross and Blue Shield plans, the new commercial policies offered an indemnity benefit. *Id.*

<sup>45</sup>See *id.* at 13.

<sup>46</sup>See Walsh, *supra* note 23, at 213.

were necessary to handle a situation, regardless of cost.<sup>47</sup> Physicians tendered bills to patients, and the insurance company covered the expenses.<sup>48</sup> Consequently, due to the willingness of the insurance company to pay whatever costs incurred, neither the physician nor the patient were motivated to utilize any cost controlling measures.<sup>49</sup> This resulted in high profits to physicians, but extended heavy burdens on the insurance companies required to fulfill payment schedules.<sup>50</sup> In essence, the fee-for-service model encouraged physicians to over-utilize treatment and accumulate expenses at alarmingly rapid rates, which yielded significantly more money ultimately landing in the physicians' pockets.<sup>51</sup>

With the increasing costs placed upon insurance companies, cost containment measures became necessary for institutional survival.<sup>52</sup> Therefore, "escalating health care costs and innovative medical technology forced insurers, policymakers and employers to consider a new method for the delivery of health care."<sup>53</sup> To this end, Congress passed the Health Maintenance Act in 1973, marking the official recognition of managed care as a new system of affordable quality health care to those enrolled.<sup>54</sup>

### The Managed Care System and Utilization Review

When the Health Maintenance Act was passed in 1973, managed care was thrust into the mainstream insurance industry.<sup>55</sup> Despite its popularity and overall dominance currently,<sup>56</sup> the concept of managed care was not

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<sup>47</sup>*See id.* "Physicians exerted exclusive control over the diagnosis and treatment of patients and had complete discretion to choose the method and cost of treatment." *Id.*

<sup>48</sup>Unlike the current managed care system, these bills submit by physicians were beyond review, and payment was made immediately without question. *See id.*

<sup>49</sup>*See id.*

<sup>50</sup>*See id.*

<sup>51</sup>*See* Walsh, *supra* note 23, at 213.

<sup>52</sup>*See Id.*

<sup>53</sup>*Id.*

<sup>54</sup>*See id.* at 213-15. The purpose of the Federal HMO Act is to provide financial assistance to HMOs that meet the established criteria. This financial aid comes in the form of loans and grants allocated to individuals interested in creating HMOs that meet the guidelines. *See id.* at n.32. The Health Maintenance Organization Act of 1973 can be found at 42 U.S.C §§ 300e-300e-17 (1994) (amended 1976, 1978, 1981, 1986, 1988).

<sup>55</sup>*See id.* at 214-15.

<sup>56</sup>Over sixty million people, about 24% of American workers and dependents, are eligible for an HMO or other form of managed care entity. Frank J. Rief, III, *The Evolution of Managed Care*, C653 ALI-ABA 1, 3 (1991). Today, 85% of insured employees have moved from traditional fee-for-service plans into managed care plans, including HMOs. Gorman, *supra* note



entirely new.<sup>57</sup> Previously, prepared managed care plans were utilized in various contexts: by nineteenth century slave owners for their slaves' medical treatment; by powerless workers concerned with adequate health coverage; and by large industries dealing with increasing numbers of work related injuries.<sup>58</sup> Managed care was also instituted in the late 1920s and early 1930s when employers began to offer prepaid health care to employees.<sup>59</sup> Regardless of the year, managed care enterprises shared one thing, a commitment to cost containment measures.<sup>60</sup>

Managed care systems work towards cost containment in medical situations through a number of systematic practices involving various structures, including HMOs and PPOs.<sup>61</sup> "An [sic] HMO is an organized system of health care delivery for both hospital and physician services in which care delivery and financing functions are offered by one organization."<sup>62</sup> Since the HMO provider list is limited, patients have little or no flexibility in determining from which providers to seek medical treatment.<sup>63</sup> HMO service is provided for both a fixed and a prepaid fee, and the financial risk is shifted from the third-party payer to the service provider.<sup>64</sup> "PPOs contract directly with an employer through the employer's health benefits department or indirectly through an insurance carrier to provide health care services from a pre-selected group of providers."<sup>65</sup> Because of the limited list of qualified providers, the overall

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1, at 23.

The truth is, Americans are probably as healthy today as they ever were, and are paying less for their health coverage. Thanks at least in part to managed care, vaccination rates are up, premature births are down, more women are getting mammograms than ever before and costs have fallen dramatically. Managed care saved between \$150 billion and \$250 billion last year alone out of total U.S. health-care spending of \$1 trillion.

*See id.* at 24.

<sup>57</sup>*See* Walsh, *supra* note 23, at 210.

<sup>58</sup>*See id.* at 210-11.

<sup>59</sup>*See id.* at 212.

<sup>60</sup>*See id.* at 215.

<sup>61</sup>*See* Randall, *supra* note 2 and accompanying text.

<sup>62</sup>Randall, *supra* note 2, at 20.

<sup>63</sup>*See id.* at 19, 23.

<sup>64</sup>*See id.* at 20. "This shift means that HMOs can obtain cost savings only by controlling both utilization and expenses. They do so by encouraging fewer hospital admissions, more outpatient procedures, and fewer referrals to specialists." *See id.*

<sup>65</sup>*See id.* at 22-23.

expense to patients within a PPO is lower than with traditional insurance measures, and participants have the ability to choose from a list of physicians.<sup>66</sup>

Managed health care is provided to subscribers on a contractual basis between the health care contractor and the managed care organization.<sup>67</sup> Several methods are utilized to monitor the care rendered:

- (1) peer review and utilization review;
- (2) quality control and monitoring of patient data;
- (3) cost control management;
- (4) high practice standards by physicians; and
- (5) efficient administration of the facility as a business.<sup>68</sup>

Although all of these measures are significant in managed care, utilization review is quite possibly the most well-known and most controversial.

### Utilization Review

Utilization review, as implemented by managed care organizations, is a means of lowering health costs by decreasing unnecessary medical procedures, hospital stays, and patient tests.<sup>69</sup> In other words, utilization review assures that payment is only made in cases where the services are medically necessary and appropriate given the patient's needs and the plan policy.<sup>70</sup> Each subscribing patient's records are reviewed in a two-step process by a practitioner on a case-by-case basis in order to prevent unnecessary and overly costly medical procedures.<sup>71</sup> Typically, a non-physician reviewer, such as a nurse or another provider, applies a

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<sup>66</sup>See *id.* "Physicians entering into provider contracts with PPOs agree to accept both utilization review controls and financial risk shifting structures. Third-party payers give consumers economic incentives to use the PPO physicians through reduced fees for services." *Id.*

<sup>67</sup>See Randall, *supra* note 2, at 19-20.

<sup>68</sup>Rief, *supra* note 56, at 3.

<sup>69</sup>See Walsh, *supra* note 23, at 216. See also Randall, *supra* note 2, at 26-29. Utilization review is the process by which a health care entity determines if medical services are "appropriate and necessary. Managed care products perform [Utilization Review] by examining providers' authorization and furnishing of services to detect variations from the norm that may indicate unnecessary or inappropriate care. When the third-party payer detects variation, it either does not pay the provider's charges (retrospective [utilization review]) or refuses to authorize the provision of the service (concurrent [utilization review]) and prospective [utilization review]." *Id.*

<sup>70</sup>See Michael A. Dowell, *Avoiding HMO Liability for Utilization Review*, 23 U. TOL. L. REV. 117, 117 (1991).

<sup>71</sup>See Walsh, *supra* note 23, at 216-17; Dowell, *supra* note 70, at 118.

predetermined set of criteria to the case presented.<sup>72</sup> If the treatment suggested does not satisfy the criteria, the matter is referred to a utilization review physician consultant.<sup>73</sup> The physician consultant and attending doctor then discuss the case, and the medical necessity of the treatment is determined.<sup>74</sup> Non-authorization results in non-payment of claims, while authorization, sometimes with restrictions, means that reimbursement will occur.<sup>75</sup> Three types of utilization review exist: prospective, concurrent and retrospective.<sup>76</sup>

Prospective utilization review occurs before treatment is ever rendered, and as such, the process is similar to an approval of services.<sup>77</sup> This program requires the service provider to obtain pre-authorization before treatment is rendered.<sup>78</sup> This is especially applicable in cases of hospitalization, expensive testing, and situations involving non-contract physicians.<sup>79</sup> The claim reviewer determines whether the treatment sought is medically necessary.<sup>80</sup> If the treatment is deemed medically necessary, then a treatment schedule is approved and the procedure can be performed.<sup>81</sup> However, if the treatment is viewed not medically necessary, the reviewer will submit a refusal for reimbursement of the treatment costs.<sup>82</sup> Concurrent review occurs throughout the course of treatment to determine whether a treatment prescribed is necessary at the time and specifies the number of visits or procedures for which payment will be authorized.<sup>83</sup> Retrospective utilization review, as the name implies, occurs after treatment is completed.<sup>84</sup> If a reviewer determines that a completed service was unnecessary, the managed care entity will refuse to cover the costs of treatment.<sup>85</sup>

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<sup>72</sup>See Dowell, *supra* note 70, at 118.

<sup>73</sup>See *id.*

<sup>74</sup>See *id.*

<sup>75</sup>See Walsh, *supra* note 23, at 217; Dowell, *supra* note 70, at 118.

<sup>76</sup>See Walsh, *supra* note 23, at 217.

<sup>77</sup>See *id.*

<sup>78</sup>See Dowell, *supra* note 70, at 118.

<sup>79</sup>See *id.*

<sup>80</sup>See Walsh, *supra* note 23, at 217.

<sup>81</sup>See *id.* at 216.

<sup>82</sup>See *id.* at 216-17.

<sup>83</sup>See *id.* at 217; Dowell, *supra* note 70, at 118.

<sup>84</sup>See Dowell, *supra* note 70, at 117; Walsh, *supra* note 23, at 217.

<sup>85</sup>See Walsh, *supra* note 23, at 217.

Utilization review in the managed care setting has not gone unnoticed.<sup>86</sup> Since patient treatment, and sometimes well-being, is determined by the decision whether or not to authorize a prescribed treatment, utilization review decisions are often the topic of debate.<sup>87</sup> In some instances, authorization decisions have fueled such emotional debate that the legal system intervened in the managed care hierarchy.<sup>88</sup>

In *Sarchett v. Blue Shield*,<sup>89</sup> the California Supreme Court affirmed an insurer's fundamental right to disagree with the treating physician's determination of medical necessity.<sup>90</sup> However, the court held that if coverage is denied, the insurer must inform the insured of contractual rights to an independent review of the case.<sup>91</sup> The *Sarchett* court acknowledged the "increasing practice of health care payers to require pre-authorization for elective procedures."<sup>92</sup>

Another important decision from California regarding utilization review is *Wickline v. State*.<sup>93</sup> In *Wickline*, a Medicaid patient underwent coronary artery bypass surgery for Leriche's Syndrome.<sup>94</sup> Although only

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<sup>86</sup>This is particularly because of that which is at stake in the utilization review process.

A utilization reviewer has a strong interest in minimizing the amount of treatment to patients which can create a conflict for a physician who determines that a treatment is medically necessary for his patient. Although the MCO may deny treatment, the physician is responsible for the treatment and care of the patient. Therefore, the question becomes, who is responsible when a physician stops treating a patient because the MCO denies coverage for the treatment and the patient is injured as a result.

*Id.* at 224. This is the very question that has recently led to a number of court cases to decide who is responsible for the patient after a denial of benefits from utilization review occurs.

<sup>87</sup>*See id.*

<sup>88</sup>*See id.* at 224-39.

<sup>89</sup>*Sarchett v. Blue Shield*, 729 P.2d 267 (Cal. 1987).

<sup>90</sup>*See id.* at 273.

<sup>91</sup>*See id.* at 276-77.

<sup>92</sup>*See id.* at 275; Linda V. Tiano, *The Legal Implications of HMO Cost Containment Measures*, 14 SETON HALL LEGIS. J. 79, 82 (1990). However, fearing that payers may become overly aggressive in coverage decisions, "the decision included a reminder that any doubts and uncertainties in an insurance policy will be construed in favor of coverage for the insured. As a result, the court predicted that the decision of a treating physician will rarely be reversed as being unreasonable or contrary to good medical practice." *Id.*

<sup>93</sup>*Wickline v. State*, 192 Cal. App. 3d 1630 (Cal. Ct. App. 1986).

<sup>94</sup>*See id.* at 1634. *See Dowell, supra* note 70, at 119-20. The procedure and ten days of post-surgical hospitalization were authorized, and due to complications, an eight day extension was sought by the physician to continue hospitalization. The Medicaid representative only authorized four additional days, and the patient was discharged at the end of this period. *Id.*

an intermediate court ruling, the court discussed utilization review and held that negligent utilization review decisions may result in a denial of necessary treatment, but that it is the physician who is responsible to determine medical necessity.<sup>95</sup> As such, the third-party reviewer could be held liable for “defects in the design or implementation of cost containment mechanisms” resulting in the denial of necessary medical procedures, but not the underlying decision.<sup>96</sup>

Managed care entities relied extensively on the *Wickline* decision to protect themselves from liability for appropriate utilization review decisions that resulted in patient injury.<sup>97</sup> However, the MCOs were reluctant to use the decision as a rationale to deny treatment after the California Court of Appeals denied summary judgment motions “brought by private insurance companies and a utilization review entity being sued for negligent utilization review.”<sup>98</sup> Then a new case came into the courts that opened the door for injured plaintiffs to sue their MCOs if a denial of benefits played a significant role in a patient’s injury.<sup>99</sup>

In *Wilson v. Blue Cross of Southern California*,<sup>100</sup> the Court of Appeals distinguished the *Wickline* case, where the decision to deny benefits met the medical standard for care as defined in the California Administrative Code and the Welfare and Institutions Code, from the case at hand where the decision to discharge the patient by his insurance company raised a question of fact for the jury to decide.<sup>101</sup> *Wickline* was also distinguished on the basis that the payment of benefits was pursuant to the provisions of a code, not a contract.<sup>102</sup> The *Wilson* Court, applying

<sup>95</sup>See *Wickline*, 192 Cal. App. 3d at 1643-47.

<sup>96</sup>See *Wickline*, 192 Cal. App. 3d at 1645; Dowell, *supra* note 70, at 121; Tiano, *supra* note 92, at 84.

<sup>97</sup>See Walsh, *supra* note 23, at 228.

<sup>98</sup>See *id.*

<sup>99</sup>See *infra* notes 100-105 and accompanying text.

<sup>100</sup>*Wilson v. Blue Cross of Southern California*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990). Howard Wilson was admitted to the hospital for drug dependency, anorexia and depression. His treating physician determined that it was medically necessary for Howard to remain in the hospital for a few hours for observation and treatment. The utilization review process determined that Howard did not meet the criteria necessary for a hospital admission and denied any benefits after Howard’s eleventh day in the hospital. Howard was therefore released, and twenty days later killed himself. *Id.* at 877-78.

<sup>101</sup>*Wilson*, 271 Cal. Rptr. at 885; Walsh, *supra* note 23, at 229.

<sup>102</sup>See *Wilson*, 271 Cal. Rptr. at 879. Actually, *Wickline* was distinguished from *Wilson* when the court stated the following:

tort liability principles, stated that any defendant whose negligent conduct is a substantial factor in bringing about a patient's injuries can be held liable.<sup>103</sup> Also, the court rejected the defendants' argument that a treating physician has a responsibility to challenge utilization review decisions, and failure to do so renders the treating physician responsible for the discharge and in resulting injury.<sup>104</sup> Essentially, "the *Wilson* court opened the door for injured plaintiffs to sue their MCOs if denial of benefits is a substantial factor in the patient's injury and reversed the rule that physicians are solely responsible for all discharge decisions."<sup>105</sup>

These cases are certainly not the only ones challenging the process of utilization review.<sup>106</sup> A recent case, *McGraw v. Prudential Insurance Company of America*,<sup>107</sup> addresses several issues: Employee Retirement Income Security Act of 1974 (ERISA) preemption, utilization review, denial of benefits, and the responsibility of managed care entities for the decisions made in terms of the patient's well-being.<sup>108</sup>

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(1) The Wickline decision to discharge met the statutory standard of care for physicians treating Medicaid patients. No statutory standard of care was at issue in *Wilson*. (2) The Wickline utilization review activities were not undertaken pursuant to a contract, as they were in *Wilson*, but were guided by state statutes and regulations. (3) The statutory standard of care in *Wickline* established a public policy exception to usual standards for tort liability regarding utilization review decisions for Medicaid services. The *Wilson* court concluded that no expressed public policy considerations existed to alter the normal rule of tort liability for utilization review activities undertaken pursuant to a private contract. (4) *Wickline* did not involve a cost-containment procedure limitation that 'permitted . . . corrupt medical judgment . . .,' as the court implied was the case in *Wilson*.

Dowell, *supra* note 70, at 124.

<sup>103</sup>*Wilson*, 271 Cal. Rptr. at 883. "The elements of joint tort liability are: The actor's negligent conduct is a legal cause of harm to another [because] (a) his conduct is a substantial factor in bringing about the harm, and (b) there is no rule of law relieving the actor from liability because of the manner in which his negligence has resulted in the harm." Walsh, *supra* note 23, at n.149 (citing Restatement (second) of Torts § 431 (1965)).

<sup>104</sup>See *Wilson*, 271 Cal. Rptr. at 884-85.

<sup>105</sup>Walsh, *supra* note 23, at 230.

<sup>106</sup>See *Hughes v. Blue Cross of Northern California*, 215 Cal. App. 3d 832 (Cal. Ct. App. 1989), in which a California Court of Appeals upheld a trial court award of \$700,000 in punitive damages and \$150,000 in compensatory damages against the insurance company based upon a finding of an incorrect determination of medical necessity during the utilization review process.

<sup>107</sup>*McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253 (10th Cir. 1998).

<sup>108</sup>See *id.*; see *infra* notes 109-201.

## SUBJECT OPINION

### *McGraw v. Prudential Insurance Company of America*

The court in *McGraw v. Prudential Insurance Company of America* considered a number of significant issues arising from Linda McGraw's appeal of three adverse orders in the denial of claims regarding her medical insurance coverage.<sup>109</sup> The related holdings can be summarized as follows. First, ERISA<sup>110</sup> was found to govern the action.<sup>111</sup> Second, the insurance carrier's refusal to cover benefits for the patient's physical

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<sup>109</sup>See *McGraw*, 137 F.3d at 1253.

<sup>110</sup>29 U.S.C. § 1003(b)(1) (1998). A comprehensive study of ERISA is well beyond the scope of this paper. However, a brief description of ERISA will assist in a general understanding of the materials that follow.

ERISA is the primary federal law of employee benefits. Congress promulgated ERISA in response to findings that existing minimum standards for employee benefit plans were inadequate, plan funds were often insufficient to pay promised benefits, and plans were often terminated before the accumulation of requisite funds, thus depriving many employees and their beneficiaries of anticipated benefits.

L. Frank Coan, Jr., *You Can't Get There From Here -- Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1037 (1996).

ERISA's primary purpose is to 'protect . . . the interests of participants in employee benefit plans and the beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information.' The Act carries out this purpose 'by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.' Specifically, the statute prescribes minimum standards relating to participation, funding and vesting. It also sets forth procedural requirements concerning reporting, disclosure, and fiduciary responsibility. Moreover, a plan participant or beneficiary may enforce ERISA's provisions by bringing an action to recover benefits due under the terms of the plan, to enforce rights that the plan grants, or to clarify rights to future benefits.

*Id.* With ERISA, Congress intended to carve out an area of exclusive federal concern to establish a system of uniform regulation of employee benefit plans for multi-state employers while preserving state regulation of tangential areas, so as not to create a regulatory void, nor to infringe on the states' police powers. To accomplish this, ERISA authors drafted an express preemption provision that applies generally to all state laws related to employee benefit plans sponsored by an employer or employee organization. Nicole Weisenborn, *ERISA Preemption and Its Effect on State Health Reform*, 5-FALL KAN. J.L. & PUB. POL'Y 147, 147 (1995).

<sup>111</sup>*McGraw*, 137 F.3d at 1258.

therapy was deemed arbitrary and capricious.<sup>112</sup> Third, exhaustion of the plan-sponsored dispute remedies would have been futile, and therefore was unnecessary.<sup>113</sup> Each of these aspects of the court's decision will be discussed.

### Linda McGraw's Medical Condition

In 1983, twenty-eight year old Linda McGraw was diagnosed with multiple sclerosis (MS).<sup>114</sup> Within seven years of the initial diagnosis, Linda McGraw began using a walker to assist with movement and relying on a wheelchair for traveling long distances.<sup>115</sup> In 1991, a neurologist at the Mayo Clinic performed a comprehensive evaluation of Ms. McGraw and recommended that she undergo an inpatient evaluation to closely analyze her mobility problems.<sup>116</sup> Since she was unable to travel back to the Mayo Clinic, Ms. McGraw was referred to a neurologist closer to her area.<sup>117</sup> This physician also confirmed the recommendation for an inpatient evaluation.<sup>118</sup> Ms. McGraw subsequently sought the services of a rehabilitation center for physical and occupational therapy twice daily.<sup>119</sup>

Concurrently, Ms. McGraw underwent treatment for recurrent urinary tract infections related to the MS.<sup>120</sup> Since self-catheterizations were impossible due to Ms. McGraw's hand numbness and immobility, the treating physician prescribed home nursing visits to perform additional

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<sup>112</sup>See *id.* at 1263.

<sup>113</sup>See *id.* at 1264.

<sup>114</sup>See *id.* at 1255. MS is a disease of the central nervous system which occurs in relapsing/remitting form, "in which exacerbations or relapses, periods of symptom flare-ups, are interrupted by remissions, times when no new symptoms occur or symptoms improve." *Id.* at 1254. Symptoms of the disease, including strength loss, coordination and balance difficulties, loss of bladder control, and numbness, tingling or blurred double vision, are often interrupted by remissions and times when no new symptoms occur. *Id.* Accordingly, the course of MS is altogether unpredictable. Since the cause of the disorder is as elusive as the disease itself, no preventative treatment or cure is currently known. See *id.* Myriad treatments for the related effects of MS are utilized, including drugs that may alter the course of the disease. See *id.* at 1255. Rehabilitation is also an available alternative to promote function and independence by those suffering from the debilitating symptoms. *Id.*

<sup>115</sup>See *id.* at 1255.

<sup>116</sup>See *McGraw*, 137 F.3d at 1255.

<sup>117</sup>See *id.*

<sup>118</sup>See *id.*

<sup>119</sup>See *id.*

<sup>120</sup>See *id.*



catheterizations when her husband was at work.<sup>121</sup> A nurse would visit her home daily to provide the necessary home health care.<sup>122</sup>

Due to the seriousness of Ms. McGraw's disease and the complications posed by her recurrent urinary tract infections, her physician ordered additional outpatient therapy to improve her strength, endurance, and mobility.<sup>123</sup> Seeking an approved referral for this treatment, the doctor wrote to Ms. McGraw's medical insurance provider, the Prudential Insurance Company of America.<sup>124</sup> In 1992, the site of the prescribed physical therapy sessions was moved from an outpatient facility to Ms. McGraw's home due to her marked mobility limitations.<sup>125</sup> Essentially, entering the facility proved too difficult a task for Ms. McGraw.<sup>126</sup>

In May of 1993, Ms. McGraw's physician again sought inpatient pre-certification for care because she lost the ability for self-care and required intensive physical and occupational therapy that could not occur in the home.<sup>127</sup> This second inpatient stay was followed by another round of home physical therapy and skilled nursing home care.<sup>128</sup>

### Prudential's Denial of Payment

Following each of the episodes of inpatient care, Gary McGraw, Ms. McGraw's husband, submitted claims to his medical insurance totaling \$47,000.<sup>129</sup> Prudential Insurance Company denied each claim under the policy's general exclusion of services not deemed medically necessary.<sup>130</sup> Under the plan provisions, "to avoid the exclusion and receive payment, the service must be needed or medically necessary."<sup>131</sup> According to the Prudential Plan, to be medically necessary, a service must satisfy all of the following qualifications:

- (a) It is ordered by a Doctor.

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<sup>121</sup>See *McGraw*, 137 F.3d at 1255.

<sup>122</sup>See *id.*

<sup>123</sup>See *id.*

<sup>124</sup>See *id.*

<sup>125</sup>See *id.*

<sup>126</sup>See *McGraw*, 137 F.3d at 1255.

<sup>127</sup>See *id.*

<sup>128</sup>See *id.*

<sup>129</sup>See *id.*

<sup>130</sup>See *id.*

<sup>131</sup>*McGraw*, 137 F.3d at 1255.

- (b) It is recognized throughout the Doctor's profession as safe and effective, is required for the diagnosis and treatment of the particular Sickness or Injury, and is employed appropriately in a manner and setting consistent with generally accepted United States medical standards; and
- (c) It is neither Educational nor Experimental or Investigational in nature.<sup>132</sup>

To determine whether reimbursement would occur under the McGraw's Prudential policy, a case manager reviewed the claim and submitted a recommendation to the medical director.<sup>133</sup> A three-tiered utilization review process followed.<sup>134</sup> First, a local medical director decided whether the submitted claim was covered by the insured's policy.<sup>135</sup> Second, any challenge of this decision were to be sent to a regional medical director.<sup>136</sup> Finally, an Appeals committee consisting of several members submitting individual ballots confirmed or reversed the regional director's decision.<sup>137</sup>

In Linda McGraw's case, the medical director made the decision to deny payment of the claim based on the belief that physical therapy was not an appropriate method to affect the course of MS, therefore was determined not "medically necessary" under the definitions of the policy.<sup>138</sup> The regional director, a pediatric specialist, concurred in the decision, as did the appeals committee.<sup>139</sup>

Linda McGraw subsequently filed a lawsuit claiming that Prudential breached its duty to deal fairly and act in good faith under Oklahoma law by failing to pay for her medical expenses.<sup>140</sup> Ms. McGraw initially alleged that her husband's health insurance qualified as a governmental plan and was therefore exempt from ERISA.<sup>141</sup> Prudential sought summary judgment, alleging that ERISA preempted any applicable state law and therefore barred three of Ms. McGraw's claims because she did

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<sup>132</sup>See *id.*

<sup>133</sup>See *id.*

<sup>134</sup>See *id.*

<sup>135</sup>See *id.*

<sup>136</sup>See *McGraw*, 137 F.3d at 1255.

<sup>137</sup>See *id.*

<sup>138</sup>See *id.*

<sup>139</sup>See *id.*

<sup>140</sup>See *id.*

<sup>141</sup>See *McGraw*, 137 F.3d at 1256.

not exhaust plan-sponsored dispute remedies.<sup>142</sup> Furthermore, Prudential argued for summary judgment on the grounds that the denial of Ms. McGraw's other two claims were not arbitrary and capricious.<sup>143</sup>

### District Court Opinion

The district court entered three separate orders in granting summary judgment in favor of Prudential.<sup>144</sup> The court first rejected the Plaintiff's effort to characterize her husband's insurance plan as exempt from ERISA, instead finding that the plan was governed strictly by ERISA.<sup>145</sup> As a result, the court granted summary judgment because Ms. McGraw failed to exhaust her administrative recourse alternatives for the submitted claims, as required by ERISA.<sup>146</sup> The court then focused on the denial of coverage, holding the determination that the treatment was not medically necessary was not arbitrary and capricious, despite the fact that the decision was made without the review of the patient's medical records.<sup>147</sup> Instead, the court found Prudential's decision was made in good faith.<sup>148</sup>

The district court held that the decision to deny benefits for physical therapy followed a reasonable interpretation of the policy in question.<sup>149</sup> The decision to deny reimbursement was based on the reviewing physician's belief that physical therapy does not affect the course of MS.<sup>150</sup> This decision was made even though the physician did not review Ms. McGraw's medical records, speak with her referring physicians, examine Ms. McGraw, or consult any medical literature on the subject.<sup>151</sup> In the physician's opinion, this was a simple and straightforward decision based on the nature of the disease.<sup>152</sup> According to this decision, physical therapy would only be warranted if the patient's overall medical condition would improve first.<sup>153</sup> Since there was no evidence that physical therapy would provide any benefit, and since no evidence indicated a possible

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<sup>142</sup>See *id.* For a discussion of the ERISA preemption process, see *supra* note 110.

<sup>143</sup>See *McGraw*, 137 F.3d at 1256.

<sup>144</sup>See *id.*

<sup>145</sup>See *id.*

<sup>146</sup>See *id.*

<sup>147</sup>See *id.*

<sup>148</sup>See *McGraw*, 137 F.3d at 1255.

<sup>149</sup>See *id.* at 1259.

<sup>150</sup>See *id.*

<sup>151</sup>See *id.*

<sup>152</sup>See *id.*

<sup>153</sup>See *McGraw*, 137 F.3d at 1255.

overall improvement, the treatment prescribed was not deemed medically necessary.<sup>154</sup> Ms. McGraw subsequently appealed to the Court of Appeals for the Tenth Circuit.<sup>155</sup>

### Appellate Court Opinion

Reviewing the district court's decision *de novo*, the Court of Appeals examined each issue independently. First, the court focused on whether or not the insurance policy constituted a governmental plan.<sup>156</sup> Under ERISA, "The term 'governmental plan' means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing . . ."<sup>157</sup> This section was described by the court as focusing on the public entity, which ERISA deems exempt.<sup>158</sup>

In arguing that her insurance policy was free from ERISA control, Ms. McGraw attempted to utilize this provision by categorizing her plan as a governmental entity exempt from ERISA.<sup>159</sup> The court focused on the degree of control exerted by the Emergency Medical Services Authority (EMSA), an Oklahoma public trust that exercises control over her husband's job.<sup>160</sup> According to the court, such a shadowing of an employee's work with a governmental facade shifts the statutory focus and blurs the primary issue of whether ERISA governs the action.<sup>161</sup> Therefore, the court found that EMSA did not establish the insurance policy held by the McGraw's and did not directly employ Mr. McGraw.<sup>162</sup> Although Mr. McGraw performed tasks assigned to a public agency under Oklahoma law, the court held that the conditions of his employment were

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<sup>154</sup>*See id.*

<sup>155</sup>*See id.* at 1254.

<sup>156</sup>*See id.* at 1257.

<sup>157</sup>*See id.* at 1257; 29 U.S.C. § 1002(32).

<sup>158</sup>*See McGraw*, 137 F.3d at 1257.

<sup>159</sup>*See id.*

<sup>160</sup>*See id.* Ms. McGraw argued that "although her husband's paycheck comes from Lifefleet, Inc., a company owned by Secomerica, Inc., a subsidiary of a Japanese corporation, EMSA, in fact, controls and supervises all of her husband's work, owns all of the equipment connected with the delivery of ambulance services, purchases all supplies under its tax exempt status, and holds the license permitting emergency workers supplied by Lifefleet to operate." *Id.*

<sup>161</sup>*See id.*

<sup>162</sup>*See id.*

more closely related to private sector employment settings.<sup>163</sup> The court ultimately held that the health plan was not governmental in nature.<sup>164</sup> Consequently, ERISA preemption of Oklahoma law provided Ms. McGraw with numerous devices through which remedy could be sought.<sup>165</sup>

After determining that ERISA governed the action at issue, the court turned its attention to the denial of benefits under ERISA.<sup>166</sup> Following the guidelines established by the Supreme Court in *Firestone Tire and Rubber Company v. Bruch*,<sup>167</sup> the appellate court articulated the position that a challenge of denial of benefits should be “reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”<sup>168</sup> If the benefit plan does offer discretion to the administrator or fiduciary operating under a conflict of interest, the conflict must be considered as a determining factor in establishing whether an abuse of discretion occurred.<sup>169</sup> “Thus, ‘a conflict of interest triggers a less deferential standard of review.’”<sup>170</sup>

The plan administered by Prudential expressly gave the insurer discretion to determine what constitutes medically necessary treatment, creating a conflict of interest.<sup>171</sup> Therefore, the court opted to review the district court’s application of the arbitrary and capricious standard de novo.<sup>172</sup> However, since every decision regarding benefits made by Prudential directly impacts the company’s finances, the court afforded these decisions less deference relative to the degree of corresponding

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<sup>163</sup>See *McGraw*, 137 F.3d at 1258.

<sup>164</sup>See *id.*

<sup>165</sup>See *id.*

<sup>166</sup>See *id.*

<sup>167</sup>*Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989). In this case, former employees who were terminated by their employer and subsequently rehired by another corporation immediately upon sale of employer’s plant brought suit for alleged violations of ERISA. See *id.* This case was used by the court in *McGraw* to supply “the standard of judicial review of benefit determinations by fiduciaries or plan administrators.” *McGraw*, 137 F.3d at 1258.

<sup>168</sup>*McGraw*, 137 F.3d at 1258 (citing *Firestone*, 489 U.S. at 115 (1989)).

<sup>169</sup>See *id.*

<sup>170</sup>*Id.* (citing *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996); *Pitman v. Blue Cross & Blue Shield*, 24 F.3d 118, 123 (10th Cir. 1994); *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149, 152 (4th Cir. 1996)).

<sup>171</sup>See *id.* at 1259.

<sup>172</sup>See *id.*

conflict.<sup>173</sup> The court held that “[a] decision to deny benefits is arbitrary and capricious if it is not a reasonable interpretation of the plan’s terms.”<sup>174</sup>

Reviewing the Plaintiff’s medical opinions in the matter, the court found a set of facts that differed drastically from those considered by the district court which relied on portions of expert testimony.<sup>175</sup> Ms. McGraw’s physicians testified that a distinction exists between what is treatable and what is curable, pointing out that treatment in the context of MS concentrates on whatever symptoms exist at the moment.<sup>176</sup> Therefore, in the case of MS, not getting worse was correctly described as a form of improvement.<sup>177</sup> The physicians further testified that it would be extremely difficult to find a physician who would emphatically deny the use of physical therapy in the course of treatment for MS.<sup>178</sup> Following this thought, the court found that sixteen of Ms. McGraw’s almost forty outpatient visits were automatically paid and deemed medically necessary.<sup>179</sup> As a result, the court found a “significant improvement” equal to a “measurable and substantial increase in the patient’s physical functional abilities compared to his/her ability at the time treatment began.”<sup>180</sup>

Upon review, the court noted that Prudential modified its definition of medically necessary to include the additional requirement that treatment

<sup>173</sup>See *McGraw*, 137 F.3d at 1255.

<sup>174</sup>*Id.* at 1259 (citing *Sentmer v. Group Health Serv. of Okla.*, 129 F.3d 1390, 1393 (10th Cir. 1997); *Torix v. Ball Corp.*, 862 F.2d 1428, 1429 (10th Cir. 1988)).

<sup>175</sup>See *id.*

<sup>176</sup>See *id.*

<sup>177</sup>See *id.* “Thus, maintaining functionality—stretching out the legs to prevent contractures which commonly afflict MS patients, coordination exercises, strengthening the upper body—is addressed in the literature submitted in the Appendix and uncontraverted by Prudential, as essential in the treatment for the effects of MS.” *Id.* at 1259-60.

<sup>178</sup>See *McGraw*, 137 F.3d at 1260. “To a question about whether there could be a reasonable good faith disagreement among doctors about the place of physical therapy in the treatment of MS, [Dr. Landstrom] answered, ‘Well, I suppose there could be, doctors can disagree about just about anything, but I think it would be difficult to find a physician who would say that physical therapy has no place in the treatment of multiple sclerosis.’” *Id.*

<sup>179</sup>See *id.* This information was based on a confidential internal Group Claim Division Memorandum which the regional medical director referenced when making a decision. See *id.* This guideline discusses medical necessity as follows. “Physical therapy should be a short-term intensive and goal-oriented program ordered for a condition having potential for significant improvement. We consider a ‘significant improvement’ to be a measurable and substantial increase in the patient’s physical functional abilities compared to his/her ability at the time treatment began.” *Id.*

<sup>180</sup>*Id.* at 1260.

provide a measurable and substantial increase in functioning and allow for significant improvement.<sup>181</sup> However, despite this additional guideline, the medical director and subsequent reviewers were only charged with determining whether the treatment met the three criteria listed previously.<sup>182</sup> Accordingly, Prudential chose to describe the prescribed treatment as “medically beneficial” but not “medically necessary” since the treatment was not believed to alter the disease’s course.<sup>183</sup> In the court’s view, a thorough reading of the hospital records by the Prudential representative would have led to a discovery that each physician ordered physical therapy to assist with Ms. McGraw’s condition and to aid her in living more comfortably.<sup>184</sup>

Although Prudential contested the fact that Ms. McGraw left the hospital on a pass with her husband, the court interpreted this fact as a positive occurrence.<sup>185</sup> The court expressed the opinion that there was nothing in the record mandating that inpatient therapy necessitates twenty-four hour confinement or that periods away from the hospital are inappropriate.<sup>186</sup> Instead, the court applauded such an opportunity and stated that “one would assume the opportunity for entertainment would be not only therapeutic, but also desirable in treating the illness.”<sup>187</sup>

The court ultimately held that Prudential “made the discretionary decision to ‘give up on’ Ms. McGraw.”<sup>188</sup> It found the evidence contained no indication that the denial of benefits was made following any review of medical records or a close case analysis.<sup>189</sup> Additionally, since Prudential’s decision impacted the company’s profitability, the court accorded little deference to the insurer’s determination.<sup>190</sup> Thus, the court held that the denial of benefits was both arbitrary and capricious, and reversed the decision of the district court.<sup>191</sup>

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<sup>181</sup>*See id.*

<sup>182</sup>*See id.*

<sup>183</sup>*McGraw*, 137 F.3d at 1255.

<sup>184</sup>*See id.*

<sup>185</sup>*See id.* at 1261.

<sup>186</sup>*See id.* at 1261.

<sup>187</sup>*Id.*

<sup>188</sup>*McGraw*, 137 F.3d at 1262.

<sup>189</sup>*See id.*

<sup>190</sup>*See id.* at 1263.

<sup>191</sup>*See id.*

The court finally examined the issue of whether Ms. McGraw exhausted the administrative remedies available to her.<sup>192</sup> ERISA contains no explicit exhaustion requirement within its boundaries, although exhaustion of administrative remedies is an implicit requirement when judicial relief is sought.<sup>193</sup> The court found that the futility exception is limited to cases where resort to administrative solutions would be useless, but nonetheless determined that the record clearly established futility in numerous instances.<sup>194</sup> Foremost, Prudential representatives processed and reviewed the requests for treatment in an inefficient manner.<sup>195</sup> Delays plagued the process, blurring the distinction between denial of one claim and the next.<sup>196</sup> Additionally, since the prescribed therapy was deemed medically necessary by Ms. McGraw's treating physicians, Prudential utilized its own view of the plan without taking into account the needs of the patient.<sup>197</sup> Finally, the court found that Prudential did not evaluate Ms. McGraw's claim on an individual basis, but instead automatically denied each claim arising out of this particular disease.<sup>198</sup>

The court ultimately held that the district court abused its discretion in holding that three of Ms. McGraw's claims were not exhausted through internal review.<sup>199</sup> These claims were remanded for determination of whether the denial of payment was arbitrary and capricious under the guidelines established by this court.<sup>200</sup> The court further affirmed the district court's decision that ERISA governed the action.<sup>201</sup>

## ANALYSIS

The organization of managed care entities and HMOs/PPOs raises serious questions about the attempts of such insurance programs to attain cost-containment through money saving techniques in the health care market. Insurance must be viewed as a business. Insurance companies,

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<sup>192</sup>See *id.* at 1263.

<sup>193</sup>See *McGraw*, 137 F.3d at 1263.

<sup>194</sup>See *id.* at 1264.

<sup>195</sup>See *id.*

<sup>196</sup>See *id.*

<sup>197</sup>See *id.*

<sup>198</sup>See *McGraw*, 137 F.3d at 1264.

<sup>199</sup>See *id.*

<sup>200</sup>See *id.*

<sup>201</sup>See *id.* at 1265.



specifically HMOs and PPOs, have at their core a need to save money and earn additional money in order to survive in an increasingly tight and competitive market. However, insurance companies also have a responsibility to those customers who pay premiums, expecting quality care if and when medical treatment is necessary. As a result of the dichotomy presented between the economic and medical aspects of health insurance, cost-containment measures greatly affect health care systems.<sup>202</sup> Specifically, cost containment measures can vastly affect the quality of care that patients receive, a problem that worries many consumers.

“Quality health care requires a high level of health care services that assist an individual in remaining free from physical and mental incapacity while maximizing social capacity.”<sup>203</sup> In a system which seeks to keep overhead as low as possible, the primary challenge is to offer quality assurance measures to protect patient care in the face of counterproductive economic incentives.<sup>204</sup> High quality care has been defined by the AMA’s Council on Medical Service as that which “consistently contributes to improvement for maintenance of the quality and/or duration of life.”<sup>205</sup> In an effort to clarify the proposed definition of quality medical care, the Council on Medical Service has established eight factors believed necessary for quality care delivery:

- (1) the production of optimum improvement in the patient’s physical condition and comfort;
- (2) the promotion of prevention and early detection of disease;
- (3) the timely discontinuation of unnecessary care;
- (4) the cooperation and participation of the patient in the care process;
- (5) the skilled use of necessary professional and technological resources;
- (6) concern for the patient’s welfare;
- (7) efficient use of resources; and

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<sup>202</sup>See Randall, *supra* note 2, at 32.

<sup>203</sup>*Id.* at 33.

<sup>204</sup>See *id.*

<sup>205</sup>*Id.* Quality care has also been defined as the “component of the difference between efficacy and effectiveness that can be attributed to care providers, taking into account the environment in which they work.” *Id.*

- (8) sufficient documentation of medical records to ensure continued care and for evaluation of the care by peer review.<sup>206</sup>

The above stated guidelines appear reasonable from the viewpoint of a medical care consumer. However, this expectation may not truly coincide with the reality that consumers experience. In an ideal world, all of the factors necessary for quality care would be strictly followed, for none of them appear to be too burdensome to the treating physician or the health care entity. Financial incentives may provide for a different perspective, however. Physicians, long concerned about the quality of care provided to patients, are limited in the era of managed care since the insurance entity makes the ultimate decisions regarding what treatment plans will be covered. Therefore, the physician is put in quite a precarious situation at times, forced to decide between offering the necessary care knowing that the financial resources will not be provided, or adhering to the managed care groups' guidelines of what treatments can be prescribed and in what specific circumstances.

Some may argue that quality care exists within the managed care world, as individuals are healthier than ever and have more opportunities to see physicians. Others assert that an overwhelming obsession by developers of managed care products with cost containment measures have resulted in the failure to recognize quality assurance in health care.<sup>207</sup> The fact remains that some patients are not receiving necessary care, and managed care entities appear to be placing financial concerns ahead of patient care needs.<sup>208</sup> Courts and legislatures must step in when possible to offer adequate remedies to the aggrieved.

## IMPACT

In an age of big-business organizations and economically based decisions in the health care field, the *McGraw* decision is of the utmost significance. This case demonstrates that the courts are willing to take on managed care authorization decisions that place economic gain and cost-containment

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<sup>206</sup>See *id.* (citing AMA Council on Medical Service, Quality of Care, 256 JAMA 1032 (1986)).

<sup>207</sup>See Randall, *supra* note 2, at 35.

<sup>208</sup>See *id.*

ahead of patient well-being. Health insurance is designed to provide individuals with the means necessary to protect themselves, should something unforeseen threaten their health. From the early days of insurance policies, insurance provided every class of citizen the means to receive necessary medical treatment. Patient care was initially the focus of decision-making, particularly when the insurance companies operated on a fee-for-service basis, and physicians could not only prescribe treatment plans without worrying about the costs, but could also reap the benefits of payment for such procedures. The insurance industry at this time was not willing to forsake patient care for economic gain, and individual well-being was accorded the highest degree of importance.

With the advent of managed care and cost containment measures, this emphasis on patient care gradually diminished in favor of cost cutting and economic gain. The purpose of health insurance was no longer necessarily patient well-being, but fiscal integrity of the industry. The patient then struggles to gain adequate care. Patients constantly were forced to battle with their managed care provider, watching every decision made by the agency in reviewing claims in order to ensure that necessary treatments were provided under the policy. When quality care seemed jeopardized, individuals began taking matters into their own hands through difficult battles often involving litigation.

Cases such as *McGraw* clearly suggest that the well-being of patients must be put before cost-control measures. No longer should arbitrary utilization review decisions be made under guidelines unknown to the recipient. Managed care providers need to reevaluate their methods of utilization review so as to make educated, knowledgeable, and reasonable decisions regarding the health and welfare of their participants. Decisions must be made in terms of the best interests of the patient and the group, and not just the entity as a financial enterprise. Automatic denial of treatments by providers will no longer be tolerated by society or the courts. It is time for the managed care providers to acknowledge that individuals with valid and serious ailments need treatment, not insurance hassles and battles.

This avenue paved by the courts raises a number of questions. Can utilization review processes ever take the patient's needs into account before those of cost cutting? Could the managed care system survive under such guidelines? Will the health care industry accept a system that focuses not on financial and business concerns but on the well-being of the patients? What about the consumers? What will the response be of

those individuals who must deal with the managed care entities if the trend continues and their needs are increasingly subverted to the financial stakes of the company? Is there anything that consumers can do to alter the increasingly strong system that currently dominates the health care industry?

These are but a few of the questions that must be answered in order to bring any satisfaction to the consumers who currently suffer at the hands of managed care insurance entities. Although the future of health care might not be clear, what is clear is that the system must change in order to fully protect and preserve patient well-being. Only when the financial and medical aspects of insurance can be reconciled will the consumers be satisfied and content, and will the insurance providers be able to successfully achieve ethical cost-containment and financial profit.

Many states and the federal government have attempted to intervene in this quandary of managed care and patient care. At the federal level, many versions of a Patients Bill of Rights have been proposed.<sup>209</sup> State regulations have also been passed that attempt to regulate managed care within their jurisdiction.<sup>210</sup> For instance, Oregon has instituted a comprehensive Patient Protection Act which forces health care plans to disclose the financial incentives offered to physicians to control costs.<sup>211</sup> Oregon's plan also offers consumers the right to a full appeals process when denied treatment, as well as allowing access to emergency care.<sup>212</sup> Texas also has a bill of rights for patients and has made all HMO complaint records public.<sup>213</sup> Additionally, Texas is the only state that allows consumers to sue insurance companies if they fail to engage in "ordinary care" in denying or delaying treatment.<sup>214</sup> These regulations are a strong starting point to assuring quality patient care, but much more is necessary to rectify the dichotomy between big business and patient care.

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<sup>209</sup>See Karen Tumulty, *Let's Play Doctor*, TIME, July 13, 1998, at 28, 30.

<sup>210</sup>It must be remembered that the state regulations face much difficulty in regulating anything because of the strong preemptive presence of ERISA in this arena.

<sup>211</sup>See Tumulty, *supra* note 208, at 30.

<sup>212</sup>See *id.*

<sup>213</sup>See *id.*

<sup>214</sup>See *id.* at 31.

## CONCLUSION

“In theory, the [health care] marketplace should provide a check on health plans that cut too far; if your managed-care organization won’t deliver the quality of care you need, you can always switch to one that will. But that assumes there is competition and free choice.”<sup>215</sup> In practice, “most employers let their workers choose from only a handful of plans. Industry consolidation, meanwhile, is reducing competition even further.”<sup>216</sup> This is not the plan envisioned by the initial founders of health maintenance organizations, whose idea was to have complete health care providers focusing on prices and quality.<sup>217</sup> The necessary plan of action to improve the healthcare marketplace must attempt to restore the system to its initial focus regarding both price and quality care for consumers. Until this occurs, individuals such as Linda McGraw may unfortunately face difficult struggles to ensure that they receive the treatments needed and deserved regardless of cost. Not until this dilemma of finance versus patient care can be rectified will the health care industry function accurately, effectively, and efficiently; nor will patients receive the quality care rightfully owed to them by their health insurance provider.

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<sup>215</sup>Gorman, *supra* note 1, at 26.

<sup>216</sup>*See id.*

<sup>217</sup>*See id.* “The form it took, driven by employers, is competition on price alone.” *Id.*