TORT LIABILITY OF THIRD PARTY PAYORS:
WILSON V. BLUE CROSS OF SOUTHERN CALIFORNIA

INTRODUCTION

Traditionally, a patient's financial circumstances could not factor into a physician's determination of the patient's course of treatment. However, this standard developed years ago when patients paid physicians directly on a fee-for-service basis. Today, physicians are primarily reimbursed through third party payors — insurance companies, Medicare, and Medicaid programs.

Under the present system, third party payors make independent decisions regarding what treatment they believe is medically necessary to provide for their plan members under the plan members' particular plan. When a third party payor determines that any further treatment of a patient is unnecessary, the payor informs the hospital or physician that it will finance no further treatment for the patient. If at that time the physician stops medically necessary treatment, the legal result is clear: the physician will be held liable for any harm that the patient suffers because of this termination of treatment. What is not so clear are the legal consequences the third party payor may face when it determines any additional treatment of a patient is medically unnecessary, and therefore decides to stop funding any further treatment. If the payor's decision is arbitrary or unreasonable, the question arises as to whether the payor may be held responsible

1. See infra notes 123-25 and accompanying text.
3. Id. Third party payors are also referred to as health care payors, or simply payors.
   Medicaid is a cooperative federalism program in the United States which provides medical care for the poor and disabled. The federal government apportions a certain amount of money each fiscal year for this program. A state may opt not to participate in the program, but if a state wants to receive federal money for participation in the program, it must meet minimum standards established by the federal government. The sums made available for the program are paid to the states once the programs have been approved by the Secretary of Health and Human Services. Social Security Act, 42 U.S.C. 1396 (1983).
5. Id. at 1633-34, 1637-39, 239 Cal. Rptr. at 811-12, 813-15.
7. See infra notes 152-72 and accompanying text.
for any harm that the patient suffers as a result.\(^8\)

In *Wickline v. State*,\(^9\) a patient sued Medi-Cal, the state Medi-caid program, because of a decision that Medi-Cal had made to stop paying for the hospital stay of one of its Medicaid recipients.\(^10\) The California Court of Appeal stated that a physician who stops treatment on a patient because of cost constraints prescribed by a third party payor is ultimately responsible and legally liable for any harm caused by premature termination of treatment.\(^11\) The court held that a third party payor could not be the physician’s “scapegoat”; therefore, Medi-Cal was not liable.\(^12\) Third party payors viewed the *Wickline* case as a victory because it appeared to confirm that payors merely make financial decisions and cannot be brought into the medical malpractice causation chain.\(^13\) Yet, just four years later, the same court in *Wilson v. Blue Cross of Southern California*\(^14\) stated that *Wickline* should be limited to its particular facts, and held that a third party payor may be held liable for a decision when its decision is a substantial factor in the injury to one of the payor’s health care recipients.\(^15\)

This Comment reviews the *Wickline* and *Wilson* decisions and examines their consistency.\(^16\) This Comment also addresses the ramifications of expanding liability to third party payors in a prospective payment system.\(^17\) Finally, this Comment analyzes whether the extension of tort liability to third party payors is an answer to problems with cost-containment programs in the health care area and concludes that this expansion is a plausible solution.\(^18\)

### FACTS AND HOLDINGS

#### *Wickline v. State*\(^19\)

Lois Wickline, a woman in her mid-forties, began suffering from pain in her back and legs.\(^20\) After Wickline failed to respond to phys-
ical therapy, her family practitioner admitted her to the hospital. Wickline's physician then brought in a vascular surgeon whose diagnosis was that Wickline had Leriche's Syndrome, causing insufficient blood flow to her legs. Wickline's physician determined that it was necessary to perform surgery to insert a graft in place of one of Wickline's arteries. Because Wickline was a participant in Medi-Cal, the state of California Medicaid program, she was discharged home to wait for Medi-Cal to authorize this surgery.

Medi-Cal authorized the surgery, as well as ten days of hospital stay. On January 7, 1977, Wickline's physician performed what he characterized as "very major surgery." After the operation, a blood clot formed in Wickline's right leg. As a result, Wickline was taken back into surgery to have the clot removed. During the next few days, Wickline experienced spasms in her right leg; these spasms would have caused more blood clots if the spasms were not immediately relieved. To alleviate the problem, on January 12, 1977, Wickline underwent further surgery and a chain of nerves was successfully removed from her leg.

Wickline was originally scheduled for discharge from the hospital on January 17, 1977. At least one day prior to the scheduled discharge, all three of Wickline's attending physicians concluded that it

21. Id. at 1634, 239 Cal. Rptr. at 812.
22. Id. Leriche's Syndrome, otherwise known as arteriosclerosis obliterans with an occlusion of the abdominal aorta, is caused by obstruction of the terminal aorta. The aorta is the principal artery of the body which carries blood from the heart to arteries in all parts and organs of the body. Id.
23. Id. at 1635, 239 Cal. Rptr. at 812.
24. Id. Medi-Cal is the state of California program for health care services to the aged who are medically indigent as well as to recipients of public assistance. CAL. WELF. & INST. CODE § 14000 (West 1980). The intent of this program is to provide access to the same quality of health care for the indigent that the mainstream of the population receives. Id. Utilization controls were designed into the system for cost containment and remain a primary focus of the Medi-Cal program. Comment, Provider Liability Under Public Law 98-21: The Medicare Prospective Payment System in Light of Wickline v. State, 34 BUFFALO L. REV. 1011 n.3 (1985). Under Medi-Cal, providers must acquire authorization prior to rendering services to a patient. CAL. WELF. & INST. CODE § 14133 (West 1980). Only those services which an employee of Medi-Cal deems to be medically necessary will be approved for payment. Id.
25. Wickline, 192 Cal. App. 3d at 1635, 239 Cal. Rptr. at 812.
26. Id. This surgery consisted of removing a part of Wickline's artery and inserting a synthetic artery in place of it. Id.
27. Id.
28. Id.
29. Id. at 1635-36, 239 Cal. Rptr. at 812-13.
30. Id. at 1635, 239 Cal. Rptr. at 812-13. The surgery to relieve these spasms is called a lumbar sympathectomy. Id. This surgery involves removing a portion of the chain of nerves that lie on both sides of the spinal column. The blood vessels below this area then become paralyzed alleviating the patient's spasms. Id.
31. Id. at 1636, 239 Cal. Rptr. at 813.
was medically necessary for her to remain hospitalized for an additional eight days because of post-surgical complications. However, Medi-Cal approved only a four day extension. Feeling intimidated by Medi-Cal’s determination that four more days of hospital stay were sufficient, Wickline’s physicians discharged her from the hospital.

After her discharge, an infection developed and another blood clot formed in Wickline’s right leg. She was readmitted as an emergency patient. In two subsequent operations, Wickline’s right leg was amputated above the knee. Wickline’s principal treating physician, the vascular surgeon, concluded that had Wickline stayed at the hospital for the full eight days requested by her physicians, she would not have lost her leg.

Wickline sued the state of California alleging that it had negligently discontinued her benefits under Medi-Cal. Wickline asserted

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32. *Id.* There were numerous reasons that Wickline’s physicians wished her to remain hospitalized: the danger of infection, the possibility of further clotting, and the need for critical observation. Wickline’s physicians believed they would be able to save both of her legs and wanted to monitor her condition closely. *Id.*

33. *Id.* at 1638, 239 Cal. Rptr. at 814. To obtain an extension for a recipient of Medicaid benefits, a form must be completed and given to Medi-Cal. Wickline’s treating physician had signed a form which gave a complete and accurate description of Wickline’s medical problems. *Id.* at 1636-37, 239 Cal. Rptr. at 813. Medi-Cal employed a registered nurse, who had the authority to approve the extension after reviewing the form for extension of hospital stay. *Id.* at 1637, 239 Cal. Rptr. at 813-14. If the nurse felt that she could not approve the full extension, she had to telephone a physician-consultant, employed by Medi-Cal, who would make the final decision. The Medi-Cal nurse called a Medi-Cal consultant who concluded that Lois Wickline was not critically ill. The physician approved four rather than eight days of extended hospital care. *Id.* at 1637-38, 239 Cal. Rptr. at 813-14. Medi-Cal employs specialists that are available to Medi-Cal consultants to help the consultants make determinations in areas beyond their general knowledge. *Id.* at 1639, 239 Cal. Rptr. at 815. Although the Medi-Cal consultant who made the utilization review decision for Wickline was not experienced in the area in which he was being consulted, he made no efforts to consult with a vascular surgeon, who was available to him. *Id.* at 1637, 1639, 239 Cal. Rptr. at 814, 815.

34. *Id.* at 1639, 1645, 239 Cal. Rptr. at 815, 819. None of Wickline’s physicians attempted to take any further steps in requesting an extension for Wickline. *Id.* at 1639, 239 Cal. Rptr. at 815. Her doctors believed that no additional factors had occurred since the last request had been denied; they believed any additional attempt would only be futile. *Id.*

35. *Id.* at 1641, 239 Cal. Rptr. at 816.

36. *Id.* When a Medi-Cal patient is admitted in an emergency situation, no prior authorization from Medi-Cal is necessary. *Id.*

37. *Id.* at 1641, 239 Cal. Rptr. at 816-17.

38. *Id.* at 1642, 239 Cal. Rptr. at 817. The vascular surgery specialist was the “senior man” in charge of Wickline and was considered by his associates to have the primary responsibility in treatment decisions for Wickline. *Id.* at 1638, 239 Cal. Rptr. at 815.

39. *Id.* at 1633, 239 Cal. Rptr. at 811. Wickline declined to sue her treating physicians because she believed that they had done everything in their power for her. Chenen, *Prospective Payment Can Put You in Court*, MEDICAL ECONOMICS, July 9, 1984, at 134, 138.
that the negligence of the state had caused her to be discharged from
the hospital while she was still in need of hospital care; consequently,
her leg had to be amputated. At the close of the trial, and after a
mere four hours of deliberation, a jury returned a verdict for Wic-
kline of $500,000. The state of California appealed.

The California Court of Appeal stated that the central issue in
the case was “who bears responsibility for allowing a patient to be
discharged from the hospital, her treating physician, or the health
care payor . . . .” The court stated that when a patient is harmed by
not receiving care which should have been provided, the patient may
recover from all those responsible for depriving the patient of the
needed care. The court also recognized that a third party payor
may be held liable if medically inappropriate decisions result because
of a deficiency in a cost-containment program. As an example, the
court stated that if requests made by a physician are unreasonably
disregarded or ignored, then a definite defect in the cost-containment
program exists.

The court stated that the intimidation Wickline’s physicians felt
by the Medi-Cal program was understandable, but the court empha-
sized that this intimidation should not have rendered the physicians
powerless. If, in the physicians' medical judgment, Wickline
needed an additional four days in the hospital, then her physicians
should have taken some measures to keep her there. The court
stated that when a physician complies with a third party payor’s re-
imbursment limitations without protesting, the physician cannot
avoid his or her “ultimate responsibility” for the harm to the patient
which was caused by premature termination of treatment.

The California Court of Appeal concluded that Medi-Cal had not
usurped the medical judgment of Wickline’s physicians. In fact, be-
because the physicians had not appealed the decision of Medi-Cal to
fund only four post-operative days of hospitalization, Medi-Cal was
never given the “opportunity” to improperly influence the physi-

40. Wickline, 192 Cal. App. 3d at 1633, 239 Cal. Rptr. at 811.
41. Comment, 34 BUFFALO L. REV. at 1012.
42. Wickline, 192 Cal. App. 3d at 1633, 239 Cal. Rptr. at 811.
43. Id. at 1644, 239 Cal. Rptr. at 819.
44. Id. at 1645, 239 Cal. Rptr. at 819.
45. Id.
46. Id.
47. Id.
48. Id. at 1645-46, 239 Cal. Rptr. at 819.
49. Id. at 1645, 239 Cal. Rptr. at 819. Because the physician is ultimately responsi-
ble for the patient, the physician cannot use a third party payor as a “scapegoat” when
his or her medical determinations prove to have been wrong. Id.
50. Id. at 1646, 239 Cal. Rptr. at 819.
The California Court of Appeal reversed the jury award, holding that Medi-Cal was not liable for Wickline's injuries as a matter of law.52

**WILSON v. BLUE CROSS OF SOUTHERN CALIFORNIA**53

On March 1, 1983, Howard Wilson, Jr. was admitted to a Los Angeles hospital, suffering from drug dependency, anorexia and major depression.54 Wilson's physician decided that three to four weeks of in-patient care were necessary.55 Ten days later, Wilson's insurance company informed the physician that it would not pay for any further care.56 Because no one in Wilson's family could afford the cost of hospitalization, Wilson was discharged.57 On March 31, 1983, Wilson committed suicide.58 Wilson's physician testified that, in his medical judgment, it was "reasonably probable" that Wilson would be alive if his hospitalization had not been terminated prematurely.59

The administrator of Wilson's estate sued Wilson's insurance company, Alabama Blue Cross, as well as the other related utilization review entities employed by Blue Cross.60 At trial, summary judg-

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51. *Id.* at 1645-46, 239 Cal. Rptr. at 819.
52. *Id.* at 1647, 239 Cal. Rptr. at 820. The court expressed that cost limitation programs, which have become quite prevalent in health care systems, cannot be allowed to "corrupt medical judgment." But the court concluded that under the instant facts, no corruption of medical judgment had occurred. *Id.*
55. *Id.* at —, 271 Cal. Rptr. at 877.
56. *Id.* at —, 271 Cal. Rptr. at 877.
57. *Id.* at —, 271 Cal. Rptr. at 877-78. Wilson's aunt testified that no one in the family had enough money to pay for Wilson's hospitalization. *Id.* at —, 271 Cal. Rptr. at 882.
58. *Id.* at —, 271 Cal. Rptr. at 878.
59. *Id.* at —, 271 Cal. Rptr. at 882.
60. Utilization review by a third party payor refers to a system in which the payor independently determines what procedures are "medically necessary" for its plan participants based on information supplied to the payor by the patient's treating physicians and nurses. *Id.* at —, 271 Cal. Rptr. at 881, 882. See *infra* notes 145-48 and accompanying text.
61. *Id.* at —, 271 Cal. Rptr. at 880. The defendants were as follows: Blue Cross and Blue Shield of Alabama ("Alabama Blue Cross"), Blue Cross of Southern California and Blue Cross of California ("California Blue Cross"), Western Medical Review, and Dr. Wasserman — a physician and employee of Western Medical. *Id.*
The decedent's insurance policy was with Alabama Blue Cross. Alabama Blue Cross had delegated authority to California Blue Cross who later contracted with Western Medical to conduct "utilization review of the 'medical necessity' of hospitalizations of all Blue Cross insureds." *Id.* at —, 271 Cal. Rptr. at 881. Dr. Wasserman, a physician and employee of Western Medical, had made the utilization decision for Western Medical that Wilson's hospitalization was not medically necessary. *Id.* at —, 271 Cal. Rptr. at 881.
Neither Alabama Blue Cross nor Dr. Wasserman are mentioned in the statement.
ment was granted for all four defendants based on the trial court’s interpretation of Wickline v. State. On appeal, the California Court of Appeal, the same court which had decided Wickline, stated that the principal issue in Wilson was the extent to which the Wickline decision extended “beyond the context of Medi-Cal patients to an insured under an insurance policy issued in the private sector.”

The defendants contended that they were not liable under the Wickline decision for three reasons: (1) a treating physician has the sole responsibility to decide whether to discharge a patient or provide further treatment; (2) important public policy reasons favor protecting insurance companies that use prospective utilization review; and (3) a treating physician in a utilization review program must pursue appeal measures when a patient’s benefits by a third party payor have been cut off.

The defendants’ first contention was that a treating physician has the sole responsibility to determine whether to discharge a patient, regardless of the reimbursement decision of the third party payor. This contention was premised on the court’s language in Wickline, which stated that the sole responsibility for a discharge decision is on the physician. The court in Wilson stated that this language from Wickline was mere dicta. Furthermore, the court in Wilson restated its Wickline position that a patient harmed by the withholding of necessary treatment may recover from all parties responsible for the lack of care, including health care payors. The court clarified this position by adopting the test posited by the Restatement (Second) of Torts regarding whether an actor’s conduct is a legal cause of harm to another —whether the negligent conduct of the actor was a substantial factor in the resulting harm. The court

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62. Id. at ——, 271 Cal. Rptr. at 878. See supra notes 19-53 and accompanying text.
63. Id. at ——, 271 Cal. Rptr. 878.
64. Id. at ——, 271 Cal. Rptr. at 883. See infra notes 67-73 and accompanying text.
65. Id. at ——, 271 Cal. Rptr. at 884. See infra notes 74-80 and accompanying text.
66. Id. at ——, 271 Cal. Rptr. at 884. See infra notes 81-85 and accompanying text.
67. Id. at ——, 271 Cal. Rptr. at 883.
68. Id. at ——, 271 Cal. Rptr. at 883.
69. Id. at ——, 271 Cal. Rptr. at 883.
70. Id. at ——, 271 Cal. Rptr. at 879 (citing Wickline, 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 810).
71. Wilson, 222 Cal. App. 3d at ——, 271 Cal. Rptr. at 879. Section 431 of the Restatement (Second) of Torts provides: “The actor’s negligent conduct is a legal
in *Wilson* determined that there was enough evidence to find that (1) had Wilson remained hospitalized, he probably would not have committed suicide, (2) the sole reason for Wilson's discharge was that he had no money to pay for the hospital services, and (3) the reason that Wilson could not fund his hospital stay was that his insurance company had directed that no further payments would be made for his treatment.\(^7\) Thus, the California Court of Appeal concluded that a triable issue existed as to whether the defendants' decision not to approve further hospital care was a substantial factor in causing Wilson's death.\(^7\)

The defendants' second contention was that public policy reasons favor the protection of all third party payors, including insurance companies, when these payors demonstrate concern for medical cost containment by implementing prospective utilization review.\(^7\) Therefore, the defendants argued that for policy reasons, the normal rules of tort liability should be altered as they had been in the *Wickline* decision.\(^7\) The court rejected this argument.\(^7\) The court noted that in *Wickline* it had explicitly stated that "all persons are required to use ordinary care to prevent others being injured as a result of their conduct . . . [and] in the absence of a statutory provision declaring an exception . . . no such exception shall be made unless clearly supported by public policy."\(^7\) The court in *Wilson* noted that in *Wickline* the public policy that constituted an exception came from regulatory and statutory law and that policy supported the denial of Medicaid benefits after a utilization review had been conducted.\(^7\) The court stated that there was no statute that permitted private insurance companies to terminate their insureds' benefits like the Medi-Cal statute which allowed for the termination of benefits.\(^7\) The court found no public policy reason to support immunity from tort liability when a private insurance company terminates benefits after a utilization review.\(^7\)

The defendants' third contention was that in a utilization review

\(\text{cause of harm to another if (a) his conduct is a substantial factor in bringing about the harm, and (b) there is no rule of law relieving the actor from liability because of the manner in which his negligence has resulted in the harm.}^{7}\) RESTATEMENT (SECOND) OF TORTS § 431 (1965).

73. *Id.* at —, 271 Cal. Rptr. at 885.
74. *Id.* at —, 271 Cal. Rptr. at 884.
75. *Id.* at —, 271 Cal. Rptr. at 884.
76. *Id.* at —, 271 Cal. Rptr. at 884.
77. *Id.* (quoting *Wickline*, 192 Cal. App. 3d at 1643, 239 Cal. Rptr. at 818).
80. *Id.* at —, 271 Cal. Rptr. at 884.
program, a treating physician must pursue appeal measures when a patient's benefits have been cut off by a third party payor. The court held that the Wickline dicta on which the defendants had relied for this argument applied in neither Wickline nor Wilson because both suits were against the payor, not against the physician. Furthermore, the court added that the defendants in Wilson had failed to demonstrate that a request for further review would have been granted. The court stated that the Wickline decision should be limited to its particular facts. Therefore, the court held that summary judgment was improper because a triable issue of fact remained as to whether the defendants' termination of benefits was a substantial factor in causing Wilson's death.

BACKGROUND

Problems with Third Party Retrospective Payment Plans

Prior to 1983 essentially all reimbursement policies of third party payors were retrospective. Retrospective reimbursement is a system which provides for payment by a third party source to the medical provider — the physician or hospital — for costs of the services after those services have already been rendered to the patient. Under such a system, insured patients have no reason not to request that every helpful medical procedure be performed because a third party payor reimburses virtually all of the patient's costs. Similarly, medical providers under a retrospective system have every incentive to utilize all beneficial services for patient care because the providers will receive a fee for each service performed. Thus, under such a system the more services rendered, the higher the revenues generated.

Moreover, for physicians who were subjected each year to the increasing risk of lawsuits, the retrospective payment system allowed

81. Id. Again, this argument was developed from language in Wickline. Id.
82. Id. at ——, 271 Cal. Rptr. at 884.
83. Id. at ——, 271 Cal. Rptr. at 885.
84. Id. at —, 271 Cal. Rptr. at 878.
85. Id. at —, 271 Cal. Rptr. at 885.
86. Widem, Pincus, Goldman & Jencks, Prospective Payment for Psychiatric Hospitalization: Context and Background, 35 Hosp. & Community Psychiatry 447 (1984) [hereinafter Widem].
87. Id.
88. Id.
89. Id. Morreim, Cost Containment and the Standard of Medical Care, 75 Calif. L. Rev. 1719, 1720 (1987).
90. Morreim, 75 Calif. L. Rev. at 1720; Widem, 35 Hosp. & Community Psychiatry at 447.
full reimbursement for the practice of defensive medicine.91 The practice of defensive medicine refers to medical decisions which are primarily made to protect the physician against charges of negligence.92 By ordering extra diagnostic tests and essentially performing every beneficial procedure for a patient, physicians protect themselves from lawsuits.93 Because of newly emerging technologies, and the fact that retrospective third party reimbursement was essentially limitless, physicians were encouraged to practice defensive medicine and provide their patients with the highest quality of care, regardless of expense.94

Between 1960 and 1983, health care costs in the United States rose from five percent to nearly eleven percent of the gross national product.95 Although this escalation was partially due to the aging of the population and expensive, new technology, the defensive practices encouraged by retrospective third party payor systems also contributed to the increase of money being spent on medical care.96

A serious ramification of this medical cost escalation was that Medicare had been projected to be more than $250 billion in debt by 1995 if the then current system of retrospective reimbursement was not reformed.97 Additionally, corporations, which pay one-third of this country's health care costs through employee benefits, found it significantly more difficult to compete in the international marketplace because of expanding labor costs.98 Texaco, for example, spent $11 million on health benefits in 1973 and $500 million in 1983.99 It was clear that health care costs needed to be somehow reduced.100

91. Morreim, 75 CALIF. L. REV. at 1724 n.25, 1726; Wagner, Defensive Medicine; Health Care's Hidden Costs, MODERN HEALTHCARE, Sept. 10, 1990, at 2 (LEXIS, Nexis library) (pagination in accordance with LEXIS screens); Widem, 35 HOSP. AND COMMUNITY PSYCHIATRY at 447.
92. Wagner, MODERN HEALTHCARE, at 4.
93. Bovbjerg, The Medical Malpractice Standard of Care: HMOs and Customary Practice, 1975 DUKE L.J. 1375, 1377; Wagner, MODERN HEALTHCARE, at 5. An example is that children who have fallen almost never suffer a skull fracture. Even if a physician truly does not believe the child could have suffered a skull fracture, the physician will order an X-ray to protect himself or herself from the possibility of future litigation. Wagner, MODERN HEALTHCARE, at 5. Another tactic in defensive medicine is to deny treatment altogether: 90% of family practitioners now refuse to even begin treatment on "high-risk patients" because they may face too high a risk of eventually being sued. Id.
94. Bovbjerg, 1975 DUKE L.J. at 1377; Morreim, 75 CALIF. L. REV. at 1726.
95. Morreim, 75 CALIF. L. REV. at 1720.
96. Id.
97. Hunt, Do They Finally Have the Guns to Kill Fee-For-Service? MED. ECON., Apr. 2, 1984, at 145, 146.
98. Morreim, 75 CALIF. L. REV. at 1720-21.
99. Hunt, MED. ECON. at 146.
100. See supra notes 97-101 and accompanying text.
Corporate and government purchasers of health care packages reacted to the astronomically escalating medical costs with fundamental changes in the financing of medical care.  

101 Congress enacted the Prospective Payment for Medicare In-Patient Hospital Services Amendment to the Social Security Act in 1983.  

102 Congress indicated in this legislation that the old retrospective system provided an incentive to over-hospitalize and over-treat patients.  

103 Under the prospective payment system now incorporated into Medicare, cost efficiency is encouraged because set rates of payment to medical providers are determined before any services are rendered to the patient.  

104 The first available statistics demonstrate that the length of most patients' hospital stays can be reduced and the cost of care more easily controlled through prospective payment plans.  

105 As some commentators had predicted, other insurers followed the direction Medicare took with regard to reimbursement plans.  

106 Many state Medicaid programs and commercial insurance companies have either turned to a prospective payment system completely or require prior authorization of elective procedures and specify a limited amount of time in the hospital.  

107 Corporations have begun to seek more economical health care plans as well, and by doing so have encouraged third party payors to compete for their business.  

108 With both public programs and private insurance companies changing from retrospective to prospective payment plans, wherein preapproval of most medical procedures is required, physicians must
keep costs down if they wish to receive such approval. To contain costs, many therapeutic procedures previously considered "necessary" are no longer used. For a hospital to profit, not every possible beneficial procedure can be utilized by the physician. For example, in a prospective payment system a hospital that can perform appendectomies with the least cost is the hospital that will realize the greatest profits. While the retrospective payment system created an incentive for physicians to maximize the use of procedures which ultimately raised the standard of care, the prospective payment system emphasizes utilization of fewer procedures to control costs. When hospitals profit from their patients receiving less treatment from physicians, there is a clear incentive in a prospective payment system for hospitals to undertreat patients.

THE EFFECT OF THIRD PARTY REIMBURSEMENT DECISIONS ON PHYSICIANS

In a prospective payment system, third party payors exert pressure on hospitals to reduce health care costs by not reimbursing the hospital for patient treatment which the payor determines is unnecessary. The hospital then exerts pressure on its physicians through disciplinary action. A hospital monitors the practices of its physicians to determine if any cause repeated financial loss to the hospital. A hospital may charge a physician with "economic irresponsibility" for (1) ordering or performing diagnostic tests which are later deemed unnecessary by a third party payor, (2) admitting patients whose condition does not justify hospitalization; and (3) failing to discharge patients quickly enough. Generally, a hospital's first course of action is the education of the physician; if the education proves futile, the physician may be removed from the hospital.

110. Morreim, 75 CALIF. L. REV. at 1724. "Therefore, for the first time . . . health care payors are pressuring physicians to do less for their patients, and to discharge hospitalized patients earlier." Id.
111. Id.
112. Dougherty, Ethical Perspectives on Prospective Payment, HASTINGS CENTER REP., Jan./Feb., 1989 at 5, 7.
113. See supra notes 93-96 and accompanying text.
114. Dougherty, HASTINGS CENTER REP. at 5; Morreim, 75 CALIF. L. REV. at 1724.
115. Wickline, 192 Cal. App. 3d at 1634, 239 Cal. Rptr. at 811; Morreim, 75 CALIF. L. REV. at 1750.
118. Id. at 428.
Particularly in hospitals which have a high percentage of revenue from government programs, overutilization of procedures or unnecessarily lengthy hospital stays are tolerated to a lesser degree. Some private hospitals merely attempt to intimidate the physician with letters of admonishment or threats of deprivation of staff privileges.

In response to hospital and government pressure, physicians have been forced to include the hospital's reimbursement amount from third party payors into the physician's medical determinations. Yet, the case law on the under-treatment of patients generally states that any type of inadequate care rendered to a patient which is based on a non-medical consideration, such as cost, constitutes a form of negligence. A physician has always been allowed to refuse to accept a patient for any reason, even because a patient does not have enough money to pay for the services. As soon as the patient is accepted, however, the physician owes the patient the same standard of care "whether the patient be a pauper or a millionaire."

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119. Id.
120. Chenen, Prospective Payment Can Put You in Court, MED. ECON., July 9, 1984 at 134, 141. Santa Monica Hospital Medical Center receives 60% of its revenue from Medicare. The president of the hospital stated that "overutilizers" are "tolerated" for six months. Id.
121. Morreim, 75 CALIF. L. REV. at 1724. Medicare's prospective payment system pays hospitals a set rate for services rendered to Medicare patients. Id. This rate is based on predetermined average costs of hospitalization that are specifically set out in Medicare's Diagnostic Related Groups ("DRGs"). Dougherty, HASTINGS CENTER REP. at 5. If a physician performs more procedures on a Medicare patient than the patient's DRG will reimburse, the hospital will not profit from treating the patient. Id. A 1988 survey revealed that 63% of the hospitals surveyed use the DRGs of Medicare to monitor the profitability of an individual physician. Id. at 8.
123. See Clark v. United States, 402 F.2d 950, 953 (4th Cir. 1968) (stating that any non-medical, unjustifiable delay in the utilization of a standard diagnostic procedure constitutes negligence); Tunkl v. Regents of University of California, 60 Cal. 2d 92, —, 383 P.2d 441, 448, 32 Cal. Rptr. 33, 40 (1963) (holding that there is no distinction in a physician's duty of care between a paying and non-paying patient); Becker v. Janinski, 15 N.Y.S. 675 (C.P. 1891) (holding that a physician owes the same duty of care to each of the physician's patients, even if the patient cannot afford all of the medical services encompassed within the standard); Smith v. Yohe, 412 Pa. 94, —, 194 A.2d 167, 173 (1963) (stating that a cost consideration does not excuse a physician from the failure to take x-rays which are later deemed necessary); Wilkinson v. Vessey, 295 A.2d 676, 683 (R.I. 1972) (holding that for every patient, a physician must avail himself to all of the diagnostic facilities available to him). See also Morreim, 75 CALIF. L. REV. at 1725.
124. Morreim, 75 CALIF. L. REV. at 1725.
125. Id. (citing Becker, 15 N.Y.S. at 677). The physician's standard of care encompasses existing technology, as well as the physician's skill. Morreim, Stratified Scarcity: Redefining the Standard of Care, 17 LAW, MED. & HEALTH CARE 356, 357 (1989). As medical technologies develop, they merge with the physician's duty. Id. at 357.
technologies, the word "available" has been interpreted to denote geographically available. Whether the patient can afford these available technologies is irrelevant to the legal system. Thus, with third party payors turning to prospective payment plans, there are two conflicting forces acting upon the physician — cost containment pressures and legal liability.

THE LEGAL LIABILITY OF A THIRD PARTY PAYOR

Third party payors under retrospective payment plans have been held liable for the cost of a patient's treatment as well as for punitive damages when the payors have made bad faith decisions not to reimburse a patient. In Hughes v. Blue Cross of Northern California, Patrick Hughes, a twenty-one-year-old man, repeatedly stabbed himself in the abdomen with a screwdriver and attempted to overdose on aspirin. Over the following year, Hughes was repeatedly hospitalized because of similar suicide attempts, violent thoughts, and schizophrenic behavior. Hughes's insurance company, Blue Cross, denied payments for all but a month of Hughes's treatment based on the insurance company's own determination that the treatment was medically unnecessary. The California Court of Appeal found that the Blue Cross utilization review decision was based on medical standards that were substantially more restrictive than community standards. The court held that when an insurance company uses such restrictive standards to deny payments to a plan member, the insurance company has acted in bad faith.

In Aetna Life Insurance Co. v. Lavoie, Mrs. Lavoie was examined by her physician who recommended that she be admitted to the hospital for evaluation and treatment of her "various ail-

Consequently, physicians have been held legally liable for not ordering X-rays, biopsies, intravenous pyelograms, and other advanced diagnostic technologies. Id. See supra notes 115-21, 123-27 and accompanying text. See infra notes 129-42 and accompanying text. 215 Cal. App. 3d 832, 263 Cal. Rptr. at 850 (1989). Id. at 838, 263 Cal. Rptr. at 852-54. Id. at 839-41, 263 Cal. Rptr. at 852-54. Id. at 842, 215 Cal. Rptr. at 855. Id. at 845-46, 263 Cal. Rptr. at 857. The court stated that such a restricted definition of medical necessity frustrated the justified expectations of the insured, and was "inconsistent with the liberal construction of policy language required by the duty of good faith." Id. at 845, 263 Cal. Rptr. at 857. Id. at 845-46, 263 Cal. Rptr. at 857. The court stated that an insurance company's definition of "medical necessity" must be consistent with the medical community's definition. Id. The court also held that evidence supported the jury's award of $700,000 in punitive damages. Id. at 838, 846-47, 263 Cal. Rptr. at 852, 858-59. 505 So. 2d 1050 (Ala. 1987).
ments." During a twenty-three day hospital stay, many tests were performed on Lavoie. After Lavoie was released from the hospital, the hospital mailed her medical records along with a bill to Lavoie's insurance company. Before receiving all of Lavoie's hospital records, a senior claims examiner decided that her medical records illustrated that Lavoie's hospital stay was unnecessary. Lavoie's insurance company decided to only pay half of her bill. The Supreme Court of Alabama stated that the insurance company breached its duty to use good faith in considering a claim because it had failed to evaluate all of the patient's medical information before making its utilization review decision.

As discussed above, third party payors initially used retrospective reimbursement systems, wherein the necessity of medical services was evaluated after the services had already been rendered. However, when it later became clear that the retrospective payment system was a significant cause of skyrocketing medical costs, payors began to turn to prospective payment systems, wherein the necessity of medical services was determined prior to the patient receiving services.

The court in Wickline v. State discussed the ramifications of an erroneous decision under a prospective utilization review and the detrimental effects such a decision may have on a patient. A wrong conclusion about the necessity of medical treatment after a retrospective review results in the payment being withheld. In contrast, a mistaken decision after a prospective review process results in the necessary treatment being withheld, "potentially leading to a patient's permanent disability or death." Because prospective payment systems are relatively new, the case law regarding third party payors' liability under such a system is largely undeveloped.

137. Id. at 1051.
138. Id.
139. Id.
140. Id. Lavoie's progress notes and nurses' notes were not yet in Lavoie's medical file at the time Aetna denied payment for the entire amount owed on the bill. Id. Aetna's own witnesses stated that these notes are critically important in determining the medical necessity of a hospital stay. Id. at 1053.
141. Id.
142. Id. at 1052-53. The jury had awarded the plaintiff $3.5 million in punitive damages, but the Supreme Court of Alabama affirmed the case on the condition that the plaintiff remit $3 million of the jury award. Id. at 1051 n.1, 1054.
143. Widem, 35 Hosp. and Community Psychiatry at 447.
144. Morreim, 75 Calif. L. Rev. at 1720; see supra notes 101-05.
146. Id. at 1634, 239 Cal. Rptr. at 811-12.
147. Id. at 1634, 239 Cal. Rptr. at 812.
148. Id.
The issue, though, remains essentially the same: whether third party payors may be held liable for a patient's injury which results from the payor's unreasonable utilization decision to terminate the funding for treatment which is later deemed to have been necessary.150

ANALYSIS

In Wickline v. State,151 Lois Wicklin sued Medi-Cal, the state of California Medicaid program, for damages caused by a utilization review decision Medi-Cal had made.152 An employee of Medi-Cal had determined that it was not medically necessary for Wickline to be hospitalized for the length of time requested by her physicians; Wickline's physicians acceded to Medi-Cal's demand and released her from the hospital. 153 As a result of her premature release and later complications, one of Wickline's legs had to be amputated.154 The California Court of Appeal held that Medi-Cal was not liable as a matter of law because a statute specifically exempted Medi-Cal from such liability.155 The court did note, however, that a third party payor could be held liable for harm caused by the payor's utilization review decision, unless a clearly expressed public policy provided immunity.156

Four years later, in Wilson v. Blue Cross of Southern California,157 Howard Wilson's estate sued Wilson's insurance company, as well as the other related entities that had been involved in the utilization review for the insurance company.158 Wilson was released from the hospital after his insurance company announced it would not pay for any further hospitalization.159 Subsequently, Wilson committed suicide.160 The court in Wilson stated that the Wickline rationale should be limited to its facts, and that there was no clearly expressed public policy reason for not holding a private insurance company liable for its decision.161 The court adopted the test posited by the Restatement (Second) of Torts for determining tort liability: any actor who engages in negligent conduct which is a substantial

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150. Id.
152. Id. at 1633, 239 Cal. Rptr. at 811.
153. Id. at 1639, 239 Cal. Rptr. at 814-15.
154. Id. at 1641, 239 Cal. Rptr. at 816-17.
155. Id. at 1646-47, 239 Cal. Rptr. at 820. See supra note 24 and accompanying text.
156. Id. at 1645-47, 239 Cal. Rptr. at 819-20.
158. Id. at —, 271 Cal. Rptr. at 878-80.
159. Id. at —, 271 Cal. Rptr. at 877-78.
160. Id. at —, 271 Cal. Rptr. at 877-78.
161. Id. at —, 271 Cal. Rptr. at 878, 884. See supra notes 74-85 and accompanying text.
factor in a resulting harm can be held liable for the harm caused to another.162

THE CONSISTENCY AND SOCIAL Necessity of Wickline and Wilson

The Wickline and Wilson decisions are consistent with each other and advance socially necessary approaches to cost-containment problems in the health care area.163 The court in Wickline stated that a patient who is harmed when the appropriate care has not been provided may recover from all parties responsible, including third party payors.164 However, in Wickline, the court had identified a public policy exception to this rule which was clearly expressed by statute. 165 These statutes required utilization review in the state Medicaid system and provided that state benefits could be denied if the standards upon which this denial of care was based did not drop below the medical standard of care.166 In Wickline, the plaintiff had suffered harm because of a third party payor’s decision not to reimburse Wickline’s eight days of hospitalization.167 However, her four day hospital stay, which Medi-Cal did approve, was within the accepted medical standard of care.168 Therefore, Medi-Cal was not found liable because its action came within the clearly expressed statutory exception.169

In contrast, in Wilson there was no evidence of any policy reasons to protect private insurance companies.170 Because there were no clearly expressed policy reasons to exempt a private insurance company from liability, the defendant in Wilson could not come under the public policy exception of Wickline.171 Consistent with the reasoning in Wickline, if the plaintiff in Wilson could have proved that the third party payor was a substantial factor in the harm to the decedent, the third party payor could be held liable for this harm.172

There are also public policy reasons for holding a private insurance company, but not a state program, liable for harm caused by an

162. Wickline, 222 Cal. App. 3d at —, 271 Cal. Rptr. at 883. See supra note 71 and accompanying text.
163. See infra notes 168-76 and accompanying text.
164. Wickline, 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 819.
165. Id. at 1646-47, 239 Cal. Rptr. at 820.
166. Wilson, 222 Cal. App. 3d at —, 271 Cal. Rptr. at 884.
167. See supra notes 32-38 and accompanying text.
168. Wickline, 192 Cal. App. 3d at 1646, 239 Cal. Rptr. at 819.
169. Id. at 1646-47, 239 Cal. Rptr. at 820.
170. Wilson, 222 Cal. App. 3d at —, 271 Cal. Rptr. at 884.
171. Id. at —, 271 Cal. Rptr. at 884.
172. Id. at —, 271 Cal. Rptr. at 884-85. See supra notes 44-45 and accompanying text.
A state program such as Medi-Cal could not continue to serve the purpose for which it was created—to provide medical care for the indigent—if it were continually subjected to the high cost of litigation. Forcing the state program to pay litigation costs from its limited budget would have serious ramifications. First, the program would have less money in its budget, and thus would not have the resources to conform its utilization review program to the medical community's standard of care. Second, the program would eventually be depleted of its limited funds, and would be unable to provide services for those who rely on the program to pay their medical costs.

Unlike state programs, when a private insurance company is held liable for the harm it causes, the insurance company can spread its losses by increasing its premiums. Thus, the insurance company can recover its losses, while a state program must pay any judgment out of its existing limited budget. The insurance company will have greater revenues from the increase in premiums, and will be able to afford to conform its utilization review program to the standards of the medical community. Imposing liability on a private insurance company for unreasonable utilization review decisions may ultimately result in a safer utilization review process. Holding an insurance company liable for unreasonable utilization review decisions may create an incentive for the insurance company to develop a review process in conformance with medical standards.

Even though third party payors may be held liable for their decisions, physicians will still be held accountable if they deny or terminate necessary treatment to their patients when the treatment was required by the physician's standard of care. Furthermore, physicians still must exhaust all options to help the patient receive fund-

173. See infra notes 174-81 and accompanying text.
174. See supra notes 24, 91-92 and accompanying text.
175. See infra notes 176-77 and accompanying text.
177. See supra note 24.
179. Wilson, 222 Cal. App. 3d at —, 271 Cal. Rptr. at 884.
180. Id. at —, 271 Cal. Rptr. at 884; Wickline, 192 Cal. App. 3d at 1646-48, 239 Cal. Rptr. at 819-20.
182. Wilson, 222 Cal. App. 3d at —, 271 Cal. Rptr. at 884.
183. Wickline, 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 819. The physician is ultimately responsible for his or her patient and cannot pass this responsibility on to a third party payor. Id. See supra notes 126-27 and accompanying text.
THIRD PARTY PAYOR LIABILITY

ing from the health care payor.\textsuperscript{184} The \textit{Wickline} and \textit{Wilson} decisions are consistent with each other and promote the greatest benefit to society by holding that unless there is a public policy exception, \textit{all} those who cause harm to a patient — including the third party payor — should be held liable for such harm.\textsuperscript{185}

EXTENDING LIABILITY TO THIRD PARTY PAYORS IN A PROSPECTIVE PAYMENT SYSTEM

The decision in \textit{Wickline}, as clarified by the court in \textit{Wilson}, stated that third party payors can be held liable when the financial pressures exerted from a cost-containment, utilization program are a substantial factor in causing harm to a patient who is a recipient of their benefits.\textsuperscript{186} However, some commentators have asserted that liability should not extend to third party payors.\textsuperscript{187} Essentially, three reasons have been advanced for not extending liability to third party payors: (1) courts have an erroneous perception of the relationship between the payor, physician and patient, i.e., third party payors do not directly pressure physicians into providing substandard care;\textsuperscript{188} (2) only physicians should be held liable because the obligations of the third party payor are controlled by contract and statute;\textsuperscript{189} and (3) because payors have no authority to intervene in the doctor-patient relationship, they cannot have any tort liability for harm which ensues from this relationship.\textsuperscript{190} None of these arguments is persuasive.\textsuperscript{191}

The first rationale for not extending tort liability to third party payors is that payors make only economic decisions regarding reimbursement of the hospital or physician for patient care and do \textit{not}, as some courts have implied, directly pressure the physician into providing substandard care.\textsuperscript{192} This view is simplistic and unrealistic. The court in \textit{Wickline} and \textit{Wilson} recognized that in a third party payor system the payor pressures the hospital to control costs, and

\begin{itemize}
    \item \textsuperscript{184} Hirsh, \textit{Cost Containment, Reimbursement, and Quality Assurance}, 40 \textit{LEGAL MED.} 427, 430 (1988).
    \item \textsuperscript{185} See supra notes 164-82 and accompanying text.
    \item \textsuperscript{186} See supra notes 43-45, 70-73 and accompanying text.
    \item \textsuperscript{187} See infra notes 188-90 and accompanying text.
    \item \textsuperscript{188} Morreim, \textit{Cost Containment and the Standard of Care}, 75 \textit{CALIF. L. REV.} 1719, 1748-50 (1987).
    \item \textsuperscript{189} Id.
    \item \textsuperscript{190} Id. Comment, \textit{Reexamining the Physician's Duty of Care in Response to Medicare's Prospective Payment System}, 62 \textit{WASH. L. REV.} 791, 807, 811 (1987).
    \item \textsuperscript{191} See infra notes 192-212 and accompanying text.
    \item \textsuperscript{192} Morreim, 75 \textit{CALIF. L. REV.} at 1749-50. Morreim states that the court in \textit{Wickline} incorrectly used words that denote that third party payors \textit{directly} pressure physicians, e.g., Medi-Cal "authorizes" and physicians "choose" whether to "comply." Id. at 1749.
\end{itemize}
the hospital in turn pressures the physician.\textsuperscript{193} Although the pressures exerted by the payor upon the physician are indirect, the payor may nevertheless be a substantial cause of inadequate treatment through its system of payment determinations.\textsuperscript{194} Therefore, a court should be willing to extend liability to a third party payor when the payor arbitrarily or unreasonably denies any further payment for treatment of a patient.\textsuperscript{195}

Furthermore, third party payors were held liable even before the Wilson decision for determinations they had made not to reimburse treatment in retrospective payment plans.\textsuperscript{196} Pressures to control costs are clearly stronger upon physicians in a prospective payment system.\textsuperscript{197} Thus, a court could reasonably find that the "indirect" pressures upon physicians are so substantial as to justify holding a third party payor liable when the payor's decision to terminate funding is without justification.\textsuperscript{198} Recognizing the effect that a payor's reimbursement decision has upon a physician's treatment decision, the court in Wilson correctly held that if the negligent conduct of the payor is a \textit{substantial factor} in causing a patient harm, then the payor may be held liable.\textsuperscript{199}

The second reason for not extending tort liability to third party payors is that a payor's obligations are controlled solely by contract and any applicable statutes and regulations — not by common-law tort theories.\textsuperscript{200} This assertion is an inaccurate statement of both contract and tort law. American courts have extended tort liability to almost every type of contract when the promisee is harmed by the promisor's defective performance.\textsuperscript{201} Although insurance policies are generally thought of as contracts, any bad faith failure to pay the insured, \textit{especially} on a medical policy where the need is critical, may subject the insurer not only to tort liability but also to punitive and mental distress damages.\textsuperscript{202} Holding third party payors liable simply

\begin{footnotesize}
\begin{enumerate}
\item[193.] \textit{Wilson}, 222 Cal. App. 3d at ——, 271 Cal. Rptr. at 883; \textit{Wickline}, 192 Cal. App. 3d at 1633, 239 Cal. Rptr. at 811.
\item[194.] \textit{Wilson}, 222 Cal. App. 3d at ——, 271 Cal. Rptr. at 884-85. If the physician treats a patient when the hospital will not receive reimbursement for this patient, the physician will be disciplined. \textit{See supra} notes 117-23 and accompanying text. The prospect of being disciplined directly pressures physicians to discharge patients from hospitals earlier than the physician normally would. \textit{See supra} notes 117-23 and accompanying text.
\item[195.] \textit{Wickline}, 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 819.
\item[196.] \textit{See supra} notes 129-42 and accompanying text.
\item[197.] \textit{See supra} notes 115-21 and accompanying text.
\item[198.] \textit{Wilson}, 222 Cal. App. 3d at ——, 271 Cal. Rptr. at 883.
\item[199.] \textit{Wilson}, 222 Cal. App. 3d at ——, 271 Cal. Rptr. at 883.
\item[200.] Hirsch, 40 \textit{LEGAL MED.} at 430.
\item[201.] PROSSER, \textit{supra} note 182, § 92, at 660 (5th ed. 1984).
\item[202.] \textit{Id.} at § 92, at 91 (5th ed. Supp. 1988).
\end{enumerate}
\end{footnotesize}
for breach of contract is not sufficient; payors should also be subjected to tort liability for arbitrary and unreasonable utilization review determinations which cause harm to a health care recipient.\textsuperscript{203}

The third argument advanced for not extending tort liability to third party payors is that the payor does not have any authority to alter the doctor-patient relationship because the payor is not a party to that relationship.\textsuperscript{204} This argument concludes that without authority to alter the doctor-patient relationship, there can be no tort liability on the part of the payor for harm which resulted within that relationship.\textsuperscript{205}

This argument fails to recognize the dynamics of today's health care environment.\textsuperscript{206} Physicians do not have endless hours of time to spend working out a patient's reimbursement plans with a third party payor.\textsuperscript{207} A physician can spend only a limited amount of time away from treating patients to act as a patient advocate.\textsuperscript{208} According to the American Society of Internal Medicine, which recently began a campaign to address the "hassle factor" in relationships between third party payors and physicians, there are three areas which are of the greatest concern for physicians.\textsuperscript{209}

First, physicians are being penalized for providing "too much care" to their patients, care which physicians believe is medically necessary.\textsuperscript{210} The hospital loses money if the physician performs medical procedures which are not considered medically necessary by a third party payor because the payor will not reimburse the hospital for such procedures.\textsuperscript{211} Thus, hospitals pressure physicians to perform fewer medical procedures on each patient.\textsuperscript{212}

Second, there is a continually increasing demand for paperwork to get services reimbursed.\textsuperscript{213} Presently, internists devote about twenty percent of their time to administrative tasks.\textsuperscript{214} It is somewhat ironic that cost-containment programs, which are concerned with the rising costs of health care, are actually increasing medical costs by adding administrative costs.\textsuperscript{215}

\begin{footnotes}
\begin{enumerate}
\item See supra notes 205-06 and accompanying text.
\item Hirsh, 40 LEGAL MED. at 430; Comment, 62 WASH. L. REV. at 807, 811.
\item Hirsh, 40 LEGAL MED. at 430; Comment, 62 WASH. L. REV. at 807, 811.
\item See infra notes 207-15 and accompanying text.
\item Koska, Medical Society Campaigns to Reduce Red Tape for Physicians, HOSPITALS, Nov. 20, 1990, at 36.
\item Id.
\item Id.
\item Id.
\item See supra notes 117-18 and accompanying text.
\item See supra notes 117-21 and accompanying text.
\item Koska, HOSPITALS at 36.
\item Id.
\item Id. See supra notes 94-114 and accompanying text.
\end{enumerate}
\end{footnotes}
Third, a greater number of medically necessary services are arbitrarily denied.\textsuperscript{216} For example, in 1990, a private insurance company with a prospective payment system refused to pay for any more claims of a patient when it erroneously asserted that the patient had died.\textsuperscript{217} The patient's treating physician spent six months acting as the patient's advocate trying to prove to the insurance company that his patient was in fact alive.\textsuperscript{218}

The arguments advanced for not holding third party payors liable are inadequate at best.\textsuperscript{219} It is socially beneficial to hold third party payors liable for their utilization determinations when these decisions are a substantial factor in causing harm to a plan participant.\textsuperscript{220} Health care payors have no inherent immunity from the tort system and, therefore, should be held liable when their unreasonable decisions are a substantial cause of harm.\textsuperscript{221} Furthermore, if all private payors are held liable, then they will be forced to bring their utilization review programs up to the medical community's standard of care.\textsuperscript{222}

CONCLUSION

In \textit{Wickline v. State of California},\textsuperscript{223} a patient sued Medi-Cal for a utilization review determination that Medi-Cal had made under its prospective payment system causing the patient harm.\textsuperscript{224} The California Court of Appeal stated that although a third party payor could be held liable for harm resulting from a negligent utilization review decision, Medi-Cal was not liable under the particular facts of the case because a statute set out a public policy which exempted it from such liability.\textsuperscript{225}

In \textit{Wilson v. Blue Cross}\textsuperscript{226} the same court, four years later, stated that the \textit{Wickline} rationale should be limited to its facts and that there was no statutory or public policy reason for not holding a private insurance company liable.\textsuperscript{227} The court in \textit{Wilson} adopted

\begin{itemize}
\item \textsuperscript{216} Koska, \textit{HOSPITALS} at 36.
\item \textsuperscript{217} Id. This insurance company, Blue Cross and Blue Shield of Colorado, was given the "Red Tape Dispenser Award" by the American Society of Internal Medicine for qualifying as the external entity which most "hassled" physicians. Id.
\item \textsuperscript{218} Id.
\item \textsuperscript{219} \textit{See supra} notes 186-218 and accompanying text.
\item \textsuperscript{220} \textit{See supra} notes 164-84 and accompanying text.
\item \textsuperscript{221} \textit{Wilson}, 222 Cal. App. 3d at ——, 271 Cal. Rptr. at 883.
\item \textsuperscript{222} \textit{See supra} notes 178-81 and accompanying text.
\item \textsuperscript{223} 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986).
\item \textsuperscript{224} \textit{Wickline}, 192 Cal. App. 3d at 1645-47, 239 Cal. Rptr. at 819-20; \textit{see supra} notes 50-52 and accompanying text.
\item \textsuperscript{225} \textit{See supra} notes 50-52 and accompanying text.
\item \textsuperscript{226} 222 Cal. App. 3d 660, 271 Cal. Rptr. 876 (1990).
\item \textsuperscript{227} Id. at ——, 271 Cal. Rptr. at 878, 884.
\end{itemize}
THIRD PARTY PAYOR LIABILITY

the test of joint tort liability from the Restatement (Second) of Torts — any actor who engages in negligent conduct which is a substantial factor in a resulting harm can be held liable for the harm he or she causes another.228

This approach is a rational solution to an extremely complex problem with cost-containment programs in the health care area. Although physicians should still be held responsible for their sub-standard treatment decisions, health care payors should also be held liable when they make unreasonable reimbursement decisions which result in harm to the patient. When a third party payor, through its utilization review decision, denies funding for treatment that a patient's physician deems necessary, the decision certainly puts money in the payor's pocket. However, each utilization decision the payor makes denying treatment might also lead to the death or serious injury of one of its insureds. Because third party payors choose to gamble with these business risks, they need to accept the responsibility for their business decisions. Policy reasons exist for not holding some government third party payors liable for their decisions.229 However, no policy reasons exist for exempting private insurance companies from tort liability for arbitrary and unreasonable actions which are a substantial factor in causing harm to one of their plan participants.

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228. Id. at ——, 271 Cal. Rptr. at 883. See supra note 71 and accompanying text.
229. See supra notes 173-77 and accompanying text.