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WHEN HMO PATIENTS CAN’T GET NO SATISFACTION

Ardyth J. Eisenberg

INTRODUCTION

As work on this article began, newspapers announced that health maintenance organization (HMO) members' satisfaction with their health plans had declined and litigation against HMOs about the quality of patient care was increasing.¹ Information released by Hewitt Associates, a national benefits consulting firm, in late 1999 indicated that 22 percent of members were dissatisfied with their managed care plans in 1998, compared to 17 percent in 1997.² In 1998, 30 percent reported they were not satisfied with their plans' "timeliness, professionalism or accuracy."³ Another national consultant reported that enrollment in HMOs had dropped for two consecutive years, to 46 percent of all workers, while enrollment in more flexible preferred provider organizations increased in 1998, to 43 percent of all workers.⁴

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³Japsen, supra note 1.

⁴See id.

⁵See id.
At the same time, the U. S. Supreme Court granted certiorari for Pegram v. Herdrich to determine whether an HMO’s performance incentives for its physicians violated the fiduciary duty requirements of the Employee Retirement and Income Security Act (ERISA). At a time when HMO enrollment has reached an all-time high, both popular and legal pressures have come to bear on the entire nature of the managed care arrangement.

This Comment will explore whether HMO patient satisfaction levels indicate the likelihood of litigation being filed against the HMO. It begins by examining the evolution of managed care arrangements, then considers the ways the public and patients can record their satisfaction with health care received through HMOs. After briefly explaining HMO accreditation processes and rating systems, the Comment analyzes appellate-level cases against HMOs rated highly and lower in several published rankings. Finally, the Comment considers how HMOs may respond to litigation by dissatisfied members.

BACKGROUND

From Private Care to Managed Care

The evolution of health care financing has generated entire textbooks, and is known to most people interested in health care. Nevertheless, a review of the early differences between HMOs and commercial health insurance offers insight to the current convergence of dissatisfaction and litigation that surrounds HMOs.

Until the early 1980s, HMOs and prepaid medical plans operated separately from and in competition with health insurers. They enrolled

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6For clarity and consistency, this article relies on the National Committee for Quality Assurance’s definition of health maintenance organization (“HMO”): It is a health plan that furnishes health care in return for a specific monthly payment. The health care is usually delivered by a network of health care providers, which the HMO members must use, in order to receive paid-for care. NATIONAL COMMITTEE FOR QUALITY ASSURANCE, Choosing Quality: Finding the Health Plan That’s Right for You, at http://www.ncqa.org/pages/communications/publications/brotext.
7Prepaid medical plans consisted of contracts between employee or employer groups and individual physicians. The group agreed to pay the physicians a fixed monthly fee and the
only a minority of people. HMOs served as the only source of medical care for their members. The actual care came from limited panels of physicians and hospitals which had either contractual, employment or ownership relationships with the HMO. In this sense, early HMOs both provided for and financed health care. Members' prepayment of specified fees ostensibly gave the HMOs (and their affiliated hospitals and physicians) an incentive to deliver care efficiently.

By contrast, health insurers at the time were normally branches of large commercial insurance companies. They lacked formal arrangements with physicians and hospitals and did not place limits on the members' choices of health care providers. Although they assumed financial risk for the resulting medical costs, the insurers had physicians agreed to provide all the medical care the employees required. Paul Starr, The Social Transformation of American Medicine 301-06 (1982).

See id at 298, quoting Douglas MacIntyre, Voluntary Health Insurance and Rate Making 124-25 (1962). "Insurance theory says that the hazard insured against should be definite and measurable. In some respects service contracts were like blank checks for [patients], physicians and hospitals; they were open-ended and did not limit the plans' dollar liabilities." See id at 27 (discussing the medical profession's use of prepaid medical plans to maintain physicians' independence from hospitals and health insurers: "Prepaid health plans, now called 'health maintenance organizations,' represent a competitive form of bureaucratic organization in medical care. Insurance companies, under pressure to control medical costs, search for methods to regulate medical decisions.").

In 1972, the country had fewer than 40 HMOs, which enrolled about 3 million people. Tom J. Manos, Take Half an Aspirin and Call Your HMO in the Morning -- Medical Malpractice in Managed Care. Are HMOs Practicing Medicine Without a License?, 53 Univ. Miami L. Rev. 195, 202 (Oct. 1998).

See id See also, David L. Trueman, Managed Care Liability: Today's Laws, Cases, Theories, and Current Issues, 33 J. Health Law 191 (Spring 2000).

[Minnesota physician Paul M] Ellwood had been trying for several years to get a hearing [at the U.S. Department of Health, Education and Welfare] for his view that reform of the health system had to address its "structural incentives." In rehabilitation, as in other fields, fee-for-service payment penalized medical institutions that returned patients to health. The financing system, Ellwood argued, ought to reward health maintenance; prepayment for comprehensive care would achieve that end. Starr, supra note 7, at 395.

Blue Cross and Blue Shield Plans "straddle the line" between commercial insurers and HMOs. They were prepaid, nonprofit plans, but did not own or operate hospitals or medical practices. While they had contractual relationships with many independent hospitals and physicians, the plans did not normally limit members' choices of health care providers, as did HMOs. See id at 295-310. Starr goes on to note, "American private insurance was 'piggybacked' on preexisting organizations[.]. the voluntary hospitals, the medical profession, and the life insurance industry." See id at 332.

See id at 291-92.
no involvement in the delivery of actual care.\textsuperscript{14} Generally, commercial insurers had a financial arrangement with members but no involvement in the actual delivery of care.\textsuperscript{15}

The insurance arrangement drew criticism in the early 1970s for contributing to escalating health care costs by creating incentives to provide too much and unnecessary care.\textsuperscript{16} "From different directions, the efficiency-oriented and the rights-oriented critics had arrived at many of the same reform proposals."\textsuperscript{17} The result was the passage of the Health Maintenance Organization Act of 1973.\textsuperscript{18} At this time, health policy makers believed HMOs could neutralize incentives for physicians to increase their income by providing unnecessary care.\textsuperscript{19} By limiting payments to physicians and providing regular preventive treatment, which insurers at that time did not cover, HMOs would create incentives to keep patients healthy.\textsuperscript{20} The Act promoted the development of HMOs through start-up grants and marketing advantages that allowed them to compete with health insurers.\textsuperscript{21}

Nevertheless, health care costs continued to rise, making HMOs more attractive to employers.

As employer interest in HMOs grew, so did investor interest. In 1981, only 18 percent of all HMOs were for-profit, and they enrolled only 12 percent of all HMO members.\textsuperscript{22} By 1997, the for-profits

\textsuperscript{14}See id.
\textsuperscript{15}See id.
\textsuperscript{16}The Federal government, private business and individuals all perceived "a crisis of money" in the health care system in the late 1960s and early 1970s, with pronouncements by President Nixon, BUSINESS WEEK and FORTUNE, among others. STARR, supra note 7, at 381-88. "[A] more fundamental explanation [for rising health care costs] lay in the basic incentives in the health care system, especially its financing arrangements..." See id. at 384.
\textsuperscript{17}See id. at 393.
\textsuperscript{18}See id. at 394-98.
\textsuperscript{19}STARR, supra note 7. President Nixon, in a speech specifically addressing the health care cost crisis, announced HMOs as "a new national health strategy" to correct the traditional system, which operated on "illogical incentive[s]" that caused health care providers to profit from sickness rather than from health. STARR, supra note 7, at 395.
\textsuperscript{20}To qualify under the Act, HMOs had to offer treatment for mental health and alcohol and drug abuse, home health services and family planning services, and accept, at least once a year, any enrollee, regardless of the person's health status. See id. at 400-01.
\textsuperscript{21}See id.
\textsuperscript{22}Susan Meltsner, For-profit Or Not: Where's the Best Care?, BUSINESS & HEALTH, July 1998, at 46. See also, STARR, supra note 7, at 439: "Large, multi-unit corporations are also gaining a major position in the organization of HMOs. At the beginning of the 1970s, the
occupied the field, representing 75 percent of all HMOs and 62 percent of all HMO patient enrollment. The investors included many private health insurers that had earlier eschewed the HMO approach of providing direct care. These “traditional” programs had come to be seen as “the most expensive insurance option.” To keep prices down, the insurers followed the lead of the HMOs and sought discounted fees and capitation arrangements from private providers to establish “virtual” HMOs. This arrangement shifted some of the financial risk for delivery of care to the contracting providers.

Although the insurers frequently advertised that “their” providers were of the highest quality, they disclaimed any involvement in the actual delivery of care by identifying hospitals and physicians as independent contractors. Share Health Plan of Illinois, defendant in prepayment plans, except for Kaiser, were locally controlled. None were profit-making companies. By 1980 the majority of HMOs were being drawn into several large networks run by Kaiser, Blue Cross, INA, and Prudential ... Surviving HMOs will increasingly become part of large corporate networks.”

Meltzner, supra note 22.


Under capitated arrangements, health care providers receive a fixed monthly fee for every HMO member they treat, no matter how many or how few medical services are required. See id. HMOs determine the fixed fee from the number and kind of services members are likely to require in the future. But, this budgetary approach also gives physicians a reason to reduce or delay services, because they will receive their monthly payment from the HMO anyway. Trudy Lieberman, Choosing an HMO, CONSUMER REP., Aug. 1996, at 32.

Originally, HMOs employed their own physicians or groups of physicians, who worked only for one HMO and saw only patients who were members of the HMO. Lieberman, supra note 26. The HMOs could also own their own hospitals and clinics. In this sense, the HMO had a physical identity that was clear to its health care providers and to the members who used those providers. See STAPP, supra note 7, at 322. By contrast, newer HMOs consist of independent hospitals and physicians in private practice, who work in their own offices. The hospitals and physicians are tied to the HMO through contractual, not ownership or employment arrangements, and they are likely to contract with a number of HMOs or health insurance companies. See Lieberman, supra note 26. These HMOs have no physical identity, other than their business offices, and work through providers who do not have an exclusive loyalty to any particular HMO.

Lieberman, supra note 26.
Petrovich v. Share, is an example:29 Its member handbook stated it would provide “comprehensive high quality services,” but also demurred: “The SHARE Plan physician is solely responsible for the medical services provided to any Member.”30

Nonetheless, the contractual arrangements placed a third party into what was once a private interaction between patient and provider.31 Where once the frustrations of dealing with health insurance red tape occurred after the delivery of care, now the insurer’s involvement begins before the care can be provided.32 Both a legal conundrum and a marketing dilemma have resulted: While health insurers have followed HMOs in shifting financial risk to providers, and have represented themselves to patients as sources of health care, they have sidestepped most legal risk for that care.

Measuring HMO Performance
The reinvention of the American health care financing system has transformed the physician-patient relationship into a shaky triangle of patient-HMO, HMO-physician and physician-patient arrangements.33 The concept of prepayment, once the hallmark of a handful of not-for-profit medical plans, has displaced much of fee-for-service medicine, to

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30 See id. at *9-*10.
31 Today, however, one might ask whether patient rights are compatible with managed care. After all, much of the impetus for managed care was to counter the rising demand for, and cost of, medical care. Much of the managed care industry’s success in lowering ... costs may be attributed to limiting patient choices and treatments, especially with regard to the length of hospital stays. Indeed, the managed care industry does not speak of the rights of ‘patients.’ Instead, it describes the rights and responsibilities of members or consumers.” Wendy K. Mariner, Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care, 15 J. CONTEMP. HEALTH LAW & POL’Y 1, 1-2 (1998). Mariner goes on to discuss the thinking of Professor George J. Annas, an expert in patient rights who has questioned managed care’s effort to turn the patient into a consumer and thereby lose valuable protections that patients have, but consumers lack. See id. at 3. Mariner notes, “Everyone is, or will be, a patient, whether or not one has health insurance. The rights of patients developed outside the context of commercial markets, independently of health insurance...” See id. at 7.
33 Ironically, this conglomeration of contracts, developed separately, over decades, may leave the patient the least protected of the parties, but that is a topic for another article.
become "the cornerstone of the health care industry octopus of the nineties..."34

[Capitation clearly shifts the incentives physicians have to a more conservative management of patient care...in an environment where clinical decisions must be weighed against questions of appropriate resource utilization.... The capitated physician is rewarded for preventing illness, so in theory, prevention, patient education, and screening should be far more important than in [fee-for-service] settings.35

In the public's perception, the dark side of prevention's admirable goal emerged at least as the potential deprivation of necessary care.72 "Health maintenance organizations have been chided, in the pages of Business & Health and elsewhere, for being too closely identified with cost containment. That emphasis ... causes consumers and lawmakers to doubt the quality and accessibility of medical care in HMOs.37 The perception that HMOs under-serve rather than promote prevention has produced a number of formal and informal measures of HMO performance.38 These measures, which will be discussed below, include:

- Accreditations by the nonprofit HMO accreditation body, the National Committee for Quality Assurance (NCQA)

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34Starr, supra note 7, at 291-92.
35See id at 175.
37Karen Ignani, Don't Choose an HMO Just to Save Money, 13 Bus. & Health 56, 56 (July, 1995).
38Dwight McNeill, What's Happened to Employers' Push for Quality, 17 Bus. & Health 26, 26 (April 1, 1999) (discussing corporations' use of purchasing groups to develop information about health plans, use of national data sets, and activities of independent monitoring groups); Barbara Sande Dimmit, Accreditation, What's the Big Deal, 13 Bus. & Health, December 1995, at 38 (analyzing the increase in requiring private accreditation of managed care organizations and the perceived correlation between accreditation and quality of care); Shelly Reese, What's Behind Those Satisfaction Surveys?, 8 Bus. & Health, August 1, 1997, at 29 (reporting on the shortcomings of using surveys to assess members' satisfaction with their managed care plans).
• "Report cards" prepared by employers and national magazines
• Turnover rates of members

Accreditation

Similar to the Joint Commission of Accreditation for Hospitals, which evaluates most American hospitals, the National Commission for Quality Assurance (NCQA) develops and maintains accreditation standards for HMOs. It uses these standards and site visits to rate HMOs. NCQA's Quality Compass, a national database of accredited HMOs, is available to the public on its website. While accreditation is voluntary, most HMOs in the country seek it and many major employers will not offer HMOs that do not have NCQA accreditation. In addition to accreditation, the NCQA's Health Plan Employer Data and Information Set (HEDIS) has become the "measurement system of choice among managed care plans, many of whom report [the] data to employer clients or use [it] to inform their quality improvement efforts." Many HMO members can also obtain this data through their employers. HEDIS measures and compares HMOs' results in delivering health care, including providing immunizations, screening for serious health conditions, managing chronic conditions like high

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39 The standards, over 60 in all, look at members' access to care, the levels of medical and customer service delivered, how the HMO evaluates its doctors, the preventive health services delivered, delivery of care to sick members and treatment of chronic conditions. The assessment does not include a review of an HMO's pending or settled lawsuits. National Committee for Quality Assurance, An Overview, available at http://www.ncqa.org/pages/main/overview3.htm.

40 See id.

41 See id.

42 See id. Among the companies that require or request an HMO's accreditation before allowing employees to enroll are American Airlines, AT & T, Citibank, Chrysler, Federal Express, Ford, General Electric, IBM, PepsiCo, United Parcel Service and Xerox.

43 See id.

blood pressure and diabetes, assuring use of appropriate medications; satisfying members; and providing health information to members.\textsuperscript{45}

While observers have called HEDIS "a welcome attempt to evaluate the quality of care provided by health plans,"\textsuperscript{46} they have acknowledged:

\begin{quote}
[T]he information's utility is limited. It relies primarily on counting the number of members who receive relatively simple procedures like mammograms and immunizations.... [T]o measure quality in such cases [as diabetes, cancer and other complicated conditions] because of the differences in the standards of practice in different locations...\textsuperscript{47}
\end{quote}

As a result, even Trudy Lieberman, an unpaid member of the NCQA Board of Directors, and author of several \textit{Consumer Reports} articles on assessments of HMOs, has observed that the existing performance data cannot help shoppers find the best HMO in terms of individual physician performance.\textsuperscript{48} "That's because there are no good comparisons...on measures like these."\textsuperscript{49} One reason for this is "there are no exemplary models of health plans or providers who deliver care that is uniformly and consistently of the highest quality," according to the Institute of Medicine.\textsuperscript{50}

\textbf{Report Cards}

During the 1990s, three national magazines, \textit{Consumer Reports}, \textit{Newsweek} and \textit{U.S. News \& World Report}, released reports comparing HMOs' performance.\textsuperscript{51} At least two other groups, J.D. Power and

\textsuperscript{46}Mariner, supra note 31, at 24.
\textsuperscript{47}See id.
\textsuperscript{49}See id.
\textsuperscript{50}See id.
\textsuperscript{51}How Good Is Your Health Plan?, supra note 44, at 40-41; \textit{How Does Your HMO Stack: Up?}, supra note 44, at 28-29; \textit{Rating 43 of America’s Largest HMOs}, supra note 44, at 60;
Associates and Caredata, prepared regional comparisons of HMOs. In addition, employers, either collectively or individually, conducted their own evaluations to determine what HMOs to offer and to assist employees in selecting an HMO. Despite this explosion of ratings, "[h]ealth-care information today is as confusing as product information and labeling were some 30 years ago."

**Member Turnover Rates**

NCQA requires that accredited HMOs track the rate at which HMO members voluntarily leave their plans, as an indicator of consumer dissatisfaction. The number does not include entire groups of members whose employer has cancelled its contract with the HMO, and it does not include members who leave the HMO because they terminated employment with the sponsoring employer. However, there is no way to determine who left for a less expensive HMO.

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How Health Plans Stack Up, supra note 44, at 77; America’s Top HMOs, supra note 44, at 69; America’s Top HMOs, supra note 44, at 81.


53Consumer Satisfaction: Member Satisfaction Rising for POS but Falling for HMOs, Caredata Finds, BNA’s HEALTH CARE DAILY REP., Sept. 1, 1999 (indicating assessment of HMOs in 13 markets).

54The Minnesota Health Data Institute, under legislative mandate, posts its results on the Internet for individuals and employers to use. In California, the California Cooperative Health Care Reporting Initiative conducts surveys for 30 employers and 21 health plans. American Express surveys its 27,000 employees annually about their satisfaction with 130 HMOs nationwide. The California Public Employees Retirement System (CalPERS) also uses its own standardized survey. Shelly Reese, What’s Behind Those Satisfaction Surveys?, BUS. & HEALTH, Aug. 1, 1997, at 29. The Greater Detroit Area Health Council, which represents, among others, the Big Three auto makers, the United Auto Workers and the AFL-CIO, has adopted common measures for evaluating health plan performance for 1.4 million people. Jack A. Meyer and Elliot K. Wicks, Coalitions Keep Quality Alive, BUS. & HEALTH, July 1, 1999, at 30.

55Lieberman, supra note 48, at 23. In an earlier article, Lieberman captured the dilemma with this question: "[I]s a managed-care plan with a mammography rate of 82 percent better overall than one with a mammography rate of 75 percent?" Trudy Lieberman, In Search of Quality Health Care, CONSUMER REP., Oct. 1998, at 38.


57Conversation with Blue Cross Blue Shield of Illinois marketing manager, Chicago, IL (Jan. 4, 2000).

58See id.
While the member turnover rate can indicate potential dissatisfaction, it too has its limitations. First, most people receive their insurance through an employer or union on a “take it or leave it basis.” In a typical retail transaction, dissatisfied customers can “vote with their feet” when they are unhappy with quality and/or service, but to do so with an HMO would require the individual to pay out of pocket for something that is already provided as part of his employment package. The second restriction for HMO members is the restricted choice of health care providers. Going to a physician outside the HMO panel would require the patient to pay out of pocket, unless the HMO approves.

Moreover, managed care members have, at most, limited opportunities to move to another HMO. Not all employers give employees a choice of several HMOs or other kinds of insurance. Furthermore, most employers who sponsor multiple HMOs or other health plans for their employees only allow the employee to change plans once a year. With all these constraints, leaving an HMO hardly represents a direct or immediate expression of dissatisfaction with the HMO or a particular physician.

Is Litigation Another Measure of HMO Performance?
The measures discussed above may indicate the relative performance of HMOs. Some members, however, have turned to the legal system to express their dissatisfaction more directly. HMO members and critics link the effect of the physician-HMO relationship to poor medical

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55Mariner, supra note 31, at 22-23. About 150 million people receive health coverage through group plans, but only ten million are enrolled in managed care plans as individuals. Mariner, supra note 31, at note 71.

59Conversation with Blue Cross Blue Shield of Illinois marketing manager, Chicago, IL (Jan. 4, 2000). See also, Mariner, supra note 31, at 5, pointing out that, ideally, buyers and sellers have equal bargaining power, allowing them to make their buying decisions freely.

60 Managed care plans that have a closed panel of physicians place contractual restraints on the patient’s freedom to consult any licensed physician.” Mariner, supra note 31, at 16.

61 Manos, supra note 9, at 212.

62 See id

63 See id

64 Choosing health-care coverage has become an annual fall ritual for most Americans. Lieberman, supra note 26, at 30.
outcomes, and have sought to hold both accountable. This Comment now considers whether one ultimate assessment of an HMO's performance may be its litigation history. This section looks briefly at the effects of ERISA and theories of liability being applied to HMOs. It then uses the various national report cards to identify highly rated and lower-rated HMOs, and looks at their recent appellate history.

As HMOs have crossed (or at least straddled) the line between health insurance and health care, some members have sought to sue the HMO, along with the physician, for adverse medical outcomes or perceived poor quality care. "[E]xpanding malpractice liability to include managed care organizations has become the rage.... Physicians got squeezed, patients got scared and lawyers got interested." The dilemma of whether, when and how ERISA preempts suits against HMOs has been thoroughly discussed in other law review articles and settled by the U. S. Supreme Court in Pegram v. Herdrich, discussed below.

Plaintiffs' lawyers have sought to circumvent barriers to litigation to address the quality of health care received from HMO provider panels. Suits have used several theories of liability, including vicarious liability/respondeat superior and apparent/implied agency, breach of fiduciary duty, either by the HMO physician or the HMO.

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65. HMO practices are crossing the line and encroaching into the physician-patient relationship [and] a trend is developing where HMOs are viewed as engaged in the practice of medicine." Manos, supra note 9, at 198.

66. See id.


corporate negligence, and breach of contract, in cases involving benefits eligibility disputes, which fall outside the scope of this Comment.

Assuming creative litigators will continue to file suits against HMOs, notwithstanding the U.S. Supreme Court's *Pegram* decision in June 2000, the questions remain: Which HMOs are likely to be sued? For what causes of action, and on what fact patterns? Do higher and lower quality HMOs have different likelihood of being sued? Is there any correlation between the quality of HMO medical care and overall consumer-patient satisfaction with their health plan, or between the frequency and nature of litigation and the level of satisfaction? The remainder of this Comment considers these questions and HMOs' possible responses to the threat of more litigation.

**ANALYSIS**

The HMOs Selected for Study

For this Comment, the author arbitrarily but systematically identified the HMOs rated highest and lowest in at least two of six national magazine ratings published in the late 1990s. The highly rated HMOs included:

Fallon Community Health Plan HMO, Massachusetts (Fallon)
Finger Lakes Blue Choice HMO, New York (Finger Lakes)

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73 *Pegram v. Herdrich*, 120 S.Ct. 2143 (2000), discussed *infra*

74 *Jones v. Chicago HMO Ltd. of Ill.*, 2000 WL 637290 (Ill. May 18, 2000), discussed *infra*.

75 "Patients in managed care systems are more likely to be dissatisfied with their health care than patients who use the traditional fee-for-service system. Accordingly, patients in managed care plans are probably more likely to claim malpractice than patients who have the freedom to choose their doctors." Scott Forchand, *Note & Comment Helping the Medicine Go Down. How a Spoonful of Mediation Can Alleviate the Problem of Medical Malpractice Litigation*, 14 OHIO ST. J. ON DISP. RESOL. 907, 908 (1999), citing a study of more than 10,000 people showing that patients were up to 20 percent more likely to consider their health care "very good" or "excellent" when they chose their physicians, Julie Schmittiel, et. al., *Choice of a Personal Physician and Patient Satisfaction in a Health Maintenance Organization*, 273 JAMA 1596 (1997).

76 See supra, note 51.
Harvard Pilgrim Health Care HMO, Massachusetts, Maine, New Hampshire, Rhode Island (Harvard-Pilgrim)
Kaiser Foundation Health Plan of the Northeast, Connecticut (Kaiser)
Tufts Health Plan HMO, Massachusetts, Maine, New Hampshire, Rhode Island (Tufts)

The lowest ranked plans were:

Aetna US Healthcare, California (Aetna)
CIGNA Healthcare of San Diego, California (CIGNA)
Foundation Health Plan (merged with HealthNet), California (HealthNet)
NYLCare of the Gulf Coast, Texas (NYLCare)
Prudential Healthcare of Northern California (Prudential)

Of note, only one of the top five HMOs, Kaiser, is a for-profit corporation; the rest are not-for-profit. By contrast, all of the five lower-rated HMOs are for-profit subsidiaries of commercial insurance companies. While all HMOs want to operate in the black, for-profit HMOs also have an obligation to perform for their stockholders, "a third party, who is not the payer of the premium, the patient or the doctor." By comparison, non-profit HMOs tend to be older with established track records....By law, they must funnel all 'profits' back into the organization...".

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G. Arnold Relman, quoted in Meltsner, supra note 22, at 46.

See id.
Three of the top five HMOs, Fallon, Tufts, and Harvard-Pilgrim, recently received NCQA's new "excellent" accreditation. NCQA rated all of the others "commendable." This reflects the observation in the most recent US News rankings: "A surprise that emerged ... was the weak relationship between a plan's score and its accreditation status. While it may be logical to assume that plans with full ... accreditation would outperform plans with lower status, it didn't work out that way."

For each of the HMOs listed above, the author ran searches in both LEXIS and Westlaw. There are obvious limitations to this analytic approach, however structured the selection of subjects. HMOs may vary in their litigation and settlement strategies. Consumer litigiousness may vary in different areas. Some HMOs may require that their members follow an internal appeals process or engage in mandatory, binding arbitration requirement, which would limit the number and type of cases that could go to the courts.

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82 NCQA accreditation surveys — which consist of both an on- and off-site component — are conducted by teams of physicians and managed care experts. A national oversight committee of physicians analyzes the team's findings and HEDIS data and then assigns one of five possible accreditation levels (Excellent, Commendable, Accredited, Provisional, or Denied). Only about 10 percent of all plans can earn the top designation. National Committee for Quality Assurance, An Overview, http://www.ncqa.org/pages/main/overview3.htm.


84 The search ran against the all Federal and all state case databases, to identify appellate suits decided between October 1994 and October 1999, roughly the period that NCQA performance standards and accreditations have existed. Searches involving HMOs that merged or changed names included all previous and current corporate names. Suits involving Medicare HMOs, which are subject to federal regulation, were excluded, as were suits that did not involve care of a patient. See National Committee for Quality Assurance, An Overview: NCQA Timeline, at http://www.ncqa.org/pages/main/timeline.htm.

85 Conversations Dec. 1999 with Len Kurfurst, a Chicago malpractice and insurance defense attorney who generously reviewed and critiqued this Comment as if it were an appellate brief.
No Link Between Reputation and Litigation

Three recent Illinois cases point out the lack of correlation between reputation and litigation. Although the causes of action arose in the early 1990s, before widespread NCQA accreditation and the publication of many HMO report cards, they are nevertheless instructive.

Pegram v. Herdrich

In *Pegram v. Herdrich*, the case the U.S. Supreme Court decided in June, 2000, Cynthia Herdrich saw her Health Alliance Medical Plan (HAMP) physician Lori Pegram twice in one week for abdominal pain. Although Pegram identified an inflamed abdominal mass measuring two-and-a-half by four inches, she failed to diagnose it as possible appendicitis. She delayed a diagnostic test for another week and then scheduled it at another HAMP clinic fifty miles away. Before the test, however, Herdrich’s appendix ruptured, exposing her body to a dangerous infection.

Herdrich filed a medical malpractice suit against Pegram and HAMP and won a jury verdict of $35,000 against Pegram in state court. HAMP sought removal to Federal court, citing ERISA preemption. In response, Herdrich amended her suit to claim HAMP had breached its ERISA fiduciary duty. This Comment will discuss the U.S. Supreme Court’s June, 2000 holding further below.

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86 *Pegram*, 120 S.Ct. 2143; *Petrovich*, Docket No. 85726, 1999 Ill. LEXIS 970; *Joncs*, 2000 WL 637290.
88 *Pegram*, 120 S.Ct. at 2147. One author described her as “doubled over from abdominal pain” on the first visit, which was first diagnosed as a urinary tract infection. On the second visit, “a few days later,” the diagnosis changed to ovarian cyst. *See* Savage, *supra* note 87.
90 *Pegram*, 120 S. Ct. at 2147.
91 Savage, *supra* note 87.
92 *Pegram*, 120 S. Ct. at 2147.
93 *See id.*
94 *See id.*
95 *Pegram*, 120 S. Ct. at 2147.
Petrovich v. Share Health Plan of Illinois, Inc.

In Petrovich v. Share Health Plan of Illinois, Inc., plaintiff brought a cause of action against her physician for negligence in failing to diagnose an oral cancer, and against her HMO for malpractice, under a vicarious liability theory. In September 1990, she had complained to her HMO primary care physician of foul mucus in her mouth and persistent pain in her mouth, tongue, throat, and face. He referred her to specialists, but said her HMO would not approve recommended tests. Still in pain seven months later, plaintiff again saw a specialist, who diagnosed cancer in her tongue and larynx.

On appeal, the Supreme Court of Illinois stated "the national trend of courts is to hold HMOs accountable for medical malpractice under a variety of legal theories." The court held "An HMO may be held vicariously liable for the negligence of its independent-contractor physicians under both the doctrines of apparent authority and implied authority."

Jones v. Chicago HMO, Ltd.

In Jones v. Chicago HMO Ltd., the Illinois Supreme Court reinforced its doctrine of HMO responsibility, holding HMOs have a duty to "act as would a 'reasonably careful' HMO under the circumstances." It reasoned, "HMOs undertake an expansive role in arranging for and providing health care services to their members [and] they have corresponding corporate responsibilities as well." Twice on January 18, 1991, Sheila Jones called her HMO physician's office because her three-month-old daughter was "sick, constipated,...crying a lot and felt very warm." The doctor returned her call late in the evening and told her to give the child castor oil. The next day, seeing no improvement,
Jones took the child to a hospital.\textsuperscript{106} The child had bacterial meningitis, which caused her permanent disability.\textsuperscript{107}

Citing the doctrine of institutional negligence established in \textit{Darling v. Charleston Community Memorial Hospital}, the court determined HMOs' multiple roles include being a provider of medical care, which imposed upon them the same duty "to conform to the legal standard of reasonable conduct in light of the apparent risk."\textsuperscript{108}

While HAMP, Share and Chicago HMO were all defendants because of physicians' poor medical care, their similarities end there, since HAMP is now one of NCQA's 40 "excellent" HMOs.\textsuperscript{109} It received among the highest ratings from US News both in 1997 and in 1998.\textsuperscript{110} By contrast, neither Share HMO nor Chicago HMO have NCQA accreditation.\textsuperscript{111} This dichotomy between ratings and litigation continues for the rest of the HMOs studied for this Comment.

\textbf{The HMOs Selected for Study}

As a group, the five highly rated HMOs were party to more appellate cases than the lower-ranked ones.\textsuperscript{112} The number of cases involving

\textsuperscript{106}See id.

\textsuperscript{107}Jones, 191 Ill.2d 278, 282-83.

\textsuperscript{108}See id. at 292-93, citing Darling v. Charleston Community Memorial Hospital, 33 Ill.2d 17 (1965), which applies the "principles of common law negligence to hospitals in a manner that comports with the true scope of their operations".


each HMO varied: one of the best (Harvard-Pilgrim) had as many suits as a low-ranked one. Some HMOs at both ends of the scale had no or only one suit. For example, Harvard-Pilgrim appeared near the top of every Newsweek, U.S. News and Consumer Reports HMO list, and, until recently, had an "excellent" accreditation from NCQA. Notwithstanding, it has five appellate cases on record involving patient care, and one unpublished opinion. Four of the five were decided in favor of the patient. At the other end of the rankings, HealthNet, with low Consumer Reports and Newsweek ratings, had the highest number of appellate cases on record, although eight were unpublished.
opinions. Of the other four, the patient prevailed in three. HealthNet won only a suit challenging denial of autologous bone marrow transplant treatment for breast cancer. All the decisions involving these HMOs were procedural and did not reach the merits of the case.

At first blush, the appellate cases display the same dichotomy seen in Pegram, Petrovich and Jones: HMOs, regardless of their reputations, can end up in court, sometimes several times over. Do HMOs with more litigation share any characteristics, despite their ratings? In a nutshell, the answer is, yes. Compared to its highly rated peers, Harvard-Pilgrim was the only one with a high complaint ratio. Similarly, HealthNet had the highest member turnover in the 1997 US News rankings (24 percent annually compared to 15-17 percent for the top HMOs and 19-31 percent for the low-ranked ones). Furthermore, in measures designed to indicate the quality of medical care received, both Harvard-Pilgrim and HealthNet scored poorly within their peer groups.

118 The unpublished opinions were not included in this study and hence are not listed here.
122 In the 1999 Consumer Reports ratings, nine percent of Harvard-Pilgrim members reported "trouble getting needed care," compared to five percent of Tufts and Finger Lakes members. By contrast, 17 to 23 percent of members in lower-ranked HMOs said they had trouble getting needed care. Ratings and Recommendations: HMOs, CONSUMER REP., Aug. 1999, at 28-29.
124 See supra note 122. In addition, U. S. News reported the percent of members who felt they had access to physicians, with the national average being 84 percent. Harvard had the lowest score among the top-quality HMOs, 74 percent. Other highly ranked plans ranged from 74 to 91 percent. U. S. News reported only 36 percent of members at Foundation (now part of HealthNet) felt they had access to physicians. Other lower-ranking plans scored 88 to 93 percent. State-by-State Rankings, U. S. NEWS & WORLD REP., Oct. 13, 1997, at 69.
In summary, highly rated HMOs, like Harvard-Pilgrim and HAMP, can end up in appellate court as often lower-rated ones. This validates some of the criticism of managed care report cards, but also indicates the importance of comparing data about member dissatisfaction. Finally, the litigation history of all the HMOs considered in this comment also raises the question of whether the HMO accreditation process truly conveys whether quality care is delivered to members, particularly since the NCQA evaluation does not address potential, pending, or completed litigation.

The Future of HMO Members' Discontent

Thus far, this Comment has looked at ways to evaluate health plans and ways members can express dissatisfaction with their plans. It has concluded that, whether a plan has an overall good evaluation or a weaker one, it may still be subject to litigation. "Managed-care companies - like makers of cigarettes, lead paint and guns - are under growing legal attack. This includes at least 16 recent class-action suits ... Several new state laws and measures in Congress could open the industry to still more suits." Reflecting this public sentiment, the American Bar Association called the Pegram case "cost-cutting consequences." Pegram notwithstanding, the ERISA preemption of certain state actions against HMOs has begun to weaken, giving rise to

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125 "[T]he [managed care plan] report cards are woefully incomplete. They grade treatment, not outcomes. Outcomes are what most patients care about; knowing how many breast cancers were caught early and how many women recovered successfully generally matters ... more than how many women received mammograms." Michael M. Weinstein, The Grading May Be Too Easy on Health Plans' Report Cards, N.Y. TIMES, Aug. 19, 1999, at C2.

126 See supra note 39 for a summary of NCQA accreditation criteria. Of the HMOs studied and discussed in this Comment, all were accredited. Even some of highly ranked ones had "commendable" (the rank below "excellent") ratings from NCQA, and all of the lower-ranked HMOs had "commendable" NCQA ratings. The true value of accreditation, from a legal standpoint, may be that it helps establish the standards with which a "reasonable HMO" must comply: "Darling ... firmly established that, in an action for institutional negligence against a hospital, the standard of care applicable to a hospital may be proved via a number of evidentiary sources. ... We likewise conclude that, an action for institutional negligence against an HMO, the standard of care ... may be proved through a number of evidentiary sources...." Jones v. Chicago HMO Ltd., 191 Ill.2d 278, 298 (Ill. 2000).


128 Savage, supra note 87.
"[c]ivil lawsuits from aggrieved patients." The American Health Lawyers Association reports that, between 1980 and 1987, only one suit was filed against a managed care plan based on the care, treatment or decision-making for a plan member. Between 1989 and 1997, between four and 13 cases a year were filed, jumping to at least 20 each in 1998 and 1999.

*Pegram, Petrovich and Jones*, taken together, may indicate what could be in store for HMOs, in terms of litigation. Although the *Pegram* case received widespread scrutiny before and after it was argued, its holding is actually quite narrow. On behalf of a unanimous Court, Justice Souter asked "whether treatment decisions made by [an HMO], acting through its physician employees, are fiduciary acts within the meaning of [ERISA]." The Court held these decisions are not fiduciary acts under ERISA, meaning that patients cannot sue their HMOs for poor medical outcomes under the ERISA fiduciary duty provision.

Reasoning that an HMO physician’s decision to treat or not to treat was “inextricably mixed” with eligibility decisions involving a member’s coverage for particular plan benefits, Justice Souter wrote: “we think Congress did not intend...[an] HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.” Alone, this observation comes as good news to HMOs seeking to avoid a new theory of liability (breach of ERISA fiduciary duty) under the Federal law that had previously shielded them


131See id.


134See id.

135See id. at 2154.

136See id. at 2155.
from most members' causes of actions. The Court has plainly stated that ERISA's fiduciary duty requirement does not attach to an HMO, with regard to treatment decisions its doctors make.

As written, however, the decision leaves open two important points relevant to prospective plaintiffs and worrisome for HMOs. First, the decision frequently and specifically refers to "physician employees" of HMOs. It makes no reference to whether the Court intends the decision to apply to HMOs using contracted groups of independent physicians, rather than paid physician employees, to deliver services. Moreover, while the decision specifically declines to allow malpractice causes of action to enter into federal courts, the Court references, but does not proscribe, state-based malpractice claims against HMOs:

It is true that in States that do not allow malpractice actions against HMOs the fiduciary claim would offer a plaintiff a further defendant to be sued for direct liability, and in some cases the HMO might have a deeper pocket than the physician. But we have seen enough to know that ERISA was not enacted out of concern that physicians were too poor to be sued, or in order to federalize malpractice litigation in the name of fiduciary duty for any other reason.

137Johnson, supra note 129, at 1.
138Pegram, 120 S. Ct. at 2147.
139See "acting through its physician employees," id. at 2147; "all HMOs acting through their owner or employee physicians," id. at 2150; "the physician employee would also be subject to liability," id. at 2158.
140HAMP was a closed panel or "staff model" HMO, which actually employs the physicians who treat HMO members. "However, the majority of medical care is rendered by physicians who are not directly employed by the [HMO], but who are on a list of affiliated... independent practicing physicians." David L. Trueman, Managed Care Liability Today: Laws, Cases, Theories, and Current Issues, 33 J HEALTH L. 191, 194 (Spring 2000).
141"What would be the value to the plan participant of having this kind of ERISA fiduciary action? It would simply apply the law already available in state courts and federal diversity actions today, and the formulaic addition of an allegation of financial incentive would do nothing but bring the same claim into a federal court under federal-question jurisdiction." Pegram, 120 S. Ct. at 2158.
142See id.
The Court’s failure to speak against state-based malpractice suits against HMOs, combined with the holdings of the Supreme Court of Illinois in Petrovich and Jones, indicates that HMOs could be subject to more state-based litigation relating to patient care. The American Health Lawyers Association’s survey of suits against HMOs (AHLA survey) shows that actions against HMOs increased in the late 1990s.143

**Protecting Against Litigation**

Using the cases discussed above and the author’s past experience in the managed care industry, the rest of this Comment predicts possible actions HMOs may take as protection against the changing legal landscape.144

The most common cause of action against HMOs, according to the AHLA survey, was vicarious liability.145 Monitoring physician performance and preventing poor medical care pose the greatest difficulty for HMOs, for several reasons. First, Pegram and the Harvard-Pilgrim cases show even respected HMOs that employ full-time physicians cannot prevent bad outcomes.146 Similarly, the Harvard-Pilgrim cases demonstrate that monitoring performance of individual employee physicians is difficult.147 Second, open-panel HMOs that contract with physicians in private practice have even less involvement

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143 Zaremski, *supra* note 130.

144 For 25 years before enrolling in law school, the author held various management positions in several large health insurance and managed care companies, and was primarily involved in developing the managed care programs these companies offered to employer groups.


146 Dr. Pegram was part of the Carle Clinic, which also functioned as a for-profit HMO. Pegram, 120 S.Ct. at 2147. Harvard-Pilgrim is also a staff-model HMO. *See* Nascimento v. Harvard Community Health Plan, 1997 Mass. Super. LEXIS 166 at *1 (Mass. Super. 1997).

147 *See supra*, note 117. The four cases involved a newborn who developed brain damage after contracting meningitis; a failure to timely find and treat breast cancer; a wrongful death arising out of negligent treatment; and negligent use of an experimental prenatal treatment that caused the newborn’s death. All of the cases won on procedural grounds, but did not go to trial on the merits, indicating that out-of-court settlements likely occurred.
in the actual delivery of care.\textsuperscript{143} These HMOs use a variety of financial techniques to shift risk to and create incentives for the physicians who make treatment decisions.\textsuperscript{149} Among these are paying a blanket fee per patient (called capitation), to cover any services that may be needed, withholding a portion of fees paid to use as a future incentives, and simply obtaining discounted fees from the doctors.\textsuperscript{142} The intent behind these arrangements is to encourage the private physician to serve as a gatekeeper for the HMO, with a resulting economic reward or risk.\textsuperscript{151} As Justice Souter noted in \textit{Pegram}, "in an HMO system, a physician's financial interest lies in providing less care, not more."\textsuperscript{152}

Some actions HMOs may take to limit potential malpractice causes of action are conducting more aggressive performance monitoring of individual physicians; providing members with more information about physician performance; strengthening disclaimers printed in provider directories; requiring more disclosure by physicians about potential and pending malpractice suits; and changing their marketing and operational strategies. Each of these is discussed below.

\textbf{Performance Monitoring}

To date, much of the monitoring of physician performance, as established by NCQA, involves delivery of preventive services and treatment of certain chronic and cancer-related conditions.\textsuperscript{153} Faced with more potential exposure for malpractice, HMOs may seek to target physicians whose patients file the most complaints. They may provide "quality of care hotline" numbers, so members can report quality of care issues or withholding of services.\textsuperscript{154} More performance profiling

\textsuperscript{149}See Shuren, \textit{supra} note 148, at n.57. Share Health Plan of Illinois, the HMO in the \textit{Petrovich} suit, was this type of HMO: "Share...arranges and pays for health care by contracting with independent medical groups and practitioners." \textit{Petrovich}, 1999 Ill. LEXIS 970, at *5.
\textsuperscript{151}See \textit{id.} See also, Trueman, \textit{supra} note 138.
\textsuperscript{152}Pegram v. Herdrich, 120 S. Ct. at 2148.
\textsuperscript{154}Conversation with Blue Cross Blue Shield of Illinois marketing manager, Chicago, IL (Jan. 4, 2000).
and hotlines for members are likely to meet with physician resistance, but could help HMOs intervene before litigation emerges, as well as improve their public image.

**Information**

HMO provider directories generally give location and specialty information, but little more. By providing additional background about physicians (such as number of complaints filed and the frequency with which members leave one physician for another) HMOs could help members to identify providers with the most satisfied patients, and avoid physicians whose performance generates complaints. Fewer members using physicians who are the subject of frequent complaints could reduce the likelihood of suits involving the HMO on a vicarious liability, duty of care or institutional negligence theory.

**Disclaimers**

Some HMOs' literature already includes disclaimers that the providers are independent practitioners, in an attempt to insulate the HMO from liability for the providers' actions. One can assume that, as formal contracts, HMO-provider contracts are likely to include indemnification language. Nevertheless, HMOs' attorneys may attempt

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155 The need to improve the perception held both patients and physicians that HMOs interfere with treatment decisions and physician performance was underscored when United HealthCare, a major national HMO, announced it would discontinue certain forms of review of physician decisions. One paper summed it up as, "United HealthGroup's decision to tell health-plan administrator to but out and let doctors prescribe patient treatment on their own is elating physicians tired of being second-guessed." Bruce Japsen, Doctor Power No Cure-All, Chi. TRIB. Nov. 10, 1999, at 3-1.

156 Conversation with Blue Cross and Blue Shield of Illinois marketing manager, Chicago, IL (Jan. 4, 2000).

157 See id.

158 Trueman, supra note 140. Astonishingly, the National Practitioner Data Bank, which hospitals and health plans may use to screen physicians, is not open to the public. See David Greising, It's Time to Doctor MD Data Bank for Public Access, Chi. TRIB., Nov. 14, 1999, at 5-1. See also, Jeffrey A. Lovitky, The National Practitioner Data Bank: Coping with the Uncertainties, 33 J. HEALTH L. 355, 357 (Spring 2000).
to draft stronger, clearer language for both documents, and make disclaimers clearer in sales literature.

Disclosure

NCQA-accredited HMOs are required to obtain information about their physicians' malpractice history when the physician joins the HMO and periodically thereafter. Between these points in time, however, much patient care is delivered. HMOs may wish to consider requiring their physicians to notify them, on a confidential basis, of adverse events involving HMO members.

Changed Marketing and Operational Strategies

HMOs frequently assure their members they will receive quality medical care. One HMO physician directory, which was published before the Petrovich decision, included "We are committed to delivering quality, choice and value in an affordable health care plan," and "We routinely measure our plan's performance to continually enhance clinical quality." These statements help position the HMO as a provider of care instead of simply a payer for care and give support to a plaintiff's apparent agency, vicarious liability or institutional negligence cause of action. One major Illinois HMO has already

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161 "The [Share] handbook states to its members that Share will provide 'all your healthcare needs' and 'comprehensive high quality services.'" Petrovich, 1999 Ill. LEXIS 970 at *7. Sheila Jones testified, "[Chicago HMO] told me he was a good doctor..." Jones v. Chicago HMO Ltd., 191 Ill.2d 278, 285 (Ill. 2000).


163 The Petrovich and Jones courts concluded exactly this: "Share held itself out as the provider of health care without informing plaintiff that the care was given by independent contractors." Petrovich, 1999 Ill. LEXIS 970, at *25. "Because HMOs undertake an expansive role in arranging for and providing health care services to their members, they have corresponding corporate responsibilities as well." Jones, 191 Ill.2d 278, at 293. The Petrovich court also noted, "the national trend of courts is to hold HMOs liable for medical malpractice
stopped making marketing statements about the quality of care members may receive from its contracting providers. As additional protection, HMOs may assign members of their general counsel’s legal staff to sit on internal quality and utilization monitoring committees.

To date, HMOs have invested time, staff and financial resources into monitoring the quality and quantity of preventive and primary care services, in part because this was their original mission and in part because external performance requirements have emphasized these areas. But, as the suits in this Comment show, the practice of preventive medicine is not what gives rise to litigation. Pegram, Petrovich and Jones, and the Harvard-Pilgrim and HealthNet cases, all involved patients who presented their physicians more than once, with specific, obvious symptoms which were later misdiagnosed or mistreated. HMOs may shift their focus from assuring consistent delivery of routine, primary care to closer monitoring of the delivery of acute care, with an eye toward determining what situations are most likely to result in legal action.

This author suggests one way for HMOs to accomplish this is by establishing a clearinghouse of suits filed against them at the trial court level, to help identify where members perceive that delivery of care has broken down. As research for this Comment demonstrates, it is not possible to find patterns of litigation for a particular HMO. Therefore, such a clearinghouse should exist at a national level, perhaps sponsored by the American Association of Health Lawyers, the American Association of Health Plans and/or the Blue Cross Blue Shield Association. Only by looking at the facts of all litigation filed against under a variety of legal theories, including vicarious liability...direct corporate negligence, breach of contract and breach of warranty." Petrovich, 1999 Ill. LEXIS 970, at *14.

"Conversation with Blue Cross Blue Shield of Illinois marketing manager, Chicago, IL (Jan. 4, 2000).


"See discussion supra, notes 112-119.

all HMOs will any meaningful patterns emerge to inform efforts to protect against liability. Similarly, complaints filed against HMOs with State Departments of Insurance could help identify similar patterns, as could the appeals required by patient rights legislation. Moreover, these tracking efforts could yield better indicators of HMO quality than any public report card that exists today.

CONCLUSION

This Comment has shown that HMOs have attempted simultaneously to manage care, reduce the cost of care, and promise their members "quality" care, without assuming related legal risks and responsibilities. Despite monitoring and reporting activities, and numerous independent rating and evaluation methods, HMO medical care has resulted in litigation. This, together with continuing public dissatisfaction and new case law, is likely to cause HMOs to look more carefully at how to reduce their legal risks and produce a more positive public image.

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