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INDEMNIFICATION AND MCOs

PHYSICIANS SEEKING INDEMNIFICATION FROM MANAGED CARE ORGANIZATIONS: TRANSFORMING EQUITIES AND REMEDIES

Lois Wolf Schwartz* and Jeffrey Cambra**
with Lawrence I. Schwartz, M.D.***

I. INTRODUCTION

This article explores new legal relationships between physicians and managed care organizations (MCOs) and the impact of these changes on allocation of liability in malpractice actions. The physician and the MCO are increasingly at odds in determining the type and extent of medical services patient subscribers may receive. Traditionally, the physician bore most, if not all, of the responsibility for such decisions when they resulted in malpractice actions; MCOs were thought to be immune since as corporations they were not practitioners of medicine. As liability theories have adjusted and responded to structural changes in health care delivery systems, physicians are still on the front line in malpractice awards. However, recent statutory and case law clearly establishes that MCOs can no longer evade liability entirely. As the equities change, physicians have new opportunities to obtain indemnification if necessary. Physicians seeking such relief from MCOs need to adapt for their own purposes much of the legal theory generally associated with plaintiff claims.

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II. THE DEVELOPMENT OF NEW LEGAL RELATIONSHIPS BETWEEN MANAGED CARE AND PHYSICIANS

A. The Emergence of Managed Health Care

Approximately fifty-six million Americans rely on managed care organizations (MCOs) for their health care. Health maintenance organizations (HMOs), the most common type of MCO, are said to be enrolling 14,000 Americans per day.\(^1\) Managed care organizations have existed in the United States since the 1930s, but they burst into dramatic growth in the 1970s in response to the passage of the federal Health Maintenance Organization Act of 1973,\(^2\) which provided for government funding, development, and regulation of HMOs certified under the Act. This statute supplied managed care organizations with two essential missing elements: credibility and financial support. At the same time, traditional health care insurance costs began to skyrocket. Managed care organizations, which are intended to organize and manage physicians, hospitals, and health care services in a cost-effective manner and are thus able to provide comparatively low-cost medical services to a broad base of patient subscribers, have been credited with taming inflation in the expensive American health care system.\(^3\)

Managed health care is usually provided by a health maintenance organization. An HMO is defined as a "legal entity through which physicians and other health care professionals agree to deliver comprehensive health care services to a defined voluntarily enrolled membership for a fixed fee paid in advance of the [date] such services [are rendered]."\(^4\) This arrangement is distinguished from the traditional fee-for-service model, in which patients or health care insurance providers pay the health care provider directly for services received based on each specific service rendered.

As a rule, managed care organizations such as HMOs use four general models to structure their organizations: staff, group, network, or individual practice association.

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1 Steve Sakson, HMO Backlash Brings Waves of Legislation, CONTRA COSTA TIMES, March 16, 1996, at 1C. It should be noted that for purposes of this article, the terms HMO (health maintenance organization) and MCO (managed care organization) are often used interchangeably. In fact, an HMO is only one type of MCO.


(IPA). Some MCOs combine these arrangements. In the staff model, the MCO directly employs physicians and other providers to work in a facility owned by the MCO. The network model allows the MCO to contract with more than one physician group for services. In the IPA model, the MCO contracts to deliver care in the physician's office for prenegotiated fees.

In the group model, a health care plan contracts with a physician group or a number of groups. The physicians pool their income and share common facilities, support staff, and medical records. They often use facilities owned or operated by the MCO. The physicians are independent contractors of the MCO, but the MCO still pays the physicians' group a set fee for services rendered to subscribers. The group pays its members on a fee-for-service basis, a capitated basis (that is, a fixed dollar amount per patient per month, regardless of services provided, if any), or some combination of the two. The group is expected to provide exclusive or near-exclusive services to the MCO.

The traditional theories under which patients directly sued physicians for malpractice must now be modified to account for numerous players in the field: the MCO, the physician group, the individual physicians, and the patient herself. For example, Kaiser physicians are all employees of the Permanente Medical Group and a vast number are even shareholders. The Permanente Medical Group provides services only to Kaiser and Kaiser generally receives medical services only from the Permanente Medical Group. Thus, the physicians are in a formal employment relationship with the provider group and the provider group is in a formal contractual relationship with the MCO. This ambiguity has serious ramifications when plaintiffs attempt to identify co-defendants, when courts attempt to allocate liability, and when claims, defenses and cross-claims are predicated on theories of vicarious liability.

As this article indicates, courts have elected to define the legal relationship between the physicians and the MCO functionally rather than formally. Group-plan physicians who act in a manner that is generally characteristic of employees, including modification of their services to comply with MCO policies, may be perceived as agents rather than independent contractors. In addition, the role of the group

5 Jan Lewis, HMO Liability for Negligent Patient Care, 26 TRIAL 73, 73 (September 1990).
6 Id.
7 Groups are often multi-specialty in character. They may also include professionals other than physicians, such as dentists, osteopaths, or other health care providers. For purposes of consistency, the authors refer to physician groups rather than provider groups.
8 Bearden & Maedgen, supra note 3, at 6.
9 Id.
providing the physicians is a new factor. For example, the MCO likely pays fixed fees to the group rather than the physicians. The group thus has an incentive to encourage its member physicians to provide health care in a cost-conscious fashion, with the result that the group's profits are enhanced. If this practice causes harm to the patient, it may be appropriate to name the group as a co-defendant.

Finally, the relationship between physicians and subscriber patients must be reconsidered. If the patient "looks to the institution" for care and has limited choice in the selection of an individual physician, if the patient perceives that the physician is an employee of the MCO, or if the MCO "holds out" in its marketing literature or other materials that the physician is its employee, courts are increasingly willing to allow claims based on the theory of ostensible agency or agency by estoppel. If an MCO uses a true staff model, it can be held vicariously liable as an employer for malpractice committed by its employee physicians (and other practitioners). On the other hand, if the MCO adopts the group, network, or IPA model, it has greater opportunity to insulate itself from liability for malpractice; the MCO can claim that the physician acted as an independent contractor and thus assumes full responsibility for her own actions. The courts have been willing to look beyond this legal camouflage, however, and to impute agency in situations where it is technically nonexistent. The California Legislature has also stepped in to address this situation. As will be discussed below, lawmakers are increasingly willing to allocate direct liability to MCOs in situations where cost-containment or other nonmedical factors affect the standard of care.

B. The New Relationship between Physician and Managed Care Organizations

In the past, physicians enjoyed great autonomy in practicing medicine. Most practitioners were self-employed. They could depend on unquestioning reimbursement from the patient's health care insurer (which could be either private or government) for services provided. In a June 15, 1987 article in the Chicago Tribune entitled *System Puts Doctors, Cost Cutters at Odds*, journalist Michael L. Millenson


11 California Health and Safety Code § 1371.25 (West Supp. 1996) states that hold-harmless clauses are now unenforceable in this state. This means that health plans cannot shift their liability to physicians by including hold-harmless clauses in their employment contracts. All contracting parties are responsible for their own acts or omissions. Thus, an HMO can no longer evade liability under a hold-harmless clause and can be implicated under "doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability." See Medical Insurance Exchange of California [MIEC] Claims Alert, April 1996, at 2.
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states: "The practicing physician could count on an extraordinary degree of freedom to practice medicine however he [sic] wished and to bill whatever he chose."\textsuperscript{12} The largely unmonitored fee-for-service arrangement was perceived to encourage overutilization.\textsuperscript{13} Overutilization might include extra appointments, unnecessary procedures, expensive treatments, and overlong hospital stays. This in turn resulted in increasing costs of health coverage. Employers providing employee benefit packages that included health care and individuals who were required to obtain their own health insurance complained that the expenses were out of control. Even an article in the conservative Journal of the American Medical Association in 1990 acknowledged the skyrocketing cost of medical care.\textsuperscript{14}

As managed care organizations such as HMOs grew in popularity, they presented an attractive alternative to both subscribers and physicians. Subscribers benefitted financially from the fact that the managed care organization held costs down by monitoring utilization of medical resources.\textsuperscript{15} Under the staff model, physicians were attracted by promises of shorter hours, a guaranteed income, and relief from the business concerns of starting or running a medical practice.\textsuperscript{16} In exchange for these benefits, the physician working with an MCO must accept the MCO's heightened oversight and restrictions: "[f]or example, physicians might be barred from using an institution's facilities for a disapproved medical procedure, or payment might be conditioned on compliance with treatment protocols. Other rules might include policies and procedures governing referrals, payments, submission of claims, and resolution of grievances."\textsuperscript{17}

\textsuperscript{12} Cited in Helene L. Parise, comment, \textit{The Proper Extension of Tort Liability Principles in the Managed Care Industry}, 64 \textsc{Temple L. Rev.} 977, 985 (1991).

\textsuperscript{13} \textit{Id.} at 984.

\textsuperscript{14} \textit{Id.} at 977, citing David M. Eddy, \textit{What Do We Do About Costs?}, 264 \textit{JAMA} 1161, 1161 (1990).

\textsuperscript{15} This has been characterized alternatively in the literature as regulation of services or rationing of services, depending on one's point of view. \textit{See} Parise, \textit{supra} note 12, at 980.

\textsuperscript{16} Alternatively, under the group or IPA model, physicians were attracted by the potentially steady flow of patients and the resulting income. IPA physicians generally continue to run their own offices and to treat patients outside the subscriber pool of the MCO with which they are affiliated.

\textsuperscript{17} Parise, \textit{supra} note 12, at 986-987.
C. Cost Containment as a Means of MCO Control over Physicians

The MCO exercises a good deal of direct and indirect control over medical services by setting policies for health care delivery that emphasize cost containment. There are two broad categories of such cost-containment measures:

First, administrative factors are designed to contain costs, including benefit package design, underwriting, eligibility determination, provider selection, health care delivery methods, and controls on quality of care. Second, direct cost-containment measures are employed, such as reducing frequency of medical services and claims, reducing expenditures for services rendered, and changing the point of service to less expensive locations or procedures.\(^{18}\)

The physician is necessarily influenced by the MCO's policies in providing services to patients. This affects the functional and legal relationship between physician and MCO:

Cost-containment measures can and do create conflicts between doctors and patients. . . . Treating physicians working with managed care organizations are almost always placed in the middle of this conflict. On the one hand, they are obligated to provide acceptable medical care to patients. On the other hand, if they do too many tests, spend too much money, or order too long a hospitalization, they may not get paid as much by the HMO. . . . In some cases, physicians may even be penalized. Physicians are, therefore, essentially forced to choose between potential medical malpractice lawsuits if they provide too little care, or risk not getting paid for their services if they choose to provide too much care, in the opinion of the HMO . . . \(^{19}\)

This conflict presents pressing ethical issues as well as legal issues. One author suggests that "physicians should be encouraged to act as agents of individuals and to consider their [patients'] welfare above anything else. The use of financial incentive arrangements to pressure physicians into keeping costs at a minimum will undoubtedly present conflicts of interest between patients, physicians, and payers."\(^{20}\) In fact,


\(^{19}\) Salmon, *supra* note 18, at 81.

\(^{20}\) Parise, *supra* note 12, at 989.
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Concern over financial incentive arrangements is so great that the Stark Amendment, ultimately enacted in 1991, now prohibits HMOs from "knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided" to any Medicare or Medi-Cal beneficiary. As we shall see below, courts are no longer reluctant to factor cost-containment measures into the allocation of liability between a co-defendant's physician and managed care organization.

D. The Effect of MCO Involvement on the Standard of Medical Care

Assumptions about quality in health care and its defense are rooted in the past, a past in which the doctor ruled. Strangely, these assumptions have survived the revolutions that now deny the doctor the sole authority to judge and guide care. The doctor no longer really controls health care, as in the days of solo practice, but, when it comes to quality, the doctor is still held accountable.

When the payers and the regulators turn on their searchlights, they want doctors in their glare. Control is shifting, structure is shifting, the pattern of care is shifting; but accountability is not.

The physician working for an MCO surrenders some measure of control over her autonomous judgment, since she is acting within a system that offers incentives for perceived underutilization and punishments for overuse of medical resources, particularly under the capitation system, where "the physicians share the profits if fewer services than expected are provided and share the losses if the costs of providing the needed services are greater than expected." At the same time, case law has made clear that MCO affiliation does not absolve the physician of legal responsibility for the effects of her conduct. The physician is presumed to be the


22 William M. Sage et al., Enterprise Liability for Medical Malpractice and Health Care Quality Improvement, 20 AM. J.L. & MEDICINE, 1, 1 (1994) (quoting Donald M. Berwick et al., Curing Health Care: New Strategies for Quality Improvement 12 (1990)). Sage and his co-authors offer the radical suggestion that MCOs should be solely liable for negligent injury to enrollees caused by the health plan's affiliated practitioners and providers and that physicians practicing as employees or under contract to the MCO should be immune from suit.


24 See, e.g., Wickline v. State of California, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986), rev. dismissed, 741 P.2d 613, 239 Cal. Rptr. 810 (1987), and progeny, discussed more fully below. The Wickline court made clear that a physician has a legal obligation to actively object to an HMO policy when he believes that it will result in a level of patient services that fall below the standard of care.
gatekeeper, the person in the best position to assess the patient's needs and to determine proper care.  

Courts face a dilemma in dealing fairly with malpractice claims when an MCO doctor is sued:

Commentators have proposed that courts should allow MCO physicians to be judged by a different standard of care than fee-for-service physicians, in recognition of the different approach to care that MCOs have adopted to control costs.

However, the scholars advancing this position go on to state that existing doctrines for determining adherence to the standard of care should be sufficient to apply to all. They claim that "[t]ort doctrine such as the 'best judgment rule,' the 'respectable minority' doctrine, and the reliance on medical experts to establish the standard of care, may well be sufficient to accommodate the more conservative, cost-effective style."  

As courts and legislative bodies acknowledge cost-containment measures as inevitable factors in health care delivery, the standard of medical care will change accordingly. Advances in medicine already encourage this trend. For example, surgery to remove a gall bladder used to require a five- to seven-day hospitalization. With the advent of laparoscopic surgical techniques, the procedure can now be done on an out-patient basis. An MCO is likely to encourage the less expensive laparoscopic surgery. Thus, the standard of care shifts from five to seven days of hospitalization to zero days of hospitalization. Interestingly, there can also be a backlash effect; recently, hospitals have begun to keep women for a longer stay after childbirth, because the costs of health care for infants and mothers discharged too early began to be financially significant.

MCOs have certainly been characterized in the popular press as greedy opportunists who force physicians to fall below the standard of acceptable medical care in order to enhance profitability. The January 1996 issue of Time Magazine

25 Linda O. Prager, Gatekeepers on Trial: Primary Care Liability Risks are Rising with Growth of Managed Care, AMERICAN MEDICAL NEWS, Feb. 12, 1996, at 1, 71.


27 Id. at 482.

28 MCOs use a variety of techniques as incentives for holding costs down, such as per diem payments to hospitals or capitation arrangements with medical groups or physicians. A capitation program provides for a fixed monthly payment from the MCO to the physician or physician group for each subscriber who selects the physician as his or her primary care physician (sometimes referred to as the "gatekeeper"). Physicians absorb all costs of that subscriber's medical care needs. Costs are paid from the pool of funds maintained by the
contains a chilling article describing the struggle of Christy Demeurers, a Health Net subscriber, who sought adequate treatment from the HMO for her cancer. The article interweaves Christy's story with an expose of Health Net's corporate wheelings and dealings as it amasses staggering profits by means of buy-outs and takeovers.

In some cases, the popular press has blamed HMOs for events that were beyond their direct control. For example, an article entitled *Death by HMO: One Woman's Horror Story*, details the story of Karin Smith, who died at 29 after her cervical cancer went undetected by a medical lab. The article implies that the HMO was at fault, but does not clarify the nature of the HMO's involvement or the extent to which it monitored laboratory practices and procedures.

**E. The Effect of the Capitation System**

Capitation is a payment system in which the physician or the provider group is paid a fixed periodic amount per patient in exchange for providing or arranging for health care services for certain assigned MCO enrollees. The amount of compensation is based on statistical expectations of services utilization for the patient population in question, rather than on actual services rendered. The Health Maintenance Organization Act of 1973 specifically allows HMOs to make arrangements with physicians or other health professionals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health care services by the physicians or other health professionals. This is often achieved by a capitation system, which shifts the burden of the cost of medical care from the MCO to the group and/or the physician. The MCO thus places the physician in the precarious position of having to make decisions regarding the patient's health care that

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physician. This practice of risk sharing can be implemented in a number of different ways but it shifts the cost of health care from the MCO to the physician. As such, the MCO's profit is not entirely dependent on the subscriber's actual health care costs.


31 For example, if the MCO contracts with an outside laboratory that produces inaccurate test results, the extent of HMO liability may be determined by the terms of the contract with the lab or the extent to which the MCO is required to conduct quality control reviews. Of course, if the MCO owns the lab, its liability is clear. But if the laboratory is a completely independent entity, any doctor who uses the lab would be misled by the same erroneous test results, whether associated with an MCO or not.

32 Hitchner et al., *supra* note 23, at 304, n. 16. This article provides a comprehensive and detailed description of various models of MCOs.

will directly affect the physician's financial well-being. Public policy would seem to
disfavor a system that provides incentives for limiting health care. Yet, this seems to
be the direction in which we are moving. The physician must always emphasize the
conflict created by capitation in any claim for indemnification against the MCO.

F. The Role of Managed Care in Malpractice Litigation

During the past twenty years, as managed health care has flourished, a plethora
of cases and federal and state legislation has attempted to effect, anticipate, or simply
keep up with these institutional changes. As the professional and legal relationships
among patients, physicians, and managed care organizations change dramatically,
medical malpractice litigation is in a constant state of flux. Much has been written
about the potential benefit to the plaintiff of including the managed care organization
as well as the physician as a co-defendant in a claim for medical malpractice; virtually
all of the material cited in this article is written from that point of view. It is
interesting to note that managed care has existed in this country for over half a
century, but malpractice claims against MCOs were only considered in 1975, and that
discussion took place in the scholarly literature rather than in a court action. Judicial
reluctance to allow an MCO as a co-defendant in a malpractice action appears to have
changed with the passage of the federal Health Maintenance Organization Act of
1973, discussed above. The Act is perceived to have endorsed the role of HMOs in
the delivery of health care, to have encouraged the proliferation of HMOs by
providing funding and, correspondingly, to have increased the potential for
malpractice litigation against managed care organizations.

Less has been written that directly addresses the legal relationship between co-
defendants physician and MCO once an award has been granted to the plaintiff
patient, either by judgment or by settlement. What happens when the medical

34 This trend continues. In 1996, in California alone, more than eighty bills addressing the managed health care
industry were under consideration in the Legislature. See Sakson, supra note 1, at C1.

William Curran and George Moseley, The Malpractice Experience of Health Maintenance Organizations, 70
Nw. U. L. Rev. 69 (1975). Managed care organizations initially were thought to be immune from suit because
of the traditional prohibition against a corporation practicing medicine. See generally, Bearden & Maedgen,
supra note 3, for a discussion of the abandonment of this principle.

36 Shah-Mirany, supra note 35, at 358, n. 2.

37 An interesting law review article deals with the converse issue of HMO recovery from the physician's
malpractice carrier. See Michael Roth et al., Financial Health of Health Care Providers: Do Third Party
Payers Pay?, 15 Whittier L. Rev. 125 (1994). Such subrogation is based on the theory that the physician's
negligence causes the HMO to incur expenses for services it would not have provided absent the negligence.
malpractice insurance carrier has paid the award and attempts to seek indemnification from the MCO? The legal literature has largely ignored the rights of these co-defendants against each other. This is particularly surprising in an area where judgments and settlements are high and a great deal stands to be gained by re-allocating the costs of such awards.

Often, medical malpractice insurance carriers representing physicians are on the front line as far as malpractice awards are concerned. Until recently, physicians working for MCOs have borne the brunt of malpractice settlements and judgments.\(^{38}\) MCOs originally attempted to defend against claims by invoking the characterization favored by hospitals, in which the health care institution was protected from liability because it was “a passive facility where independent practitioners attempt to meet the medical needs of their patients.”\(^{39}\) As discussed in greater detail below, recent judicial opinions have tended to acknowledge the level of involvement of MCOs in health care decisions. Nevertheless, the law is clear that physicians are still expected to exercise independent judgment that complies with the acceptable standard of medical care, regardless of whether the MCO has authorized treatment or not.\(^{40}\)

The physician's hybrid status as ostensible employee/independent contractor lays the foundation for the conflict between physician and MCO co-defendants in a claim for indemnification. The physician seeks to have the court allocate a fair share of

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The author quotes an MCO officer, who states with unapologetic candor that “careful handling of these kinds of claims can add two to three percent to the bottom line of the HMO. This is found money.” Id. at 125.

38 See Sage et al, supra note 22, at 3. The authors, who advocate full liability for HMOs and immunity for physicians, describe both the public and judicial perception of accountability for health care services. They speculate that “[w]e all feel a certain ambivalence about placing health care within an industrial model because of the personal and humanitarian appeal engendered by illness and because of the intimacy with which we view those who care for us.” Id. at 4. The authors go on to state that “[m]any observers believe that the roles of management and provision of health care services can never merge. . . . Those who view management and service provision to be as unmixable as oil and water cannot imagine that removing liability from 'front-line' clinicians to 'bean counters' could possibly improve care.” Id. at 5.

39 William J. Curran and George B. Moseley, III, The Malpractice Experience of Health Maintenance Organizations, 70 Nw. U. L. Rev. 69, 73 (1975). Writing more than twenty years ago, the authors contend, “...the law of medical malpractice for HMOs is virtually nonexistent. Consequently, HMO liability must be analyzed by analogy, most profitably to the legal status of hospitals.” Id. at 71. The authors also point out that as early as 1966, the U.S. Supreme Court declined to upset the decision in Darling v. Charleston Community Memorial Hospital, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), cert. denied 383 U.S. 946 (1966). The authors suggest that the U.S. Supreme Court “chose to recognize that the hospital now has become the focus of the total health care delivery procedure, with the attending physician just one of many factors or resources determining the quality or effectiveness of the procedure, over which the hospital has or should have primary control.” The authors also suggest that with Darling lawmakers began to acknowledge that hospitals are liable for a wide range of factors affecting the quality of health care, including the competence of non-employee physicians on the hospital's medical staff.” Id.

40 Prager, supra note 25, at 72.
liability to the MCO, based on any practices or policies that contributed to the harm to the patient such as the refusal to authorize certain tests or an adequate hospital stay. The MCO inevitably defends against such liability by claiming that the doctor acted as an independent contractor exercising her own judgment and skills. As we shall see below, the results are mixed.

Generally, an employer is not liable for the negligence of an independent party with whom the employer has contracted for services. The traditional view holds that in the medical setting, physicians are usually treated as independent contractors rather than employees; the hospital [and, by analogy, the MCO] is thus relieved of any agency-based liability for their negligent acts.

Courts early rejected the defense that a health care institution cannot be a participant in malpractice. Earlier cases involved hospitals rather than MCOs as the institutional defendant, but the logic applies to the managed care context. As early as 1980, the court in *Capan v. Divine Providence Hospital* looked beyond the technical formalities of the doctor/hospital relationship in order to hold the hospital liable for malpractice even though it claimed to have played a passive institutional role.

Recent courts have been ready and willing to apply the doctrine of institutional liability to MCOs. In the absence of a true staff model, courts have imputed a closer employer/employee relationship, thus paving the way for vicarious liability or ostensible agency causes of action. For example, in *Sloan v. Metropolitan Health Council of Indianapolis, Inc.*, the Sloans sued the named HMO for negligent failure to diagnose. The HMO defended against the claim by contending that its physicians acted independently in their practice of medicine and were not subject to control by the HMO over their diagnosis or treatment decisions, despite quality control reviews. The HMO claimed it had no veto power over tests, diagnoses, prescriptions or treatments and also invoked the rule legally prohibiting a corporation from practicing medicine. The Indiana appellate court rejected the HMO's defense, stating that there

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41 *Restatement (Second) of Torts*, § 409 (1965).

42 Furrow et al., *supra* note 26, at 482.

43 In terms of litigation, hospitals were the first institutional providers of health care, and their role served to defeat the legal notion that corporations cannot practice medicine. MCOs, the new institutional "player" in the health care industry, should logically come within the ambit of hospital liability doctrine. However, some scholars have expressed reservations about automatically assuming that theories of liability historically applied against hospitals for the malpractice of physicians apply to MCOs, which have a very different relationship with physicians. *See* Bearden & Maedgen, *supra* note 3, at 9.


was substantial evidence that the physician was under the HMO's control, in large part because such control was exercised by its medical director, a physician himself. Although this logic sounds rather forced, the court concluded that the control was sufficient to "establish an employment relationship where the employee performed acts within the scope of his [sic] employment."\(^{46}\)

In a federal court case, \textit{Schleier v. Kaiser Foundation Health Plan},\(^{47}\) HMO Kaiser was held vicariously liable for malpractice committed by an independent consulting physician. The consultant had been engaged by an HMO doctor and was supervised by him. The HMO had the right to discharge the consultant. This was deemed to be sufficient evidence of Kaiser's control over his behavior and permitted the court to impute agency.

In a third case, \textit{Boyd v. Albert Einstein Medical Center},\(^{48}\) a state court was willing to hold an HMO liable in a malpractice action because the plaintiff's decision to subscribe indicated that he looked to the institution for care and not solely to the physicians and that he detrimentally relied on the plan's representations.\(^{49}\) Thus, the malpractice carrier seeking indemnification from an MCO must be prepared to produce evidence consistent with an employer/employee relationship. This would include facts pertaining to MCO control such as distinct oversight by the medical director, the right of denial or approval of tests and procedures, control over the length of hospital stays, utilization review, monitoring of services for quality control, and the perceptions of subscribers based on representations by the MCO.

**G. The Role of Managed Care in Claims for Indemnification**

This article discusses the developing legal rights of physicians and their medical malpractice insurance carriers against MCOs. We suggest that malpractice insurers seeking indemnification from an MCO must take into consideration a number of factors in seeking repayment, including: formulation of a viable theory of recovery

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46 \textit{Id.} at 1109.

47 876 F.2d 174 (D.C. Cir. 1989).


49 \textit{Id.} at 615, 547 A.2d at 1232. \textit{But see:} Williams v. Good Health Plus, Inc., 743 S.W.2d 373 (Tex. App. 1987) and Raglin v. HMO Illinois, Inc., 230 Ill. App. 2d 642, 595 N.E.2d 153 (1992) in which claims of HMO liability based on such representations were rejected. In \textit{Raglin}, the fact that the MCO was based on an IPA model was fatal to the contract claim.
against the MCO based on applicable tort and contract doctrine; selection of an effective litigation strategy; careful assessment of any actions by the court in the instant case or of the effect of a settlement agreement with one party; working knowledge of the developing relevant case law; understanding of the advantages and limitations imposed by state and federal statutory authority and administrative law; familiarity with specific contract provisions which may affect the efforts of the malpractice carrier to obtain reimbursement; and awareness of public policy considerations which may serve to protect or expose the MCO.

III. EQUITABLE INDEMNIFICATION
AS THE BASIS OF RECOVERY FROM AN MCO

The cases described above lay the foundation for litigation against physicians and MCOs as co-defendants, but they do not reach the secondary issue that arises when the MCO physician's malpractice insurance carrier has paid a malpractice judgment or settlement and is now attempting to obtain indemnification from the MCO. The malpractice carrier, similar to the patient plaintiff, must base such a claim on the theory that cost-containment measures or other MCO policies caused the physician's conduct to fall below the standard of medical care, or that there was misrepresentation or grounds for a finding of ostensible agency. Since there is no case law directly on point, the malpractice insurer must appropriate a legal theory allowing it by analogy to shift all or part of the liability to the MCO.

The California Court of Appeal has defined indemnification as an obligation resting on one party, the indemnitor, to make good a loss or damage that is incurred

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50 It should be noted at this point that plaintiffs have been generally unsuccessful in bringing claims for breach of contract against MCOs. See generally Pulvers v. Kaiser Foundation Health Plan, 99 Cal. App. 3d 560, 564-565, 160 Cal. Rptr. 392, 393 (1979) (rejecting patient's breach of warranty claim against MCO and dismissing claims based on what the court considered "generalized puffing" in promotional literature promising high standards of medical services). But see Depenbrok v. Kaiser Foundation Health Plan, 79 Cal. App. 3d 167, 171 144 Cal. Rptr. 724, 726 (1978) (permitting malpractice action against MCO to sound in contract [breach of warranty] where patient detrimentally relied on specific promises made by surgeon). Since the terms of the plaintiffs contractual agreement with an MCO are different from those in a physician's contractual arrangement with the same organization, analysis of plaintiff patient causes of action has limited application to a malpractice insurance carrier's pursuit of indemnification from an MCO.

51 This could include preservation of the right to request indemnification by cross-complaining against the HMO at the time the complaint is filed (the preferred strategy); filing an independent action for indemnification after conclusion of the original plaintiffs action; or filing a postjudgment motion for contribution among tortfeasors. Practitioners should consult the relevant case law and statutory sections set forth in chapter 300 (Indemnity and Contribution) of CALIFORNIA FORMS OF PLEADINGS AND PRACTICE (Matthew Bender 1995), at 89.

52 The malpractice carrier should be aware that these cases do not necessarily involve MCOs. They do, however, provide an expansive legal theory which may provide a strong basis for an indemnification claim.
by another party, the indemnitee, in the absence of an express indemnity agreement. The California Civil Code defines indemnity as "a contract by which one engages to save another from a legal consequence of the conduct of one of the parties, or of some other person." Claims for indemnification can be based in contract or tort. A physician may be entitled to indemnification for a malpractice award based on: (1) an express contractual indemnity provision or (2) a determination of comparative liability among tortfeasors. Courts may also derive a third basis for indemnification from public policy concerns.

Express contractual indemnity is governed by California Civil Code sections 2772 through 2784.5. Public policy considerations are addressed in California Civil Code section 1668, which deals with contracts exempting an indemnitor from liability for fraud, willful injury, or violation of law. Statutory provisions, which are framed in the language of contribution among joint obligers or tortfeasors, must be harmonized with judicially established principles of comparative negligence, discussed more fully below. The case law is generally considered to have superseded statutory provisions using contributory negligence concepts. This is because the courts attempt to render decisions regarding indemnification that are consistent with the modern doctrine of comparative negligence.

Because MCOs are unlikely to include an express provision in provider contracts agreeing to indemnify physicians for malpractice claims, the malpractice insurer is likely to be required to invoke a tort theory for recovery. The doctrine of equitable indemnification is best suited to a claim for recovery against the MCO. Restatement (Second) of Torts states in pertinent part that the theory of equitable indemnification can be invoked to provide restitution in a variety of contexts:

54 CAL. CIV. CODE § 2772 (West 1993).
56 CAL. CIV. CODE §§ 2772-2784.5 (West 1993). See also note 11 supra regarding hold-harmless clauses.
57 CAL. CIV. CODE § 1668 (West 1985). See also note 11 supra.
58 The contribution doctrine of California Civil Code sections 875, 876, and 878-880 (West Supp. 1996) is difficult to reconcile with the comparative liability policy announced by the California Supreme Court in American Motorcycle Association v. Superior Court of Los Angeles County, 20 Cal. 3d 578, 578 P.2d 899, 146 Cal. Rptr. 182 (1978), but the statutory language remains unmodified despite the action of the courts.
(1) If two persons are liable in tort to a third person for the same harm and one of them discharges the liability of both, he [sic] is entitled to indemnity from the other if the other would be unjustly enriched at his expense by the discharge of the liability.

(2) Instances in which indemnity is granted under this principle include the following:

(a) The indemnitee was liable only vicariously for the conduct of the indemnitor;
(b) The indemnitee acted pursuant to directions of the indemnitor and reasonably believed the directions to be lawful;
(c) The indemnitee was induced to act by a misrepresentation on the part of the indemnitor, upon which he [sic] justifiably relied.\(^5^9\)

Under evolving case law involving physicians and MCOs as co-tortfeasors, the physician paying an award and seeking reimbursement from the HMO would most likely want to invoke subsections (2)(b) and (2)(c) as persuasive authority. The MCO seeking indemnification from the physician would rely on subsection (2)(a).

A. Equitable Indemnification Defined by the California Courts

The right to equitable indemnification, also referred to as comparative indemnity or implied indemnity, may be express or implied.\(^6^0\) Originally, indemnification was an all-or-nothing proposition. An indemnitee was entitled only to recover full repayment or nothing at all. However, the California Supreme Court has stated that a single “comparative indemnity doctrine” applies in this state, permitting partial indemnification on a comparative fault basis or allowing a total shift of liability, as determined on a case-by-case basis.\(^6^1\)

\(^5^9\) Restatement (Second) of Torts § 886B(1) & (2)(a-c) (1979).

\(^6^0\) Equitable indemnification is applied in different contexts under various names. For example, the court in Angelus Associates Corp. v. Neonex Leisure Prods., Inc. 167 Cal. App. 3d 532, 213 Cal. Rptr. 403 (1985) referred to implied equitable indemnity, partial equitable indemnity, and comparative equitable indemnity; the court in Bay Dev. Ltd. v. Super. Ct., 50 Cal. 3d 1012, 269 Cal. Rptr. 720, 722, 791 P.2d 290, 292 (1990) referred to implied contractual indemnity.

In American Motorcycle Association v. Superior Court of Los Angeles County, the California Supreme Court abandoned all-or-nothing recovery as an exclusive indemnification rule. The American Motorcycle court established the availability of partial equitable indemnification on a comparative fault basis.

B. Equitable Indemnification Consistent with Principles of Contributory Negligence: Early Applications

The principle of equitable indemnification was first applied in California in 1958 in City and County of San Francisco v. Ho Sing. The City of San Francisco and contractor Ho Sing were sued by a plaintiff who was injured when she tripped over a sidewalk skylight. The City paid a substantial part of the judgment and sought to recover the expenditure from Ho Sing, who now owned the skylight. The City based its demand for indemnification on the fact that Ho Sing's predecessor had actively engaged in the negligent alteration of the sidewalk for its own benefit, while the City merely had a passive duty to keep the sidewalk safe. In ordering Ho Sing to indemnify the City for its award to the plaintiff, the Ho Sing court relied on an early United States Supreme Court decision, Washington Gas Company v. District of Columbia. The Court in Washington Gas had abandoned the traditional notion that the law will not abet wrongdoers — i.e., co-tortfeasors — in obtaining relief and had instead stated:

The principle of equitable indemnity qualifies and restrains within just limits the rigor of the rule which forbids recourse between wrongdoers... The rule is, in pari delicto, potior est conditio defendantis. If the parties are not equally criminal, the principal delinquent may be held responsible to his co-delinquent for damages incurred by their joint offense.

In Ho Sing, the municipality had a general duty to maintain the sidewalk but was only passively negligent in causing the injury. Ho Sing's predecessor had altered the sidewalk and thus had actively caused the harm. The court found that the passive tortfeasor was entitled to indemnification from the active tortfeasor. Such distinctions

63 51 Cal. 2d 127, 330 P.2d 802 (1958).
64 161 U.S. 316 (1896).
65 Id. at 327-328, cited in Ho Sing, 51 Cal. 2d at 133, 330 P.2d at 805.
in the nature of the conduct of co-tortfeasors were acknowledged as the basis for indemnification.

The California Court of Appeal in *Alisal Sanitary District v. Kennedy*, a 1960 decision, affirmed the concept of equitable indemnification, although it too held that the doctrine of equitable indemnification was available only to shift the entire liability for the payment of the award from a passive tortfeasor to an active tortfeasor. This approach was consistent with the principles of contributory negligence which were still good law at the time the cause of action arose. The *Alisal* court expressed a willingness to consider “differences in the character or kind of wrongs which cause the injury and in the nature of the legal obligation owed by each of the wrongdoers to the injured person.” The court used the terminology of primary/secondary liability rather than active/passive liability, explaining:

The right of indemnity rests upon a difference between the primary and secondary fault of two persons each of whom is made responsible by law to an injured party. It is a right which inures to a person who, without active fault on his part, has been compelled by reason of some legal obligation, to pay damages occasioned by the initial negligence of another, and for which he himself is only secondarily liable [emphasis added].

Although the *Alisal* holding inured to the benefit of the passive defendant (which would be the role played by the MCO), it broke new ground with the theory of primary and secondary liability. The *Alisal* court stated that secondary liability “may be imputed or constructive only, being based on some legal relationship between the parties, or arising from some positive rule of common or statutory law or because of a failure to discover or correct a defect or remedy a dangerous condition caused by the act of the one primarily responsible.” In light of *Alisal*, the legal relationship between a physician and an MCO, however complex, must be sufficient to support a claim of vicarious liability in order to satisfy this legal requirement.

The principle of equitable indemnification based on principles of contributory negligence/total recovery was affirmed in extremely broad language in 1964 by the California Court of Appeal in *Herrero v. Atkinson*, which stated that:

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67 Id.


69 Id. at 75, 4 Cal. Rptr at 383.
[t]he duty to indemnify may arise, and indemnity may be allowed in those fact situations where in equity and good conscience the burden of the judgment should be shifted from the shoulders of the person seeking indemnity to the one from whom indemnity is sought. The right depends upon the principle that everyone is responsible for the consequences of his own wrong, and others have been compelled to pay damages which ought to have been paid by the wrongdoer, they may recover from him.\footnote{70}

The \textit{Herrero} court focused on the injustice that occurs when one defendant assumes the burden of the entire liability. It affirmed that indemnification is a legal right in and of itself which exists as a right of restitution and is a flexible doctrine dependent on "the facts of each case."\footnote{71} The holding in \textit{Herrero} is framed in language broad enough to apply to indemnification rights of both the primary and the secondary tortfeasor against each other.

\section*{C. Equitable Indemnification Interpreted Under Modern Principles of Comparative Negligence}

Courts were naturally reluctant to require indemnification under the all-or-nothing approach dictated by contributory negligence. Shifting the full burden from one tortfeasor to another often exceeded the demands of equity imposed by a specific set of circumstances. A major change applicable to equitable indemnification came about when California abandoned the common law doctrine of contributory negligence. In 1975, the California Supreme Court in \textit{Li v. Yellow Cab} held that:

\begin{quote}
the "all-or-nothing" rule of contributory negligence as it presently exists in this state should be and is herewith superseded by a system of "pure" comparative negligence, the fundamental purpose of which shall be to assign responsibility and liability for damage in direct proportion to the amount of negligence of each of the parties.\footnote{72}
\end{quote}

While the holding of the California Supreme Court applied to an injured plaintiff and a single tortfeasor, the abandonment of contributory negligence signaled a corresponding change in philosophy regarding equitable indemnification. That change occurred three years after \textit{Li v. Yellow Cab} in \textit{American Motorcycle Association v.}

\footnote{70}{227 Cal. App. 2d 69, 74, 38 Cal. Rptr. 490, 493 (1964).}

\footnote{71}{Id.}

\footnote{72}{13 Cal. 3d 804, 828, 532 P.2d 1226, 1243, 19 Cal. Rptr. 858, 875 (1975).}
Superior Court of Los Angeles County, mentioned in section II.A, above. In American Motorcycle, a teenage boy was injured in a motorcycle race sponsored by the American Motorcycle Association. The Association attempted to cross-complain against the parents of the boy, alleging that the parents negligently failed to supervise the minor child. The California Supreme Court ordered a hearing on its own motion and issued a writ directing the trial court to grant the Association leave to file the proposed cross-complaint. The California Supreme Court stated:

In order to attain such a system, in which liability for an indivisible injury caused by concurrent tortfeasors will be borne by each individual tortfeasor "in direct proportion to [his] respective fault," we conclude that the current equitable indemnity rule should be modified to permit a concurrent tortfeasor to obtain partial indemnity from other concurrent tortfeasors on a comparative fault basis.

D. Policy-Based Limitations on Equitable Indemnification

Despite the expanded potential for recovery available to the malpractice insurance carrier under an equitable indemnification theory that employs comparative negligence principles, a number of limitations exist. These include participation by one or more of the co-defendants in a good-faith settlement agreement and common-law and statutory restrictions on equitable indemnification.

1. Good Faith Settlement

California courts favor settlement, and the majority of cases do settle. In American Motorcycle, the California Supreme Court identified and emphasized the "strong public policy in favor of encouraging settlement of litigation." Since settlement precludes repayment by the settling codefendant, this is significant dicta. A good-faith settlement discharges the settling tortfeasor from all liability for equitable indemnification to any other parties. The California Code of Civil

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73 20 Cal. 3d 578, 578 P.2d 899, 146 Cal. Rptr. 182 (1978).
74 Id. at 598, 578 P.2d at 912, 146 Cal. Rptr. at 195.
75 Id. at 603, 578 P.2d at 915, 146 Cal. Rptr. at 198.
76 For a good discussion of factors the courts will look to in determining the "good faith" of any settlement entered into by a plaintiff and co-defendant tortfeasor sufficient to bar a non-settling co-defendant's claim for equitable indemnification, see Tech-bilt, Inc. v. Woodward-Clyde & Assoc., 38 Cal. 3d 488, 698 P.2d 159, 213 Cal. Rptr. 256 (1985). For further analysis of the effect of a good faith settlement as it relates to the passive-active
Procedure provides statutory authority governing the release of one or more joint tortfeasors or co-obligers and the effect upon the liability of others. It provides in pertinent part:

Where a release, dismissal with or without prejudice, or a covenant not to sue or not enforce a judgment is given in good faith before a verdict or judgment to one or more of a number of tortfeasors claimed to be liable for the same tort . . . [i]t shall discharge the tortfeasor to whom it is given from all liability for any contribution to any other tortfeasors.\footnote{CAL. CIV. PROC. CODE § 877(b) (West Supp. 1996).}

Conversely, the California Court of Appeal has held that a settling tortfeasor may recover equitable indemnification from a nonsettling tortfeasor.\footnote{Bolamperti v. Larco Mfg., 164 Cal. App. 3d 249, 210 Cal. Rptr. 155 (1985).} Finally, a good faith settlement by one tortfeasor will not bar the remaining co-defendant tortfeasors from pursuing an equitable indemnification claim against a settling co-defendant tortfeasor when such right to equitable indemnification arises out of an express right in a contract.\footnote{C.L. Peck Contractors v. Super. Ct., 159 Cal. App. 3d 828, 205 Cal. Rptr. 754 (1984).} Thus, the carrier would preserve the right to obtain indemnification from the MCO even if it settles with the plaintiff prior to a judgment. However, the malpractice carrier can be precluded from indemnification if the MCO settles. If the MCO settles and the malpractice carrier has reason to believe that the settlement is grossly disproportionate to what a reasonable person at the time of settlement would estimate the settlor’s liability to be,\footnote{Tech-Bilt, Inc. v. Woodward-Clyde & Associates, 38 Cal. 3d 488, 698 P.2d 159, 213 Cal. Rptr. 256 (1985).} the malpractice carrier can institute judicial proceedings to determine the good faith of the settlement.\footnote{California Code of Civil Procedure section 877.6 (West Supp. 1996) covers both joint tortfeasors and co-obligers in contract. It states: “Any party to an action wherein it is alleged that two or more parties are joint tortfeasors or co-obligers on a contract debt shall be entitled to a hearing on the issue of the good faith of a settlement entered into by the plaintiff or other claimant and one or more alleged tortfeasors . . . (2) In the alternative, a settling party may give notice of settlement to all parties and to the court, together with an application for determination of good faith settlement and a proposed order. . . .”}

\footnote{Classification of tortfeasors for equitable indemnification purposes, see Far West Finan. Corp. v. D & S Co., 46 Cal. 3d 796, 760 P.2d 399, 251 Cal. Rptr. 202 (1988).}
2. MICRA Limitations on the Size of Noneconomic Awards

In *Western Steamship Lines v. San Pedro Hospital*, the California Supreme Court determined that the Medical Injury Compensation Reform Act of 1975 (MICRA) reflects "a strong public policy to contain the costs of malpractice insurance by controlling or redistributing liability for damages, thereby maximizing the availability of medical services to meet the state's health care needs." The court in *Western Steamship Lines* held that MICRA's $250,000 limitation [on noneconomic damages] applies to an action for equitable indemnification against a hospital and doctor. It should be noted that the original judgment in *Western* was made under federal maritime law; initial application of California law might have produced a different result.

If the physician's medical malpractice carrier wishes to pursue indemnification from the MCO, it may be possible to apply the public policy argument in *Western* as the basis for an argument in favor of shifting a portion of a damage award apportioned to the physician to the HMO. One basic premise of tort law is to use insurance to relieve the individual of the burden of damages by spreading the cost over a broader portion of the population. Insurance companies pay damage awards and apportion the cost in the form of rates to their insureds. In this way, each member of society pays a small portion of many injury awards. Distributing injury awards among the largest number of insureds lowers the cost per person. It may be possible to argue that shifting damage awards from the malpractice carrier to MCOs is justified if the MCO membership base is larger than the malpractice insurer's policyholder base.

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82 8 Cal. 4th 100, 876 P.2d 1062, 32 Cal. Rptr. 263 (1994).

83 MICRA is codified at California Civil Code section 3333.2 (West Supp. 1996). It limits the size of any award for noneconomic damages in an action against a health care provider to $250,000.

84 8 Cal. 4th at 104, 876 P.2d at 1063, 32 Cal. Rptr. at 264.

85 *Id.* Noneconomic damages generally include pain, suffering, inconvenience, mental suffering, emotional distress, loss of companionship or consortium, and injury to reputation. Economic damages include medical expenses, loss of earnings or employment, and other quantifiable expenses. *See Cal. Civ. Code § 1431.2* (West Supp. 1996) for a more comprehensive list of the different damages.

86 *See* Sage et al, *supra* note 22, for a cogent discussion of malpractice insurance theory.
3. Potential Pre-emption by ERISA

Other limitations on the usefulness of the doctrine of equitable indemnification are imposed by ERISA, the federal Employees Retirement Income Security Act of 1974.\(^\text{87}\) ERISA contains broad preemption provisions that may interfere with the state claims when a claim "has a 'connection to or reference to' a benefit plan."\(^\text{88}\) If ERISA precludes a patient's state-law malpractice claim against both the physician and the MCO, any discussion of indemnification in state court is moot, since the action could be shifted to federal court. If ERISA is interpreted to preempt claims against the MCO only, the doctor could be made to assume full liability and the malpractice carrier would forfeit any right of indemnification arising out of that action. The physician and malpractice carrier are well advised to attempt to guard against such a result.

Whether a malpractice claim is "related" to a benefit plan per the language in ERISA remains to be settled by the courts. For example, the federal district court in *Independence HMO, Inc. v. Smith*\(^\text{89}\) denied an HMO's request for an injunction against a patient malpractice claim. The HMO argued that the claim was blocked by ERISA pre-emption. The court allowed the malpractice claim against both physician and HMO, reasoning that the injury itself had nothing to do with denial of rights under the plan itself, but other courts have disagreed.\(^\text{90}\) Still, the California Court of Appeal


\(^{88}\) *See, e.g.*, *Elsesser v. Hosp. of Philadelphia College*, 802 F. Supp. 1286, 1289-91 (E.D. Penn. 1992) (allowing a claim against an HMO when it was demonstrated that the claim was not based on obligations under the HMO's benefit plan).


\(^{90}\) *Id.* at 988. For the U.S. Supreme Court's rather ambiguous definition of law that "relates to" an employee benefit plan, *see Shaw v. Delta Air Lines*, 463 U.S. 85 (1983). For a good discussion of the types of claims allowed under "the broad sweep of ERISA," *see Lane v. Goren*, 743 F.2d 1337, 1339 (9th Cir. 1984).

In *Rioci v. Gooberman*, 840 F. Supp. 316 (D.N.J. 1993), the U.S. District Court granted an HMO's motion to dismiss a patient's state tort claim that her HMO was vicariously liable for alleged medical malpractice of one of its providers, where the vicarious liability claim "related to" an employee benefit plan and stating that ERISA preempted the claim.

In *Nealy v. U.S. Healthcare H.M.O.*, 844 F. Supp. 966, 973 (S.D.N.Y. 1994), the U.S. District Court granted defendant's motion for dismissal of a complaint, holding that the plaintiff's claims for breach of contract in misrepresentation, wrongful death, loss of consortium and breach of fiduciary duty arose out of alleged improper provision of health care against an HMO provided under a health care plan *offered as part of an employee benefit plan* provided by an employer.

Most recently, the Pennsylvania Superior Court denied a motion for summary judgment based on an ERISA preemption defense by an HMO, stating, "We, too, do not believe that Congress can have intended, prior even to invention of the cost containment system which inheres in USHC's [the defendant HMO] review process,
is generally on record as stating that absent an express Congressional command, state law is preempted by ERISA only if the state law actually conflicts with the federal statute or if the federal statute thoroughly occupies the legislative field.91

IV. DEVELOPING AN EFFECTIVE THEORY FOR PURSUING MCO INDEMNIFICATION

A. Procedural Considerations

One of the fundamental principles of equitable indemnification is “there can be no indemnity without liability.”92 In order for a physician or her malpractice carrier to bring an action against an MCO for equitable indemnification, the MCO must be shown to have engaged in some type of culpable activity, either as an express or implied co-obligor in contract or as a co-tortfeasor. Given the trend in the courts toward holding MCOs responsible for negligence in provision of medical care, it is unlikely that a plaintiff patient today would fail to name the MCO as a defendant in a medical malpractice action. The physician has three procedural options and a wide range of legal theories on which to base his demand for indemnification. Because every contract contains distinct provisions affecting the relative liability of physician and MCO, we focus our discussion on recovery in tort actions.93

A co-defendant tortfeasor must generally elect one of two litigation strategies in order to obtain equitable indemnification: (1) by filing a cross-complaint for


On the other hand, the Ninth Circuit in Hewlett-Packard Co. v. Barnes, 571 F.2d 502, 504 (9th Cir. 1978) held that “The clear wording of section 514 and the relevant legislative history show that Congress unmistakably intended ERISA to preempt a state law such as Knox-Keene that directly regulates employee benefit plans.”

The Ninth Circuit in Blau v. Del Monte Corp., 748 F.2d 1348 (9th Cir. 1985) rejected an employer's denial of benefits as arbitrary and capricious, but held that ERISA preempted employees' common-law theories of breach of contract implied in fact, promissory estoppel, estoppel by conduct, fraud and deceit, and breach of contract.


declaratory relief concerning the right to indemnity against the indemnitee in the suit brought by the plaintiff, whether or not the indemnitee is already a party to the action, or (2) by filing an independent action for indemnification against the indemnitee after conclusion of the original plaintiff’s action. A third option is a postjudgment motion for “contribution among tortfeasors.” If the first option is selected, the insurance carrier must remain “invisible” in order to avoid prejudicing the outcome against the physician, despite the carrier’s substantial interest in the lawsuit. Only under the most unusual circumstances would the carrier attempt to intervene; the physician’s cross-complaint against the MCO should be sufficient to preserve the rights of the carrier in subsequent litigation under the second option. Note also that the third approach may be risky. Courts may object to the statutory language in section 878, which is based on the principles of contributory negligence superseded by American Motorcycle.

The right of a co-defendant to seek equitable indemnification may be precluded by collateral estoppel if the co-defendant indemnitee is determined to have no liability to the plaintiff in pretrial proceedings. For example, the court might grant a motion to dismiss or enter a summary judgment in favor of the defendant. However, collateral estoppel does not apply if the plaintiff’s complaint and the defendant’s cross complaint for comparative negligence assert different theories of liability.

94 See American Motorcycle Assn. v. Super. Ct., 13 Cal. 3d 804, 532 P.2d 1226, 19 Cal. Rptr. 858 (1975. See also CAL. CIV. PROC. CODE § 86 (a)(7)(A) (West Supp. 1996) and Cal. Civ. Proc. Code § 428.10(b) (1973). A very recent case in Pennsylvania, Pappas v. Asbel, 1996 WL 112981 (Pa. Super. March 15, 1996), involved claims by HMO subscriber Pappas of medical malpractice by a doctor and negligence by the hospital for delaying transfer of the patient to a facility equipped to address the medical emergency in question. The hospital then filed a third-party complaint against the HMO, joining it as a party defendant for its refusal to authorize the transfer of the plaintiff to the hospital selected by its physicians. The doctor filed a cross-claim against the HMO seeking contribution and/or indemnity. The HMO raised the defense of ERISA preemption. The Pennsylvania Superior Court reversed the trial court’s order granting summary judgment, emphasizing that ERISA preemption was not a valid defense, and remanded. Although the merits of the cross-complaint by the doctor are yet to be decided, the court did not dismiss them outright. ERISA issues are discussed in section II.D.3 of this article.


96 CAL. CIV. PROC. CODE § 878 (West 1980).

97 See Roth et al., supra note 37, for a discussion of the rights of MCOs against physicians. See also, Sage et al, supra note 22, in which the authors propose to shift liability entirely to MCOs.

The California Fair Responsibility Act, originally referred to as Proposition 51, also affects the ability to seek indemnification. The Act effectively destroys several liability among co-obligers under certain conditions. It provides that in personal injury actions based on principles of comparative fault, "[e]ach defendant shall be liable only for the amount of noneconomic damages allocated to that defendant in direct proportion to that defendant's percentage of fault." Thus, the trial court must fully apportion damages among all co-tortfeasors (including both named and unnamed defendants) pursuant to the plaintiff's theory. Although this appears to vest a good deal of control in the plaintiff, in fact it shifts the risk to the plaintiff, who must now collect noneconomic damages from each individual defendant; one co-defendant cannot be compelled to assume full responsibility for the entire judgment with the expectation that he or she will obtain indemnification for such a pay-out at a later time. In the event that co-defendant lacks coverage or the ability to pay, the risk is shifted from the defendants to the plaintiff.

B. Case Law Establishing Direct Liability of MCOs and Providing the Basis for Indemnification Claims

Malpractice carriers seeking indemnification from MCOs need to formulate a theory of recovery to support their demand. Because there are no cases directly on point, the theory behind the claim for recovery must be derived from the doctrine that has evolved through patient litigation against MCOs or other related third-party payers. Ironically, the carrier will find itself recapitulating many of the same arguments used in patient/plaintiff claims.

In California, the first case to attempt to link a third-party payor into the medical malpractice causation chain under a corporate negligence theory based on a utilization decision was Wickline v. State of California. In this case, the third party payor was the State of California through its administration of the Medi-Cal Program, a different type of managed care organization. In Wickline, the state had allowed only a four-day hospital stay for Mrs. Wickline after surgery resulted in medical complications. Mrs.
Wickline's attending physicians had requested a stay of eight days. The plaintiff alleged direct corporate liability. The court was particularly concerned with the adequacy of the utilization review conducted by the Medi-Cal doctor; it expressed wariness that cost-consciousness might interfere with good medical judgment.\(^\text{103}\)

The issue of liability of a third party payor for early release based on cost-containment considerations was never squarely addressed by the Wickline court because the court ruled in favor of the State and based liability solely on the physician's duty to the patient. The Wickline court did remark, however, that under other circumstances cost-containment programs cannot be allowed to "corrupt medical judgment."\(^\text{104}\) The court found that the treating physician was liable because "while still of the subjective, non-communicated, opinion that Wickline was seriously ill and that the danger to her was not over, [he] discharged her from the hospital .."\(^\text{105}\)

In assigning full liability to the physicians and none to the Medi-Cal program, the court further commented on the effects of the changing relationship between the physician and third-party payers such as Medi-Cal. It stated that the physician must rely on his own judgment: "There is little doubt that [the treating physician] was intimidated by the Medi-Cal program but he was not paralyzed by [Medi-Cal's] response nor rendered powerless to act appropriately if other action was required under the circumstances."\(^\text{106}\) However, the Wickline court qualified the MCO physician's responsibility:

> Third party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.\(^\text{107}\)

The court in Wickline implied that a physician's liability can preclude shifting responsibility to the MCO or other third-party payor unless the physician first provides and communicates sufficient medical information to the payor to adequately notify the payor of the patient's medical needs. If necessary, the physician has the

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104 Id. at 1647, 239 Cal Rptr. at 820.

105 Id. at 1640, 239 Cal. Rptr. at 815 (emphasis added).

106 Id. at 1645, 239 Cal. Rptr. at 819.

107 Id.
affirmative burden of challenging the decision made by the payor. At the same time, Wickline places payers on notice that liability may result from administrative decisions that are based on cost-containment considerations and which are not based on the patient's medical needs if such decisions injure the patient.

Four years after Wickline, the California Court of Appeal issued a second opinion in Wilson v. Blue Cross of So. California, a case in which the plaintiff also alleged corporate negligence based on improper utilization review.\(^\text{108}\) The Wilson court revisited the Wickline decision and rejected the idea of exclusive physician liability when a third-party payor makes decisions affecting medical services: "The language in Wickline which suggests that civil liability for a discharge decision rests solely within the responsibility of a treating physician in all contexts is dicta."\(^\text{109}\) The Wilson court, which found defendant Blue Cross to be negligent in failing to authorize adequate hospitalization for a depressed patient who subsequently committed suicide, rejected Blue Cross's argument that under Wickline, cost-containment measures were valid public policy. Although the Wilson court was willing to acknowledge the value of such objectives for public systems, it distinguished this policy from the profit motive of a private health care organization.\(^\text{110}\)

In Bush v. Dake, an unpublished 1989 case filed in Sagninaw County, Michigan,\(^\text{111}\) the plaintiff asserted that the capitation arrangement with her HMO provided physicians with an incentive for "not rendering services, not referring to specialists, not admitting to hospitals, and ... conducting audits of Pap test utilization" in a manner that violated acceptable standards of medical practice, ethics, morality and public policy.\(^\text{112}\) The plaintiff alleged that the capitation arrangement was a "significant causative factor" in the resulting malpractice by physicians. The trial court held that the plaintiff's theory was viable and could proceed to the jury, although it did comment that the state legislature approved HMOs and thus there was no


\(^{109}\) Id. at 666-667, 271 Cal. Rptr. at 879-880.

\(^{110}\) Id. at 664, 271 Cal. Rptr. at 87. See also Fox v. Health Net, No. 21962 (Cal., Riverside City. Super. Ct., December 28, 1993), in which the jury awarded the surviving spouse plaintiff $89,128,153 against the HMO that breached its contract, acted in bad faith, and recklessly inflicted emotional distress when it denied her a bone-marrow transplant based on the theory that such a procedure was experimental. Although the award was appealed, no subsequent decision has been published. See Julie Gannon Shoop, Jury Holds HMO Liable for Refusing Coverage, TRIAL, March 1994, at 90, 90-91. Further information about the verdict is available on Westlaw; see 1993 WL 794305 (T.D. Cal. Jury).


\(^{112}\) Quoted in Parise, supra note 12, at 995. See also Salmon, supra note 18, at 83.
violation of public policy. The case settled, so the legal significance is limited. Still, the court's receptiveness to the plaintiff's theory of liability is noteworthy.

The California Courts of Appeal in Wickline and Wilson reached opposite conclusions about the liability of third-party payers. The California Supreme Court has not yet stepped forward to offer the final word on apportionment of responsibility between the treating physician and the payor. Thus, practicing attorneys can still invoke Wickline to avoid MCO liability or Wilson to apportion liability to an MCO based on its role in causing the harm. However, even in light of the problems that result from the strong economic motivation behind an MCO's reluctance to authorize many treatments or other services, no California decision to date has offered any formal legal test concerning assessment of the role played by cost-containment measures in causation analysis. The law in this area is just beginning to develop and merits close monitoring.

C. Case law Establishing Vicarious Liability on the Part of the MCO

Vicarious liability can be established under a number of different theories, including respondeat superior, ostensible agency, and agency by estoppel or representation. Although direct liability of HMOs will grow in the wake of the Wickline and Wilson decisions, some courts may still require that a claim for relief be based on the master-servant or principal-agent relationship. It should also be noted that comparative liability principles do not apply to an employer or principal who is found to be vicariously liable for the conduct of an employee. In other words, the principal is liable only for the agent's share; the principal's conduct is not compared on the basis of independent conduct and liability.

In Raglin v. HMO Illinois, Inc. the Illinois Court of Appeals confirmed that:

HMOs are not immune from liability. However, a lack of immunity from prosecution for malpractice does not mean a fortiori that HMOs may be held strictly liable for any injury that might occur to one of their medical care plan

113 Parise, supra note 12, at 995.

114 Other decisions add to the confusion. The California Court of Appeal in Pulvers v. Kaiser Foundation Hosp. Plan, 99 Cal. App. 3d 560, 160 Cal. Rptr. 392 (1979), rejected the plaintiff's allegations that participating physicians were motivated by a financial incentive arrangement to limit tests and treatment. The court noted that incentive plans are recommended by both professional organizations and the Federal HMO Act. The case may have been brought too early in the evolution of MCO liability doctrine.

115 The practitioner is advised to consult CALIFORNIA FORMS OF PLEADING AND PRACTICE, supra note 51, at 76, for a practical overview of litigation concerns related to vicarious liability.

subscribers during the course of medical treatment. Some recognized legal
theory must be the basis for holding an HMO liable for medical malpractice.117

The \textit{Raglin} court stated that such a legal theory could be predicated on vicarious
liability in two situations. First, it considered whether a master-servant relationship
existed between the parties and whether the alleged negligent activity was within the
scope of employment. However, because the physicians in \textit{Raglin} were independent
contractors, the master-servant relationship was not express. The \textit{Raglin} court then
considered whether an agency relationship could be created between the HMO and
physicians. The court stated that:

this approach provided two avenues by which one may attempt to create a
fact question on the issue of the liability of HMO [Illinois]: (1) by a showing
of implied authority, i.e. that the facts and circumstances indicate that HMOI
actually exerted sufficient control over the physicians to negate the
independent contractor status, at least with respect to third parties . . . or (2)
by a showing of apparent authority, i.e. that HMOI, by its actions or
statements, led a third party, who may have been unaware of the independent
contractor relationship, to believe that the physicians were controlled by
HMOI. . . .118

The California Court of Appeal interpreted the vicarious liability of an indemnitee
in \textit{Herrero v. Atkinson} and adopted a theory applicable to an employer-independent
contractor model.119 The \textit{Herrero} court also emphasized the necessity of a special
relationship in order to support a claim for indemnification. The \textit{Herrero} court
refused to impute a special relationship based solely on status as co-defendants acting
in pari delicto and stated that it would disallow indemnification based on such a
theory. It did, however, find grounds for indemnification based on the principal-agent
theory in that case.120 Thus, a physician seeking indemnification from an MCO must
be careful in her cross-complaint to specify the nature of the legal relationship and
corresponding obligations. The language in \textit{Herrero} is very broad, but may be limited
by the factual situation, which involves a principal (in \textit{Herrero}, a physician; in most
cases, an MCO) seeking recovery from agents (two other physicians who actually

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117 \textit{Id.} at 646, 595 N.E.2d at 155-156.

118 \textit{Id.} at 647, 595 N.E.2d at 156 (citations omitted).


120 \textit{Id.} at 77, 38 Cal. Rptr. at 494-495.
administered the blood transfusion causing the patient's death). The result might be quite different if the agents were seeking indemnification from the principal. Consequently, this is a weak theory for recovery.

1. **Respondeat Superior**

The doctrine of respondeat superior is based on the premise that when an innocent party is injured through tortious conduct committed in furtherance of a business enterprise, the enterprise should bear the loss as a legitimate business expense [citation omitted]. Under this doctrine, courts deliberately place the risk of loss upon the business entity because it can better absorb the loss and shift the cost to society as a whole.121

Respondeat superior does not apply to independent contractor relationships. Under the staff model, where physicians are employed directly by the MCO, this theory is useful for extending liability from physician to employer. However, relatively few MCOs, if any, use the staff model. Although the MCO may achieve a level of control similar to that of an employer by means such as denial of use of facilities for a disapproved medical procedure, compliance with treatment protocols, requirements regarding referrals, and rules for submission of claims, the theory of respondeat superior is likely to fail in the absence of the formal legal employer/employee relationship.122 Thus, when the MCO and the physicians do not stand in a true employer/employee relationship, better theories exist to support a claim of indemnification. The best of these is the theory of ostensible agency.

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121 Jim M. Perdue and Stephen R. Baxley, *Cutting Costs — Cutting Care: Can Texas Managed Care Systems and HMOs be Liable for the Medical Malpractice of Physicians?*, 27 St. Mary's L.J. 23, 30 (1995). Although this interpretation must be modified pursuant to principles of comparative negligence in California, the point remains that the master who benefits from the services of the servant should not be exempted from liability incurred by the agent when the servant is performing services for the master and is subject to the master's control. Perdue and Baxley argue that evidence of such control exists in the master's authority to determine the tools or appliances the servant will use in performing the work, the master's right to dictate where the work will be performed, and the master's right to regulate working hours.

122 See: Sloan v. Metropolitan Health Council, 516 N.E.2d 1104 (Ind. App. 1987) (holding that an HMO may be liable for the negligent acts of a physician when an employment relationship was established and rejecting the defense that a corporation cannot practice medicine), Dunn v. Praiss, 256 N.J. Super. 180, 606 A.2d 862 (1992), *cert. denied*, 611 A.2d 657 (N.J. 1992) (holding that an HMO can be held liable under the doctrine of respondeat superior despite the existence of a contract between HMO and physicians because physicians had no discretion to accept or reject patients and were subject to other forms of control by the HMO); *but see*, Raglin v. HMO Illinois, 230 Ill. App. 3d 642, 595 N.E.2d 153 (1992) (granting summary judgment for the HMO in the absence of a true master/servant relationship between the HMO and the physicians).
2. Ostensible Agency

Ostensible agency is defined as an implied or presumptive agency, which exists where one either intentionally or from want of ordinary care induces another to believe that a third person is his agent, though he never in fact employed him. Respondeat superior depends on the level of control by the principal; ostensible agency depends instead on the perception of a third party as to the formal relationship.\textsuperscript{123} Strictly speaking, agency is not involved at all; ostensible agency is based entirely on estoppel.\textsuperscript{124} Section 429 of the Restatement (Second) of Torts, explains the circumstances for the ostensible agency exception to the general rule that employers are not liable for the conduct of independent contractors. Section 429 provides:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.\textsuperscript{125}

Ostensible agency depends on three factors. The plaintiff patient must have a reasonable belief that the physician is an agent of the MCO; the MCO must have committed some act or neglect generating such a belief; and the patient must justifiably rely on the representation of the physician's authority.\textsuperscript{126} Factors that influence the court's willingness to impute ostensible agency include the perception of the MCO subscriber as to the role of the physician, claims in promotional and

\textsuperscript{123} Perdue & Baxley, supra note 121, at 33.

\textsuperscript{124} See, e.g., Grewe v. Mt. Clemens Gen. Hosp., 404 Mich. 240, 250-251, 273 N.W.2d 429, 433 (1978), which based a finding of agency by estoppel on three factors: (1) the patient must perceive the treating physician to be an employee or agent of the institution when she is not; (2) the institution must fail to inform the patient otherwise; and (3) the patient must change positions based on such reliance, that is, must pay the institution or suffer some loss.

\textsuperscript{125} \textsc{Restatement (Second) of Torts} § 429 (1965).

\textsuperscript{126} Bearden & Maedgen, supra note 3, at 310.
marketing materials, and the subscriber's freedom of choice in choosing his physician.\textsuperscript{127}

The Pennsylvania Superior Court applied this theory to a case involving hospital liability for the negligent conduct of its independent contractor physicians,\textsuperscript{128} but the same analysis could be exercised when an independent contractor physician and an MCO are named as co-defendants or joint obligers in a medical malpractice action. Other jurisdictions have had occasion to consider the question of liability of an MCO under the theory of ostensible agency. In \textit{Boyd v. Albert Einstein Medical Center},\textsuperscript{129} the plaintiff alleged that she relied on representations in the HMO's literature of "total health care." The literature stated that the HMO "provides the physicians, hospitals and other health care professionals needed to maintain good health." In finding that the physician was the ostensible agent of the HMO, the Superior Court of Pennsylvania applied the Restatement (Second) of Torts § 267, which provides that:

\begin{quote}
one who represents that another is his servant or other agent and thereby causes a third person to justifiably rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.\textsuperscript{130}
\end{quote}

The court reversed the trial court's decision to grant summary judgment for the HMO, holding that there was an issue of material fact as to whether the participating physicians were the ostensible agents of the HMO.\textsuperscript{131} The \textit{Boyd} court remanded the case to determine the nature and extent of the reliance of the plaintiff on the HMO's representations in order to determine if the representations were sufficient to invoke the doctrine of promissory estoppel. While setting the stage for the creation of the


\textsuperscript{130} \textit{Id.} at 620, 547 A.2d at 1234.

\textsuperscript{131} \textit{Id.} at 621, 547 A.2d at 1235.
agency, the court never established that an ostensible agency relationship existed under the circumstances.

The California courts have not yet addressed the issue of whether vicarious liability arises from the MCO-physician relationship on a theory of ostensible agency. However, the California Court of Appeal considered a somewhat analogous principal-agent relationship in *Noble v. Sears, Roebuck & Co.* Sears hired a state-licensed independent private investigation firm to locate a potential eye witness who had seen a Sears customer sustain an injury for which she was suing Sears. An employee of the detective agency gained admittance to a hospital room where the plaintiff was confined and deceptively secured the address of an eye witness to plaintiff's injury. In reversing the trial court's dismissal of two of the causes of action, the California Court of Appeal made statements that may be relevant to physicians and MCOs.

First, the *Noble* court held that "where a corporation undertakes an activity involving possible danger to the public under a license or franchise granted by public authorities, these liabilities may not be evaded by delegating performance to an independent contractor." Applied within the context of MCOs, the decision in *Noble* indicates that a managed care organization may not avoid responsibility for the results of its conduct by pointing its finger at the physician.

The *Noble* court used the danger policy rationale to further expand the doctrine of vicarious liability by applying the following reasoning. The court first identified the concept of negligent supervision in section 213 of the Restatement (Second):

A person conducting an activity through servants or other agents is subject to liability for harm resulting from his conduct if he is negligent or reckless . . . in the supervision of the activity; . . .

The court then proceeded to interpret this general principle in light of the public safety rationale stated above:

Although a principal may be liable for the torts of an agent committed in the scope of authority [citations omitted], that theory of vicarious liability is not based on the fact that the principal is negligent if he fails to supervise the agent. The principal is held liable as a matter of public policy, in order to

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134 33 Cal. App. 3d at 663-664, 109 Cal. Rptr. at 275.
promote safety for third persons. The theory of liability is that the principal is holding out the agent as competent and fit to be trusted, and thereby, in effect, warranting good conduct and fidelity of the agent.  

The court stated that it found no authority for basing liability on negligent hiring "in the absence of knowledge by the principal that the agent or servant was a person who could not be trusted to act properly without being supervised."  

Although the decision in Noble certainly expands the ambit of vicarious liability based on ostensible agency, it is probably most useful to a patient plaintiff suing co-defendant physician and MCO. Its utility in a cross-complaint by a physician against an MCO is questionable. The public safety rationale against allowing an MCO to delegate completely and therefore evade liability certainly expands the basis for bringing in an MCO as a co-defendant. However, no physician or carrier will be comfortable invoking the court's requirement that the hiring principal is liable only if it knows that the agent could not be trusted to act properly without being supervised.  

The Noble decision raises another interesting issue with respect to negligent hiring. The court refused to state that an employer has discharged his duty of care merely because the contractor he hires is properly licensed. The Noble court stated that "we cannot say on the record before us that, as a matter of law, this [licensure] was sufficient to show that Sears exercised reasonable care in their choice." If the California courts follow Noble, an MCO will have a difficult time arguing that the fact that a physician is licensed by the state is sufficient evidence of professional competence and relieves the MCO of liability for negligent hiring of a physician, or of liability for the negligent acts of that physician.  

Ostensible agency theory is not without limitations. Jan Lewis suggests a number of factors that may defeat a claim based on ostensible agency, including: (1) the MCO has many member physicians; (2) the physicians have authority to refer out of the plan when necessary; (3) promotional materials emphasize the patient's right to select and change physicians; (4) the subscriber contract and handbook have disclaimers stating that member physicians are independent contractors; and (5) advertising makes the independent contractor relationship clear. Of these factors, the fourth and fifth would be strong defenses against ostensible agency, but the others can be interpreted to support ostensible agency as easily as they can be perceived to defeat it: a large

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136 33 Cal. App. 3d at 664, 109 Cal. Rptr. at 275.

137 Id.

138 Lewis, supra note 5, at 76.
number of physicians is more likely to be associated with a conventional business or corporate employment arrangement; the authority to refer out is common for high level employees; and the patient's right to select a physician is analogous to any consumer's right to choose the particular employee within a business with whom she wishes to work.

D. Statutory Authority as the Basis for a Claim

The Health Maintenance Organization Act of 1973\textsuperscript{139} authorizes private causes of action for suits against private HMOs.\textsuperscript{140} Section 300e(c)(5) of the Act requires that HMO agreements provide "meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization." If the HMO fails to satisfy this requirement, a member might bring, say, a claim against the HMO if she was not provided with a timely decision as to specific medical care (termed "time critical") and the delay resulted in aggravating the condition. Such conduct constitutes a statutory violation and the plaintiff can then proceed on both negligence and negligence per se causes of action. The effect of the HMO Act on a claim for indemnification is difficult to assess, since it appears to implicate physicians as well as HMOs themselves. However, it may be possible for a physician to argue that she attempted in good faith to comply with the terms of the Act, but that an HMO-created delay interfered with her ability to deliver proper health care.

As discussed above, ERISA considerations may also affect a claim for indemnification. ERISA only preempts claims filed by a plan participant that relate to employee benefits. The United States Supreme Court addressed the breadth of ERISA preemption as against third parties in *Mackey v. Lanier Collection Agency and Servs. Inc.*\textsuperscript{141} The Court held that "lawsuits against ERISA plans for run-of-the-mill state-law claims . . . or even torts committed by an ERISA plan" are not contemplated by Congress as subject to preemption.\textsuperscript{142}

\begin{footnotes}
\item[141] 486 U.S. 825 (1988).
\item[142] *Id.* at 833.
\end{footnotes}
Managed care organizations in California are licensed by the California Department of Corporations. The duties of such managed care organizations are set forth in the Knox-Keene Act. Although the Knox-Keene Act calls for administrative remedies and does not provide for private causes of action, violations of its provisions may support a negligence per se cause of action in establishing duty and breach.

In 1994, the California Department of Corporations brought an administrative accusation and petition to assess penalties against licensee Takecare Health Plan, Inc. for failure to provide a timely referral to a qualified specialist and subsequent denial of payment for medically necessary treatment of a young member's life-threatening cancer. Although the action has limited precedential value, it does lay out statutory and administrative law that may provide the basis for a complaint of negligence per se. The Department of Corporations charged Takecare with violation of Health and Safety Code section 1367(d), which states in pertinent part that every licensed health care service plan shall furnish “ready referral of patients to other providers at such times as may be appropriate consistent with good professional practice.” Furthermore, the Department relied on Health and Safety Code section 1367(e), which provides that “[a]ll services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.” The Department also invoked subsection (g) of the statute provides that “[t]he plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.” Finally, the Department cited Rule 1300.70(b)(1)(D), which reaffirms that appropriate care may not be withheld or delayed for any reason, “including a potential financial gain and/or incentive to the plan providers.”

143 The Knox-Keene Health Care Service Plan Act is fully codified at California Health and Safety Code sections 1340 through 1399.7 (West 1990 & Supp. 1996). For a good basic explanation of the origin and objectives of the Knox-Keene Health Act, see Wayne Simon, State Regulation of HMOs: Current Issues, 11 WHITTIER L. REV. 7 (1989).

144 Comm'r of Corps. of the State of Cal. v. Takecare Health Plan, Inc., No. 933-0290 (filed with the Department of Corporations of the State of California).

145 Id. at 7.

146 Id. at 8.

147 Id. at 11.

V. CONCLUSION

A physician who seeks equitable indemnity from a managed care organization should be prepared to advance a viable theory for recovery, based in large part on the doctrine that has evolved through plaintiff patient causes of action. The physician or malpractice carrier should also have a solid understanding of the strengths and limitations of indemnity doctrine in the context of the physician/managed care organization context. The equitable indemnification cases make clear that the courts traditionally attached secondary or passive liability, at best, to principals when they have been found liable for negligent conduct involving their agents. Thus, the physician assumed the burden of most malpractice awards and had limited, if any, rights for indemnity from the MCO.

In today's health care structure, this one-way model is outmoded. The physician should be prepared to contend that recent judicial decisions and legislation acknowledge that MCOs are increasingly active participants in determining medical care.\textsuperscript{149} Lawmakers have responded to this shift and as a result plaintiffs have an increasing opportunity to assign greater direct and indirect liability to MCOs. To be consistent with these developments, we must abandon the traditional theories of indemnification that protected the MCO against assuming liability for the actions of the physician. Modern equitable principles should be available to protect physicians against shouldering full financial responsibility for damages caused by the policies of the MCO.

\footnotesize{149 See Prager, supra note 25, at 72, referring to a recent unpublished 1995 decision in which a plaintiff sued physicians and an HMO for medical malpractice and unreasonable cost-containment measures, respectively. The suit also claimed that the physicians had breached their fiduciary duty by failing to disclose their financial incentives for withholding care. That claim was dismissed, but the plaintiff was awarded $3 million in damages against the HMO.}