

MEDICAL MALPRACTICE IN THE ERA OF MANAGED CARE

*Lyle Griffin Warshauer
Warshauer Law Group, P.C.*

I. Introduction

Today, nearly 77 million Americans, the majority of individuals who have health insurance, are covered under a managed care system as opposed to the traditional fee-for-service¹ medical insurance.² Obviously, there are cost benefits to the plan member as well as the provider under this managed care system. However, simply because the practice of medicine has necessarily become more concerned with the costs associated with treatment, this should not mean that those considerations can legally be allowed to affect treatment regimes when to do so would adversely affect patients' health.³ Our concern as consumers and as lawyers representing individuals is to what extent the plan member and potential patient is protected in the event the care received is less than adequate under the circumstances.⁴ This is especially important here because "[u]nlike consumers in other markets, patients lack sufficient knowledge to ascertain what service they want, how valuable it is, and whether they received a quality version of it."⁵

The problem with the concept of "suing HMOs" is that we are trying to make a "market oriented health policy" fit within our traditional "system of liability and agency rules that developed under a different, nonmarket paradigm of medical care."⁶ It used to be that accountability for medical negligence was rather clear; either the physician or his direct employer was liable for the physician's negligence. However, under the more complex environment of managed care, agency principles are complicated by contractual obligations and loopholes that can make or break a patient's claim that he has been injured as a result of substandard care. Thus, lawyers who may be well versed in general

medical negligence law are nevertheless unable to effectively prosecute claims against an HMO. An understanding of the organizational structure of managed care groups and how these organizations' benefit plans differ from the traditional fee-for-service scheme is essential to an understanding of how tort actions in this area may be pursued.

II. What is an HMO?

The term Health Maintenance Organization, or HMO, is typically used when referring to the now predominant form of health care plan in existence in the United States today. However, there are several variations of plans that fall into the general category of Managed Care Organization (MCO). "Managed care" plans can range from ones that simply require preauthorization for a hospital stay to Staff Model HMOs that focus on utilization review, which emphasizes price for service. The nature of the plan at issue may determine in large part whether a claim for substandard medical care against the benefit provider is a viable option. Initially, the structure of an HMO, which defines the HMO-physician relationship, will be an important factor in evaluating an HMO's exposure to liability. Other factors to consider include the contracts between the organization and participating physicians, the agreements between the HMO and its subscribers, and the nature of the HMO's advertising. Finally, as is the case in traditional vicarious liability claims, the degree of control an HMO exercises over a physician may impact the HMO's potential liability for the conduct of the physician.⁷

Managed care programs provide comprehensive healthcare services to an enrolled membership for a fixed fee. There are several forms of organizations that fall under the rubric of managed care. Health maintenance organizations themselves fall into three categories. A staff model HMO actually employs its own salaried physicians, who treat only HMO patients in a facility owned and operated by the HMO. A group model HMO contracts with a group of physicians to care for, in part, HMO members at the group's facilities for a fixed monthly fee per covered individual. Finally, in the independent practice association ("IPA"), the HMO contracts with an independent association of

physicians which in turn contracts with each of its dependent physicians to provide care to HMO members in his or her own office. Usually, an HMO will have characteristics of more than one model.

Currently, the most popular system of managed care is the Preferred Provider Organization (“PPO”). A PPO is a network of physicians and hospitals that contract to provide care to a defined group of patients on a fee-for-service basis. Typically, the PPO will offer discounts to members using plan-designated physicians and hospitals and will require higher deductibles or co-payments where subscribers choose to use caregivers who are not members of the plan.

Traditional common law actions may or may not be asserted against an MCO depending upon its framework. For example, the availability of *respondeat superior* theory is limited to plaintiffs participating in a staff model HMO, because the staff model is the only system where the provider is in a direct employment relationship with the organization.⁸ However, in group or IPA models, as well as PPOs, the health care providers are usually independent contractors, not employees, of the organization. Thus, a theory of “ostensible agency” is usually relied upon in asserting claims against these organizations.⁹ Direct actions against any of the plan models raise concerns over the entity’s ability to “practice medicine” and similar defensive issues. Historically, Managed Care Organizations defended common law actions under traditional common law principles. However, practitioners in this arena today must be poised to respond to more complicated defenses based on federal statutory law.

Managed care differs from the traditional fee-for-service method of medical care in that, while under the traditional method doctors were encouraged to provide whatever services they deemed necessary to treat; managed care attempts to reduce health care costs in part by changing the system of incentives under which physicians operate so that less treatment means more revenue for the physician. An MCO runs according to a capitation reimbursement scheme in which a fixed amount of money is available to

provide agreed upon services to an identified group of individuals.¹⁰ Generally, an MCO will compensate physicians on a per patient rather than a per service basis. Usually, a primary physician will act as a “gatekeeper” to higher or additional levels of care.

Additionally, an MCO engages in “utilization review” to monitor and evaluate the medical necessity and appropriateness of its physicians’ prescribed treatment. The utilization review process is prospective and consequently is a significant departure from the traditional insurer’s approach in which it employed a retrospective analysis of treatment actually rendered to determine if reimbursement for the care is warranted. Under that approach, the care of the patient is not compromised by the insurer’s decision whether to pay or reimburse fully for procedures the patient has already undergone. In contrast, the MCO’s “prospective review” process is dangerous, especially in an emergency situation, because while the company is determining if care is warranted in light of the costs to be incurred, valuable time needed to implement treatment is wasted. The results can be devastating.¹¹

Through these methods of cost control, a Managed Care Organization is essentially making decisions that can and often do harm patients. Harm may be the result of straight malpractice by plan physicians due to incompetence, neglect or anything that would give rise to a cause of action in the traditional medical malpractice context. Additionally, patients are harmed by the MCO’s limitations on access to specialty care and hospitalization, as well as poor drug choices and delayed diagnosis.¹² Even the physicians taking part in these organizations recognize that the new system, which emphasizes cost as opposed to quality, can lead to substandard care.

Doctors who deal with PPOs frequently perceive that “high quality” is not the primary criterion: according to the general counsel of the American Medical Association, if you are a cheap doctor, you are going to be in the [PPO] plan, whether you are good or bad. . . . [T]he incentives operating on HMOs and cost-containment programs can go too far, facilitating a significant number of incidents of medical malpractice, at least when malpractice is itself defined in conventional Learned Hand cost-benefit terms.¹³

Yet, until very recently, an MCO has been subject to little risk when its medical and administrative decisions result in injury. It is imperative that we reconsider how to judicially attack these decisions so that patient needs again take precedence over the Almighty dollar.

III. Theories of Liability

While there are few cases in which direct actions against an MCO have been attempted, the few that do exist establish that several potential causes of action are available. Generally, a claim against an MCO will fall into two main categories: those based on the quality of care received; and those premised on the wrongful denial of medical treatment or benefits under the plan. Significantly, the courts addressing such claims, while not always allowing the plaintiff to recover against the benefit provider, often go out of their way to *suggest* possible ways to prevail in the future. Without a doubt, courts and commentators recognize the need for and the inevitability of tort actions as a means of regulating care in the age of cost containment.¹⁴ As one commentator aptly put it: “More tort litigation, rather than less, is needed to incentivize managed care systems to pay attention to patient risks.”¹⁵

A. Vicarious Liability

The doctrine of *respondeat superior*, in which an employer is vicariously liable for the negligence of its employee acting within the scope of employment, has been applied in traditional medical malpractice actions against hospitals. The doctrine is equally applicable in the context of HMO liability assuming the organizational structure is similar. Courts imposing vicarious liability on staff model plans look to the operation of the organization to determine whether its conduct is similar to that of a health care provider. Analysis of an organization’s liability begins with a determination of the control exercised by the plan over its physicians.

*Sloan v. Metropolitan Health Council*¹⁶ is most often cited in discussing vicarious liability against an MCO. The Sloans sued Metro, an HMO, alleging a negligent failure

to diagnose. Metro denied liability claiming that its physicians were independent contractors and that Metro had no control over their diagnosis or treatment decisions. Because it is unlawful for a corporation to practice medicine in Indiana, Metro claimed that it could not be said to be practicing medicine. The court rightfully rejected the defense, finding it to be a “non sequitur to conclude that because a hospital cannot practice medicine or psychiatry, it cannot be liable for the actions of its employed agents and servants who may be so licensed.”¹⁷ Thus, the argument that the HMO should be insulated in this fashion was equally flawed. In holding the HMO vicariously liable, the court focused on the HMO’s employment contract and evidence of the HMO’s control exercised over the physicians whose care was at issue.¹⁸

Some courts have gone even further by using agency principles to impose liability for consulting physicians chosen by the HMO’s employee physicians. For example, in *Schleir v. Kaiser Found. Health Plan*,¹⁹ a staff model HMO was held vicariously liable for the actions of an independent consulting physician based on four factors: (1) the consultant had been engaged by an HMO-employed physician; (2) the HMO had the right to discharge the consultant; (3) services provided by the consultant were part of the regular business of the HMO; and (4) the HMO had some ability to control the consultant’s behavior because he answered to the primary care physician who was a plan doctor.²⁰

Also borrowed from the hospital arena is the doctrine of ostensible agency to impose liability against an MCO for the conduct of independent contractor physicians. Under this theory, the court will look to whether there is an appearance, through advertising or provisions in the plan itself, that an agency relationship exists between the HMO and the negligent doctor and, further, whether it is reasonable to assume that the patient looked to the HMO rather than the individual physician for her care. For example, in *Boyd v. Albert Einstein Medical Center*,²¹ the court stated:

[B]ecause appellant's decedent was required to follow the mandates of HMO and did not directly seek the attention of the specialist, there is an inference that appellant looked to the institution for care and not solely to the physicians; conversely, that appellant's decedent submitted herself to the care of the participating physicians in response to an invitation from HMO.²²

The court seemed to rely on the organization's advertising, which touted the HMO as a "total care program," and an "entire health care system," in finding that there was a representation that the physicians were its employees.²³ The additional factors relied upon by the court to find ostensible agency are often characteristics of HMOs in general, which suggests that *Boyd* may be applied rather broadly to find liability against these organizations. The critical factor will still be a finding of the appearance of agency and the reasonable belief by the patient that he is being treated by the HMO.

B. *Direct Institutional Liability*

The theory of corporate negligence is based on the principle that the health care organization, either the hospital or the MCO, has a duty to its patients to provide competent medical staff and quality care. It does so through appropriate selection, review and evaluation of the physicians who are selected to participate in the organization. Where the organization is negligent in its selection or supervision of member physicians, it may be liable for injury caused by the provider's negligence.

In *McClellan v. Health Maintenance Organization of Pennsylvania*,²⁴ dealing with an IPA model HMO, the plaintiff brought claims under theories of ostensible agency,²⁵ corporate negligence, breach of contract/warranty, and intentional misrepresentation or fraud. The court determined that such organizations have a nondelegable duty to select and retain only competent primary care physicians and upheld the plaintiff's claim that the HMO intentionally misrepresented that its physicians passed vigorous screening and that the primary care physicians would promptly make referrals to medical specialists.²⁶

The court's ruling in *McClellan* can be a double-edged sword for an HMO. The court's rationale makes it essential for an HMO to carefully evaluate the credentials,

qualifications and competence of its member physicians. However, in doing so, the HMO's involvement in selecting, and especially supervising, physicians is evidence of the "control" over its physicians necessary for a finding of ostensible agency. Thus, in an effort to avoid liability based on direct negligence claims, the HMO may set itself up for a finding of vicarious liability.

Again, the organization's structure will be an important consideration in determining if either approach fits. For example, an IPA model HMO may defend on the basis of its selection only of the group IPA, not the individual physicians. Additionally, where an HMO uses an outside physician credentialing firm in the selection process, there is less evidence of direct control. These are all matters that must be addressed in formulating a complaint against an MCO.

C. *Cost-Containment Mechanisms*

Managed Care Organizations attempt to keep costs down by determining, ahead of time, whether a physician's prescribed treatment will be covered. This utilization review process can be aggravating to both the practitioner and his or her patient. Additionally, the system of incentives that is often in place serves to encourage *underutilization* by physicians, as their personal profit margin increases when they order less tests and make fewer referrals. Both the utilization management engaged in by the organization's administrative component as well as the underutilization that is induced by physician incentives exposes plan participants to a risk of injury. However, it also exposes the MCO to increased liability.

The leading case addressing liability for an MCO's improper use of cost containing methods, and the seminal case discussing HMO liability in general, is *Wickline v. State*.²⁷ The plaintiff in *Wickline* was originally treated by Dr. Daniels, a family practitioner, for back and leg problems. She was later hospitalized at Van Nuys Community Hospital where she was examined by Dr. Polonsky, a peripheral vascular surgeon.²⁸ He diagnosed Leriche's Syndrome, a condition caused by obstruction of the

terminal aorta due to arteriosclerosis, and recommended surgery. Ms. Wickline was eligible for Medi-Cal, the medical assistance program in California; thus, Dr. Daniels sought authorization for the hospitalization and surgery. Ten days were allowed. Dr. Polonsky performed the surgery, which he characterized as “very major surgery.”²⁹ Later, a clot developed and Dr. Polonsky performed a second procedure after which Ms. Wickline’s recovery was described as “stormy.” Finally, a lumbar sympathectomy was performed on January 12th.³⁰

Ms. Wickline was to leave the hospital on January 17th; however, Dr. Polonsky determined that it was “medically necessary” for her to remain for another eight days.³¹ The Medi-Cal nurse responsible for completing such request forms felt that she should not approve the entire eight-day extension; therefore, she contacted the Medi-Cal consultant, Dr. Glassman, who rejected the request and authorized only four additional days. Drs. Polonsky and Daniels then each wrote discharge orders based on the four day extension. While they were aware that they could request a further extension, neither did, and Ms. Wickline was discharged at four days.³² Dr. Polonsky testified that he felt his hands were tied as to further appeals. The medical experts agreed that he was within the standard of practice in discharging Ms. Wickline when he did.³³

Within a few days of discharge, Mrs. Wickline’s leg began to deteriorate. Nine days later she was ordered back to the hospital. Efforts to save her leg were unsuccessful and Dr. Polonsky had to amputate.³⁴ He later testified that had she remained in the hospital, he would have observed the changes in the leg, recognized that a clot had formed, and ordered further surgery. It was his opinion to a reasonable degree of medical certainty that she would not have lost her leg if she had remained in the hospital.³⁵

The California court held that Medi-Cal could not be responsible because the decision to discharge the patient was that of the treating physician. However, the court’s dicta is significant: “While we recognize realistically that cost consciousness has become

a permanent feature of the health care system, it is essential that cost limitation programs [not be] permitted to corrupt medical judgment.”³⁶ The court went on to note:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors 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 However, the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.³⁷

The facts of *Wickline* did not support a finding against the MCO, but the decision does suggest that there are situations where a cause of action will be appropriate. Clearly, the decision stands for the proposition that the doctor is ultimately responsible. If critical of the insurer’s decision or policy, for legal success against the MCO it needs to be clearly conveyed that the *ultimate* decision was mandated by the organization, not the physician. Certainly, the insurer is not going to protect the doctor’s decision if it means that liability will instead be imposed on it. This puts the physician in an uncomfortable position of being on the one hand a part of the MCO team, in which he is expected to adhere to the judgment of the group, and on the other hand an advocate for the patient.³⁸

In keeping with the *Wickline* court’s forecast, other cases have held that external utilization review entities can be held liable for negligent review if a patient is harmed as a result of a denial of care. In *Wilson v. Blue Cross of Southern California*,³⁹ the court limited *Wickline* and expanded potential liability for utilization review decisions.⁴⁰ Howard Wilson sought and was denied in-patient treatment for drug problems, depression and other psychiatric problems. His physician hospitalized him and requested approval for a three to four week hospital stay. Wilson’s plan specifically authorized up to 30 days of hospitalization if the treating physician deemed it medically necessary.

However, without any support in the plan documents, Blue Cross submitted the request to an outside company, Western Medical, for utilization review.⁴¹ Western Medical's physician consultant determined that Wilson's treatment could be adequately administered on an outpatient basis and said that the hospitalization request was "not justified or approved."⁴² Wilson was discharged and committed suicide shortly thereafter. His physician testified that Wilson would have survived if he could have remained longer in the hospital for treatment.⁴³

Blue Cross argued that public policy favors concurrent cost utilization procedures and even provides for some immunity for organizations engaging in cost containment procedures in the administration of their plans. However, the court said that no such public policy exists.⁴⁴ Addressing the *Wickline* court's analysis of the physician's responsibility in that case, the court found that language to be merely dicta, "unnecessary to the decision and in all contexts does not correctly state the law relative to causation issues in a tort case."⁴⁵ Instead, the court focused on the joint liability of the participants and found that the decision of Blue Cross and Western Medical not to approve the hospital stay requested by the treating physician could be found to be a "substantial factor" in causing Wilson's death.⁴⁶

Because of the dearth of case law in this area, it is too soon to opine whether courts will follow the public policy considerations addressed in *Wickline* or whether they will adhere to the *Wilson* court's reasoning. It is likely, however, that courts will continue to focus on the conduct of the HMO to determine its contribution to the plaintiff's injury. When economic incentives override patient care, not only will courts be more likely to allow claims to go to the jury, but punitive damages may even be warranted.

D. *Bad Faith*

Bad faith claims against an HMO may be asserted in a variety of contexts; usually, the claim is that certain treatment was denied for financial reasons. Examples of

conditions that may give rise to a finding of bad faith may include the following: (1) the HMO refuses to approve a referral to a specialist; (2) the failure to approve diagnostic testing; (3) denial of coverage for purportedly preexisting conditions; (4) misleading or deceiving patients about the HMO's benefits and coverage; (5) making false promises to potential subscribers to induce enrollment in the plan; (6) refusal to cover "experimental" procedures; and (7) refusal to approve admission to the hospital or to approve extensions of hospital stays.⁴⁷ The factual situation should be considered in light of the organization's rationale for its decision to deny care. If the patient's interests have not been given at least as much weight as the HMO's financial concerns, an argument for bad faith refusal is warranted.

Managed Care Organizations will most likely be susceptible to adverse jury verdicts in bad faith claims which involve economic incentives offered to participating physicians to limit costs and control the utilization of outside, specialized health care services. For example, in *Bush v. Dake*, the court refused to dismiss the plaintiff's complaint which alleged that the organization's cost containment system had caused her physicians to provide inadequate care resulting in her injury.⁴⁸ The plaintiff focused on the fact that physicians were allowed to share in any surplus funds resulting from a low number of specialist referrals or hospitalization days ordered that remain in the HMO coffers at the end of the fiscal year. It should be noted, however, that while the court allowed the suit to go forward by denying summary judgment, it specifically stated that the organization could not be held liable simply for having cost-containment measures as part of the plan. Obviously, the plaintiff would still have to prove negligence and causation.

The largest reported verdict to date was awarded in 1993 by a Riverside County, California jury in *Fox v. Health Net*.⁴⁹ The HMO had denied coverage for a bone marrow transplant for a breast cancer patient on the ground that the treatment was experimental. This was despite the fact that the coverage book stated that the requested

procedure was covered. When the coverage was denied, the family raised the more than \$200,000 needed for the procedure; however, Ms. Fox later died after undergoing the transplant. Nevertheless, the plaintiffs were successful in convincing the jury that the denial of treatment by the HMO was profit motivated. Thus, the jury awarded approximately \$12,000,000 in compensatory damages for bad faith, breach of contract, and reckless infliction of emotional distress and further awarded \$77,000,000 in punitive damages.⁵⁰

In yet another California case, *Hughes v. Blue Cross of Northern California*, a family sued for breach of the implied covenant of good faith and fair dealing and punitive damages as a result of the denial of coverage for psychiatric hospitalization for their severely mentally ill son.⁵¹ The appellate court affirmed the jury's award of compensatory and punitive damages, holding that the jury could have reasonably inferred that Blue Cross's denial of coverage was based on company policy, which included operating a review process in conscious disregard of the insured/patient's rights. Interestingly, the court seemed to find that the company's cursory review of medical records in the process of determining if medical necessity existed to be a violation of established standards of care, implying a level of direct negligence by the organization itself.⁵²

IV. A Roadblock to Recovery: ERISA

Generally, claims involving substandard medical care are based on state law. However, Managed Care Organizations are increasingly defending claims for negligence, breach of contract, fraud and misrepresentation by relying on the broad preemption provisions of the Employees Retirement Income Security Act of 1974 (ERISA).⁵³ ERISA is probably "the most significant legal barrier to the widespread application of third-party payor liability for negligence in utilization review decisions."⁵⁴ ERISA is a comprehensive statute providing for federal oversight of the administration of employer-sponsored pension and welfare benefit plans.⁵⁵ It is designed to promote the interests of

employers and their beneficiaries in employee benefit plans by setting uniform minimum standards for such plans and providing for uniform remedies in the enforcement of the plans.⁵⁶

Section 514(a) of ERISA preempts state law insofar as it “may now or hereafter **relate to any employee benefit plan.**”⁵⁷ However, while ERISA provides the federal government with broad regulatory powers over benefit plans, it does not provide for complete preemption.⁵⁸ Numerous cases have addressed the question of to what extent ERISA does preempt state law claims and which claims are unaffected. The current state of affairs seems to suggest that claims against an HMO which deal with a denial of benefits will be preempted, as will claims based on misrepresentation and breach of contract, on the ground that they “relate to” a benefit plan, even if they are not claims dealing directly with the denial of coverage of the failure to pay benefits. However, ERISA does not necessarily preempt state common law medical malpractice actions even when asserted against an HMO.⁵⁹ One court has reduced the inquiry to: “Where the factual setting giving rise to a state tort claim overlaps that of an ERISA claim, ERISA does not preempt the state tort claim.”⁶⁰

In *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*,⁶¹ the court determined that the plaintiff’s claims against the HMO based on vicarious liability were not preempted, but the claim that the HMO was liable for refusing to pay for certain procedures *was* preempted, since that claim actually referenced the benefit plan. Additionally, the court held that the claims for intentional misrepresentation of the physicians’ qualifications and the breach of contract claim were also preempted. The preemption of the misrepresentation claim was due to the fact that the claim had a connection with the plan since it was based on representations of the benefits available under the plan.⁶² Preemption of the breach of contract claim was founded on its connection with the plan due to the contractual obligation under the plan to provide for qualified physicians.⁶³

The 1995 United States Supreme Court decision in *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*⁶⁴ clarified somewhat the threshold level of “connection” that a state law must have to an ERISA plan in order to trigger preemption.⁶⁵ Significantly, the Court’s reasoning explicitly refutes the argument that ERISA should preempt vicarious liability claims against Managed Care Organizations because allowing such suits will affect the cost of administering employee benefit plans.⁶⁶

The Court’s reasoning in *Travelers*, in which it significantly limited the breadth of the section 514 “relate to” clause, has served to assist those opposing preemption of vicarious liability claims against Managed Care Organizations. Defense claims that medical malpractice actions are preempted solely on the ground that they may affect the administration of the plan or costs in providing plan benefits are now less likely to defeat malpractice actions against an HMO.

The consolidated cases of *Dukes v. U.S. Healthcare, Inc.* and *Visconti v. U.S. Health Care*,⁶⁷ provide an excellent summary of virtually all of the issues discussed in this article and lend support to the idea that claims against HMOs are alive and well in spite of ERISA. In the context of the preemption argument the case suggests that claims which deal with the denial of benefits pursuant to utilization review will be treated differently from claims which attack solely the quality of care received. The opinion contains, however, an extensive recitation of cases which have gone both ways on the issue and thus provides an excellent source for counsel seeking an understanding of how courts have dealt with ERISA preemption defenses in a variety of contexts.⁶⁸

In *Dukes*, Daryl Dukes’ doctors recommended that he undergo blood testing following ear surgery. For various reasons the tests were delayed. Mr. Dukes’ condition worsened and when the tests were eventually performed they revealed an extremely high blood sugar level leading to his death. Mrs. Dukes brought suit in state court against various defendants, including the HMO. Claims against the HMO were premised on ostensible agency - that the organization was responsible for the negligence of its various

doctors. The complaint also asserted direct negligence claims for the failure to exercise reasonable care in the selection, retention, and monitoring of the personnel who provided medical services to Dukes.⁶⁹ *Visconti* concerned claims by parents for the wrongful death of their stillborn daughter. They attempted to hold the HMO liable for the obstetrician's malpractice under ostensible and actual agency theories, and also under a direct negligent selection and retention theory.⁷⁰ Both cases were removed to federal court on the ground that the claims were completely preempted by ERISA. The district court then denied remand and dismissed both suits.⁷¹

On appeal, the Third Circuit considered the legislative history of ERISA, other courts' interpretation of state law claims in light of ERISA's preemption requirement and the statute's remedial section to determine if the claims were properly removed and dismissed by the district court. The court found that the plaintiffs' state law claims against the HMO did not fall within the scope of ERISA's civil enforcement provisions and therefore disagreed with the lower court's finding that the cases were subject to removal due to complete preemption under *Metropolitan Life Ins. Co. v. Taylor*.⁷²

To determine whether the plaintiffs' state law claims fall within the scope of section 502 of ERISA, the court "must determine whether those claims, properly construed, are 'to recover benefits due . . . under the terms of [the] plan, to enforce rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan.'"⁷³ The court noted that review of the actual plan documents would be helpful to this inquiry, and further noted the parties' dispute as to the characterization of the plaintiffs' claims and the meaning of the word "benefit." The court did not resolve this dispute, however, and merely assumed that "the medical care provided (and not merely the plaintiffs' memberships in the respective HMOs) is the plan benefit for the purposes of ERISA," and that "the HMOs, either as part of or on behalf of the ERISA plans, arrange for the delivery of those plan benefits."⁷⁴ Nevertheless, the court held that preemption was not in order because the claims merely attacked the quality of the

benefits received; there was no claim that the benefits themselves were withheld.⁷⁵ “Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such.”⁷⁶

Finally, the court distinguished the plaintiffs’ claims from the type of claim attacked in *Corcoran v. United Healthcare, Inc.*⁷⁷ In *Corcoran*, the plaintiff sued the HMO, Blue Cross, and the third party administrator, United, for the decisions it made under the plan’s pre-certification review program. The Fifth Circuit ruled that ERISA preempted the plaintiff’s claims against United because the plaintiff was “attempting to recover for a tort allegedly committed in the course of handling a benefit determination.”⁷⁸ The situation in *Corcoran* was distinguished because the claim against United was solely based on its participation in the utilization review process -- it was not involved in providing the actual medical services. “The difference between the ‘utilization review’ and the ‘arranging for medical treatment’ roles is crucial for the purposes of § 502(a)(1)(B) because only in a utilization review role is an entity in a position to deny benefits due under an ERISA welfare plan.”⁷⁹ Both *Corcoran* and *Dukes* stand for the proposition that ERISA is implicated only where utilization review is at issue because it is in that context that decisions are “‘made in connection with a cost containment plan.’”⁸⁰

The distinction in *Dukes* between claims involving the quality versus the quantity of medical care leaves one to believe that claims which are grounded on the HMO’s cost containment strategies, e.g., withholding benefits or care for financial reasons, will be preempted.⁸¹ The manner in which the court relied upon the *Travelers* case, however, suggests that despite the fact that there is an administrative component to these plans given the organizations’ arrangements with physicians, a vicarious liability claim can be maintained under state law without implicating ERISA. This will inevitably be a field that will generate additional, and most likely, conflicting decisions. Trial lawyers,

however, should take heart in the court's assertion that "patients enjoy the right to be free from medical malpractice regardless of whether their medical care is provided through an ERISA plan."⁸²

IV. CONCLUSION

Managed care has become the way of the world in healthcare. Any cause of action questioning the quality of care received by a patient will inevitably have to take into consideration the potential liability of a health maintenance organization. While that task may seem daunting at first, a careful look at the structure of the organization, including its relationship to both its healthcare providers and member patients, will likely reveal a scenario that establishes a basis for liability against the organization. Given the overwhelming emphasis on cost control in the health care arena, claims calling into question the financial motivation behind treatment decisions will likely proliferate. If claimants are to prevail, however, a thorough understanding of complex preemption issues is essential. Claims against Managed Care Organizations can and should be asserted in an effort to reestablish patient health as the primary focus of healthcare decisions.

¹ "Fee-for-service" is the traditional way of paying for medical care. Payment is made for all services provided and the amount of payment is commensurate with the amount of service rendered.

² Mark O. Hiepler, *Grappling with HMOs - Shaping the Future of Health Care Law*, 12 Prof. Negl. L. Rptr. 194 (December 1997).

³ See Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 Va. L. Rev. 1525, 1534 (1996).

⁴ See Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 Colum. L. Rev. 1674, 1676 (1994) ("Despite the political and economic momentum toward managed care as a means to prevent overtreatment and conserve costs, little empirical evidence exists to show how well this system protects patients against undertreatment.").

⁵ Elhauge, *supra* note 3 at 1536-37. Patients are dependent on others for advice -- those who may have financial incentives to over-treat or under-treat depending on the circumstances of their profit mechanism. Thus, extra consumer protection is needed in this area.

⁶ Clark C. Havighurst, *Making Health Plans Accountable For the Quality of Care*, 31 Ga. L. Rev. 587 (1997).

⁷ Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 *Baylor L. Rev.* 285, 299 (1995).

⁸ *See, e.g., Sloan v. Metropolitan Health Council, Inc.*, 516 N.E.2d 1104 (Ind. Ct. App. 1987) (holding that a direct employment relationship arguably existed where a staff model HMO engaged physicians by written “employment contracts” that referred to the HMO as “employer” and provided for an annual salary and benefits package).

⁹ *See, e.g., Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229 (Pa. Super. 1988) (holding that because the defendant restricted physician selection to a limited list, received payment directly from plan participants and used its primary care physicians as gatekeepers to higher level care, a reasonable jury could infer that the HMO had held out the physicians as its employees).

¹⁰ Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 *Ga. L. Rev.* 419, 431(1997).

¹¹ *See, e.g., Wickline v. State*, 1192 Cal. App. 3d 1630, 239 Cal. Rptr. 810, 812 (1986) (“A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient’s permanent disability or death.”).

¹² Furrow, *supra*, note 10 at 425.

¹³ Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be On American Tort Law and Malpractice Law*, 79 *Cornell L. Rev.* 1339, 1363-34, 1366-67 (1994).

¹⁴ *See* William M. Sage, “*Health Law 2000*”: *The Legal System and the Changing Health Care Market*, *Health Aff.*, Fall 1996, at 9, 13 (“Eventually, . . . the legal system is likely to hold the organizations controlling clinical care - whether they be capitated medical groups, hospital-run networks, or insurance companies - accountable for negligent patient injury.”).

¹⁵ Furrow, *supra* note 10 at 425. *See also* Elaine Lu, Recent Development, *The Potential Effect of Managed Competition in Health Care on Provider Liability and Patient Autonomy*, 30 *Harv. J. on Legis.* 519, 533 (1993) (“Courts have correspondingly demonstrated a willingness to recognize the growing risks to patients of cost-containment measures and to extend tort liability to insurers where their utilization review process has displaced accepted medical judgment.”).

¹⁶ 516 N.E.2d 1104 (Ind. Ct. App. 1987).

¹⁷ *Id.* at 1108.

¹⁸ *Id.* at 1109. *But see Propst v. Health Maintenance Plan, Inc.*, 582 N.E.2d 1142, 1143 (Ohio Ct. App. 1990) (refusing to hold HMO liable, court found that the model of HMO was irrelevant; “[s]ince the corporate [HMO does] not practice medicine, [it] may not be held liable under a complaint which sounds in medical malpractice.”).

¹⁹ 876 F.2d 174 (D.C. Cir. 1989).

²⁰ *Id.* at 177-78. The court went on to note support for a finding of “ostensible agency” based on these findings. *Id.* at 178.

²¹ 547 A.3d 1229 (Pa. Super. 1988).

²² *Id.* at 1235.

²³ *Id.* at 1232 n. 6. The brochure also specifically provided that the HMO “[a]ssumes responsibility for quality and accessibility.” *Id.* This case is an example of how the plan documents themselves may provide the basis for asserting liability based on agency principles.

²⁴ 604 A.2d 1053 (Pa. Super. Ct. 1992).

²⁵ The court also held that the doctor could be found to be an ostensible agent for purposes of the vicarious liability count of the complaint. *Id.* at 1058.

²⁶ *Id.* at 1059-61. Interestingly, although the court first found that because the IPA model HMO “could not be viewed as having ‘assumed the role of a comprehensive health center,’” and could not “oversee . . . patient care,” it could still be found liable. The court determined that it was unnecessary “to extend the theory of corporate negligence to IPA model HMOs in order to find that such HMOs have a nondelegable duty to select and retain only competent primary care physicians.” *Id.* at 1059.

²⁷ 239 Cal. Rptr. 810, 192 Cal. App. 3d 1630, *review granted*, 727 P.2d 753 (Cal. 1986), *review dismissed and case remanded*, 741 P.2d 613 (Cal. 1987).

²⁸ 239 Cal. Rptr. at 812.

²⁹ *Id.*

³⁰ *Id.* at 812-13.

³¹ *Id.* at 813.

³² *Id.* at 815.

³³ *Id.* at 815.

³⁴ *Id.* at 816-17.

³⁵ *Id.* at 817.

³⁶ *Id.* at 820.

³⁷ *Id.* at 819.

³⁸ While the court noted “[t]here is little doubt that Dr. Polonsky was intimidated by the Medi-Cal program,” it went on to state that “he was not paralyzed by Dr. Glassman’s response nor rendered powerless to act appropriately if other action was required under the circumstances.” *Id.* See also John G. Salmon, *Litigating Claims Against Managed Health Care Organizations*, Trial (February 1995) 80, 81. (“Physicians are therefore, essentially forced to choose between potential medical negligence 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 or PPO.”). The doctors’ “dilemma” also concerns to what extent physicians must disclose to patients tests that might be available even if not recommended. See, e.g., Lu, *supra* note 15 at 550 (discussing “informed refusal”).

³⁹ 271 Cal. Rptr. 876, 222 Cal. App. 3d 660 (1990).

⁴⁰ Specifically, the court considered to what extent *Wickline* extended beyond Medi-Cal to private insurers.

⁴¹ 271 Cal. Rptr. 876, 880-81.

⁴² *Id.* at 882.

⁴³ *Id.*

⁴⁴ *Id.* The *Wilson* court contrasted the situation involved there with *Wickline*, where there was a clearly expressed public policy favoring limiting the scope of liability of public systems such as Medi-Cal.

⁴⁵ *Id.* at 880.

⁴⁶ *Id.* at 883-84. Thus, summary judgment was denied.

⁴⁷ See Joanne B. Stern, *Bad Faith Suits: Are They Applicable to Health Maintenance Organizations?*, 85 W. Va. L. Rev. 911, 920-26 (1983).

⁴⁸ No. 86-25767 NM-2 (Mich., Saginaw County Cir. Ct., April 27, 1989).

⁴⁹ No. 21962 (Cal., Super. Ct, Riverside Co., Dec. 28, 1993).

⁵⁰ See Salmon, *supra* note 38 at 84; Bearden & Maedgen, *supra*, note 7 at 329.

⁵¹ 263 Cal. Rptr. 850 (Ct. App. 1989), *cert dismissed*, 495 U.S. 944 (1990).

⁵² *Id.* at 858-59.

⁵³ 29 U.S.C. §§ 1001-1461 (1988 & Supp. V 1994).

⁵⁴ David D. Griner, Comment, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 Ga. L. Rev. 861, 912 (1991).

⁵⁵ In most cases, an HMO will be covered by ERISA because it is sponsored by an employer through a qualified benefit plan. An ERISA plan is one that meets five criteria: (1) a “plan, fund or program” (2) established or maintained (3) by an employer or by an employee origination, or by both (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, . . . (5) to the participants or their beneficiaries.

See *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982).

⁵⁶ *Shaw v. Delta Air Lines*, 463 U.S. 85, 90, 103 S. Ct. 2890 (1983).

⁵⁷ 29 U.S.C. § 1144(a) (1994).

⁵⁸ See, e.g., *Yanez v. Humana Medical Plan, Inc.*, 969 F. Supp. 1314, 1316 (S.D. Fla. 1997) (rejecting the HMO’s ERISA preemption argument finding that while courts construe the preemption clause broadly, “there are limits to this principle of broad construction.”). One should recognize, however, that there are certain types of claims that do invoke “complete preemption” as that term has been used to impose an exception to the well-pleaded complaint rule. Where the claims seek “to recover [plan] benefits . . . under the terms of the plan, to enforce, . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan” as those phrases are used in section 502(a)(1)(B) of ERISA, 20 U.S.C. § 1132 (a)(1)(B) the claims are preempted and removal is proper. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542 (1987). Practitioners working in this area should be familiar with the distinction between the jurisdictional requirements for removal triggered by section 502 and section 514’s “related to” or substantive preemption language. For a discussion on the difference between complete preemption and substantive preemption, see Linda A. Way, *Protecting Medical Malpractice Claims Against ERISA Preemption*, Trial (March 1997) 34.

⁵⁹ See *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 832-33 (1988) (“Run-of-the-mill state law claims such as . . . torts committed by an ERISA plan” fall outside the scope of section 514(a) of ERISA.).

⁶⁰ *Burke v. Smithkline Bio-Science Lab.*, 858 F. Supp. 1181, 1184 (M.D. Fla. 1994) (citing *Clark v. Coats & Clark, Inc.*, 865 F.2d 1237 (11th Cir. 1989) (holding that the breach of contract claim against the HMO was preempted because the claims were grounded in the administration of the plan; but allowed claims predicated on principles of medical malpractice by an agent).

⁶¹ 802 F. Supp. 1286, 1290-92 (E.D. Pa. 1992).

⁶² *Id.* at 1292.

⁶³ *Id.*

⁶⁴ 514 U.S. ____, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995).

⁶⁵ Earlier, the Court had described the ERISA preemption statute as “broadly worded,” “deliberately expansive,” and “conspicuous in its breadth,” in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138, 111 S. Ct. 478 (1990). Questions remained, however, as to how expansive and how broad ERISA’s preemption would be in its application.

⁶⁶ 115 S. Ct. at 1679.

⁶⁷ 57 F.3d 350 (3d Cir. 1995).

⁶⁸ *Id.* at 360.

⁶⁹ *Id.* at 352.

⁷⁰ *Id.* at 353.

⁷¹ *Id.* at 352-53.

⁷² *Id.* at 355-56 (citing *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63, 107 S. Ct. 1542 (1987)).

⁷³ *Id.* at 356.

⁷⁴ *Id.*

⁷⁵ *Id.* at 357. The court noted that the legislative history failed to reveal an intent to create a remedy for a participant injured by medical malpractice or a desire to control the *quality* of the benefits received.

⁷⁶ *Id.* (citing *Travelers Ins. Co.*, 115 S. Ct. 1671). The court did recognize that “the distinction between the quality of benefits due under a welfare plan and the quality of those benefits will not always be clear,” but that the situation therein involved did not cause this quandary. *Id.* at 358.

⁷⁷ 965 F.2d 1321 (5th Cir.), *cert. denied*, 121 L. Ed. 2d 684, 113 S. Ct. 812 (1992).

⁷⁸ *Id.* at 1331.

⁷⁹ 57 F.3d 350, 360.

⁸⁰ *Id.* (quoting *Corcoran*, 965 F.2d at 1333 n. 16).

⁸¹ The case also suggests that claims based on contract will similarly be preempted. *Id.* at 359. *See also* Havighurst, *supra* note 6 at 644-45.

⁸² 57 F.3d 350, 358.