10-1-1998

Take Half an Aspirin and Call Your HMO in the Morning-Medical Malpractice in Managed Care: Are HMOs Practicing Medicine Without a License?

Tom J. Manos

Follow this and additional works at: http://repository.law.miami.edu/umlr

Part of the Health Law Commons

Recommended Citation
Available at: http://repository.law.miami.edu/umlr/vol53/iss1/5

This Comment is brought to you for free and open access by Institutional Repository. It has been accepted for inclusion in University of Miami Law Review by an authorized administrator of Institutional Repository. For more information, please contact library@law.miami.edu.
Take Half an Aspirin and Call Your HMO in the Morning—Medical Malpractice in Managed Care: Are HMOs Practicing Medicine Without a License?

I. INTRODUCTION ...................................................... 195

II. HISTORICAL OVERVIEW ............................................. 199
   A. The Birth of HMOs .............................................. 201
   B. Medical Ethics .................................................. 204
   C. Increasing Litigation ........................................... 205
   D. Tort Reform .................................................... 208
   E. Increasing Presence of HMOs ................................... 209

III. TYPES OF HMOs .................................................... 211

IV. CRITICISM OF HMOs ................................................ 212
   A. Inferior Care .................................................... 212
   B. Volume Healthcare ............................................. 214
   C. Capitation Schemes ............................................. 215
   D. Utilization Management ....................................... 216
   E. Financial Incentives ............................................ 217
   F. Gag Clauses ..................................................... 219

V. ERISA PREEMPTION .................................................. 220
   A. Split Decisions Regarding Complete Preemption (§ 502) ............. 222
      1. SECOND CIRCUIT .............................................. 222
      2. THIRD CIRCUIT .............................................. 222
      3. SEVENTH CIRCUIT ............................................ 223
      4. FIRST CIRCUIT ................................................ 224
   B. Split Decisions Regarding Conflict Preemption (§ 514) ................ 225
      1. TENTH CIRCUIT .............................................. 225
      2. SEVENTH CIRCUIT ............................................ 225
      3. FIFTH CIRCUIT ............................................... 226
      4. NINTH CIRCUIT ............................................... 226
      5. EIGHTH CIRCUIT ............................................. 227
   C. Synopsis of ERISA Decisions .................................... 228

VI. CORPORATE PRACTICE OF MEDICINE DOCTRINE ....................... 229

VII. LEGISLATION ........................................................ 234
   A. State Legislation ............................................... 234
      1. TEXAS ...................................................... 234
      2. NEW YORK ................................................... 235
      3. CALIFORNIA .................................................. 235
      4. GEORGIA ...................................................... 236
      5. NEW JERSEY .................................................. 236
      6. OTHER STATES ............................................... 237
   B. Federal Legislation ............................................. 238

VIII. CONCLUSION ........................................................ 239

I. INTRODUCTION 

Lamona Adams was a member of the Kaiser Foundation Health Plan of Georgia, a Health Maintenance Organization ("HMO") that con-
tracted to provide comprehensive medical care for Ms. Adams and her family. Ms. Adams brought her six-month-old son, James, to the Kaiser facility where he was briefly examined by a Kaiser physician and diagnosed with an upper respiratory infection and post nasal drip. The doctor told Ms. Adams to use a vaporizer, and to administer saline nose drops and Tylenol. She followed the doctor’s instructions but awoke at 3:50 a.m. to find her baby even more feverish.

Ms. Adams called the Kaiser emergency number and advised the Kaiser nurse who answered that the baby’s temperature was 104 degrees, that he was having breathing difficulty, and that he was moaning and limp. The Kaiser employee called the on-call physician and incorrectly advised him that she had already ruled out respiratory distress. Based upon that erroneous information, the doctor directed that the child be taken to a hospital 42 miles away! This hospital was under a multi-million dollar contract with Kaiser that would provide the cheapest service for Kaiser, but it was not the closest hospital to Ms. Adams’ son.

En route to this distant hospital, the baby lost consciousness and experienced respiratory and cardiac arrest. The child’s father immediately changed course and sped to the nearest hospital where the emergency room physician noted that the child was unresponsive. The doctors began emergency resuscitation measures and were finally able to obtain a pulse although the baby’s breathing was labored. Although color returned to the baby’s body, it did not return to his hands and feet. Despite intensive efforts to regain perfusion, by the third day of hospitalization the child’s arms were black from below his elbows to his fingertips, and his legs were black from his mid-thigh to his toes. The child subsequently underwent amputation of his arms and legs.

This real-life case is an example of the nightmarish results that can occur when non-physician corporate personnel make emergency life and death decisions over the telephone, and when HMOs make decisions

---

1. Perfusion is the injecting of fluid or blood into or through an organ or structure of the body in order to thoroughly permeate it. Re-establishing vascular circulation in the limbs can be attempted through various medical techniques including use of blood thinners and vasodilators. See Robert E. Rothenberg, M.D., F.A.C.S., The New American Medical Dictionary and Health Manual 240 (3d rev. ed. 1975).


regarding emergency care based upon financial criteria rather than medical criteria. In this instance, a decision was made to send the patient to the cheapest hospital, not the nearest hospital.\textsuperscript{4} Traditionally, this kind of claim, if brought against an HMO, might be dismissed based upon legal technicalities discussed in this article,\textsuperscript{5} and might result in plaintiffs like James Adams, being left uncompensated for injuries caused by the HMO's negligence.\textsuperscript{6} All of that may be changing.

The recent shift in clinical decision-making from doctors to managed care providers has dramatically changed the ability of traditional tort concepts to redress medical malpractice claims.\textsuperscript{7} This area of the law is in a current state of flux. The Federal Employment Retirement Income Security Act ("ERISA"),\textsuperscript{8} which once seemed an impenetrable wall that protected HMOs from liability in medical malpractice suits, is crumbling, leaving HMOs subject to liability and vulnerable to accusations that they are practicing medicine without a license.

After the enactment of ERISA in 1974,\textsuperscript{9} it was extremely difficult for plaintiffs to succeed in medical malpractice claims against HMOs. In many cases, the state court claims were removed to federal court where they were dismissed on the basis of ERISA preemption.\textsuperscript{10} Ironically, ERISA, a law that was originally designed to protect workers,\textsuperscript{11} has been used to harm workers and their families by denying them recovery for their injuries.

Plaintiffs' attempts to sue HMOs are generally based on theories which include direct corporate negligence, vicarious liability (actual agency, agency-in-fact, and ostensible agency), breach of contract, unauthorized practice of medicine, fraud, breach of fiduciary duty, equitable estoppel, and negligent utilization review.\textsuperscript{12} Many of these theories

\textsuperscript{4} Id.
\textsuperscript{5} See infra parts V and VI.
\textsuperscript{6} In this particular case, however, the plaintiffs received a jury verdict of $45 million. Defendant moved for a new trial and JNOV, and the parties settled for an undisclosed sum. It should be noted that the attorneys for Kaiser did not raise any affirmative defenses in this case. See Adams v. Kaiser, No. 93-VS-79895-E, Fulton County Ct., Ga. Feb. 2, 1995, Complaint, Answer, Jury Verdict, Judgment, and Dismissal of Motion for New Trial and Judgment Notwithstanding the Verdict.
\textsuperscript{9} Id.
\textsuperscript{11} 29 U.S.C. § 1001(2) (1994) (noting that the well-being of millions depends upon the soundness of employee benefit plans).
\textsuperscript{12} See Ryan, supra note 7, at 5.
have proved unsuccessful, and the Courts have been far from consistent in their approach to such cases. If a case can get past the difficult ERISA preemption hurdle, it faces additional obstacles in states that have adopted the Corporate Practice of Medicine Doctrine. Courts applying this doctrine have circularly reasoned that since the doctrine prohibits corporations from practicing medicine, corporations cannot be held liable for medical malpractice.

With more and more courts now holding that claims against HMOs either fall within ERISA's narrow exemptions or are not preempted, along with courts recognizing that HMO practices are crossing the line and encroaching into the doctor-patient relationship, a trend is developing where HMOs are viewed as engaged in the practice of medicine. It is not uncommon to find non-physician HMO personnel making medical decisions on the basis of financial considerations. Critics characterize such policies by HMOs as the unauthorized practice of medicine, and HMOs are increasingly finding themselves subject to liability and public scorn.

Moreover, the debate between trying to provide low cost minimum health care for the general public on the one hand, versus allowing lawsuits against HMOs which arguably would raise health care costs on the other, has led to proposed legislation on both the state and federal levels. This may ultimately obviate the need for further cases to interweave these legal theories to establish liability.

HMOs will have to re-think their traditional lines of defense and restructure their approach to doing business in order to avoid nightmares like the James Adams story, as well as to rebuild public confidence,

14. See generally Malone & Thaler, supra note 2.
16. See id.
17. See David Orentlicher, Health Care Reform and the Patient-Physician Relationship, 5 HEALTH MATRIX 141, at 143.
18. See Ryan, supra note 7, at 5.
19. See id.
20. See HMO Liability Bill Sent to Bush's Desk, UPI, May 12, 1997, available in WL. Sponsors of proposed legislation say that "extending civil liability to HMOs will make the burgeoning managed health care industry more responsible and accountable." Id. See also, Ryan, supra note 7, at 5.
21. See, e.g., id.; HMO Liability Bill Sent to Bush's Desk, UPI, May 12, 1997, available in WL. Sponsors of proposed legislation say that "extending civil liability to HMOs will make the burgeoning managed health care industry more responsible and accountable." Id.
minimize liability, and allow resources to be spent where they can do the most good — on patient well-being.

II. Historical Overview

The first medical malpractice case was recorded in England in 1374 involving a surgeon who was sued for negligent treatment of a wound. Public criticism of health care professionals is not a new phenomenon; even the French philosopher Voltaire once commented: “Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing.” Although the medical profession has come a long way since the days of Voltaire, there still remain tremendous uncertainties inherent in the task of healing and equally tremendous uncertainties in the legal ramifications of that treatment.

It has long been established in the medical profession that the physician is the “captain of the ship” when it comes to taking care of his patients. The doctor is ultimately responsible for all treatment, or lack thereof, rendered to patients in his care. Each doctor even takes an oath committing himself to these admirable standards:

I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. I will keep pure and holy both my life and my art. In whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain forever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me.

The Hippocratic Oath, as it is known, embodies the noble ideals of the medical profession and is taken by all physicians as they enter the practice of medicine. After four years of premedical education, four years of medical school, one year of internship, and three grueling years

23. Malone & Thaler, supra note 2, at 123.
27. See id.
of residency in a teaching hospital, physicians go out into the world to heal the sick and improve the quality of life for their fellow man. They apply scientific principles etched in their minds from tireless study and combine them with artistry, creativity, ingenuity, sensitivity, intuition, innovation, and communication. This blend of art and science, along with dedication, discipline, and compassion, has resulted in miraculous medical advancements in recent history. The nature of the practice, however, appears to be changing due to what some observers characterize as the intermeddling of a new participant: The HMO. Critics see the HMO as medically untrained decision-maker who is dedicated not to patient well-being, but to the financial well-being of its CEO and upper level management. The critics have a point: Surveys show that HMO executives are collecting as much as $15 million a year in salaries and stock options. This is a far cry from medicine’s humble and noble origins.

The availability of medical care was relatively sparse in the early 1900’s and the sick were often unable to see physicians for their ailments. Health care, in general, was vastly inferior as compared with today’s level of care, and the corresponding increase in the average life span today reflects the tremendous advancements in medicine. Patients’ expectations of the medical profession have also gone through a metamorphosis which is correlative with the technological advances in medicine. Historically, it was difficult to get doctors to travel the great distances required to visit the sick in a mostly agrarian society. Consequently, if the sick were lucky enough to find a doctor or nurse,

29. See 60 Minutes: HMO 19 (CBS News television broadcast, Oct. 1, 1995. “Critics of HMOs say that while hospital services and general patient care are being cut to the bone, for-profit HMOs have become the darlings of Wall Street, posting huge profits, and HMO executives are collecting as much as $15 million a year in salaries and stock options.” Id. “In 1994, the CEO’s of some of the largest for-profit HMO’s received an average of 7 million each in compensation for the year.” Ross Perot, Intensive Care 163 (1995). Contrasting these figures are reports that some HMOs are actually losing money. For example, according to John Harkey, president of Harkey & Associates, Inc., a Nashville, Tenn., company that tracks HMOs, the average profit for an HMO in Florida fell by more than half from 1995 to 1996, and continued to drop in 1997. See Susan R. Miller, Pushing Back, The Daily Business Review, March 13, 1998, A8. Another example of HMOs losing money is the California-based HMO Pacifcare, Health Systems, Inc., which bailed out of the Florida market in 1997 after reportedly losing approximately $20 million in 1996 and $13 million in 1995. See id.
31. See Perot, supra note 29, at 58.
32. See id.
33. Interview with Dr. Heriberto Manzor, Miami, FL (1997), (describing provision of medical care in Ciego De Avila, Cuba in the 1960’s and 1970’s, and analogy to the early practice of medicine in rural areas of the United States).
patients were generally grateful for any comfort at all the health care practitioner might be able to provide. It would naturally follow that there were limited expectations from health care providers.

As medical science progressed and costs for services became more expensive, patients’ expectations naturally increased. Health care subsequently developed into a huge industry where profit is the bottom line.\textsuperscript{34} Medical costs can no longer be managed by a family bartering a chicken for a doctor’s house call.\textsuperscript{35} Costs have steadily increased to the point where, if not for insurance, most people could not afford health care at all.\textsuperscript{36} Despite the high cost of health care, many Americans perceive “access to quality health care as an entitlement . . . not as a luxury or privilege.”\textsuperscript{37} After decades of medical ethics norms reflecting no concern for costs, a new era of a socially conscious approach to medicine was dawning.

A. The Birth of HMOs

Managed health care first surfaced in the 1920s.\textsuperscript{38} The Community Hospital of Elk City, Oklahoma, established the first medical cooperative in 1927.\textsuperscript{39} Two years later, the Ross-Loos Medical Group entered into an agreement with the Los Angeles Water and Power Department to provide pre-paid medical care to Department employees.\textsuperscript{40} One of the “grandfather” managed care companies, Kaiser Foundation Health Plans, originated in the mid-1930’s to provide medical care to Kaiser employees who were working on the Grand Coulee Dam in Washington.\textsuperscript{41} During World War II, Kaiser Industries expanded its commitment to provide quality health care for its employees at various construction sites.\textsuperscript{42} During the 1950’s and 1960’s, other “HMOs” emerged, such as Group Health Cooperative of Puget Sound, the Health Insurance Plan of Greater New York, and the Group Health Association of Washington.

\textsuperscript{34} See Malone & Thaler, \textit{supra} note 2, at 123. The net worth of Kaiser, for example, increased from $14,186,093 in 1992, to $95,794,842 in 1995. \textit{See id.} (citing Annual Statement of the Kaiser Foundation Health Plan of Georgia, Inc. to the Office of the Insurance Commissioner of the State of Georgia, for the Year Ending December 31, 1995 at 31).

\textsuperscript{35} See Manzor, \textit{supra} note 33.

\textsuperscript{36} See Colodia Owens, \textit{Managed Care Organizations: Practical Implications for Medical Practices and Other Providers} 2 (1996).


\textsuperscript{39} See id.

\textsuperscript{40} See id.

\textsuperscript{41} See id.

Nevertheless, managed health care organizations remained unusual, compared to the traditional fee-for-service health insurance where doctors submit claim forms for each service they determine to be necessary. Although fee-for-service health insurance was much more common, not everyone could afford it.

Since health insurance was particularly expensive for the unemployed and elderly, the federal government initiated the Medicaid programs and Medicare in 1965. Medicaid provides health services to the poor, while Medicare provides health services to the elderly and disabled. Individual states determined how physicians were paid under Medicaid reimbursement, whereas Medicare reimbursed physicians for "customary and reasonable charges."

In the early part of the 1970's, Democrats led by Senator Edward Kennedy began to cultivate public support to develop national health insurance. The Republicans supported private alternatives to traditional health care plans, and the two parties ultimately agreed to pass the Health Maintenance Organization Act of 1973. The Act provided federal grants for development of HMOs, and loans to subsidize their initial expenses. Thus, the term "Health Maintenance Organizations" ("HMOs") was coined. After the Act passed, growth of HMOs was dramatic: In 1972 there were fewer than forty HMOs, with approximately three million members; by 1985, there were 263 HMOs, with more than eighteen million members. Recent figures show the national total of Americans who receive their medical care through HMOs exceeds 56 million. Currently, approximately eighty percent of those with medical insurance are influenced in some way by managed

43. See id.
44. See id. See also Allison Faber Walsh, Comment, The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability For Physicians and Managed Care Organizations, 31 J. MARSHALL L. REV. 207, 211.
45. See Christine C. Dodd, Comment, The Exclusion of Non-Physician Health-Care Providers from Integrated Delivery Systems: Group Boycott or Legitimate Business Practice? 64 U. CIN. L. REV. 983, 983 (1996); see also Walsh, supra note 44, at 211-12.
47. See id.
48. See Ross, supra note 46 at 43.
49. See DiCicco, supra note 42, at 22.
51. See DiCicco, supra note 42, at 22.
52. See Malone & Thaler, supra note 2, at 123.
53. See DiCicco, supra note 42, at 22.
54. See Malone & Thaler, supra note 2. The figure of 51 Million has also been quoted. See 20/20: The Ultimate Cost (ABC News broadcast, Mar. 1, 1996) [hereinafter 20/20].
Projections suggest that ninety percent of the drug market will be influenced by managed care by the year 2000. Though managed care has been around for several decades, its widespread popularity is new. Extensive growth in recent years has led to consolidation within the industry. Most notably in the 1980's, many sociological factors combined to cause dramatic increases in the cost of health care. Many insurance companies claimed that they were not making profits and were actually losing money on health care. Insurance premiums began to escalate and restrictions on covered services were implemented. Health care has been transformed from an indemnity model—where payment is made after care is rendered—to a prospective payment system where coverage is determined before the care is rendered. HMOs began using “utilization review agents” or “case managers” to monitor the length of hospital stays and medical necessity of treatment. Such monitoring translates into restrictions, and arguably, control of medical decision making. In many cases, case managers are non-medical personnel who make medical decisions based on financial considerations. It has been reported that HMOs, in order to control costs, “withhold appropriate diagnostic procedures and treatments . . .; delay or even deny necessary treatments altogether; or elect the least expensive approach; which is often contrary to the patient’s best interest.” Many HMO physicians are prohibited by “gag clauses” in their contracts from disclosing expensive alternatives to patients. HMOs further cut costs by requiring manufacturers of medical devices and pharmaceuticals to offer a cheaper “managed care product

56. See id.
57. See DiCicco, supra note 42, at 22.
58. See id. Aetna recently acquired U.S. Healthcare, Inc. for $8.9 billion in cash and stock, creating the nation’s largest managed health care company. See Malone & Thaler, supra note 2, at 125.
60. See Ryan, supra note 7, at 7.
61. See id. Utilization review agents and case managers review all proposed medical treatment and decide, based on established company guidelines, whether treatment will be approved. See id.
62. See id.
64. Malone & Thaler, supra note 2, at 123 (citations omitted).
65. See Jennifer L. D’Isidori, note, Stop Gagging Physicians!, 7 Health Matrix 187, 205 (1997). Gag clauses which preclude physicians from disclosing available procedures and options to patients may leave the physicians liable in a medical malpractice suit for failure to obtain informed consent. See generally id.
Ironically, HMOs may be withholding medical treatment or selecting the cheapest alternative medical treatment at a time when some of the most remarkable advancements in science are occurring. For example, there have been exponential advances in molecular biology in the past five years, driven in part by the Human Genome Project. There are numerous genetic products in various stages of development and some have already reached the marketplace. An entire generation of therapeutics, diagnostics, and genetic tests are on the verge of implementation.

B. Medical Ethics

It is difficult to justify cost considerations prevailing over patient well-being in the overall scheme of medical ethics, but this appears to be the case today. Traditionally, the contrary view was the norm. Modern medical ethics has developed from two distinct schools of thought—one of "professional domination," and the other of "interdisciplinary bioethics." In the earlier era of professional domination, ethical concepts were used to create codes of professional conduct which doctors imposed and enforced on themselves. These ethical principles primarily existed to maintain order in the profession and foster public respect for professional authority. Physicians defined patient well-being in a highly paternalistic and authoritarian fashion: "[B]eneficence—the best interest of the patient as determined by his or her care-giver—served as the guiding principle."

The second ethics era, the era of bioethics, commenced in approximately 1970. Bioethics was based upon individual rights and patient autonomy, not on what the doctor deemed to be in the patient's best interest. This view is exemplified by the legal innovation, the "informed consent doctrine." Under this doctrine, the doctor's role is viewed as executing the instructions of a fully informed master — the

---

66. See Malone & Thaler, supra note 2, at 123.
67. See Malinowski, supra note 37, at 332.
68. See id.
69. See id. at 332-33.
70. See id. at 333.
71. See id at 334.
72. Doctors' codes of professional conduct were self-enforced, primarily through boards and institutional proceedings. See id.
73. Id.
74. See id.
75. See id.
76. See id.
Both the professional dominance and bioethics approaches reflect a commitment to patients' medical interests, without concern for costs, regardless of any resulting inefficient distribution of societal resources. Patients are generally unaware of the cost of medical care, including medicines and treatments, and rely on their doctors to determine the best course of action. Doctors have confidence that insurance companies will pay for the treatments they recommend.

As a result of these inefficiencies, health care is entering a third era of medical ethics, the "Cost Conscious Era" or "Socioethics Era." Under this model, medical ethics is more utilitarian, where the rights of each patient are balanced against the utilitarian principle of doing the greatest good for the greatest number of people. Managed care claims that utilitarianism is its underlying principle, but implementation of this philosophy boils down to payers setting limits. HMOs effectively limit both physician discretion and patient autonomy, by dividing the physician's loyalty between patient and society.

This new role for physicians is at odds with traditional tort principles and leaves doctors in a precarious position: "It is one thing to have a societal policy where limited resources are allocated based on wealth rather than a more equitable distribution. It is quite another to have a policy where basic health care and the preservation of life itself are also to be allocated." Because of the heart-wrenching difficulty in balancing individual interests and the value of a human life with the burdens and benefits to society in general, it is not surprising that society has turned to the courts for guidance.

C. Increasing Litigation

The view that there is a "right" to medical care may have fueled, in part, the increasing number of medical malpractice lawsuits. The suc-

77. See id.
78. See id at 334-35. "[t]he health care industry represents the largest single sector of the U.S. economy. The United States spends nearly fifteen percent of its gross domestic product on health care—$900 billion in 1993—and that figure continues to rise at a rate of approximately 9.2% per year." Id. at 335 (citations omitted).
79. See id at 336-37.
80. See id. at 337.
81. See id.
82. See id. at 338.
83. See Orentlicher, supra note 17, at 149. In addition, HMOs are adopting measures to make physicians more conscious of costs, often paying bonuses to physicians who minimize the cost of patient care. Such incentives create a triple loyalty for physicians—to patients, to society, and to their own financial interests. See id.
cess of such lawsuits may have encouraged even more litigation. It appears that consumers consider health care an exact science with guaranteed results. If patients do not get the results they expect, lawsuits follow. A boom in the legal profession and a flood in the legal jobs market led to many new attorneys clamoring for cases that would enable them to keep their practices afloat. Consequently, cases that attorneys once may have rejected were now being pursued.

Attorney advertising may also have been a factor in the increasing medical malpractice litigation. In a series of cases beginning in 1977, the United States Supreme Court held unconstitutional the American Bar Association’s long-held ban on attorney advertising. By the early 1980’s most states had adopted a modified version of the ABA’s Model Code which permitted limited attorney advertising. Since 1983 more than 35 states have revised their ethical rules to conform to the ABA’s Model Rules which are even more liberal than the Model Code with regard to advertising. As lawyer advertising increased over the last two decades, it became easier for people to obtain lawyers. Consequently, more patients filed lawsuits against their doctors and hospitals.

Many lawsuits have been filed sheerly for nuisance value. Large settlements and jury verdicts may have encouraged even more lawsuits. Insurance companies providing professional liability coverage were forced to increase doctors’ premiums in order to cover malpractice settlements and awards. As a result, many physicians have elected to

85. See Jansen v. Packaging Corp. of Am., 123 F.3d 490, 543 (7th Cir. 1997).
90. See Gillers & Simon, supra note 89, at 421.
92. See id. at 421.
93. Nuisance value is where the cost of defending a suit at trial is so great that any settlement under this amount represents a savings to the defendant. See Ted Schmeyer, Legal Process Constraints on the Regulation of Lawyers’ Contingent Fee Contracts, 47 DePaul L. Rev. 371, 390 (1998).
94. See Theodore R. LeBlang, Medical Malpractice and Physician Accountability: Trends in the Courts and Legislative Responses, 3 Annals Health L. 105, 105-14 (1994) (discussing recent judicial decisions that have broadened liability for malpractice, as well as the costs associated with expanded liability).
95. See Jansen v. Packaging Corp. of Am., 123 F.3d 490, 543 (7th Cir. 1997). See also 23%
go without insurance, structuring their personal assets in a manner which protects them from judgment. Many physicians have also responded to this "medical malpractice crisis" by practicing what is known as "defensive medicine"—performing tests and procedures that may not be medically necessary in order to safeguard against liability. It is common in medical malpractice cases for plaintiffs' lawyers to allege a "failure to diagnose" and "failure to perform appropriate diagnostic procedures," along with other theories of negligence. In order to overcome the difficulty of being held to retrospective diagnostic standards, doctors began performing expensive diagnostic tests and procedures which they otherwise might not have found necessary.

Traditional indemnity insurance companies tended not to question these diagnostic tests and were required by contract to pay for all or a portion of their cost. The physician determined the appropriateness of the tests and treatments, not the insurance company. Performing the battery of tests would take the wind out of the sails of plaintiffs' attorneys in later malpractice lawsuits. Plaintiffs would find it difficult to assert that proper diagnostic tests were not performed if virtually every medical test imaginable had been performed. This arrangement benefited both the physician, who protected himself from potential lawsuits, and the patient, who would be assured that everything possible was being done. On the other hand, patients were being subjected to unnecessary procedures, many of which were uncomfortable, burdensome, and even risky. In addition, the high costs associated with such tests dramatically increased the value of claims paid by health insurance companies.

The situation reached what many perceived as critical proportions, and thereafter, political cartoons began appearing in newspapers around the country. One example depicts a patient lying in a hospital bed with

---

Liability Rate Increase Request Pegged to Managed Care, AM. MED. NEWS, Apr. 1, 1996, at 43 (discussing a Texas insurance company's request to increase professional liability rates by 22.9%). "One of the largest professional liability insurers in Texas says the use of primary physicians as "gatekeepers" is a major factor behind its need to raise rates by 22.9 percent for this type of coverage . . . . [W]e have identified increased losses due to misdiagnosis . . . . what we're saying is that managed care puts greater responsibility on primary care physicians . . . . "). Id.

96. See e.g., Frank J. Yong, What's Mine is Mine, Part IV: In Case of a Judgment, CENTRAL FLORIDA PHYSICIAN, Jan. 1990, at 14. This is the last in a four-part series on protecting assets from malpractice and creditors' claims under Florida law.


98. See Malinowski, supra note 37, at 338; see also Deven C. McGraw, Note, Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?, 83 GEO. L.J. 1821, 1822 (1995).

99. See LeBlang, supra note 94.
countless tubes, wires, monitors, x-ray machines, and IV's hooked up to
him, and surrounded by an army of medical staff. One doctor asks
another: “What is this patient being treated for?” The other responds:
“He only has a cold, but he’s an attorney so we’re not taking any
chances.”

D. Tort Reform

Legislators began to address the detrimental affect frivolous law-
suits were having on health care costs, and consequently, on people’s
access to health care. In Florida, for example, the legislature enacted the
Comprehensive Medical Malpractice Reform Act of 1985 to ensure
that Florida citizens have access to competent and reasonably priced
medical services. The Act intended to control escalating premiums
for professional liability insurance, by requiring potential plaintiffs to
follow stringent procedures prior to filing a medical malpractice
suit. Prior to initiating a medical malpractice action, a plaintiff must obtain an
affidavit from a qualified medical expert who has determined that there are
reasonable grounds to initiate a malpractice claim. The plaintiff
must then notify all potential defendants; each potential defendant is
required to conduct an investigation within 90 days and then respond by
offering a settlement, denying the claim, or offering to admit liability
and arbitrate the issue of damages. During the 90-day pre-suit period,
the parties may conduct informal discovery and obtain unsworn state-
ments. The requirements of this Act, in conjunction with the difficulty in obtaining medical experts willing to sign affidavits, have
eliminated many frivolous lawsuits.

Additionally, the Florida Legislature enacted the Florida Birth-
Related Neurological Injury Compensation Plan which, among other
things, limits the non-economic damages that can be awarded for birth-
related neurological injury claims. The Legislature was concerned

100. The source of this cartoon cannot be located.
102. See Honorable Nelly N. Khouzam, Medical Malpractice: A Review of the Presuit
Screening Provisions of the Florida Medical Malpractice Act, 20 Nova L. Rev. 453, 4563-54
103. See id.
108. See generally, Khouzam, supra note 102.
about increases in professional liability coverage for obstetricians resulting from huge jury verdicts in cases involving hypoxic brain damage at birth. The increased liability exposure and cost of professional liability insurance were causing doctors to refuse to deliver babies—an obviously critical service to society.

Tort reform legislation was only one attempt to resolve this multifaceted societal problem. Insurance companies responded by adjusting their structures to implement cost-cutting measures. Increasing HMO-type plans were the result.

E. Increasing Presence of HMOs

Spiraling medical costs and malpractice lawsuits led the insurance industry to restructure its coverages and raise premiums. As a result, traditional health insurance became cost-prohibitive. Employers who wanted to provide health care coverage to employees were finding themselves unable to do so. Employers turned to HMOs which, because of their structure, were able to provide affordable health care while containing health care costs.

An HMO is a health care financing and delivery system in which enrolled members pay a pre-paid, fixed fee for future medical care. HMOs differ from the traditional fee-for-service payment system, where patients pay a fee for each service provided by their individual doctors. There are variations on this kind of plan known as preferred provider organizations (PPOs) and point-of-service plans (POS).

HMOs reduce costs in a number of ways. One of the ways is by limiting the members’ choices of physicians and hospitals. HMOs restrict their members’ choice of physicians to a limited list of providers

111. FLA. STAT. § 766.301(2)(1997) (stating the intent of the legislature “to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation”).

112. Hypoxia is the decrease below normal levels of oxygen in inspired gases, arterial blood, or tissue. See Stedman’s Medical Dictionary (25th ed. 1990). A “Birth-related neurological injury” is defined as “injury to the brain or spinal cord of a live infant weighing at least 2,500 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post delivery period in a hospital which renders the infant permanently and substantially mentally impaired.” FLA. STAT. § 766.302(2) (1997).

113. FLA. STAT. § 766.301 (1997).

114. See Malone & Thaler, supra note 2, at 123.

115. See Pedroza, supra note 97, at 405.

116. See Panah, supra note 13, at 146.

117. See id.


119. See Darrin Schlegel, Putting the Squeeze on HMOs, Dallas Morning News, Feb. 2, 1997, at 10A.
who have contracted with, or who are employed by the HMO. Providers agree to fee concessions in exchange for a steady flow of patients, and participating providers agree to be compensated on a “capitated” or discounted fee-for-service basis. Under the typical capitation arrangement, providers agree to accept a predetermined amount per HMO subscriber, regardless of the amount or type of service provided.

In addition, HMOs attempt to reduce costs by focusing on the medical management of patients and limiting the amount they pay to providers for medical services. This is accomplished by (1) eliminating unnecessary care; (2) providing care more efficiently; (3) reducing costs by creating economies of large scale; (4) coordinating care among physicians and hospitals; (5) and mandating the use of guidelines, algorhythms, or parameters of care (utilization guidelines).

Some cost containment measures are aimed at patients, while others are aimed at providers. Some of the measures aimed at patients include: (1) avoiding the need for acute care by focusing on preventative care; (2) restricting use of physicians to those who have agreed to accept lower reimbursement; (3) denying access to emergency care by redefining and identifying emergency situations; and (4) denying access to specialists unless referred by the primary care physician.

Cost containment measures aimed at providers include: (1) requiring that providers discount from their usual fees; (2) withholding percentages of fees unless provider meets utilization goals; and (3) participating in capitation schemes, whereby the provider receives a set amount per patient for a specified period of time. During that period, the provider is expected to provide all necessary services for HMO patients. If the patient requires care in excess of the amount the HMO doctor has been paid, the doctor must absorb the financial loss. If the patient does not use the service, the physician realizes a gain since the

120. See Panah, supra note 13, at 146.
121. See id.
123. See Panah, supra note 13, at 146.
124. See id.
125. See Counsel of Ethical and Judicial Affairs, American Medical Association, Ethical Issues In Managed Care (1994) reprinted in 273 JAMA 330, at 331; see also Malone & Thaler, supra note 2, at 123.
126. See Malone & Thaler, supra note 2, at 123.
127. See id.
128. See id.
HMO has already paid for the services. This may vary, of course, depending on the type of HMO plan involved.

III. TYPES OF HMOs

Since many courts consider the type of HMO in analyzing liability, it is useful to understand the three basic models. The traditional form of HMO is the “Staff Model,” in which physicians are employed by the HMO. The idea behind this type of HMO is that the doctor will be freed from the day-to-day responsibilities of managing a practice and able to focus on providing the best possible patient care. Since the HMO is the physician’s employer, it will usually be liable under the traditional theory of respondeat superior.

Another type of HMO is the “Group Individual Practice Association” (IPA) Model, which is currently the most common form of managed care. Under this model, a group of doctors who have formed a partnership or corporation contracts with the HMO to provide care for its members. The physicians’ association then contracts directly with each doctor regarding terms and payment. The doctors may be permitted to treat fee-for-service patients as well as HMO members, although some contracts require doctors to see only HMO patients. Here, the negotiating power of a group of doctors is stronger than that of the employee doctors in the staff model. Additionally, allowing the doctors to generate additional income by treating fee-for-service patients may be attractive to doctors and entice them to participate.

Treating non-HMO patients, however, may lead to conflicts, including competition for the same appointment time slots. Doctors are paid in advance for HMO patients on a capitated basis, but fee-for-service patients represent additional income. Under this arrangement there is an incentive for doctors not to see HMO patients, or, at least, not to spend a lot of time with such patients, if they can earn additional income by seeing fee-for-service patients.

The third type of HMO is the “Group (non-IPA) Model” or “Net-
work Model." Under this arrangement, the HMO provides medical care for its members through individual physician groups or entities having provider employees. Group practices are often multi-specialty groups. Instead of one group of physicians servicing the patients, several groups provide the health care. The more control the HMO has over the health care provider, the more the HMOs liability increases.

A patient who belongs to an HMO generally selects a “primary care physician” from the list of participating physicians. The primary care physician is usually a family doctor or general practitioner. The HMO pays the physician a predetermined periodic amount for each patient who selects him as the primary doctor (capitation). Whenever the patient needs to see the doctor, he makes an appointment and sees the physician for either no charge or a nominal fee. If referrals to specialists are needed, the primary care physician must make the referral, and if possible, the referral must be to a specialist within the network of physicians participating in that HMO. All treatment must be coordinated by the primary treating physician, and all tests and procedures must be pre-approved by the HMO. The HMO determines in advance what tests and treatments it will and will not pay for. In theory, the system looks like it could be a viable solution to some of the nation’s health care problems. In practice, however, the system leaves a lot to be desired and has been the target of widespread criticism.

IV. CRITICISM OF HMOs

A. Inferior Care

In recent years, HMOs have come under attack for a variety of reasons. One complaint is that patients feel that they have lost their freedom of choice over which doctors will take care of them. Patients also complain that many of the doctors participating in the HMOs are not as good as those who do not participate and that incompetent practitioners are being employed or retained by the HMOs. Doctors’ decisions of whether or not to participate in HMOs may be based in part upon the laws of supply and demand and the doctor’s income-generating needs. Doctors with a good reputation and an established practice
may not be in a position where they need a flow of new patients. These doctors, therefore, may not need to make the fee concessions required by HMOs.148

Another criticism is that many of the physicians who participate in HMOs are those trying to build a practice and lack adequate expertise and reputation. Many of the practitioners who are competent complain that they are being overruled regarding diagnoses and recommended courses of treatment by a "medical director" whose primary concern is not the well-being of the patient.149 Many good physicians are being forced out of the business simply because they refuse to bend to the demands of the HMOs and continue to practice what they feel is medicine in the best interest of their patients.150 Many other physicians complain that HMOs have double crossed them by pressuring them to take less for the services they provide, and by failing to pay them on a timely basis, if at all.151

HMO patients also claim that necessary treatment is being withheld in order to cut costs. One such cost-cutting practice was to send mothers and their babies home "dangerously soon" after birth.152 This practice has been the focus of state and federal legislation.153 Another dangerous cost-cutting measure has been to deny requests for biopsies. In one case where an HMO physician negligently failed to order a needed biopsy, the result was spread of cancer cells, metastasis throughout the body, and death, all of which could have been prevented by a simple biopsy.154 In this type of case, plaintiffs' lawyers might argue that doctors' decisions to withhold treatments, such as pap smears and biopsies are inappropriately influenced by undisclosed financial incentives.155

Plaintiffs' lawyers also argue that one of the common bases for denial of coverage—the "experimental" nature of treatment—is inappro-

---

148. See Schlegel, supra note 119.
149. See Moore & Gaier, supra note 10. See also Carlos Sanchez, News, Senate Plan Would Increase Liability of HMO's In Texas, THE FORT WORTH STAR-TELEGRAM, [insert date], at 19 (Doctors complaints of having to get HMO permission for certain treatments, permission based upon financial instead of medical treatment).
150. See 60 Minutes, supra note 29, at 18.
152. See Malinowski, supra note 37, at 335.
154. See McClellan v. Health Maintenance Org. of Pa., 686 A.2d 801 (Pa. 1996) (holding that an HMO was liable for physician under ostensible agency theory when physician negligently failed to order a biopsy, where the HMO had advertised that it carefully screened its physicians).
155. See Hall, supra note 122, at 708.
appropriate. In one such case, a California jury held a prominent HMO liable for denying coverage of a breast cancer patient’s bone marrow transplant which the HMO argued was “experimental” treatment.\textsuperscript{156} The jury awarded $89.1 million to the family of the deceased patient.\textsuperscript{157} Evidence introduced at trial showed that the HMO’s medical director was compensated based upon the amount of money he saved the company.\textsuperscript{158} In addition to refusing to cover so-called experimental treatment, HMOs are eliminating support for medical research and development.\textsuperscript{159} This is another signal of the trend toward emphasizing \textit{quantity} of care rather than \textit{quality} of care.

B. \textit{Volume Healthcare}

Another common complaint is that HMOs provide mass-production, clinic-like treatment that is inferior. Since one of the objectives of HMOs is to lower costs by increasing volume, doctors have to see more patients, and consequently, have less time to spend with each patient.\textsuperscript{160} Appointments are over-booked and patients are kept waiting an inordinate amount of time in crowded waiting rooms. Patients also have difficulty getting immediate appointments and often have to wait weeks to get an appointment. When the patient is finally seen, the time spent with the doctor is so short that the patient is left feeling as though he is not receiving proper care. Volume health care and quality health care appear to be mutually exclusive.

By way of analogy, the Home Depot chain of large volume, warehouse-size, mega-hardware-stores has squeezed out the mom-and-pop corner hardware store by lowering prices (made possible by volume business). Similarly, HMOs are squeezing out the private family doctor and approaching health care as a volume commodity. The imagination would not have to stretch too far to envision “Medical Depot” chains popping up around the country, with “Labor Day Weekend Blowout Sales on by-pass surgery.” The point is that the Norman Rockwell portrait of a visit with the family doctor is a thing of the past. Health care today is based upon numbers and capitation.

\textsuperscript{157} See id.
\textsuperscript{158} See Hall, supra note 122, at 708.
\textsuperscript{159} See Science and Technology, Health Policy: Managing to Care, The Economist, Sept. 23, 1995, at 70, 75.
\textsuperscript{160} See Ezekiel J. Emanuel, Preserving the Doctor-Patient Relationship in the Era of Managed Care, JAMA, Jan. 25, 1995 at 323 (doctors can spend only 11 minutes with each patient on an average day).
C. Capitation Schemes

"Capitation" is one of the more common complaints against HMOs and has attracted significant television news coverage.\(^{161}\) Capitation is a form of HMO reimbursement whereby the doctor is compensated at a flat rate for each patient enrolled in the HMO for a specific time period.\(^{162}\) Doctors are paid a pre-determined fixed fee based upon the number of patient subscribers.\(^{163}\) The doctor receives the same amount for each patient on a monthly basis regardless of the services provided to the patient or how much those services cost.\(^{164}\) If a patient does not require any medical service during a particular month, the doctor still receives a monthly payment.\(^{165}\) On the other hand, if a doctor has to provide care beyond the projected amount, the doctor is not paid any additional amount for the extra services provided to the patient.\(^{166}\)

Since under a capitated system the financial risk of caring for the participants shifts to the primary care physician,\(^{167}\) the thrust of the criticism is that capitation creates a disincentive for doctors to see and treat the patients for which they have already been paid a flat fee by the HMO.\(^{168}\) If a doctor has a choice of seeing a non-HMO patient who will generate additional money for the practice and seeing an HMO patient for whom the doctor has already been paid, the doctor has a financial incentive to see the non-HMO patient. If the doctor also has to utilize staff and supplies to treat the HMO patient for which he has already been paid, that represents an expense and loss of profit for the doctor. If, on the other hand, the doctor sees the non-HMO patient, the doctor has the opportunity to make additional money and increase profitability. The net effect is that HMO patients feel they are getting low priority and inferior care. Disgruntled patients who question their doctor’s motivation for not providing medical treatment then seek redress in court.\(^{169}\)

HMOs have created tremendous liability problems for doctors.\(^{170}\)

\(^{161}\) Telephone interview with Robin Kish, Television News Journalist, Miami, Florida, Nov. 18, 1997, regarding her investigative report, \textit{Dr. Dilemma} (NBC 6 television broadcast Oct. 31, 1997)(transcript on file with Robin Kish at NBC 6); \textit{See also} 60 Minutes, supra note 29; 20/20, supra note 54.


\(^{163}\) \textit{See} Orentlicher, \textit{supra} note 17, at 158.


\(^{165}\) \textit{See} id.

\(^{166}\) \textit{See} Walsh, \textit{supra} note 44, at 219.

\(^{167}\) \textit{See} McGraw, \textit{supra} note 164, at 1827.

\(^{168}\) \textit{See} Orentlicher, \textit{supra} note 17, at 157.

\(^{169}\) \textit{See} Walsh, \textit{supra} note 44, at 221.

\(^{170}\) \textit{See} Malinowski, \textit{supra} note 37, at 356.
As doctors are forced to assume the role of "gatekeeper" for the HMO, primarily concerned with keeping costs down, patients are falling through gaps between providers.\textsuperscript{171} As a result, patients are becoming angry and suing their doctors and insurance companies.\textsuperscript{172} Not everyone, however, is critical of capitation. Despite the inherent problems with capitation, President Clinton’s health care reform proposal in 1996 advocated capitation as the primary form of reimbursement in HMOs as well as for Medicaid and Medicare recipients.\textsuperscript{173} Although capitation aims to correct over-treatment incentives, it tends to lead to under-treatment because doctors earn more by providing less care, and fewer tests and referrals.\textsuperscript{174}

D. Utilization Management

Another criticism of HMOs is the issue of “Utilization Management.” Many view utilization review as a significant intrusion into the physician-patient relationship. This is due to the fact that life and death decisions between physician and patient are trivialized by the utilization review’s emphasis on costs versus benefits.\textsuperscript{175} There are three types of utilization review: (1) prospective utilization review, (2) concurrent utilization review, and (3) retrospective review.

Prospective utilization review is performed by the HMO prior to the administration of treatment.\textsuperscript{176} The utilization manager determines whether the doctor’s recommended treatment for the patient is medically necessary.\textsuperscript{177} If the proposed treatment is not deemed to be medically necessary, the HMO will not reimburse the cost of the treatment.\textsuperscript{178}

Concurrent utilization review occurs during the treatment course to determine whether proposed treatment is medically necessary. The HMO case manager monitors the patient throughout treatment to determine whether each procedure is medically necessary.\textsuperscript{179}

The last type of utilization review, retrospective review, occurs after treatment is already rendered.\textsuperscript{180} If a review of the treatment ren-

\textsuperscript{171.} See id.
\textsuperscript{172.} See id.
\textsuperscript{175.} See David Mechanic & Mark Schlesinger, The Impact of Managed Care on Patients’ Trust in Medical Care and their Physicians, 275 JAMA 1693, 1695 (1996).
\textsuperscript{176.} See Patricia A. Younger et al., Managed Care L. Man. 2 (1996).
\textsuperscript{177.} See id.
\textsuperscript{178.} See id.
\textsuperscript{179.} See id.
\textsuperscript{180.} See id.
dered indicates that a medical service was unnecessary, the HMO will deny payment.\textsuperscript{181} Doctors, in particular are critical of utilization management because it undermines their authority regarding prescribed courses of treatment for their patients. According to one authority, "the general concern is that managed care reduces physicians, once the ultimate health care decision makers, to proverbial cogs in a very large and impersonal health care machine."\textsuperscript{182} There is particularly strong criticism of HMOs insistence on pre-approving emergency care. As Texas state Senator Jane Nelson put it, "When you're sick, you don't want to spend 30 minutes on the phone just to hear a data processor at a computer tell you that you don't need medical treatment. When my child is gasping for breath in a pool of blood, I know it's an emergency and I'm not going to waste time calling an HMO for approval to get her to the hospital."\textsuperscript{183}

E. Financial Incentives

Traditional health insurance gave doctors an incentive to do as many tests and procedures as could be medically justified at the doctor's discretion.\textsuperscript{184} The more medical treatment a doctor provided, the more money he could make.\textsuperscript{185} Moreover, the more tests he ordered, the less liability he faced for medical malpractice.\textsuperscript{186} Under the HMO structure, incentives to do too much have been replaced with incentives to do too little.\textsuperscript{187} Payment incentives such as risk pools, bonuses, capitation, fines and penalties are utilized to discourage referrals, diagnostic tests and other medical services. These payment incentives encourage doctors to use fewer outside services and also reward the doctor for fewer referrals, tests and medical services incurred by the HMO.\textsuperscript{188} Payment incentives are used to encourage physicians to provide cost-effective medical care but may instead be resulting in sub-standard care.

The first kind of incentive, "risk pools," is a system wherein a portion of the doctor's capitated income is withheld and placed in a pool along with the withholdings from other doctor-members.\textsuperscript{189} Money

\begin{footnotes}
\item[181] See id.
\item[182] See Malinowski, supra note 37, at 351.
\item[183] See Schlegel, supra note 119, at 10-A.
\item[185] See id.
\item[186] See Schwartz, supra note 162, at 1361.
\item[188] See Barbara A. Noah, The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?, 48 Mercer L. Rev. 1219, 1227 (1997).
\item[189] See Walsh, supra note 44, at 219.
\end{footnotes}
from the risk pool is used to pay for referrals to specialists and also for hospitalization costs. Doctor-members divide any funds left in the pool at the end of the accounting period, but also share in the loss if no money remains because of excessive referrals or hospital stays. Not only does this system discourage doctors from making referrals, it encourages participating doctors to apply pressure on each other to keep referrals to a minimum.

The second kind of incentive, “bonuses,” are very similar to risk pools, except that money is not withheld from doctor’s capitation payment. At the beginning of the accounting period, the HMO will place a certain amount of money in a fund set aside for hospitalizations and referrals. Any money left in the fund at the end of the accounting period will be distributed to the participating physicians above and beyond their regular capitation compensation.

The third kind of incentive, “expanded capitation,” is where the doctor’s capitated amount for each patient includes an amount for anticipated referrals and hospitalizations. All tests, referrals and expenses are included in the amount paid to the physician. If the doctor makes a referral, it is paid by the physician out of the money the physician has already received from the HMO. This places all the risk of loss upon the doctor and also provides an incentive to keep ancillary care to an absolute minimum.

In addition to these incentives, some HMOs are imposing fines on physicians for treatment they deem to be excessive. For example, one doctor was fined $500 for each day his patient was hospitalized that the HMO determined was unnecessary.

Yet another penalty for participating physicians who make too many referrals is the looming threat of losing the physician’s HMO membership status. Physicians who have disregarded the bonus incentives and made the referrals they deemed necessary, and in the process exceeded the number of referrals allowed under the utilization manage-

---

191. See id.
194. See supra note 164, at 1828.
195. See id.
196. See id.
197. See id.
198. See id.
199. See 60 Minutes, supra note 29, at 14.
200. See id.
ment projections, have been penalized by losing their HMO membership entirely. The threat of losing a large portion of a physician’s practice may be enough to keep participating physicians under the limit if they are not motivated by the positive reinforcement of risk pools, bonuses and capitation. The effect of these incentives and disincentives is that HMO physicians are reluctant to make referrals to specialists, even when necessary.

This scenario places the physician in an unenviable position—he either places himself at risk of committing medical malpractice by missing a diagnosis, which may have been discovered by a specialist through additional testing, or else he places himself at risk of losing his income or even his practice by exceeding the HMO’s utilization quota of allowable referrals. The physician may find himself not only unable to practice defensive medicine, but unable to even practice medicine within acceptable medical standards.

F. Gag Clauses

HMOs have received extensive criticism for using a drastic ploy known as a “gag clause” to prevent member physicians from criticizing the HMO. Gag clauses are contractual provisions which, among other things, prevent the physician, explicitly or implicitly, from disclosing information to patients about treatment options that are not covered under their health plan. Gag clauses are shocking because they hinder open discussion between doctor and patient—an essential element of the doctor-patient relationship. Additionally, some gag clauses prohibit physicians from informing patients about limits on their coverage and incentives. Unfortunately, doctors are being fired or blacklisted for disclosing such information. Some of the other restrictions of gag clauses include prohibitions against disclosing the doctor’s employment arrangement with the HMO, soliciting non-HMO patients, and the doctor’s participation in any debates which criticize HMOs.

One interesting example of a gag clause states, “do not discuss proposed treatments with [patients] prior to receiving authorization from the plan.” Another example of a common gag clause is: “the physician

201. See Kish, supra note 161.
202. See Malinowski, supra note 37, at 350.
206. See generally id.
207. See Martin & Bjerknes, supra note 204, at 444.
agrees not to exert influence on members to switch their enrollment to another form of healthcare coverage, or to involve members unnecessarily in Plan administrative or procedural issues, but instead, agrees to seek problem resolution through the Plan grievance procedures."208 Thus, it is clear that gag clauses limit communication between doctor and patient, and undermine the patient's trust in his doctor. Moreover, gag clauses seem to validate the growing criticism against HMOs.209

Since gag clauses interfere with the well-established tort doctrine of informed consent,210 and may otherwise be unconscionable, many states are enacting legislation to make such clauses illegal. So far, 16 states have enacted legislation prohibiting gag clauses in physician contracts with HMOs.211 Similarly, a new federal regulation of the Department of Health & Human Services provides that any contract limiting a doctor's ability to advise and counsel a Medicare patient violates Medicare rules.212 Additionally, the U.S. House of Representatives recently passed a Republican-sponsored health care bill which contained a provision that would eliminate gag clauses. Because of debates along traditional party lines, however, President Clinton is likely to veto the bill unless bipartisan changes are incorporated, thus, federal measures are likely to be stalled.213 Fortunately for patients and also for doctors (from a informed consent liability standpoint), these kinds of clauses appear to be becoming a thing of the past.

V. ERISA PREEMPTION

HMOs have successfully isolated themselves from liability by asserting Federal Employment Retirement Income Security Act (ERISA) preemption. This defense has the effect of leaving doctors liable for medical malpractice claims which actually may have resulted from decisions imposed by the HMO.214 For example, if the primary care physician did not make a referral to a specialist for diagnostic tests

---

210. See Schloendorff v. Society New York Hosp., 105 N.E. 92, 93 (N.Y. 1914) (Judge Cardozo wrote that "every human being of adult years and sound mind has the right to determine what shall be done with his own body."); see also Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) (recognizing "requirement of a reasonable divulgence by physician to patient").
211. See Grinfeld, supra note 209, at 85.
212. See id.
213. See HMO Reform Bill Passes House, MIAMI HERALD, July 17, 1998; see also House Backs Republican Health Reform Bill, REUTERS NEWS, July 24, 1998.
because of an HMO decision or constraint, and that resulted in a failure
to diagnose which harmed the patient, in most cases the doctor, not the
HMO, could be sued for the malpractice because the HMO is often
shielded from liability under ERISA.

ERISA "provides a detailed system of civil enforcements which
limits who may file suit, the grounds for such suits, and the relief to
which a litigant is entitled."215 Congress also added a preemption pro-
vision which dictates that ERISA shall supersede all state laws insofar as
they "relate to any employee benefit plan."216 The phrase, "relate to"
has been the key question in many lawsuits challenging preemption, but
in principle, the Supreme Court has interpreted ERISA’s preemptive
provision as having a very broad reach.217

Despite the complex and confusing nature of the statute, some rules
of thumb have emerged. ERISA preemption can only occur where an
HMO has been provided through employment.218 HMO coverage
obtained independent of employment is simply not preempted by ERISA
at all. Also, ERISA does not apply to governmental employees or
church employees,219 and ERISA preemption can only be applicable if
the plan is an ERISA employee welfare benefit plan.220

There are two types of preemption under ERISA: "complete pre-
emption" under §502 (29 USC §1132), and "conflict preemption" under
§514 (29 USC §1144).221 If a claim is found to be preempted under
either or both sections, the result will be dismissal of the state law
claim.222 Complete preemption under §502 pertains to federal courts’
removal jurisdiction under the well-pleaded complaint rule.223 Actions
that fall under ERISA’s civil enforcement provisions of §502 are com-
pletely preempted.224 Complete preemption occurs if one or more of the
claims are characterized as: (1) an effort to recover benefits under the
plan, (2) enforce rights under the plan, or (3) clarify rights to future
benefits under the plan.225 If any of these three purposes are at the core
of plaintiff’s claim, the state law claims are precluded226 and the case

217. See District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125, 129
218. See Thomas A. Moore & Matthew Gaier, HMO Liability — Part III: ERISA Preemption,
219. See id.
220. See id.
221. See id.
222. See id.
223. See id. (citing Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 107 (1987)).
224. Id. at 107.
225. See id. (citing 24 U.S.C. § 1132(a)(1)(B)).
226. See id.
may be removed by defendants to federal court where it is subject to dismissal.

Conflict preemption (§514), on the other hand, has no jurisdictional basis for removal, but does provide a defense which may result in dismissal of the state law claims.\textsuperscript{227} Section 514 provides, with few exceptions, that there is complete preemption if the claim "relates to the plan."\textsuperscript{228}

A. Split Decisions Regarding Complete Preemption (§ 502)

The Second, Third, and Seventh Circuits have addressed vicarious liability under §502 and have all held that ERISA does not preempt state court claims under complete preemption. This is good news for plaintiffs and doctors, but bad news for HMOs. The circuits are split, however, on the issue of direct liability under §502.

1. SECOND CIRCUIT: VICARIOUS LIABILITY AND DIRECT LIABILITY NOT PREEMPTED UNDER § 502

Complete preemption was addressed by the Second Circuit Court of Appeals in \textit{Lupo v. Human Affairs Intern., Inc.},\textsuperscript{229} a case sounding in medical malpractice, breach of fiduciary duty and intentional infliction of emotional distress against a psychotherapy group. The court held that there were insufficient grounds for removal to federal court under §502 because the plaintiff's claims did not bear any significant resemblance to the type of claims covered under §502, i.e., claims to recover benefits due under the plan, to enforce rights under the plan, or to clarify rights to future benefits under the plan.\textsuperscript{230}

2. THIRD CIRCUIT: VICARIOUS LIABILITY AND DIRECT LIABILITY NOT PREEMPTED UNDER § 502

The leading case on complete preemption was the subsequent case of \textit{Dukes v. U.S. Healthcare},\textsuperscript{231} wherein the court reversed rulings in two cases where ERISA had been found to preempt the vicarious liability of HMOs for the malpractice of their physicians.\textsuperscript{232} Both cases were

\textsuperscript{227} See \textit{id.}(citing \textit{Jass v. Prudential Health Care Plan}, Inc. 88 F.3d 1482, 1485-87 (7th Cir. 1995)).
\textsuperscript{228} See \textit{Jass v. Prudential Health Care Plan}, Inc. 88 F.3d 1482, 1485 (7th Cir. 1995); \textit{see also Pacificare of Oklahoma v. Burrage}, 59 F.3d 151, 153 (10th Cir. 1995); \textit{Corcoran v. United Healthcare Inc.} 965 F.2d 1321, 1328-29 (5th Cir. 1992).
\textsuperscript{229} 28 F.3d 269 (2d Cir. 1994).
\textsuperscript{230} \textit{See id. at 272.}
\textsuperscript{231} \textit{See Dukes v. U.S. Healthcare, Inc.}, 57 F.3d 350 (3d Cir. 1995).
based upon ostensible agency and agency-in-fact, and also alleged direct negligence in selecting, evaluating, employing, and overseeing the physicians who committed malpractice. The court drew an important, albeit confusing, distinction between quality of benefits received and the quantity of benefits received: Claims based upon the quality of services are not preempted whereas claims based upon quantity of service (denial of benefits) are preempted. The court reasoned that “a claim about the quality of a benefit received is not a claim under §502(a)(1)(B) ‘to recover benefits due... under the terms of the plan.” The court did not find any plan-created right inherent in plaintiffs’ state law malpractice claims and instead viewed plaintiffs’ claims as “attempting to assert their already existing rights under the generally-applicable state law of agency and tort,” seeking to hold the HMO liable as arrangers of plaintiffs’ medical treatment. The court correctly observed that “patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan,” and also pointed out that nothing in the legislative history structure or purpose of ERISA suggested that Congress viewed §502 as creating a remedy for plan members injured by medical malpractice.

Whereas the court was probably correct in its analysis of congressional intent, their decision in Dukes creates an illogical incentive for HMOs to avoid liability by denying care altogether rather than to provide care that could be deemed of substandard quality, since denying care entirely would result in ERISA preemption under the Dukes opinion but providing inferior care would not. Moreover, the distinction of quality versus quantity is murky, since denial of benefits (quantity) can also amount to inferior quality care. Conversely, quality of care can be so minimal as to constitute a denial of benefits. Courts will ultimately have to devise a more reliable criteria than quality and quantity for determining what constitutes preemption under §502.

3. SEVENTH CIRCUIT: VICARIOUS LIABILITY NOT PREEMPTED; DIRECT LIABILITY PREEMPTED UNDER § 502

In a subsequent case, the Seventh Circuit in Rice v. Panchal decided that a plaintiff’s claim seeking to hold an HMO liable under the

---

234. See Dukes, 357 F.3d at 358.
235. Id.
236. Id.
237. See id.
238. Id.
239. See id. at 357.
240. See Rice v. Panchal 65 F.3d 637 (7th Cir. 1995).
respondeat superior doctrine for negligence of its physicians is not preempted under §502, because the claim "does not rest upon the terms of an ERISA plan, and it can be resolved without interpreting an ERISA plan." The Rice court, however, did not rule on the issue of direct negligence, but based its finding of no preemption upon the absence of a direct negligence claim, which foreshadowed its subsequent ruling in Jass v. Prudential Health Care Plan, Inc.

In Jass, the Seventh Circuit deviated from the Second and Third Circuits, by finding that claims of direct negligence against HMOs are completely preempted under §502. Jass arose out of a nurse's decision to discharge a patient after knee surgery without rehabilitation. The nurse, doctor, and HMO were all joined as defendants. The court held that the claims were preempted, reasoning that the claims amounted to a denial of benefits which could not be resolved without interpreting the benefits contract. The Seventh Circuit apparently rejected the Third Circuit's reasoning that such claims are asserting "already existing rights under the generally-applicable state law of agency and tort," and do not require examination of the plan to reach such determination.

4. FIRST CIRCUIT: DIRECT NEGLIGENCE FOR DENIAL OF BENEFITS PREEMPTED UNDER § 502

In the recent case of Turner v. Fallon Community Health Plan, Inc., the court held that Plaintiff's state law claims of breach of contract, wrongful death, and other state law claims, are preempted by §502. The court further held that the Plaintiff's amended complaint which contained a claim under ERISA that the HMO breached its fiduciary duty by denying an experimental bone marrow transplant, was properly dismissed because the relief expressly provided under ERISA is to secure benefits under the plan rather than to allow damages for breach of the plan. Since ERISA provides only equitable relief, and equitable relief is moot once the patient has died, no remedy is available under ERISA. The court's holding in Turner conflicts with the Eighth Circuit's recent decision in Shea v. Esensten, where the court allowed a claim for breach of fiduciary duty under ERISA, despite the availability

241. Id. at 646.
243. See id. at 1488-90.
244. Id.
245. Dukes, 57 F.3d at 358.
246. See id. at 350.
247. See Turner v. Fallon Community Health Plan, Inc., 127 F.3d 196 (1st Cir. 1997).
248. See id. at 199.
249. See id.
250. See id. at 198.
of only equitable relief.\textsuperscript{251}

B. \textit{Split Decisions Regarding Conflict Preemption (§ 514)}

As previously mentioned, §514 preempts claims that "relate to [an ERISA] plan." Although the U.S. Supreme Court has not addressed ERISA preemption in the context of medical malpractice liability, it has reviewed ERISA preemption in a general tort setting, pointing out that ERISA is not intended to preempt "run-of-the-mill state law claims such as . . . torts committed by an ERISA plan."\textsuperscript{252}

1. \textbf{TENTH CIRCUIT: NO PREEMPTION FOR VICARIOUS LIABILITY UNDER § 514}

It is with this in mind that the Tenth Circuit in \textit{Pacificare of Oklahoma, Inc. v. Burrage},\textsuperscript{253} held that a medical malpractice claim against the HMO for the negligence of its physician does not "relate to the plan," and as such, is not preempted under §514.\textsuperscript{254} The court reasoned that ERISA does not preempt "laws of general application—not specifically targeting ERISA plans—that involve traditional areas of state regulation and do not affect relations among the principal ERISA entities."\textsuperscript{255} The court further reasoned that "As long as a state law does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the [state law] has some economic impact on the plan does not require that the [state law] be invalidated."\textsuperscript{256} Merely because a plan is potentially liable for judgment "is not enough to relate the action to the plan."\textsuperscript{257} The court concluded:

\begin{quote}
Just as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent . . . . We agree with the district court that reference to the plan to resolve the agency issue does not implicate the concerns of ERISA preemption.
\end{quote}

2. \textbf{SEVENTH CIRCUIT: VICARIOUS LIABILITY PREEMPTED UNDER § 514}

The Seventh Circuit reached the opposite conclusion in \textit{Jass v. Prudential},\textsuperscript{259} holding that vicarious liability claims are preempted by §514

\textsuperscript{251} See \textit{Shea v. Esensten}, 107 F.3d 625, 628 (8th Cir. 1997).
\textsuperscript{253} \textit{Pacificare of Oklahoma, Inc. v. Burrage}, 59 F.3d 151 (10th Cir. 1995).
\textsuperscript{254} See \textit{id.} at 153.
\textsuperscript{255} \textit{id.} at 154.
\textsuperscript{256} \textit{id.}
\textsuperscript{257} \textit{id.} at 155.
\textsuperscript{258} \textit{id.}
\textsuperscript{259} \textit{See Jass v. Prudential Health Care Plan, Inc.}, 88 F.3d 1482 (7th Cir. 1996).
because they are "related to the plan." The court reasoned that the relationship between the physician and the HMO would have to be examined in order to determine whether vicarious liability existed, which meant the claim related to the plan. The court tried to distinguish *Jass* from *Pacificare* by noting that *Pacificare* involved negligent treatment, whereas *Jass* involved a failure to treat when the plan denied coverage (the quality versus quantity approach again). This distinction does not hold water from a vicarious liability standpoint, and these two cases are clearly irreconcilable.

3. **FIFTH CIRCUIT: DIRECT LIABILITY FOR DENIAL OF BENEFITS—PREEMPTED UNDER § 514**

As previously noted, claims pertaining to quantity of care (denial of benefits) and claims where an HMO failed to approve treatment face great difficulty in ERISA preemption. The Fifth Circuit held in *Corcoran v. United Healthcare, Inc.* that the wrongful death of a fetus arising from an HMO utilization reviewer's determination who denied hospitalization was preempted under §514. The court reached this conclusion since a determination of available benefits under the plan would have to be made, which causes the action to be "related to the plan."

4. **NINTH CIRCUIT: DIRECT LIABILITY FOR DELAY OR DENIAL OF BENEFITS—PREEMPTED UNDER § 514**

Following the same line of reasoning as the Fifth Circuit, the Ninth Circuit held in *Comer v. Kaiser Foundation Health Plan* that claims against HMOs arising from delays or refusals to authorize treatment are preempted by §514. Here too the court held that the plan must be reviewed in order to determine appropriateness of the delay and covered treatment, and as such, the claims were deemed "related to the Plan." Other courts have found that delays in treatment are a matter of negligence, not a denial of benefits and are not subject to preemption.

260. See id. at 1490-91.
261. See id. at 1491.
263. See id. at 1331.
264. See id. at 1332.
265. See *Comer v. Kaiser Foundation Health Plan*, 45 F.3d 435 (9th Cir. 1992).
266. See id.
267. See id.
268. See Pappas v. Asbel, 675 A.2d 711, 716 (Pa. 1996); see also Michael A. Riccardi, *Medical Suit Against HMO Not Barred By ERISA*, *The Legal Intelligencer*, Mar. 21, 1996, at 1 (discussing the Supreme Court's decision in *Pappas*).
5. **EIGHTH CIRCUIT: DIRECT LIABILITY FOR FAILING TO DISCLOSE INCENTIVES OR CANCELING SURGERY—PREEMPTED UNDER § 514; CLAIMS OF BREACH OF FIDUCIARY DUTY VALID UNDER ERISA § 1104(A)(1)**

In a case of first impression, *Shea v. Esensten*, 269 the Eighth Circuit followed the other circuits by holding that state tort claims against an HMO for failure to disclose the fact that it provided incentives designed to deter its participating physicians from making referrals, were preempted under §514. 270 The court added a new wrinkle to the ERISA morass, however, by holding that the Plaintiff’s claim of breach of fiduciary duty for failing to disclose the financial incentives was valid and could be brought under ERISA. The court pointed out that ERISA requires plan fiduciaries to “discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries.” 271 Additionally, the U.S. Supreme Court has concluded that ERISA fiduciaries must comply with the common law duty of loyalty, which includes the obligation to deal fairly and honestly with all plan members. 272 The court in *Shea* reasoned that patients “[rely] on doctor’s advice about treatment options, and the patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider.” 273 The court further pointed out that “Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it ‘knows that silence might be harmful.’” 274 The court laid down the rule that “[w]hen an HMO’s financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA’s fiduciary duties.” 275

In a previous case, the Eighth Circuit held that §514 preempted a claim against an HMO for actually canceling a scheduled surgery after its precertification review. 276 The court reasoned that precertification was directly related to administration of benefits under the plan. 277 The court indicated, however, that if an HMO had a more direct involvement

---

270. See id. at 627.
271. Id. at 628; see also 29 U.S.C. § 1104(a)(1)(1994).
274. See id. at 629 (quoting *Bixler v. Central Penn. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1300 (3d Cir. 1993)).
277. See id.
in canceling the surgery other than refusing to pay for it, there might be liability.\(^{278}\)

C. Synopsis of ERISA Decisions

Since the holding in *Dukes*, there appears to be a trend for federal courts to remand cases back to state courts.\(^{279}\) Once these cases are remanded, the state courts are less likely to find ERISA preemption.\(^{280}\) It appears that the more claims look like medical malpractice/negligence cases, the better chance they stand of avoiding ERISA preemption. Cases that assert state law claims based upon the *quality* of health care provided may be beyond ERISA’s preemptive scope. Cases that focus on *quantity* of benefits or denial of benefits are usually preempted. The majority rule is that ERISA does not preempt vicarious liability claims against HMOs, because they merely relate to the quality of benefits received and not to the plan itself.\(^{281}\) On the other hand, claims based upon direct liability such as cost containment schemes or corporate negligence relate to the administration of the plan and are therefore preempted. Claims such as breach of fiduciary duty have been held to be encompassed under ERISA and may be pursued in federal court,\(^{282}\) however, the only available remedy thereunder is equitable relief.\(^{283}\)

Plaintiff’s will be more likely to succeed by characterizing their claims as related to the quality of the care provided and asserting that the inferior care provided by the HMO was a deviation from acceptable standards. HMOs are more likely to succeed by characterizing the claims as denial-of-benefits claims within the scope of §502 (a), or as being otherwise “related to the plan” under §514(a).

HMOs best line of defense, however, may be measures that can be taken in advance of any litigation. One such measure might be to replace the state law standard of care with a higher (or lower) standard of care adopted by contract under the health plan. This would enable attorneys for the HMO to later argue that a plaintiff’s quality-of-care claim is really a denial-of-benefits claim and therefore, subject to preemption.\(^{284}\) Additionally, HMOs can reduce the likelihood of successful

---

\(^{278}\) See id.

\(^{279}\) See James Walker Smith & Christopher P. Hannon, *Focus of Managed Care: ERISA Preemption: No Longer a “Sure Thing” for HMOs*, 14 MEDICAL MALPRACTICE LAW & STRATEGY 1, 3 (1997).

\(^{280}\) See id.

\(^{281}\) See generally Panah, *supra* note 13 (noting ERISA preemption cases at both the federal trial court and appeals levels).

\(^{282}\) See Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997).


\(^{284}\) See *Dukes*, 57 F.3d at 359.
vicarious liability claims by ensuring that plan administrators, particularly physicians or nurses, serve only in an administrative capacity. A successful tack for HMOs is that they are not practicing medicine, but are merely designating what they will and will not pay. The patient is still at liberty to seek other treatment and pay for it on their own. Perhaps the best news for plaintiffs and doctors is that many states are enacting legislation specifically allowing HMOs to be sued for medical malpractice. This legislation might indirectly be good news for HMOs who can then gauge their liability more accurately, adjust covered services, adjust premiums, and generally take steps to implement systems that avoid pitfalls that lead to medical malpractice.

VI. CORPORATE PRACTICE OF MEDICINE DOCTRINE

In addition to the ERISA preemption, defendant HMOs utilize the legal doctrine known as the Corporate Practice of Medicine Doctrine as a defense. This doctrine is closely entwined with the issue of what constitutes "practicing medicine," and both must be analyzed together. Laws that specifically govern the practice of medicine vary from state to state, but almost all of the states have adopted some form of the Corporate Practice of Medicine Doctrine.285 Some state legislatures have limited the scope of the doctrine specifically providing that corporations (and HMOs) are not deemed to be practicing medicine.286 Variations of this theme appear in the statutes of several states including South Dakota, North Dakota, California, New Jersey, and New York.287

The Corporate Practice of Medicine Doctrine’s underlying premise is essentially that a corporation (such as a hospital or an HMO) cannot be licensed to practice medicine and thus cannot command or forbid any act by a doctor in the practice of medicine. The corporation’s relationship with the doctor it employs is necessarily that of an independent contractor. Hence, an entity employing a doctor cannot be held liable for a doctor’s negligence based on respondeat superior.288 The doctrine was initially conceived to preserve the independence of physicians from corporate influence.

It is ironic and somewhat perverse that this doctrine has been contorted to be used as a defense by HMOs, when the doctrine’s purpose was to protect the public from the commercial exploitation of medicine

286. See Smith, supra note 153, at 2 (States that provide that HMOs, by definition, are not medical practitioners, are: Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Maine, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, Ohio, and Tennessee).
288. See Moon v. Mercy Hospital, 373 P.2d 944 (Colo. 1962).
by entities like HMOs. The rationale for the doctrine is that “[it is] against public policy to permit a middleman to intervene for profit in establishing the professional relationship between members of the medical profession and members of the public.” The gist of HMO counsels’ twisted (albeit creative) use of this doctrine as a defense has been that since the doctrine establishes corporations are incapable of practicing medicine, they cannot be held liable for medical malpractice. Courts have widely accepted this argument, despite its ridiculous rationale. This argument is essentially no different than saying, “but officer, I am incapable of speeding because speeding is against the law!” The slight of hand is apparently in use of the word “incapable,” instead of “prohibited.” When the word “prohibited” is substituted, it becomes more apparent that the argument is a non-sequitur. Simply because something is prohibited does not mean that the prohibition has not been violated and that liability should not attach. If facts of a particular case show that a corporation has undertaken activities that amount to practicing medicine, courts should hold that the corporation violated the doctrine, not that they are cleansed of liability by it.

Along these lines, at least one court has recognized that as a matter of public policy, society is not prepared to abandon the rule against the Corporate Practice of Medicine, and held that the corporation in that case was illegally engaged in the practice of medicine. The U.S. Supreme Court has also held that the power to regulate the practice of medicine is within each state’s police power and that the police power of the state includes the power to enact comprehensive, detailed, and rigid regulations of the practice of medicine, surgery, and dentistry.

290. See id.
292. See Garcia v. Texas State Board of Medical Examiners, 358 F.Supp 1016, 1018-19 (W.D. Tex. 1973) (noting that “when a corporation employs a licensed physician to treat patients and itself receives the fee, the corporation is unlawfully engaged in the practice of medicine and the licensed physician so employed is violating the provisions of Article 4505 (12)”).
294. See id.
As the Court pointed out in *Garcia v. Texas State Board of Medical Examiners*, "Nothing is more fundamental than the rights of the various states to furnish the people competent health services, and as a direct corollary to this right they have a corresponding duty to carefully prescribe minimum requirements for the licensing of those administering medical and surgical services." The Court went on to say that since medicine is a highly specialized field of experts who deal with the very lives of the citizenry, the states must insure, to the best of their ability, the competency of these experts.

Physician licensure statutes were initially enacted to protect the populace from the early medical quacks and charlatans who abused the unwary public as entrepreneurial medicine men selling snake oil remedies. Eventually, public outrage over harmful medicines and untrained "healers" became so widespread, that federal and state governments began to act. Rigid licensing requirements were adopted by all states.

An example of a typical state law governing the practice of medicine is the Texas Medical Practice Act, which states in pertinent part: that a person shall be considered to be "practicing medicine" within the act:

(A) who shall publicly profess to be a physician or surgeon and shall diagnose, treat, or offer to treat any disease or disorder, mental or physical, or any physical deformity or injury by any system or method or to effect cures thereof; or

(B) who shall diagnose, treat, or offer to treat any disease or disorder, mental or physical, or any physical deformity or injury by any system or method or to effect cures thereof and charge therefor, directly or indirectly, money or other compensation.

Additionally, article 20A.29 of the Texas Health Maintenance Organization Act states that the Act shall not be construed to:

(a) authorize any person, other than a duly licensed physician or practitioner of the healing arts, acting within the scope of his or her license, to engage, directly or indirectly, in the practice of medicine or any healing art, or

(b) authorize any person to regulate, interfere, or intervene in any manner in the practice of medicine or any healing art.

299. See 358 F.Supp. at 1019.
300. See id.
301. See id.
302. See id.
303. See id.
305. Id.
Citing these provisions of the statute, The Court of Appeals of Texas, nevertheless held in Williams v. Good Health Plus, Inc.\textsuperscript{306} that the defendant doctors could not have been employees of the defendant HMO since that would violate the Corporate Practice of Medicine Doctrine's prohibition.\textsuperscript{307} The court did point out, however, that the record showed that at no time did any person, agent, or employee of the HMO have any right to direct and or control the work or practice of medicine by the defendant doctors, leaving open the possibility that if such direction or control were present, liability might attach to the HMO.

Similarly, in Morris v. District of Columbia Board of Medicine,\textsuperscript{308} the court overturned the District of Columbia Board of Medicine’s finding that a doctor who was not licensed in the District of Columbia and acting as Medical Director of Health Affairs for Blue Cross was practicing medicine without a license. The court determined that the doctor was acting in a purely administrative capacity and was not involved in the “pre-treatment decision making process.”\textsuperscript{309} Interestingly, the doctor himself acknowledged that if he had had a voice in the recommendations of the medical advisers and review committees, then he would have been practicing medicine.\textsuperscript{310} This rationale suggests that the court would have held differently if the doctor had been involved in making or influencing medical decisions in advance of treatment. In fact, the court left open the possibility “that on other facts a medical administrator of a health insurer such as Blue Cross which monitors and regularly questions treatment decisions by physicians, may not be found to have practiced medicine as defined as defined in §2-3301.2(7)\textsuperscript{311} “The focus must be on the actions of the individual administrator . . . .”\textsuperscript{312} The court pointed out that if the doctor had been found to be practicing medicine without a license, he would also have been subject to criminal punishment.\textsuperscript{313}

The court in Morris acknowledged dicta in its previous decision in Joseph v. District of Columbia Board of Medicine,\textsuperscript{314} that “members of the Board of Medicine are presumed to have substantially greater familiarity than do judges with the meaning of terms like ‘practice of medicine,’ so that if a decision of the Board rests upon its interpretation

\textsuperscript{306} See Williams v. Good Health Plus, Inc.—Healthamerica Corporation of Texas, 743 S.W.2d 373 (Tex. Ct. App. 1987).
\textsuperscript{307} See id. at 377.
\textsuperscript{308} See Morris v. District of Columbia Board of Medicine, 701 A.2d 364 (D.C. 1997).
\textsuperscript{309} See id. at 366.
\textsuperscript{310} See id. at 366.
\textsuperscript{311} See id. at 367.
\textsuperscript{312} See id. at 368.
\textsuperscript{313} See id.
\textsuperscript{314} See Joseph v. District of Columbia Board of Medicine, 587 A.2d 1085, 1088 (D.C. 1991).
of the statute, we must give the Board’s decision substantial weight.”
Interestingly, in *Joseph*, the court affirmed the Board’s determination
that an expert witness who testified falsely in a medical malpractice case
had made a “diagnosis” within the meaning of the statute, in that he
conducted an investigation and analysis of the nature of the plaintiff’s
condition and cause of death. This reasoning could arguably be
extended to HMO personnel who conduct an investigation and analysis
of a patient’s condition prior to denying benefits.

In distinguishing between merely administering a health organization
and practicing medicine, *control* over how services are provided to
patients seems to be a determinative factor. All health care providers
must perform business, administrative, and management chores, but as
long as these functions do not “impinge upon professional control by the
physicians of the medical practice,” the corporation is not deemed to be
practicing medicine. The main issue in allowing HMOs to “employ”
physicians becomes whether the relationship between a doctor and the
patient becomes “so destroyed as to allow the [employer] to become the
medical practitioner.”

To further aid in determining whether a corporation has engaged in
acts that constitute the practice of medicine, it is helpful to look at the
criteria established by the Illinois supreme court in the case of *Dr. Allison, Dentist, Inc. v. Allison*. The court in *Allison* stated that
merely “operating” a dental clinic office by employing a dentist to per-
form certain services for the patients and customers constituted practic-
ing medicine. The supreme court substantiated this definition in *People v. United Medical Services*, where it found that a corporation’s
contracting for the payment for medical services qualified as practicing
medicine. Although *Allison* was decided in 1936, it has not been
overturned. As such, there would appear to be a relatively low threshold
for what constitutes “practicing medicine” in Illinois. In general, there
may be a willingness of courts to find that corporations are practicing
medicine absent specific statutes precluding it, if the corporation has
exerted control over the patient care and injected itself into the doctor/
patient relationship. If an HMO is making determinations as to what

315. See *Morris*, 701 A.2d at 367.
316. See *Joseph*, 587 A.2d at 1089.
317. See Daw’s Critical Care Registry, Inc. v. Department of Labor, Employment Security
Division, 622 A.2d 622,636 (1992), aff’d 622 A.2d 518 (Conn. 1993).
318. See Women’s Medical Center v. Finley, 469 A.2d 65, 73 (1983), cert. denied, 475 A.2d
321. See id.
322. See *People v. United Medical Service*, 200 N.E. 157, 163 (Ill. 1936).
procedures and referrals it deems medically necessary or unnecessary, it may in fact, be engaging in the corporate practice of medicine. There is evidence that courts are beginning to recognize that coverage decisions are increasingly likely to have direct clinical consequences. 323

HMOs may claim that they are not practicing medicine but are merely acting as an insurer, electing to undertake certain risks and not others. But when the totality of the picture removes choices from the patient and the doctor and casts the HMO in the role of the decision maker, the pendulum could begin to swing against the HMOs.

VII. LEGISLATION

Whereas state legislatures around the country have spent the last several years attempting to cap malpractice liability and reform insurance, many of them may now expand liability of HMOs. 324 Additionally, the U.S. House of Representatives has recently passed legislation which could have a profound effect upon the liability of HMOs, although President Clinton has indicated his intent to veto the bill. 325 This section will briefly review the various states’ approaches to remedial legislation as well as the U.S. Congress’ proposed bill:

A. State Legislation

1. TEXAS

Texas is taking the lead in proposing legislation designed to increase the liability of HMOs. 326 The Texas bills would make HMOs responsible for negligent decisions when denial of medically necessary medical treatment results in patient injury. 327 Additionally, the proposed bills would require HMOs to include a “reasonable lay-person” standard in defining emergency care so that such a person could admit himself into an emergency room without prior approval by the HMO. 328 Also of significance is the prohibition of gag clauses in the proposed legislation. 329 The measures are supported by the Texas Medical Association. As its president, Dr. Hugh Lamensdorf, said, “We are not opposed to

325. See House Backs Republican Health Reform Bill, supra note 213.
326. See generally Schlegel, supra note 119; see, e.g., HMO Liability Bill Sent To Bush’s Desk, supra note 21.
327. See Schlegel, supra note 119.
328. See id.
329. See id.
managed care; we are opposed to mismanagement of care.” The response by an HMO spokesman was the rhetorical inquiry, “... are we [HMOs] going to be held accountable for medical malpractice when we don’t practice medicine?” Despite the widespread support for the proposed legislation, Texas Governor George Bush seems reluctant to sign the bill, expressing concern that it would create new avenues for filing lawsuits. Eighteen months prior to this proposed legislation, Bush vetoed the “Patient Protection Act,” because he felt it imposed too many rules which would have increased health care costs.

2. NEW YORK

New York is also considering a bill designed to hold HMOs liable for negligence related to medical decision making. Under the proposed bill, HMOs would be liable for the consequences of their decisions regarding the provision or denial of health care. The bill requires that health care organizations “use reasonable care when making decisions that affect the diagnosis, care or treatment of an enrollee, and also to exercise reasonable care in selecting and exerting influence or control over employees and other representatives acting on their behalf with regard to decisions that affect the quality of a subscriber’s diagnosis, care or treatment.” The Medical Society of the State of New York as well as the New York State Trial Lawyers Association support the bill, indicating the need to hold HMOs and insurers legally responsible when their decisions cause injury or death to a patient. This law would also serve to displace current New York law which provides that provision of health services by HMOs, either directly or indirectly, is not to be considered the practice of medicine by the HMO.

3. CALIFORNIA

California legislators have proposed nearly 50 bills, approximately 30 of which have already passed the Senate with broad bi-partisan support. The bills address a wide range of criticisms about health plans, focusing mostly on complaints about HMOs “cutting costs at the

330. See id.
331. Id.
333. See Sanchez, supra note 149, at 19.
334. See generally Ryan, supra note 7; see also Schmitt, supra note 214, at 6.
335. See Ryan, supra note 7, at 5.
336. See id.
338. Id.
expense of patient well-being.” One provision would require that the only person who can deny coverage in an HMO would be a licensed California physician. Other provisions include a public disclosure as to why treatment was refused, as well as an in-house physical exam of a patient before treatment can be denied. Although California Governor, Pete Wilson, has said that he recognizes the need for “beefed-up regulation of managed care,” he nevertheless appears reluctant to endorse wholesale changes bowing to pressure from powerful HMOs.

In a classic case of “the pot calling the kettle black,” Dr. Albert Martin, the medical Director of Blue Cross of California said, “by [the California Legislature] advancing so many control bills, the Legislature is practicing medicine and getting away with it because of so much publicity and so many anecdotal horror stories.”

4. GEORGIA

Georgia has passed several bills designed to control HMO practices. One such bill is known as the “Patient Protection Act,” which requires two-day hospital stays for normal deliveries and up to four days for Caesarean deliveries. Another bill is called “The Prudent Layperson Bill,” and is designed to expand the definition of necessary emergency room coverage and prohibiting prospective approval of emergency patients. Additional bills require HMOs to disclose treatment options to the patient; provide an expanded appeal process; and bar HMOs from providing financial incentives to doctors to deny needed care.

5. NEW JERSEY

New Jersey has recently passed “Drive-by-Delivery or “Forty-Eight Hour” rules, which protect new mothers from premature discharge after delivery. The laws also prevent HMOs from terminating doctors who advocate expensive procedures; and require that HMOs disclose financial incentives; and limit denial of medical treatment only to a physician. New Jersey is also considering the Health Care Provider

340. See id.
341. See id.
342. See id.
343. See id.
344. See id.
345. See Malone & Thaler, supra note 2.
346. See id.
347. See id.
348. See id.
349. See id.
Accountability Act of 1998, A.B. 1606. This Act holds insurance companies and HMOs liable for damages for harm caused by the failure to exercise ordinary care in making health care treatment decisions.

6. OTHER STATES

Many other states are also considering legislation designed to regulate HMOs. Hawaii’s bill recently passed the Senate and is pending in the State House. Washington and New Hampshire are also passing far-reaching managed care legislation. Missouri is presently considering a broad managed care bill in its House of Representatives. Last year, the Florida Legislature easily passed HMO liability legislation, but it was vetoed by Governor Lawton Chiles. The Legislature did not give up, however, and pushed through HMO legislation that provides the prevailing party in any suit brought to enforce an HMO contract is entitled to attorney’s fees. A similar bill in Maryland, however, died in legislative session. Maryland is considering removing referral requirements for dermatological treatment. Colorado’s proposed law would diminish the discretion of HMOs regarding coverage decisions. Connecticut’s proposed bill would create a statutory cause of action for medical malpractice against HMOs. Illinois is considering legislation that would restrict the discretion of HMOs in coverage decisions, would require HMOs to be regulated by state insurance or public health department, and would also prevent gag clauses that interfere with the Doctor-patient communication. Indiana is considering diminishing the role of HMOs in the decision making process, and will require coverage on all FDA-approved drugs and devices. Pennsylvania and Vermont are considering bills aimed at eliminating financial incentives for physicians to limit medical care. Last, and perhaps least, Virginia has limited its action to establishing a subcommittee to study the control of pharmacy benefits by HMOs. Despite the importance of these state laws, they

351. See id.
353. See id.
354. See id.
355. See id.
356. See FLA. STAT. § 641.28 (1997).
358. See Smith, supra note 153, at 3.
359. See id.
360. See id.
361. See id.
362. See id.
363. See id.
364. See id.
may become obsolete if federal legislation is signed into law.

B. Federal Legislation

Despite the proposed state legislation and recent court holdings, there are still lingering questions as to whether causes of action will be effective, absent meaningful change in ERISA.365 With this in mind, bills have been introduced by both Democrats and Republicans in the U.S. Congress. A democrat-sponsored bill designed to amend ERISA was narrowly voted down (216-210). This bill would have permitted a cause of action for denial of benefits under a managed care plan due to negligent medical decisions or decisions resulting from cost-containment measures.366 This bill was defeated in favor of the GOP bill, which provides internal and external appeals processes as a remedy against HMOs.367 One of the primary differences in the two plans is that the Democrat’s plan would expand a patient’s ability to sue a health plan, whereas the republican’s plan relies on an expanded grievance and appeals process. If a patient disagrees with a health plan’s decision, the patient can appeal internally, and then go to an independent external medical reviewer for an additional binding opinion on any medical service that costs more than $1,000.00.368 The bill contains several provisions strongly opposed by the White House including a limit on the amount that victims of medical malpractice can be awarded in lawsuits.369

Insurance companies are strongly opposed to any kind of government intervention,370 and opponents of the bill claim it would result in huge legal costs and raise the cost of health care.371 Conversely, a survey sponsored by a group called Patient Access to Responsible Care Alliance ("PARCA") indicates that 85 percent of adults surveyed favored laws ensuring HMOs are held legally accountable when their decisions to delay or deny treatment results in illness, injury or death.372

The Democrats’ proposed bill included a Patients’ Bill of Rights which Clinton backed and continues to push via his veto leverage. These rights include consumers’ rights to:

365. See Ryan, supra note 7, at 7.
366. See id.
368. See id.
369. See HMO Reform Bill Passes House, supra note 213.
371. See id.
372. See Health Care - Managed Care: Debate on Managed Care Liability Bill Splits Witnesses Along Traditional Lines, 66 U.S.L.W. 2281.
TAKE HALF AN ASPIRIN AND CALL YOUR HMO

- Receive accurately disclosed information;
- Choose health care providers;
- Have access to emergency care when and where the need arises;
- Participate fully in all decisions related to treatment;
- Receive considerate and respectful care;
- Communicate confidentially with health care providers;
- Have a fair and efficient process for resolving differences with health plans, providers and institutions.

The bill also calls for an independent external appeals process. This process would be available in cases where patients are denied payment or treatment based on “medical necessity” or “experimental treatment” grounds, and all internal avenues have been exhausted. The overwhelming public support for this pending legislation, combined with the wave of public sentiment against HMOs and increasing publicity of HMO horror stories, makes it appear that the current state of affairs with regard to HMOs is about to face dramatic change. Whether change will be in the form of a Republican-backed grievance and appeals process, a Democrat-backed right to sue HMOs, or a stalemate resulting in a temporary status quo and unknown future proposals, attorneys for both plaintiffs and healthcare providers will be required to have a thorough understanding of the HMO litigation minefield. They must also have an eye toward the changing role of the doctor and the bioethical aspects of healthcare in general.

VIII. Conclusion

Are HMOs practicing medicine without a licence? In practice, the answer is: of course they are. From a legal standpoint, it is less clear. The law in many states does not view HMOs as engaging in the unlicensed practice of medicine—even if HMOs are doing the exact same things for which individuals have been convicted under state laws governing the unauthorized practice of medicine. Although some state statutes say that HMOs are not practicing medicine, and some courts have applied the Corporate Practice of Medicine Doctrine which says that they cannot practice medicine, more and more legislatures and courts are beginning to reason that if it walks like a doctor, quacks like a doctor, makes medical decisions and directs the course of patient care, then it is probably practicing medicine, which should only be done by a doctor.

Health care reform, tort reform, and regulation of HMOs are areas of the law that are still developing. Society needs to strike a balance.

between providing quality, affordable health care for its members, while preserving the rights of plaintiffs to be compensated for harm caused by malpractice, yet also discouraging unnecessary litigation. Medical decisions should be made on the basis of scientific evaluation of an individual patient by that patient’s doctor, free from any economic coercion from HMOs, and free from the threat of unwarranted lawsuits.

With the current swell of public sentiment against HMOs coupled with non-medical personnel making medical decisions based upon economic criteria leading to huge HMO profits, HMOs may be vulnerable to a backlash reaction. The potential exists for a tremendous explosion of liability against HMOs for malpractice committed as a result of their policies. This, in turn, will have disastrous effects on the affordability of health care. HMOs will have to carefully evaluate their role in the noble practice of medicine, and restructure their approach so they do not interfere with the oath each doctor takes, to “use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing.”

Doctors must be allowed enough discretion and freedom from financial considerations to treat their patients with a quality of care that HMO executives would approve for themselves and their own families, without cost as the primary concern.

In the final analysis, HMOs cannot be faulted for wanting to make profits. The desire to make a profit has been one of the greatest motivators in our society since the beginning of time, and has led to the growth and development of our culture. But, nothing exceeds like excess. As Lao-tzu wrote in approximately 531 B.C., “There is no calamity greater than lavish desires; There is no greater guilt than discontentment; And there is no greater disaster than greed.” Whether society’s current health care problems are caused by the “greed” of terminal patients insisting on futile treatment, the greed of lawyers clamoring for the huge verdict, the greed of doctors building the lucrative practice, or the greed of insurers maximizing profits while minimizing benefits, undoubtedly, greed is to blame. Overcoming this element of human nature and striking the proper balance between a healthy populace, a healthy legal system, and healthy profits will be our challenge.

TOM J. MANOS

374. BARTLETT, supra note 26, at 88.
375. See Malinowski, supra note 37, at 351.
376. See BARTLETT, supra note 26, at 74.