

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: <https://repository.law.miami.edu/umlr>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Tom J. Manos, *Take Half an Aspirin and Call Your HMO in the Morning-Medical Malpractice in Managed Care: Are HMOs Practicing Medicine Without a License?*, 53 U. Miami L. Rev. 195 (1998)
Available at: <https://repository.law.miami.edu/umlr/vol53/iss1/5>

This Comment is brought to you for free and open access by the Journals at University of Miami School of Law Institutional Repository. It has been accepted for inclusion in University of Miami Law Review by an authorized editor of University of Miami School of Law 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. <i>The Birth of HMOs</i>	201
B. <i>Medical Ethics</i>	204
C. <i>Increasing Litigation</i>	205
D. <i>Tort Reform</i>	208
E. <i>Increasing Presence of HMOs</i>	209
III. TYPES OF HMOs	211
IV. CRITICISM OF HMOs	212
A. <i>Inferior Care</i>	212
B. <i>Volume Healthcare</i>	214
C. <i>Capitation Schemes</i>	215
D. <i>Utilization Management</i>	216
E. <i>Financial Incentives</i>	217
F. <i>Gag Clauses</i>	219
V. ERISA PREEMPTION	220
A. <i>Split Decisions Regarding Complete Preemption (§ 502)</i>	222
1. SECOND CIRCUIT	222
2. THIRD CIRCUIT	222
3. SEVENTH CIRCUIT	223
4. FIRST CIRCUIT	224
B. <i>Split Decisions Regarding Conflict Preemption (§ 514)</i>	225
1. TENTH CIRCUIT	225
2. SEVENTH CIRCUIT	225
3. FIFTH CIRCUIT	226
4. NINTH CIRCUIT	226
5. EIGHTH CIRCUIT	227
C. <i>Synopsis of ERISA Decisions</i>	228
VI. CORPORATE PRACTICE OF MEDICINE DOCTRINE	229
VII. LEGISLATION	234
A. <i>State Legislation</i>	234
1. TEXAS	234
2. NEW YORK	235
3. CALIFORNIA	235
4. GEORGIA	236
5. NEW JERSEY	236
6. OTHER STATES	237
B. <i>Federal Legislation</i>	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,¹ 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.²

This real-life case³ 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).

2. According to hospital records, the child specifically underwent bilateral wrist disarticulation, right below knee amputation, and left knee disarticulation. See *Adams v. Kaiser Found. Health Plan of Georgia, Inc.*, No. 93-VS-79895-E (Fulton County, Ga., Feb. 2, 1995); see also *MEDICAL MALPRACTICE REVIEW, MED. LITIG. ALERT*, July 1995, at 16-19; see also Thomas William Malone & Deborah Haas Thaler, *Managed Health Care: A Plaintiff's Perspective*, 32 *TORT & INS. L.J.* 123, (1996), available in WL.

3. See *Adams v. Kaiser Found. Health Plan of Georgia, Inc.*, No. 93-VS-79895-E (Fulton County, Ga., Feb. 2, 1995); see also *MEDICAL MALPRACTICE REVIEW, MED. LITIG. ALERT*, July 1995, at 16-19; see also Malone & Thaler, *supra* note 2.

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.⁴ Traditionally, this kind of claim, if brought against an HMO, might be dismissed based upon legal technicalities discussed in this article,⁵ and might result in plaintiffs like James Adams, being left uncompensated for injuries caused by the HMO's negligence.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.⁷ This area of the law is in a current state of flux. The Federal Employment Retirement Income Security Act ("ERISA"),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 1974,⁹ 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.¹⁰ Ironically, ERISA, a law that was originally designed to protect workers,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.¹² Many of these theories

4. *Id.*

5. See *infra* parts V and VI.

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.

7. See Barbara A. Ryan, *Legislature Considers Revisiting Health Care; Proposed Bill Holds HMO's Liable of Negligent Decisions*, N.Y.L.J., Aug. 25, 1997, at 5, 7.

8. 29 U.S.C. § 1001-1461 (1994 & Supp. II 1996).

9. *Id.*

10. See generally Thomas A. Moore & Matthew Gaier, *The Liability of Health Maintenance Organizations*, N.Y.L.J., July 1, 1997, at 3.

11. 29 U.S.C. § 1001(2) (1994) (noting that the well-being of millions depends upon the soundness of employee benefit plans).

12. See Ryan, *supra* note 7, at 5.

have proved unsuccessful,¹³ and the Courts have been far from consistent in their approach to such cases.¹⁴ 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.¹⁵ Courts applying this doctrine have circularly reasoned that since the doctrine prohibits corporations from practicing medicine, corporations cannot be held liable for medical malpractice.¹⁶

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,¹⁷ 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.¹⁸ Critics characterize such policies by HMOs as the unauthorized practice of medicine, and HMOs are increasingly finding themselves subject to liability and public scorn.¹⁹

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.²⁰ This may ultimately obviate the need for further cases to interweave these legal theories to establish liability.²¹

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,

13. See *id.* See also Lisa Panah, *Common Tort Liability of Health Maintenance Organizations*, 29 J. HEALTH & HOSP. L. (1996) (for a good overview of various tort theories utilized against HMOs).

14. See generally Malone & Thaler, *supra* note 2.

15. See generally Michael A. Dowell, *The Corporate Practice of Medicine Doctrine Must Go*, HEALTHSPAN, Nov. 1994, at 7, available in WL.

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.²² 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."²³ 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.²⁴ The doctor is ultimately responsible for all treatment, or lack thereof, rendered to patients in his care.²⁵ 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.²⁶

The Hippocratic Oath,²⁷ 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 pre-medical education, four years of medical school, one year of internship, and three grueling years

22. See CHARLES KRAMER & DAVID KRAMER, *MEDICAL MALPRACTICE* 5 (5th ed. 1983).

23. Malone & Thaler, *supra* note 2, at 123.

24. See *Liability Lawsuits: Casting a Wider Net*, MED. & HEALTH, May 4, 1992, available in 1992 WL 2789972.

25. See generally Ralph O. Bischof & David B. Nash, *Managed Care Past, Present, and Future*, 80 MED. CLINICS N. AM. 225 (1996).

26. The Physician's Oath (also known as the Hippocratic Oath), in JOHN BARTLETT, *BARTLETT'S FAMILIAR QUOTATIONS*, 88 (15th ed. 1980).

27. See *id.*

of residency in a teaching hospital,²⁸ 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.²⁹ 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.³⁰ 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.³¹ Patients' expectations of the medical profession have also gone through a metamorphosis which is correlative with the technological advances in medicine.³² Historically, it was difficult to get doctors to travel the great distances required to visit the sick in a mostly agrarian society.³³ Consequently, if the sick were lucky enough to find a doctor or nurse,

28. See generally OFFICE OF ADMISSIONS, UNIVERSITY OF MIAMI SCH. OF MED. ADMISSIONS INFORMATION (1997) (admissions criteria and curriculum brochure).

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 Pacificare, 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.*

30. See generally Howard Brody, *The Place of Ethics in Health Care Reform: Framing the Health Reform Debate*, Hastings Center Rep., May-June 1994.

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.³⁴ Medical costs can no longer be managed by a family bartering a chicken for a doctor's house call.³⁵ Costs have steadily increased to the point where, if not for insurance, most people could not afford health care at all.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."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.³⁸ The Community Hospital of Elk City, Oklahoma, established the first medical cooperative in 1927.³⁹ 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.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.⁴¹ During World War II, Kaiser Industries expanded its commitment to provide quality health care for its employees at various construction sites.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,

34. See Malone & Thaler, *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. 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).

35. See Manzor, *supra* note 33.

36. See COLODIA OWENS, *MANAGED CARE ORGANIZATIONS: PRACTICAL IMPLICATIONS FOR MEDICAL PRACTICES AND OTHER PROVIDERS* 2 (1996).

37. Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 336 (1996).

38. See Diana J. Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 291 (1995).

39. See *id.*

40. See *id.*

41. See *id.*

42. See Domenick C. DiCicco Jr., *Liability of The HMO For The Medical Negligence of Its Providers*, HEALTH L. LITIG. REP., NOV. 1996, at 22.

D.C.⁴³ 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.⁴⁴ Although fee-for-service health insurance was much more common, not everyone could afford it.⁴⁵

Since health insurance was particularly expensive for the unemployed and elderly, the federal government initiated the Medicaid programs and Medicare in 1965.⁴⁶ Medicaid provides health services to the poor, while Medicare provides health services to the elderly and disabled.⁴⁷ Individual states determined how physicians were paid under Medicaid reimbursement, whereas Medicare reimbursed physicians for "customary and reasonable charges."⁴⁸

In the early part of the 1970's, Democrats led by Senator Edward Kennedy began to cultivate public support to develop national health insurance.⁴⁹ The Republicans supported private alternatives to traditional health care plans, and the two parties ultimately agreed to pass the Health Maintenance Organization Act of 1973.⁵⁰ The Act provided federal grants for development of HMOs, and loans to subsidize their initial expenses.⁵¹ Thus, the term "Health Maintenance Organizations" ("HMOs") was coined.⁵² 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.⁵³ Recent figures show the national total of Americans who receive their medical care through HMOs exceeds 56 million.⁵⁴ 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.

46. *See* E. Jane Ross, *Refusing to Pay for Health Care-Part I (of III): Evolution of the Third-Party Payment System*, PROGRESS IN CARDIOVASCULAR NURSING, Winter 1996, at 42, 43.

47. *See id.*

48. *See* Ross, *supra* note 46 at 43.

49. *See* DiCicco, *supra* note 42, at 22.

50. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e-300e-17. *See also* 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].

care.⁵⁵ Projections suggest that ninety percent of the drug market will be influenced by managed care by the year 2000.⁵⁶

Though managed care has been around for several decades, its widespread popularity is new.⁵⁷ Extensive growth in recent years has led to consolidation within the industry.⁵⁸ 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.⁵⁹ 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.⁶⁰ HMOs began using "utilization review agents"⁶¹ 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.⁶² In many cases, case managers are non-medical personnel who make medical decisions based on financial considerations.⁶³ 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."⁶⁴ Many HMO physicians are prohibited by "gag clauses"⁶⁵ 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

55. See BOSTON CONSULTING GROUP, *THE CHANGING ENVIRONMENT FOR U.S. PHARMACEUTICALS* 18 (Apr. 1993).

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.

59. See Walsh, *supra* note 44, at 213-15.

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.*

63. See, e.g., Edward Hirschfield, *The Case For Physician Direction in Health Plans*, 3 ANNALS OF HEALTH L. 81, 91-92 (1994) (discussing adverse implications of non-physician control over HMO decisions).

64. Malone & Thaler, *supra* note 2, at 123 (citations omitted).

65. See Jennifer L. D'Isidori, note, *Stop Gaggling 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.*

line.”⁶⁶

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.⁶⁷ For example, there have been exponential advances in molecular biology in the past five years, driven in part by the Human Genome Project.⁶⁸ There are numerous genetic products in various stages of development and some have already reached the marketplace.⁶⁹ An entire generation of therapeutics, diagnostics, and genetic tests are on the verge of implementation.⁷⁰

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.”⁷¹ In the earlier era of professional domination, ethical concepts were used to create codes of professional conduct which doctors imposed and enforced on themselves.⁷² 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.”⁷³

The second ethics era, the era of bioethics, commenced in approximately 1970.⁷⁴ Bioethics was based upon individual rights and patient autonomy, not on what the doctor deemed to be in the patient’s best interest.⁷⁵ This view is exemplified by the legal innovation, the “informed consent doctrine.”⁷⁶ 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.*

patient.⁷⁷ 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.⁷⁸ 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.⁷⁹

As a result of these inefficiencies, health care is entering a third era of medical ethics, the "Cost Conscious Era" or "Socioethics Era."⁸⁰ 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.⁸¹ 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,⁸² by dividing the physician's loyalty between patient and society.⁸³

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."⁸⁴ 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.*

84. *See* Mark A. Rothstein, *The Ethics of Tiered Health Care*, HEALTH L. NEWS, Sept. 1995, at 2-3.

cess of such lawsuits may have encouraged even more litigation.⁸⁵ 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.⁸⁶ 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.⁸⁷ 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.⁸⁸ By the early 1980's most states had adopted a modified version of the ABA's Model Code⁸⁹ which permitted limited attorney advertising.⁹⁰ Since 1983 more than 35 states have revised their ethical rules to conform to the ABA's Model Rules⁹¹ which are even more liberal than the Model Code with regard to advertising.⁹² 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.⁹³ Large settlements and jury verdicts may have encouraged even more lawsuits.⁹⁴ Insurance companies providing professional liability coverage were forced to increase doctors' premiums in order to cover malpractice settlements and awards.⁹⁵ As a result, many physicians have elected to

85. See *Jansen v. Packaging Corp. of Am.*, 123 F.3d 490, 543 (7th Cir. 1997).

86. See Kathleen Eleanor Justice, *There Goes The Monopoly: The California Proposal to Allow NonLawyers to Practice Law*, 44 VAND. L. REV. 179, 193 (1991).

87. See Jeffrey M. Croasdel, *Regulation of Attorney Advertising Under State Constitutional Freedom of Speech Provisions*, 68 TEMP. L. REV. 1457, 1467-68 (1995).

88. See ANDREW L. KAUFMAN, PROBLEMS IN PROFESSIONAL RESPONSIBILITY 491 (Little, Brown and Company ed., 3d ed. 1989).

89. See AMERICAN BAR ASSOCIATION, ABA MODEL CODE OF PROFESSIONAL RESPONSIBILITY (1983), reprinted in STEPHEN GILLERS & ROY D. SIMON, REGULATION OF LAWYERS: STATUTES AND STANDARDS 421-99 (Little, Brown and Company ed., 1997).

90. See GILLERS & SIMON, *supra* note 89, at 421.

91. AMERICAN BAR ASSOCIATION, ABA MODEL RULES OF PROFESSIONAL CONDUCT (1983, 1989-1996), reprinted in STEPHEN GILLERS & ROY D. SIMON, REGULATION OF LAWYERS: STATUTES AND STANDARDS 3-420 (Little, Brown and Company ed., 1997).

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.⁹⁶ 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.⁹⁷ 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.⁹⁸ 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.⁹⁹

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.

97. See AM. MED. NEWS, *supra* note 95; See generally Kenneth R. Pedroza, Note, *Cutting Fat or Cutting Corners, Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399 (1996) (discussing defensive medicine).

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."¹⁰⁰

D. Tort Reform

Legislators began to address the detrimental affect frivolous lawsuits 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 1985¹⁰¹ to ensure that Florida citizens have access to competent and reasonably priced medical services.¹⁰² The Act intended to control escalating premiums for professional liability insurance,¹⁰³ by requiring potential plaintiffs to follow stringent procedures prior to filing a medical malpractice suit.¹⁰⁴ 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.¹⁰⁵ 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.¹⁰⁶ During the 90-day pre-suit period, the parties may conduct informal discovery and obtain unsworn statements.¹⁰⁷ The requirements of this Act, in conjunction with the difficulty in obtaining medical experts willing to sign affidavits, have eliminated many frivolous lawsuits.¹⁰⁸

Additionally, the Florida Legislature enacted the Florida Birth-Related Neurological Injury Compensation Plan¹⁰⁹ which, among other things, limits the non-economic damages that can be awarded for birth-related neurological injury claims.¹¹⁰ The Legislature was concerned

100. The source of this cartoon cannot be located.

101. Comprehensive Medical Malpractice Reform Act of 1985, FLA. STAT. § 766.106 (1997).

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 (1995).

103. See *id.*

104. FLA. STAT. § 766.106 (1997).

105. FLA. STAT. § 766.203(2) (1997).

106. FLA. STAT. § 766.106(2)-(3) (1997).

107. FLA. STAT. § 766.106(6)-(7) (1997).

108. See generally, Khouzam, *supra* note 102.

109. Florida Birth-Related Neurological Injury Compensation Plan ("NICA" Statute), FLA. STAT. § 766.301-766.316 (1997).

110. FLA. STAT. § 766.31(1)(b) (1997).

about increases in professional liability coverage for obstetricians resulting from huge jury verdicts¹¹¹ in cases involving hypoxic brain damage at birth.¹¹² The increased liability exposure and cost of professional liability insurance were causing doctors to refuse to deliver babies—an obviously critical service to society.¹¹³

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.¹¹⁴ 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.¹¹⁵ 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.¹¹⁶ HMOs differ from the traditional fee-for-service payment system, where patients pay a fee for each service provided by their individual doctors.¹¹⁷ There are variations on this kind of plan known as preferred provider organizations (PPOs) and point-of-service plans (POS).¹¹⁸

HMOs reduce costs in a number of ways. One of the ways is by limiting the members' choices of physicians and hospitals.¹¹⁹ 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.*

118. See generally Michael Kanute, Comment, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841 (1989).

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.¹²⁰ Providers agree to fee concessions in exchange for a steady flow of patients,¹²¹ and participating providers agree to be compensated on a "capitated"¹²² or discounted fee-for-service basis.¹²³ Under the typical capitation arrangement, providers agree to accept a predetermined amount per HMO subscriber, regardless of the amount or type of service provided.¹²⁴

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, algorithms, or parameters of care (utilization guidelines).¹²⁵

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.¹²⁶

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.¹²⁷ 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.¹²⁸ 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.*

122. See Frances H. Miller, *Health Care Capitated Payment Systems—Foreword: The Promise and Problems of Capitation*, 22 AM. J.L. & MED. 167 (1996). Capitation is one of three forms of base pay used by HMOs. The other two are salary and fee-for service. See Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 772 (1994).

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.¹²⁹ 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.¹³⁰ The traditional form of HMO is the "Staff Model," in which physicians are employed by the HMO.¹³¹ 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.¹³²

Another type of HMO is the "Group Individual Practice Association" (IPA) Model, which is currently the most common form of managed care.¹³³ Under this model, a group of doctors who have formed a partnership or corporation contracts with the HMO to provide care for its members.¹³⁴ The physicians' association then contracts directly with each doctor regarding terms and payment.¹³⁵ 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.¹³⁶ 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.¹³⁷

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.¹³⁸

The third type of HMO is the "Group (non-IPA) Model" or "Net-

129. *See id.*

130. *See* DiCicco, *supra* note 42, at 22.

131. *See id.*

132. *See id.* "Respondeat superior" is the common-law doctrine holding an employer or principal liable for the employee's or agent's actions (including torts) committed during the scope of employment. BLACK'S LAW DICTIONARY 1311 (6th ed. 1991).

133. *See* Malone & Thaler, *supra* note 2, at 139.

134. *See id.*

135. *See id.*

136. *See* DiCicco, *supra* note 42, at 22.

137. *See id.*

138. *See id.*

work Model.”¹³⁹ 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.¹⁴⁰ 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.¹⁴¹

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).¹⁴² 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.¹⁴³ 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.¹⁴⁴

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.¹⁴⁵ 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.¹⁴⁶ 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.¹⁴⁷ Doctors with a good reputation and an established practice

139. See Malone & Thaler, *supra* note 2, at 138.

140. See *id.*

141. See DiCicco, *supra* note 42.

142. See generally Miller, *supra* note 122.

143. See *id.* at 169.

144. See Moore & Gaier, *supra* note 10.

145. See Panah, *supra* note 13.

146. See Moore & Gaier, *supra* note 10.

147. See D’Isidori, *supra* note 65, at 193.

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.

151. See Susan R. Miller, *Pushing Back*, MIAMI DAILY BUSINESS REVIEW, Mar. 13, 1998, at A-9.

152. See Malinowski, *supra* note 37, at 335.

153. See "Drive-Through" Baby Deliveries Bill Picks Up Steam, CONGRESS DAILY, Mar. 29, 1996, available in 1996 WL 5515467. See also Patricia A. Smith, *HMO's Immunity Challenged*, MEDICAL MALPRACTICE LAW & STRATEGY, May 1998, at 1 (referring to the federal Newborns' and Mothers' Health Protection Act of 1996).

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.

priate. 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.¹⁵⁶ The jury awarded \$89.1 million to the family of the deceased patient.¹⁵⁷ Evidence introduced at trial showed that the HMO's medical director was compensated based upon the amount of money he saved the company.¹⁵⁸ In addition to refusing to cover so-called experimental treatment, HMOs are eliminating support for medical research and development.¹⁵⁹ This is another signal of the trend toward emphasizing *quantity* of care rather than *quality* of care.

B. *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.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.

156. See *Fox v. Health Net*, No. 219692, 1993 WL 794305 (Cal. Sup. Ct. Dec. 28, 1993).

157. See *id.*

158. See Hall, *supra* note 122, at 708.

159. See *Science and Technology, Health Policy: Managing to Care*, THE ECONOMIST, Sept. 23, 1995, at 70, 75.

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, *Dr. Dilemma* (NBC 6 television broadcast Oct. 31, 1997)(transcript on file with Robin Kish at NBC 6); See also 60 Minutes, *supra* note 29; 20/20, *supra* note 54.

162. See Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1364-65.

163. See Orentlicher, *supra* note 17, at 158.

164. See Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1827 (1995).

165. See *id.*

166. See Walsh, *supra* note 44, at 219.

167. See McGraw, *supra* note 164, at 1827.

168. See Orentlicher, *supra* note 17, at 157.

169. See Walsh, *supra* note 44, at 221.

170. See Malinowski, *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.¹⁷¹ As a result, patients are becoming angry and suing their doctors and insurance companies.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.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.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.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.¹⁷⁶ The utilization manager determines whether the doctor's recommended treatment for the patient is medically necessary.¹⁷⁷ If the proposed treatment is not deemed to be medically necessary, the HMO will not reimburse the cost of the treatment.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.¹⁷⁹

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

171. *See id.*

172. *See id.*

173. *See* Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301 (1996).

174. *See* Elizabeth O. Teisberg et al., *Making Competition in Health Care Work*, HARV. BUS. REV., July-Aug. 1994, at 131, 135.

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).

176. *See* Patricia A. Younger et al., *MANAGED CARE L. MAN.* 2 (1996).

177. *See id.*

178. *See id.*

179. *See id.*

180. *See id.*

dered indicates that a medical service was unnecessary, the HMO will deny payment.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."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 its an emergency and I'm not going to waste time calling an HMO for approval to get her to the hospital."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.¹⁸⁴ The more medical treatment a doctor provided, the more money he could make.¹⁸⁵ Moreover, the more tests he ordered, the less liability he faced for medical malpractice.¹⁸⁶ Under the HMO structure, incentives to do too much have been replaced with incentives to do too little.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.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.¹⁸⁹ Money

181. See *id.*

182. See Malinowski, *supra* note 37, at 351.

183. See Schlegel, *supra* note 119, at 10-A.

184. See Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 80 (1994).

185. See *id.*

186. See Schwartz, *supra* note 162, at 1361.

187. See Malinowski, *supra* note 37, at 338; see also Patricia M. Danzon, et al, *Consolidation Is a Tonic For Health Care Providers*, NAT'L L.J., Sept. 18, 1995, at B14.

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).

189. See Walsh, *supra* note 44, at 219.

from the risk pool is used to pay for referrals to specialists and also for hospitalization costs.¹⁹⁰ Doctor-members divide any funds left in the pool at the end of the accounting period,¹⁹¹ but also share in the loss if no money remains because of excessive referrals or hospital stays.¹⁹² 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,¹⁹³ 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.¹⁹⁴ 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.¹⁹⁵

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.¹⁹⁶ All tests, referrals and expenses are included in the amount paid to the physician.¹⁹⁷ If the doctor makes a referral, it is paid by the physician out of the money the physician has already received from the HMO.¹⁹⁸ 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.¹⁹⁹ For example, one doctor was fined \$500 for each day his patient was hospitalized that the HMO determined was unnecessary.²⁰⁰

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-

190. See Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 404 (1996).

191. See *id.*

192. See William A. Chittenden III, *Malpractice Liability and Managed Healthcare: History and Prognosis*, 26 TORT & INS. L.J. 451, 481 (1991).

193. See Thomas J. Maxwell, *A View From a Doctor's Office*, 13 Del. L. 33, 35 (1995).

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.²⁰¹ 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.²⁰² 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.²⁰³ Gag clauses are shocking because they hinder open discussion between doctor and patient—an essential element of the doctor-patient relationship.²⁰⁴ 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.²⁰⁵ 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.²⁰⁶

One interesting example of a gag clause states, "do not discuss proposed treatments with [patients] prior to receiving authorization from the plan."²⁰⁷ Another example of a common gag clause is: "the physician

201. See Kish, *supra* note 161.

202. See Malinowski, *supra* note 37, at 350.

203. See *AMA Takes Stand Against Health Plan "Gag" Rules*, West's Legal News, July 10, 1996.

204. See Julia A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of "Gag Clauses" in Physician Contracts*, 22 AM. J.L. & MED. 433, 434 (1996).

205. See Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 44, 50.

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 an 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

208. Barry M. Manuel, *Physician Liability Under Managed Care*, 183 J. Am. C. Surgeons 537, 539 (1996).

209. See Michael Jonathan Grinfeld, *Tilting at HMO'S*, Cal. L., Feb. 1997, at 85.

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.

214. See Frederick Schmitt, *New York Legislation Aims to Increase HMO Liability*, NATIONAL UNDERWRITER, Apr. 8, 1996, at 6 (quoting New York Senator Guy J. Velella, Republican - Bronx/Westchester).

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 provision 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 preemption” 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 completely 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

215. *Altieri v. Cigna Dental Health Inc.*, 753 F.Supp. 61, 63 (D.Conn. 1990).

216. 29 U.S.C. § 1144(a) (1994).

217. *See* *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 (1992).

218. *See* Thomas A. Moore & Matthew Gaier, *HMO Liability — Part III: ERISA Preemption*, N.Y. L.J., Sept. 2, 1997, at 3.

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.²²⁷ Section 514 provides, with few exceptions, that there is complete preemption if the claim "relates to the plan."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 *Lupo v. Human Affairs Intern., Inc.*,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.²³⁰

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

The leading case on complete preemption was the subsequent case of *Dukes v. U.S. Healthcare*,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.²³² Both cases were

227. See *id.* (citing *Jass v. Prudential Health Care plan, Inc.* 88 F.3d 1482, 1485-87 (7th Cir. 1995)).

228. See *Jass v. Prudential Health Care Plan, Inc.* 88 F.3d 1482, 1485 (7th Cir. 1995); see also *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995); *Corcoran v. United Healthcare Inc.* 965 F.2d 1321, 1328-29 (5th Cir. 1992).

229. 28 F.3d 269 (2d Cir. 1994).

230. See *id.* at 272.

231. See *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

232. See *Visconti v. U.S. Healthcare*, 857 F.Supp. 1097 (ED Pa. 1994); see also *Dukes v. U.S. Healthcare Systems of Pennsylvania Inc.*, 848 F.Supp. 39 (ED Pa. 1994).

based upon ostensible agency and agency-in-fact, and also alleged direct negligence in selecting, evaluating, employing, and overseeing the physicians who committed malpractice.²³³ 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.²³⁴ 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.'"²³⁵ 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,"²³⁶ seeking to hold the HMO liable as arrangers of plaintiffs' medical treatment.²³⁷ 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,"²³⁸ 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.²³⁹

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*,²⁴⁰ decided that a plaintiff's claim seeking to hold an HMO liable under the

233. See *Visconti*, 857 F.Supp. at 1102; *Dukes*, 848 F. Supp. at 42.

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."²⁴¹ 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.*²⁴²

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 §502.²⁴³ *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.²⁴⁴ 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,"²⁴⁵ and do not require examination of the plan to reach such determination.²⁴⁶

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

In the recent case of *Turner v. Fallon Community Health Plan, Inc.*,²⁴⁷ the court held that Plaintiff's state law claims of breach of contract, wrongful death, and other state law claims, are preempted by §502.²⁴⁸ 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.²⁴⁹ Since ERISA provides only equitable relief, and equitable relief is moot once the patient has died, no remedy is available under ERISA.²⁵⁰ 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.

242. *See Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir.1996).

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.²⁵¹

B. 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.”²⁵²

1. TENTH CIRCUIT: NO PREEMPTION FOR VICARIOUS LIABILITY UNDER § 514

It is with this in mind that the Tenth Circuit in *Pacificare of Oklahoma, Inc. v. Burrage*,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 §514.²⁵⁴ 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.”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.”²⁵⁶ Merely because a plan is potentially liable for judgment “is not enough to relate the action to the plan.”²⁵⁷ The court concluded:

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.”²⁵⁸

2. SEVENTH CIRCUIT: VICARIOUS LIABILITY PREEMPTED UNDER § 514

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

251. See *Shea v. Esensten*, 107 F.3d 625, 628 (8th Cir. 1997).

252. *Mackey v. Lanier Collections Agency & Service*, 468 U.S. 825, 833 (1988).

253. *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151 (10th Cir. 1995).

254. See *id.* at 153.

255. *Id.* at 154.

256. *Id.*

257. *Id.* at 155.

258. *Id.*

259. See *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir.1996).

because they are "related to the plan."²⁶⁰ 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.²⁶¹ 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.*²⁶² that the wrongful death of a fetus arising from an HMO utilization reviewer's determination who denied hospitalization was preempted under §514.²⁶³ 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."²⁶⁴

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*²⁶⁵ that claims against HMOs arising from delays or refusals to authorize treatment are preempted by §514.²⁶⁶ 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."²⁶⁷ Other courts have found that delays in treatment are a matter of negligence, not a denial of benefits and are not subject to preemption.²⁶⁸

260. See *id.* at 1490-91.

261. See *id.* at 1491.

262. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

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, *Med-Mal 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

269. *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997).

270. *See id.* at 627.

271. *Id.* at 628; *see also* 29 U.S.C. § 1104(a)(1)(1994).

272. *See Varsity Corp. v. Howe*, 116 S.Ct. 1065, 1074-75 (1996).

273. *Shea*, 107 F.3d at 628.

274. *See id.* at 629 (quoting *Bixler v. Central Penn. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1300 (3d Cir. 1993)).

275. *Shea*, 107 F.3d at 628.

276. *See Kuhl v. Lincoln Nat. Health Plan*, 999 F.2d 298, 302 (8th 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 being 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).

283. *See* 29 U.S.C. § 1132(a)(1)(B) (1994).

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

285. See *State Board of Medical Examiners v. Pacific Health Corp.*, 82 P.2d 429 (Ca. 1938), *cert. denied*, 306 U.S. 633 (1939).

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).

287. See *Holden v. Rockford Memorial Hospital*, 678 N.E. 2d 342, 346-48 (Ill. App. 2d 1997).

288. See *Moon v. Mercy Hospital*, 373 P.2d 944 (Colo. 1962).

by entities like HMOs.²⁸⁹ 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."²⁹⁰ 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.²⁹¹ Courts have widely accepted this argument,²⁹² 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.²⁹³

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,²⁹⁴ and held that the corporation in that case was illegally engaged in the practice of medicine.²⁹⁵ The U.S. Supreme Court has also held that the power to regulate the practice of medicine is within each state's police power,²⁹⁶ 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.²⁹⁷

289. See *Dunn v. Praiss*, 656 A.2d 413, 415 (N.J. 1995) (quoting Michael A. Dowell, *The Corporate Practice of Medicine Doctrine Must Go*, HEALTHSPAN, Nov. 1994, at 7).

290. See *id.*

291. See *Williams v. Good Health Plus, Inc.*, 743 S.W.2d 373, 376 (Tex. App. 1987).

292. See *id.*; see also *Garcia v. Texas State Board of Medical Examiners*, 384 F.Supp. 434 (W.D.Tex. 1974); *Garcia v. Texas State Board of Medical Examiners*, 358 F.Supp. 1016 (W.D.Tex. 1973); *California Physicians' Service v. Garrison*, 155 P.2d 855 (Cal. Ct. App. 2d 1945); *Dr. Allison, Dentist, Inc. v. Allison*, 196 N.E. 799 (Ill. 1935); *Holden v. Rockford Memorial Hosp.*, 678 N.E. 2d 342, 354 (Ill. App. 2d 1997); *Propst v. Health Maintenance Plan, Inc.*, 582 N.E.2d 1142, 1143 (Ohio App. 1990).

293. 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 *State Board of Medical Examiners v. Pacific Health Corp.*, 82 P.2d 429 (Ca. 1938), *cert. denied*, 306 U.S. 633 (1939).

295. See *id.*

296. See *Lambert v. Yellowley*, 272 U.S. 581, 603 (1926).

297. See *Douglas v. Noble*, 261 U.S. 165 (1923); *Dent v. West Virginia*, 129 U.S. 114 (1889).

As the Court pointed out in *Garcia v. Texas State Board of Medical Examiners*,²⁹⁸ "Nothing is more fundamental than the rights of the various states to furnish the people competent health services,²⁹⁹ 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."³⁰⁰ 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.³⁰¹

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.³⁰² 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.³⁰³

An example of a typical state law governing the practice of medicine is the Texas Medical Practice Act,³⁰⁴ 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.³⁰⁵

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.

298. *Garcia*, 358 F.Supp. at 1019.

299. *See* 358 F.Supp. at 1019.

300. *See id.*

301. *See id.*

302. *See id.*

303. *See id.*

304. Tex. Rev. Civ. Stat. Ann. § 1.03(12) (West 1998).

305. *Id.*

Citing these provisions of the statute, The Court of Appeals of Texas, nevertheless held in *Williams v. Good Health Plus, Inc.*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.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*,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."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.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)"³¹¹ "The focus must be on the actions of the individual administrator"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.³¹³

The court in *Morris* acknowledged dicta in its previous decision in *Joseph v. District of Columbia Board of Medicine*,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

306. See *Williams v. Good Health Plus, Inc.*— Healthamerica Corporation of Texas, 743 S.W.2d 373 (Tex. Ct. App. 1987).

307. See *id.* at 377.

308. See *Morris v. District of Columbia Board of Medicine*, 701 A.2d 364 (D.C. 1997).

309. See *id.* at 366.

310. See *id.* at 367.

311. See *id.* at 368.

312. See *id.*

313. See *id.*

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."³¹⁵ 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.³¹⁶ 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.³¹⁷ 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.³¹⁸ 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."³¹⁹

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*.³²⁰ The court in *Allison* stated that merely "operating" a dental clinic office by employing a dentist to perform certain services for the patients and customers constituted practicing medicine.³²¹ 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.³²² 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 578 (1984).

319. See *St. Francis Regional Medical Center, Inc. v. Weiss*, 869 P.2d 606, 615 (1994).

320. See *Dr. Allison, Dentist, Inc. v. Allison*, 196 N.E. 799, 800 (1935).

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

323. See William M. Sage, James M. Jorling, *A World That Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL L. REV. 1007, 1018 (1994).

324. See *Special Report Afoot in Legislatures Would Make HMOs Liable*, WASHINGTON HEALTH WEEK, Apr. 14, 1997.

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.”³³⁰ The response by an HMO spokesman was the rhetorical inquiry, “. . . [a]re we [HMOs] going to be held accountable for medical malpractice when we don’t practice medicine?”³³¹ 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.³³² 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.³³³

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.³³⁴ 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.”³³⁵ 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.³³⁶ This law would also serve to displace current New York law³³⁷ 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.³³⁸

3. CALIFORNIA

California legislators have proposed nearly 50 bills, approximately 30 of which have already passed the Senate with broad bi-partisan support.³³⁹ 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.*

332. *See Special Report Afoot in Legislatures Would Make HMOs Liable, supra* note 324, at 3.

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.*

337. New York Public Health Law § 4410.

338. *Id.*

339. *See California: Legislature Considers Numerous HMO Reform Bills, FIRST MED & HEALTH NEWS*, June 18, 1997, at 1.

expense of patient well-being”³⁴⁰ One provision would require that the only person who can deny coverage in an HMO would be a licensed California physician.³⁴¹ 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.³⁴² 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.³⁴³ 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.”³⁴⁴

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.³⁴⁵ 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.³⁴⁶ 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.³⁴⁷

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.³⁴⁸ 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.³⁴⁹ 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. 1606.³⁵⁰ 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.³⁵¹

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.³⁵² Washington and New Hampshire are also passing far-reaching managed care legislation.³⁵³ Missouri is presently considering a broad managed care bill in its House of Representatives.³⁵⁴ Last year, the Florida Legislature easily passed HMO liability legislation, but it was vetoed by Governor Lawton Chiles.³⁵⁵ 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.³⁵⁶ A similar bill in Maryland, however, died in legislative session.³⁵⁷ Maryland is considering removing referral requirements for dermatological treatment.³⁵⁸ Colorado's proposed law would diminish the discretion of HMOs regarding coverage decisions.³⁵⁹ Connecticut's proposed bill would create a statutory cause of action for medical malpractice against HMOs.³⁶⁰ 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.³⁶¹ Indiana is considering diminishing the role of HMOs in the decision making process, and will require coverage on all FDA-approved drugs and devices.³⁶² Pennsylvania and Vermont are considering bills aimed at eliminating financial incentives for physicians to limit medical care.³⁶³ Last, and perhaps least, Virginia has limited its action to establishing a subcommittee to study the control of pharmacy benefits by HMOs.³⁶⁴ Despite the importance of these state laws, they

350. See Smith, *supra* note 153, at 2.

351. See *id.*

352. See *Special Report Afoot in Legislatures Would Make HMOs Liable*, *supra* note 324, at 1.

353. See *id.*

354. See *id.*

355. See *id.*

356. See FLA. STAT. § 641.28 (1997).

357. See *Special Report Afoot in Legislatures Would Make HMOs Liable*, *supra* note 324, at 2.

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.*

367. See *Health Care Fight Heats Up On Capital Hill*, REUTERS NEWS, July 16, 1998.

368. See *id.*

369. See *HMO Reform Bill Passes House*, *supra* note 213.

370. See *Health Care Fight Heats Up On Capital Hill*, *supra* note 367.

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.

- 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.³⁷³ 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

373. See *Health Care - Managed Care: Presidential Commission Expected to Adopt Broad Consumer Bill of Rights*, U.S.L.W., Nov. 11, 1997, at 2282.

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."³⁷⁴ 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,³⁷⁵ 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."³⁷⁶ 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.