



# HMO Malpractice: Have the Floodgates Opened?

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The U.S. Supreme Court's holding in *Pegram v. Herdrich*—that decisions by an HMO's physician employees in which eligibility issues and reasonable medical treatment are inextricably mixed are not fiduciary acts under the Employee Retirement Income Security Act (ERISA)—was applauded by the managed care industry. By delineating issues on which it was not ruling, however, the Court's decision may have given a boost to additional lawsuits against managed care plans on both ERISA and malpractice grounds.

These are perilous times for the managed care industry. A recent summary of lawsuits filed against health plans listed 42 cases pending against 10 managed care companies.<sup>1</sup> The list was by no means exhaustive; in fact, it included only class action suits filed from late 1999. It did not include class action suits filed before that time, nor did it include scores of non-class action matters pending in state and federal courts around the nation. The proliferation of class action complaints and other suits against managed care reveals the disdain with which the managed care industry is viewed by consumers and the potential pot of gold the industry represents to trial lawyers.

Increasingly under attack are elements of HMO "structure,"<sup>2</sup> the internal policies and procedures that, when unreasonable, drive members to complain and/or sue. Trial lawyers who successfully challenged the tobacco industry are using the same approach by bringing allegations of fraud under the Racketeer Influenced and Corrupt Organizations Act<sup>3</sup> and failure to disclose under the Employee Retirement Income Security Act (ERISA)<sup>4</sup> to bear on the managed care industry.

These cases are notable for their attempts to shift scrutiny from the traditional venue of medical liability—the examination room—to the boardroom. Plaintiffs' attorneys are working hard to present scenarios of HMO non-feasance or malfeasance rooted in economic considerations rather than the best medical interests of patients.<sup>5</sup> In the case of providers, suits allege the health plan structure has tied

their hands and effectively eliminated their medical discretion. In the case of members, the focus is on administrative procedures that frustrate patients' attempts to understand coverage and denials of claims. There are a multitude of potentially culpable managed care structures: referral, preauthorization, precertification, and utilization review procedures that can delay or deny access to medically necessary services or appropriate providers and facilities; onerous compensation schemes that shift excessive financial risk to providers and lead to skimping on patient care; and grievance mechanisms that fail to provide timely explanations for reimbursement and medical necessity decisions that adversely affect members. These administrative practices, which form both the structure and the culture of an organization, are now themselves being accused of causing malpractice.<sup>6</sup> The heretofore clear distinction between medical malpractice and corporate negligence has become blurred.<sup>7</sup>

## ESTABLISHING A RELATIONSHIP BETWEEN INCENTIVES AND "CONCRETE HARM"

In commenting on HMO structure in *Pegram v. Herdrich*,<sup>8</sup> Justice David H. Souter, writing for a unanimous U.S. Supreme Court, observed that "no HMO organization could survive without some incentive connecting physician reward with treatment rationing."<sup>8</sup> He concluded that Congress' promotion of HMOs since the enactment of the federal

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HMO Act in 1973 should not be undermined by the judiciary allowing “wholesale attacks on existing HMOs solely because of their structure, *untethered to claims of concrete harm*” (emphasis added).<sup>8</sup> The Court’s ruling—that treatment decisions by an HMO acting through its physician employees are not fiduciary acts within the meaning of ERISA—was initially greeted with a great sigh of relief as a major victory for the industry.<sup>9</sup> Some observers believed the Court barred further ERISA suits challenging physician incentive plans, a nearly ubiquitous managed care structure.<sup>10</sup> What the Court actually said, however, was that it would not sustain a challenge to HMO structure without a showing of “concrete harm.” Owing to a lack of appropriate remedies for such harm under ERISA, the absence of explicit congressional authority and concern about flooding the federal courts with new litigation, the Court declined to create a new federal “fiduciary malpractice claim.”<sup>8</sup>

An important point found in footnote 8 in the Court’s decision was not given prominent attention initially. It recalls an early change of wording in the plaintiff’s complaint that shifted its focus from alleging breach of fiduciary obligation to disclose physician incentives that limit care, to alleging the presence of a legal obligation to avoid such incentives altogether. Consequently, the footnote continues, “Although we are not presented with the issue here, *it could be argued that [the HMO] is a fiduciary insofar as it has discretionary authority to administer the plan, and so it is obligated to disclose characteristics of the plan and of those who provide services to the plan, if that information affects beneficiaries’ material interests*” (emphasis added).<sup>8</sup> This footnote has undoubtedly given plaintiff class action lawyers reason to breathe their own sigh of relief, because it appears to validate their allegations in the pending lawsuits that there may indeed be an ERISA-sanctioned fiduciary duty to disclose. Moreover, as one health law expert observed, the “decision knocks the ball back to Congress. It also knocks the ball back to state courts.”<sup>11</sup>

## A RELATED CASE OFFERS INSIGHT

Whereas it could be argued that Justice Souter’s footnote has diminished the urgency for action by Congress to amend ERISA, there is no question that the gauntlet thrown down by the U.S. Supreme Court has been taken up in state courts. The Illinois Supreme Court’s ruling in *Jones v. Chicago HMO Ltd.*,<sup>12</sup> a non-ERISA case, was a quick reminder that “claims of concrete harm,” which the U.S. Supreme Court found absent in *Pegram*, can result from an HMO structure as innocuous as the administrative practice of setting the patient load for PCPs.

In *Jones*, the plaintiff was a Medicaid beneficiary, en-

rolled in Chicago HMO, whose three-month-old daughter became ill one day in 1991. Ms. Jones called her PCP, Robert A. Jordan, MD, as instructed by the health plan, and related that her child was sick, constipated, crying, and very warm to the touch. An assistant in Dr. Jordan’s office advised Ms. Jones to give her daughter some castor oil. When Ms. Jones insisted on speaking with Dr. Jordan, his assistant stated the doctor was not available but would return her call. Dr. Jordan did return Ms. Jones’ call later that evening and also advised giving castor oil to the child. The next day Ms. Jones took her daughter to a hospital emergency room because the child’s condition had not improved. Chicago HMO authorized the admission of the child, who was diagnosed with bacterial meningitis secondary to bilateral otitis. As a result of the meningitis, the child is permanently disabled.

The issue for the Illinois Supreme Court on appeal was whether an HMO can be held liable under the theory of institutional or direct corporate negligence. The court had only the previous year ruled that an HMO could be held vicariously liable for the medical malpractice of inde-



pendent contractor physicians under the doctrines of apparent authority and implied authority.<sup>13</sup> Relying now on the landmark 1965 case of *Darling v. Charleston Community Memorial Hospital*,<sup>14</sup> which held that a hospital could be held liable for institutional negligence, the court extended that ruling to HMOs, concurring with a court in another jurisdiction that “HMOs, like hospitals, consist of an amalgam of many individuals who play various roles in order to provide comprehensive health care services to their members.”<sup>15</sup> The court did little more than apply principles of common law negligence to the facts at hand and conclude that the law “imposes a duty upon HMOs to conform to the legal standard of reasonable conduct in light of the apparent risk. To fulfill this duty, an HMO must act as would a ‘reasonably careful’ HMO under the circumstances.”<sup>12</sup>

The standard-of-care issue at the center of *Jones* was the number of patients in Dr. Jordan’s primary care practice. Dr. Jordan was the only Chicago HMO physician willing to see public aid members in the Chicago Heights neighborhood where Ms. Jones lived. Facts adduced at the trial indicated that as of December 1, 1990, Dr. Jordan had 4,527 Chicago HMO patients in his practice. The practice also included 1,500 patients from 20 other HMOs with which Dr. Jordan contracted. The total number of HMO patients was thus over 6,000. In addition, Dr. Jordan maintained a private practice of non-HMO patients, but the number of such patients was not in the record. Chicago HMO’s Medical Director, Mitchell J. Trubitt, MD, testified at trial that the standard used by Chicago HMO was 3,500

patients per PCP, a number based “on guidelines that HCFA provides.”<sup>12</sup> Defense counsel for Chicago HMO contended that plaintiffs needed to present expert testimony on the standard of care required of an HMO for the volume of patients per PCP.

The court disagreed, holding that “in an action for institutional negligence against an HMO, the standard of care applicable to an HMO may be proved through a number of evidentiary sources, and expert testimony is not required.” The court further concluded that “Dr. Trubitt’s

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testimony is proper and sufficient evidence of the standard of care on this issue.”<sup>12</sup> The finding that a standard of care had been established but not met by Chicago HMO opened the door for the court’s final holding that the HMO “had a duty to its enrollees to refrain from assigning an excessive number of patients to Dr. Jordan.”<sup>12</sup>

### HMOs STILL VULNERABLE, AFTER ALL

The common thread running through *Pegram* and *Jones* is that the rulings seem to make the intervening act of a physician exercising medical discretion inessential to establishing medical injury or other harm. In *Pegram*, the Supreme Court was unwilling to challenge the physician-incentive mechanism at issue, in part because there is a federal law authorizing the practice, but primarily, it would appear, because the plaintiff did not “tether” the practice to concrete harm. In that sense, *Jones* was pleaded better, because the administrative practice of assigning patients to PCPs was linked to the permanent disability of a child. However, the U.S. Supreme Court appeared to be saying, albeit in nonbinding dicta, that in a situation where an HMO does exercise fiduciary responsibilities under an ERISA plan, the duty to disclose practices with a potentially adverse effect on plan beneficiaries is absolute.<sup>8</sup> In other words, such a duty exists separate and apart from demonstrating that a particular member suffered concrete harm.

### WILL ANYONE ACT IN AN ELECTION YEAR?

States where direct corporate negligence is recognized—Illinois, Pennsylvania, and Texas among them—may see an increase in litigation.<sup>16</sup> The judiciary in states that do not may be emboldened by *Jones*, or the combination of *Pegram* and *Jones*, to recognize this cause of action, unless state legislative action makes judicial action unnecessary. At the federal level, Congress clearly got a message from Justice Souter’s opinion. Representative Charlie Norwood (D-GA) saw the ruling as more than a request: “The justices are shouting at the top of their lungs for us to act.”<sup>11</sup>

The remedy in most minds is not, however, easier access to the courts; rather, the congressional remedy of choice appears to be an external review mechanism that would provide an independent medical review of any decision to deny care or coverage.<sup>17</sup>

Although a recent survey finds that health is the highest priority issue for voters in this presidential election year,<sup>18</sup> the volatility of other health reform issues puts the immediate prospect of any relief from improper financial incentives in managed care companies in doubt. The pressure may fall on state legislatures that have not already done so to enact their own external review requirements. However, Texas legislation to create both direct corporate liability for HMOs and external review was challenged in federal court on ERISA grounds, with the result that the liability provisions survived but the review measures were preempted by federal law.<sup>19</sup> Such ironies may ultimately force Congress to act. There is little in *Pegram* and nothing in *Jones* to deter the plaintiffs’ bar from pursuing their own brand of justice against unreasonable HMO administrative and marketing practices arguably based on motives of financial gain.

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