CONTROLLING THE EXPANSIVE RISK OF MANAGED CARE LITIGATION

By: David R. Johnson, Esquire
Thomson, Rhodes & Cowie, P.C.
1010 Two Chatham Center
Pittsburgh, PA 15219
(412) 232-3400
drj@trc-law.com

INTRODUCTION

Managed care organizations are increasingly vulnerable to liability risks from every direction. Participating physicians are challenging regulations, reimbursement and de-credentialling. Class action lawsuits are being filed on behalf of subscribers and doctors. And, managed care issues are becoming an increasingly important component of medical malpractice litigation, raising the risks of a high verdict for every defendant. The expansion of managed care and the corresponding risk in managed care litigation has enhanced claims against doctors and hospitals, and increased the verdict potential of medical malpractice claims. Managed care liability is an area of the law where legal principles are still evolving.

MANAGED CARE ISSUES CAN BE VOLATILE IN A TRIAL

Today, it is not uncommon for the defendants in a medical malpractice action to include managed care organizations as defendants, in addition to the physicians and hospitals who have treated the patient. Given the negative perception many people hold regarding managed care, the existence of managed care issues in a lawsuit greatly increases the verdict potential of a case. Because this factor has become apparent to plaintiff's attorneys, and also because courts continue to approve expanding avenues for recoveries against managed care organizations, lawsuits in the future will increasingly focus upon various aspects of managed care.

A majority of such lawsuits will involve not only the managed care organization, but also the physicians and hospitals which participated in providing the plaintiff's care. The presence of managed care issues in a case will increase the potential both for a finding of liability against one or more of the defendants – even though the care provided is entirely adequate – and for a higher verdict than warranted by the injuries sustained. If it is *perceived* that the quality of care has diminished as a result of managed care, the liability potential of a given case markedly increases. Hence, it is incumbent upon each of the care providers, as well as the managed care organization itself, to not only have provided quality care, but also be able to convey the impression at trial that a high level of care has been provided, unencumbered by any managed care restraints.

At the heart of managed care is the containment of healthcare costs. Unfortunately, this fundamental principle can be a dynamic factor in fueling managed care litigation. Patients do not look kindly on "economic decisions" when their

healthcare or that of their loved ones is at stake. Every juror is a potential patient. Jurors will not appreciate "economic decisions" which are demonstrated to have harmed a patient – or even to have increased the potential for harm. Thus, managed care cases present an ever increasing potential for exceedingly high verdicts. If the focus of medical malpractice cases shifts to "economic issues," the managed care organization *and* the healthcare providers themselves will have a difficult time either prevailing or holding down the amount of verdicts.

Traditionally, jurors have approached the decision-making process in medical malpractice cases by affording healthcare providers a great deal of respect. Although statistics reflect that most medical malpractice cases are settled, and that a majority of the cases where there is fault are resolved before going to trial, the high percentage of defense verdicts in medical malpractice cases demonstrates that jurors usually have not been eager to become convinced that doctors have not breached the standard of care. If a case is well presented, and if the physician is a credible witness, there is a strong likelihood that the jury will be persuaded that the doctor endeavored to act in the best interest of his patient, that he performed his duties with a reasonable degree of care, and that he met standards ordinarily expected from a physician. The problem when managed care issues are mingled with questions about the standard of care is that economically-based issues can taint the evidence that good care was provided. As a result, jurors are likely to afford physicians and other healthcare providers a much less favored position. Whenever a plaintiff can effectively present the critical issues in a medical malpractice lawsuit as ones arising from economic considerations, the plaintiff's chances of prevailing at trial will increase significantly, and the potential for a remarkably high verdict will increase exponentially.

The propensity for managed care litigation to inspire high verdicts and punitive damages was discussed in The New England Journal of Medicine (Vol. 342, No. 4, January 27, 2000). The article noted a California verdict for $89 million based upon a managed care organization's refusal to approve bone marrow transplantation treatment and high dose chemotherapy for breast cancer. And, it discussed a $120 million verdict against another managed care entity because similar treatment was delayed, while being reviewed by a managed care organization, resulting in the death of a 41-year-old man.

Acknowledging that plaintiffs would not recover all of the amounts awarded, the article explained why these shockingly high awards should not be entirely unexpected. Contrasting typical medical malpractice litigation, where punitive damages are awarded in less than 2% of all cases, with insurance lawsuits where verdicts involve punitive damages 24% of the time, the article noted how differently typical jurors perceive physicians in managed care organizations:

> "Physicians are perceived as human beings who commit regrettable but not repeated errors or oversights. Moreover, despite often having fairly comprehensive insurance policies, they do not have great personal wealth, as compared with

> corporations. Managed care organizations, on the other hand, are perceived as wealthy, impersonal targets …. In addition, any injury that an insurer causes may result from the application of policies with the potential to cause harm to many patients. Because they are carefully developed, some stringent policies concerning utilization review may even be equated with causing intentional harm, making managed care insurers likely to incur punitive damages. Finally, claims against managed care organizations may involve not only medical malpractice, but also claims of bad faith and breach of contractual obligations to enrollees."

Id. Indeed, the article went on to note, many of the policies and procedures at the heart of managed care might negatively influence a jury:

> "Restrictions on both patients' access to care and physicians' decision-making power could be grounds for awarding punitive damages against managed care organizations. Juries would probably be incensed by protocols that limit or encourage the restriction of specific types of care – for instance, diagnostic testing of a patient with chest pain. The same might be true of guidelines that explicitly prohibited the use of newer, more effective pharmaceutical products because of their higher cost. Newer anti-depressants and pain medications might fall into this category, especially if the failure to use them arguably led to substantial injury to a patient."

The article concludes that the climate is ripe for more and more managed care lawsuits with high verdicts and punitive damages:

> "As legislative and judicial trends thrust healthcare insurers into the liability spotlight, they introduce an entity into healthcare litigation that readily fits the profile of the classic defendant in cases involving punitive damages. Consolidation in the insurance market has left a few very large national health insurers. Those businesses are so large that juries may believe that punitive damages are necessary in order to get management to pay attention. Portraying the plaintiff as David and the managed care company as Goliath increases the plaintiff's chances of receiving a punitive damages award, especially against a corporation perceived as making business decisions, not a human being making simple errors."

Published reports of lawsuits throughout the country provide support for the projections and warnings articulated by the New England Journal of Medicine article:

- In a Massachusetts case the court referred to the "growing body of anecdotal evidence" leading to the conclusion that "managed care plans deny necessary and even life-threatening treatment in the name of cutting costs."

- An Arizona managed care organization was found 75% liable, resulting in an award of $3 million for the malpractice of its alleged agent, a doctor under contract with it who purportedly delayed in ordering a biopsy which would have disclosed a bacterial infection as the source of disabling back pain.

- A Texas health plan reached a $5.35 million settlement with the family of a member who died of cardiac arrest in its Dallas clinic, allegedly as a result of the negligence of poorly trained physicians and nurses because of the plan's alleged cost-cutting practices.

- In Kentucky, a jury awarded more than $13 million to a woman who was denied

insurance coverage for a recommended hysterectomy for cervical cancer. The managed care provider would only pay for a less expensive, less invasive procedure, and the family used $14,000 of its own money to pay for the operation. The plaintiff argued that the plan's denial of the operation was simply to save costs and that other plans generally allowed such operations. The legal basis of the suit was that there had been a bad faith denial of benefits. The jury awarded breach of contract damages, $100,000 for mental suffering, and $13 million in punitive damages.

- In a California case a jury awarded $120 million in damages to the widow of a California man who was denied coverage for a rare form of stomach cancer. The managed care provider had refused to pay for high dose chemotherapy, bone marrow transplantation and cryosurgery. Finally, when near the end of his life, surgery was recommended to remove the bulk of his tumor to make him more comfortable, the plan refused to pay for it. There were no ERISA limitations on the suit because the patient was a governmental employee. The jury awarded his widow $4.5 million for medical expenses and loss of companionship and $116 million in punitive damages.

Some judicial opinions even reflect a negative impression of managed care. In an Ohio case where the managed care organization had refused to pay for chemotherapy for brain cancer, the jury awarded $49 million in punitive damages and $2.5 million for bad faith. When the managed care provider sought to reduce the size of the award, the trial judge noted that the jury could have determined, based on the evidence, that there was a "high degree of reprehensibility" on the part of the defendants, "especially when viewed in light of their annual profits and disregard for the well being of the patients."

Recognizing the potential for large verdicts if managed care organizations can be placed into the forefront of medical malpractice litigation, and if economically-driven decisions can be targeted, attorneys representing plaintiffs are attempting more and more frequently to utilize medical malpractice cases as forums to demonstrate that "money" is behind medical decisions. Plaintiffs try to prove that patients have been harmed because managed care organizations were more focused upon saving money than providing quality health care. This was the essential theme presented to plaintiff's attorneys at a national seminar.

> "From the plaintiff's perspective, the litigator's goal in an action against a managed care plan is to tell a story – the plaintiff's story. To tell the court or the jury about the hurt, pain and suffering that the plaintiff endured. To explain how that hurt, pain and suffering could have been avoided if the managed care plan had honored its contractual, legal and moral obligations to provide all the medical care the plaintiff needed or – if some part of the care needed was not covered under the plan – to still inform the plaintiff about the needed care so the plaintiff would at least have had a fighting chance by getting that care somewhere else, some other way."

"Liability: A Litigator's Perspective from the Plaintiff's Side," NHLA/AAHA Managed Care Law Institute (1997).

The article concluded:

> "Managed care problems are not incurable. The 'pathology' can be treated. But so long as the 'bottom line' is the focus of the people running managed care organizations, the problems, complaints, lawsuits, legislative and regulatory efforts will continue. It is time for the managed care industry to heed the old physician's adage to 'heal thyself' or juries, judges or legislators will."

THE TRADITIONAL DEFENSE – ERISA PRE-EMPTION

Traditionally, managed care organizations have relied on ERISA as a defense to claims, arguing that the federal legislation pre-empts lawsuits against managed care organizations. In the context of conflicting decisions throughout the country on this issue, the United States Supreme Court addressed the subject of the viability of managed care lawsuits in a series of cases during the Summer of 2000. Pegram v. Hendrich involved the issue of whether or not a claim could be based on breach of fiduciary duties under ERISA, where it was alleged that a decision to delay a sonogram and have it performed at a distant location, was motivated by cost-saving interests. The court held that decisions of this nature are not encompassed by the fiduciary responsibilities envisioned by ERISA. In arriving at this conclusion, the court discussed the concept of managed care at length and held that in analyzing the role of an ERISA fiduciary, the court would not adjudicate what was and was not appropriate in the actual operation of a managed care program. The court held that it would not decide what cost-saving measures were proper, and which ones weren't. The court emphasized that efficiency and limitations are central to any managed care organization and that these components have been sanctioned by managed care legislation. Thus, allegations that an involved doctor or managed care organization were motivated to save money failed to state an ERISA claim.

In Pegram, the court accepted as a fundamental point that cost savings were the goal of all managed care organizations, and that the managed care organization's return was the fixed cost to a patient for the services which were provided by the managed care organization. Accordingly, a patient could not present a medical malpractice claim based upon the theory that a physician or an HMO, acting in accord with managed care guidelines, had breached fiduciary obligations to ERISA, simply because these managed care principles were part of the decision-making process.

At the same time, the Supreme Court discussed the fact that most decisions made by a managed care organization were not purely based upon the scope of the managed care plan, but, rather, involved elements of medical decision-making. The court utilized this analysis to point out that if it allowed there to be an ERISA claim resulting from judgments made as part of these mixed decisions, that it would be creating a federal malpractice claim and that the end result would be to pre-empt medical malpractice claims against managed care organizations allowed under state laws. In this manner, and also by citing with approval the earlier decision of Dukes v. U.S. Healthcare, Inc., 57 F.2d 350 (3d Cir. 1995), the court appeared to be tacitly affirming the viability of

state medical malpractice lawsuits against managed care organizations.

Dukes had been the prevailing law governing Pennsylvania medical malpractice claims filed in federal court. Dukes actually involved two lawsuits. One evolved out of the death of a man who died as a result, allegedly, of a failure to obtain a timely blood test by physicians associated with his HMO. The second concerned a death occurring from allegedly negligent treatment of pre-eclampsia during pregnancy. The first lawsuit was premised on a claim that the involved doctors were the ostensible agents of the HMO; the second on both ostensible agency theories and on a claim that the HMO was negligent in hiring the medical personnel involved.

Both cases were removed to federal court and the defendants sought to have the cases dismissed on the basis of ERISA pre-emption. The trial court agreed, but the decision was reversed on appeal. The Third Circuit Court of Appeals concluded that each case concerned "the quality of benefits received," not the failure to provide benefits due under the plan:

> "Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans' failure to provide benefits due under the plan. Dukes does not allege, for example, that the Germantown Hospital refused to perform blood studies … because the ERISA plan refused to pay for those studies. Similarly, [there is no claim that the mother's death was due to withholding some quantum of plan benefits due. Rather,] the plaintiffs in both cases complained about the low quality of the medical treatment they actually received and argue that the U.S. Healthcare HMO should be held liable under agency and negligence principles."

57 F.3d at 357. The court held that there was no pre-emption of such claims (and, thus, there were grounds for a cognizable medical malpractice lawsuit) since the allegations did not "concern a denial of benefits due or a denial of some other plan-created right." Id. at 361. In citing Dukes, the Supreme Court in Pegram explained how, in most cases, managed care decisions are not divorced from medical decision-making. It noted that questions about what is covered by a managed care plan are often inextricably intertwined with treatment decisions. This is

> "because a great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition. … The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case …. In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment."

The decision then listed several kinds of mixed eligibility and treatment decisions:

> "Physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of the medical condition."

Based on this analysis, it appears that most claims against managed care organizations will not be pre-empted:

> "Thus, 'mixed' eligibility decisions are not fiduciary decisions under ERISA for purposes of ERISA pre-emption, because they are not 'decisions administering a plan.' This conclusion bodes the end of ERISA pre-emption of state court claims focused on HMO's medical necessity decisions – since they are by definition 'mixed eligibility' decisions."

9 BNA Health Law Reporter 1267 (August 10, 2000).

On the same day as the Supreme Court decided Pegram, it decided not to review Bauman v. U.S. Healthcare, Inc., 193 F.3d 151 (3d Cir. 1999), which involved alleged malpractice relating to the death of a newborn girl. Discharged two days after her birth, the baby became ill. Despite numerous phone calls to the treating HMO physician, the parents were not advised to bring the child back to the hospital. A request to the HMO for an in-home pediatric nurse visit was declined. The child died of undiagnosed Group B Strep infection.

The defendant's argument in Bauman that the claims were pre-empted was rejected by the lower federal courts. The Third Circuit held:

> "Thus, it is the HMO's essential medical determination of the appropriate level of care that the Baumans claim contributed to the death of their daughter. This is not a claim that a certain benefit was requested and denied. … The Baumans never had the option of making an informed decision as to whether to pay for the hospitalization themselves as would occur in a situation in which coverage is sought and denied. Accordingly, the claims fit squarely within a class of claims that we identified in Dukes as involving the quality of care. Here, as in Dukes, 'the plaintiffs are attempting to hold the HMO liable for its role as the arranger of their [decedent's] medical treatment.'"

The fact that the Supreme Court let this case stand at the same time as it decided Pegram, further implies that the medical malpractice claims against managed care organizations based on quality of care are fully cognizable in state court, as long as the focus of the lawsuit stays away from the issue of whether or not the pivotal decision was simply a question of whether or not something was covered under a managed care plan.

Still, there may be a tangential benefit to managed care organizations from the Pegram decision. The Supreme Court in Pegram indicated that medical malpractice claims should not be premised merely upon the concept that (a) injuries arose within a managed care context, and (b) that certain aspects of the care could possibly have been influenced by managed care considerations.

While these pronouncements were made in the context of deciding issues about whether a cognizable ERISA claim existed, the Supreme Court's comment should carry some weight when plaintiff's attorneys insist – without actual foundation – that medical decisions were *somehow* influenced by managed care considerations. Certainly, the pronouncements of the Supreme Court would not bar actual claims of negligence, by either doctors or managed care organizations, which result in injuries to patients. However, the Supreme Court opinion does signal that claims should not be viable simply because they allege that doctors were acting as part of a managed care program or because the managed care program had provided some incentive to a doctor to furnish less than the maximum quantity of care.

CLAIMS AGAINST MANAGED CARE ORGANIZATIONS BASED UPON VICARIOUS LIABILITY

Vicarious liability is a legal doctrine under which liability is imposed upon a party solely because of that parties' legal relationship to a second party whose conduct causes injury to another. This legal relationship may be one of actual employment or one created based upon the appearance of employment. Vicarious liability may be the basis for claims against a managed care organization.

If an actual employment relationship exists between the parties, the liability of the first party (employer) is predicated upon the theory of respondeat superior. If an actual employment relationship is not present, but factual circumstances exist which create the appearance of an employment relationship, the first party (putative employer) may be found liable upon a theory of ostensible agency. Since participating providers are either employed directly by a managed care organization or contract with it as independent contractors, liability asserted against a managed care organization may be predicated upon a provider's conduct, based upon either the theory of respondeat superior or ostensible agency.

Under the doctrine of respondeat superior, an employer is liable for the conduct of its employee. The central issue in determining whether an employment relationship exists is whether the alleged employer controls or has the right to control the work performed by the alleged employee.

Liability for the negligence of participating providers under the doctrine of respondeat superior has been readily imposed upon staff model HMOs. Under the staff model, the HMO directly employs the physicians on a salary basis. These physicians treat the HMO's members on an exclusive basis at the HMO's facility. Under these circumstances, the courts have had no difficulty in determining that a direct employer/employee relationship exists between the HMO and its providers. Under such circumstances, the HMO will be held liable for the negligence of its provider physicians.

In contrast to staff model HMOs, courts have generally found the doctrine of respondeat superior not to be applicable to IPA

HMO models since under the IPA model, physicians retain greater autonomy and control over their practice and generally operate as independent contractors.

Ostensible agency is a theory under which a party may be held liable for the negligent conduct of another based upon the appearance of an employment relationship. The doctrine of ostensible agency has long been applied to hospitals.

Courts, on occasion, have extended the doctrine of ostensible agency to impose liability upon HMOs for the conduct of their participating physicians, even where such physicians are, by contract, independent practitioners.

The application of the doctrine of ostensible agency to HMOs is heavily reliant upon the facts of each case, but the trend in case law presents an increasing likelihood that an HMO will be found liable for the negligence of its participating physicians, despite the fact that the physicians may be independent contractors.

DIRECT LIABILITY CLAIMS AGAINST MANAGED CARE ORGANIZATIONS

In addition to liability arising from the conduct of its participating physicians, additional theories of liability may be asserted which are based upon the HMO's direct corporate conduct, although it is more likely that these claims will be subject to an ERISA pre-emption challenge. Emerging case law has addressed a number of direct corporate liability issues, including liability arising from negligent selection or supervision of participating physicians, utilization management decisions, misrepresentation, breach of warranty and bad faith.

A. Corporate Negligence

In Pennsylvania and other jurisdictions, the doctrine of corporate negligence, as applied to hospitals, provides that the hospital has certain independent and non-delegable duties with respect to ensuring the adequacy of patient care. The doctrine of corporate negligence was analyzed by the Supreme Court of Pennsylvania in Thompson v. Nason Hospital, 591 A.2d 703 (1991).

In Thompson, the Supreme Court noted that the "corporate hospital of today has assumed the role of a comprehensive health center, with responsibility for arranging and coordinating the total healthcare of its patients." For that reason, the court found that hospitals owe a non-delegable duty directly to the patient in four general areas:

1. A duty to use reasonable care in the maintenance of safe and adequate facilities and equipment;

2. A duty to select and retain only competent physicians;

3. A duty to oversee all persons who practice medicine within its walls as to patient care; and

4. A duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.

Thompson, 591 A.2d at 706-707.

In McClellan, supra., the Superior Court of Pennsylvania was called upon to determine whether the doctrine of corporate negligence enunciated in Thompson was applicable to an IPA model HMO. The court noted that to the extent that the doctrine of corporate negligence applied to an IPA model HMO, only the requirements pertaining to the selection and retention of competent physicians and formulation of adequate rules and policies would be applicable. The court concluded, however, that it was unnecessary to extend the theory of corporate negligence to IPA model HMOs. Instead, the court in McClellan relied upon §323 of the Restatement (Second) of Torts which provides:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if:
>
> (a) His failure to exercise such care increases the risk of harm or,
>
> (b) The harm is suffered because of the other's reliance upon the undertaking.

Applying §323 of the Restatement (Second) of Torts to an IPA model HMO, the court in McClellan concluded that a plaintiff states a sufficient cause of action against the HMO if it is alleged that the HMO has undertaken:

1. To render services to the plaintiff subscriber;
2. Which the HMO should recognize as necessary for the protection of its subscriber;
3. That the HMO failed to exercise reasonable care in selecting, retaining and/or evaluating the plaintiff's primary care physician; and
4. That as a result of the HMO's failure to use such reasonable care, the risk of harm to the subscriber was increased.

Another important Pennsylvania case discussing "corporate liability" is Shannon v. McNulty, 718 A.2d 828 (Pa. Super. 1998). According to that decision, managed care organizations are liable where they are "providing health services rather than merely providing money to pay for services." More specifically: "When a benefit provider, be it an insurer or a managed care organization, interjects itself into the rendering of medical decisions affecting a subscriber's care it must do so in a medically reasonable manner." The court decided that where Health America "provided a phone service for emergent care staffed by triage nurses," it had "a duty to oversee that the dispensing of advice by those nurses would be performed in a medically reasonably manner."

Further, the court in Shannon held: "We see no reason why the duties applicable to hospitals should not be equally applied to an HMO when that HMO is performing the same or similar functions as a hospital."

> "[W}e recognize the central role played by HMOs in the total health care of its subscribers. A great deal of today's healthcare is channeled through HMOs with the subscribers being given little or no say in the stewardship of their care. Specifically, while these providers do not practice medicine, they do involve themselves daily in decisions affecting their subscriber's medical care. These decisions may, among others, limit the length of hospital stays, restrict the use of specialists, prohibit or limit post hospital care, restrict access to therapy, or prevent rendering of emergency room care. While all of these efforts are for the laudatory purpose of containing health costs, when decisions are made to limit a subscriber's access to treatment, that decision must pass the test of medical reasonableness. To hold otherwise would be to deny the true effect of the provider's actions, namely, dictating and directing the subscriber's medical care."

DIRECT LIABILITY CLAIMS CAN ARISE UNDER A WIDE VARITY OF CIRCUMSTANCES

As illustrated by the cases below, there are many potential areas for direct liability claims involving all key components of a managed care system:

A. Advertising or promotional material leading to claims of misrepresentation.

Claims asserting misrepresentation as a cause of action generally allege that the plan "misrepresented the quality of care provided" and that the plaintiff "relied on the representations to his or her detriment." For example, in McClellan, supra, the court determined that the plaintiff's allegations of intentional misrepresentation withstood a demurrer. The plaintiff had alleged that his decedent had relied on the HMO's assertions that its physicians had satisfied a "vigorous screening criteria" which had been established by the HMO and that the patients' primary care physician would "promptly and properly" refer them to specialists when necessary.

Increased competition among managed care organizations has the potential to increase the volume of misrepresentation claims. As managed care organizations undertake to promote and distinguish themselves, it is important that they not mischaracterize plan benefits, unrealistically heighten subscribers' expectations, or represent that care will be provided contrary to that which actually occurs.

In Maio v. Aetna, 2000 WL 1137688 (3d Cir. 2000), a class action was dismissed because the claims could not withstand the Pegram test of showing actual harm that resulted from managed care representations. Yet the claims made in Maio serve as a good checklist of potential problem areas.

It was reported that, in Maio, the plaintiffs made these allegations:

- That the member handbook falsely alleged that a patient's healthcare is entrusted solely to physicians, thus creating an illusion that the physicians would make decisions independently, whereas, in actuality, the managed care provider's policies restricted the physicians' decision-making abilities concerning the level and extent of care to be provided in particular cases.

- That insuring documents suggested that physicians would be rewarded for providing quality care whereas, in reality, they were rewarded on how well they minimized costs under the plan.

- That undisclosed policies contradicted public statements in advertising, marketing and membership materials which falsely indicated that quality care was the plan's primary concern.

- That the managed care organization failed to disclose the existence of the restrictive agreements that it had with its physicians despite the representations in marketing materials that the plan members have the right to know how Aetna decides what services are covered.

- That the managed care organization had undisclosed financial incentives designed to reduce the quality of care, including (a) incentives and disincentives which reward physicians for large patient ratios of over 750 patients per physician; (b) incentives which seek to restrict HMO members' hospitalizations, specialists, and emergency room utilization; (c) rewards to physicians for attaining certain targets wish respect to acute hospital care, catastrophic specialist utilization and emergency room utilization.

- That the managed care organization failed to disclose that its plan disparately treats individuals who receive their benefits through ERISA plans.

The plaintiffs argued that they should be permitted to prevail even though they were not able to show actual physical injuries as a result of these facts. Their contention was that an economic injury was suffered because they had paid too much for an inferior product. The court rejected this argument, holding that a claim was not cognizable without showing that the health care they actually was compromised or diminished as a result of these policies.

B. Failure to credential claims

The doctrine of negligent credentialling was originally established with regard to hospitals and imposed a duty of proper credentialling. It is clear that under the doctrine of corporate liability, a managed care organization may be liable if it is determined that it has failed to properly credential physicians.

One of the allegations of plaintiff's complaint in the McClellan decision was that the HMO was negligent in selecting and/or credentialling the patient's primary care physician. As noted above, the Superior Court held that a plaintiff may recover directly against an HMO based upon the HMO's failure to properly select, retain and/or evaluate a participating provider.

An interesting footnote to the McClellan decision pertains to the discovery of the credentialling files of the HMO involved in that case. Following its decision in McClellan, the Superior Court reinstated the complaint and remanded the case to the trial court. Thereafter, the plaintiff requested production of the primary care physician's credentialling file maintained by the defendant HMO. The HMO objected to production of the credentialling file based upon the claim that such materials were protected from discovery by the Pennsylvania Peer Review Protection Act. Accepting the HMO's argument, the trial court refused to require production of the HMO's credentialling file, whereupon the plaintiff

again filed an appeal to the Superior Court. The Superior Court concluded that an IPA model HMO, which does not operate its own facilities but merely acts as an insurer or quasi insurer, is not covered by the Peer Review Protection Act, particularly where the HMO does not designate itself or hold itself out to be a "provider" of professional healthcare services. The Superior Court, therefore, held that the plaintiff could obtain the primary care provider's credentialling file from the HMO. See McClellan v. Health Maintenance Organization, 660 A.2d 97 (Pa. Super. 1995), affirmed, 686 A.2d 801 (Pa. 1996).

State legislation also mandates proper credentialling. Thus, it is particularly important that a managed care organization critically review the credentials of its physicians to make certain that a claim cannot be presented that the managed care organization knowingly furnished or associated itself with incompetent doctors.

C. Negligent telephone triage

A managed care organization which establishes a phone line staffed by its employees or agents, and requires its subscribers to utilize the telephone contact as a pre-requisite to receiving care, likely will be liable for any consequences that occur as a result of negligence on the person who answers the line. Illustrative of such a claim is Crum v. Health Alliance-Midwest, Inc., 47 F. Supp.2d. 1013 (C.D. Ill. 1999). In Crum, the court ruled that ERISA did not pre-empt a claim against a health plan for allegedly wrongful conduct of an advisory nurse on a telephone emergency line. The decedent's wife had telephoned her plan's specified number for advice when her husband began experiencing nausea, agitation and an urgent need, but inability, to vomit. Under the contract, enrollees were required to call the plan prior to seeking medical attention. The advisory nurse allegedly told the plaintiff that the decedent's symptoms were probably due to excess stomach acids and would be okay. His wife phoned a second time when the symptoms, which had continued, were accompanied by a pain in the middle of the decedent's chest.

According to the complaint, the nurse instructed the decedent to sit at a forty five degree angle and drink some milk, but she stated that she did not need to go to the emergency room. Twenty minutes later, when the symptoms had not ceased, the decedent's wife drove him to an emergency medical center. During the drive, he became unresponsive and died due to a heart attack.

Claims that the lawsuit was pre-empted were dismissed because the allegations were based on the quality of care received.

Shannon, supra, one of Pennsylvania's leading corporate liability cases, was also based upon telephone triage advice. Mrs. Shannon, an obstetrics patient, allegedly called HealthAmerica's emergency phone line and told them that she was having severe irregular abdominal pain, back pain which was worse at night, and that she thought she may be in pre-term labor. She also told the nurse that she had made prior calls to her doctor and that

he felt she was not in labor. The nurse told Mrs. Shannon to call her doctor again.

According to the decision, Mrs. Shannon called HealthAmerica the next day and said her symptoms were getting worse and Dr. McNulty was not responding. She again was told by the triage nurse to call Dr. McNulty. She called him, but he still did not believe that she was in labor.

The next day, with her symptoms increasing, she called HealthAmerica again. This time, she was told to go to the hospital. She delivered a one and one-half pound baby, who survived only two days before dying due to his prematurity.

The Superior Court reversed the trial judge who had dismissed HealthAmerica from the case. The court concluded that the plaintiff was entitled to have a jury decide whether the nurses had performed negligently. "HealthAmerica provided a medical service in the form of telephonic advice," the court held. "The adequacy of that service and the reasonableness of Mrs. Shannon's use thereof under the circumstances are questions for the jury."

In deciding the case, the judges appeared to accept the premise of plaintiff's expert that the HMO's triage nurses, upon receiving the first call from Mrs. McNulty, should have immediately referred her for a cervical exam and a fetal stress test. The court appeared to base its decision on the expert's testimony that, "they had a duty to follow-up Mrs. Shannon's calls by calling Dr. McNulty to insure Mrs. Shannon was actually receiving proper care from him."

Given the involvement of HealthAmerica's triage nurses, there was at least a debatable issue about whether the nurses' responses met the standard of care. Since Mrs. Shannon told the nurses that she had a myriad of symptoms, and that she had been calling her doctor repeatedly and he was not responding, it seems reasonable to expect the nurses to do something more than simply tell the patient to call her doctor again.

However, the troubling aspect of the opinion is the suggestion that the nurses had a duty to closely monitor the care being provided, and, perhaps, even to second-guess the patient's doctors. The plaintiff's expert did not just opine that the nurses had a duty to refer the patient to a hospital when the doctor was not responding, the expert said there was a duty to refer Mrs. Shannon "for a cervical exam and fetal stress test." The expert testified that the triage nurse even had a duty to notify the hospital "that this woman was probably in pre-term labor and needed to be handled immediately." The expert said the nurses had an obligation not only to call Dr. McNulty, but, also, to "insure" that "Mrs. Shannon was actually receiving the proper care for him."

There is an old adage that "bad facts make bad law," and this well might be one of those instances. Mrs. Shannon kept calling, either her doctor or the HMO, and none of the calls led to timely care. She appeared to be searching for help and the response, twice, from an HMO nurse was, simply, to call her doctor again. The case well might have had a different outcome if, in the first

instance, the nurse had told her, “You should go to a hospital immediately to be examined.”

D. Breach of contract claims

Because the relationship between a managed care organization and its enrollees is essentially one that is contractual in nature, claims may be brought against the HMO based upon causes of action arising in contract. Such claims would include breach of contract lawsuits and breach of warranty claims. These theories are triggered when a plaintiff alleges that his HMO breached its contract with him by failing to provide that which was required by the contract.

In order to survive ERISA pre-emption, it is important for such cases to allege that the “quality of the coverage provided” failed to comport with that which was promised under the contract, as opposed to a claim that the managed care plan “should have covered more.”

Illustrative of such a claim is Johnson v. Humana Health Plans, Inc., supra, discussed above. In this case, the plaintiff alleged that the managed care organization failed to live up to its contract causing the patient to pay for treatment for cervical cancer which should have been encompassed under the plan. The plaintiff received at trial an award not only for the breach of contract damages but also additional amounts for mental suffering ($100,000) and punitive damages ($13 million).

In Williams v. Health America, 41 Ohio App. 3d 245, 535 N. E. 2d 717 (1987), the plaintiff filed a breach of contract claim against both Health America and her personal physician on the grounds that they engaged in a breach of contract when they prevented her from seeking treatment by a specialist who was outside of the terms and conditions of Health America’s plan. The Ohio Court of Appeals reversed a summary judgment in favor of the HMO.

E. Statutory liability

Several states now have or are considering laws which allow a managed care organization to be sued directly for medical malpractice.

MANAGED CARE PRESENTS INCREASED LIABILITY EXPOSURE FOR PHYSICIANS

Physicians and other healthcare providers who participate in caring for a patient will always be subject to medical malpractice liability if it is determined that they have deviated from “the standard of care” generally practiced by physicians. However, the growth of managed care, brings with it the potential for new theories of liability against physicians and increased liability risks.

If, for example, it is alleged that a practice guideline advanced by the managed care organization embodies a deviation from the standard of care, the fact that the physician has complied with the guideline will be irrelevant if he is sued for negligence. On the other hand, should a problem result in a situation where a physician has not followed a practice guideline, the deviation will be advanced as evidence of negligence.

As managed care structures impose "gatekeeper" responsibilities upon physicians, there are enhanced liability risks. Unquestionably, there has always been the potential for liability if a physician was negligent with respect to seeking or foregoing a consultation, but the potential for liability in this regard increases when the patient's whole healthcare regime is largely dependent upon the management of a doctor who is required to review and authorize access to specialists, tests, and emergency care. Indeed, the potential exists for the "gatekeeper" doctor to face non-traditional risk exposures such as "breach of fiduciary duty" or "bad faith" if he is responsible for decisions which result in precluding patients from receiving medical care.

Similarly, the more closely tied the "gatekeeper" primary care physician is to the specialist, the more likely it is that he will be found to have at least secondary responsibility for the negligence of the physician to whom a referral is made. This is especially the case where the "gatekeeper" maintains responsibility for ordering specialized tests, or where the is some financial benefit to the primary care physician if he refers a patient to one specialist as opposed to another. In Swede v. Cigna Health Plan of Delaware, 1989 WL 12608 (Del. Super., Feb. 2, 1989), the plaintiff sued her health care plan, as well as her family practice physician, and sought punitive damages against the doctor, on the grounds that the HMO's system of capitation corrupted the judgment of the physician and that, as a result, he did not refer her to a surgeon in a timely manner when a lump was found on her breast.

Lawsuits built upon financial incentives can be the source of claims heretofore not faced by physicians. For example, in Gross v. Prudential Health Care Plan, No. CJ-9474267 (Okla. Cty. Ct. Oct. 1, 1996), the plaintiff claimed that his physicians and ProCare committed fraud when they failed to disclose a profit-sharing arrangement. In that same case, the plaintiff alleged breach of an implied contractual duty of good faith and fair dealing when the managed care organization and the physician failed to refer the patient to a specialist.

An increasing number of cases have been premised on the concept that the physician breached a duty to disclose to his patient economically motivated decisions to forgo certain treatment modalities. Although beyond the reaches of Pennsylvania's law of informed consent, the California Supreme Court concluded in Moore v. Regents of the University of California, 793 P.2d 479, 483, 51 Cal. 2d. 120 (1990) that the law of informed consent in that jurisdiction encompasses the issue of a whether physician has disclosed an economic interest that might affect his judgment in deciding upon appropriate treatment for his patient.

CLAIMS BY PHYSICIANS, HOSPITALS AND OTHER INSURERS AGAINST MANAGED CARE ORGANIZATIONS

Another important facet of managed care litigation is that which is driven by non-patients. Managed care organizations have liability risk exposures as a result of claims by physicians with

whom they have associated or by other healthcare providers and their insurers.

At the same time as managed care organizations have an obligation to patients to carefully credential physicians, they must be cognizant of potential liability to doctors if the credentialling process results in removing a physician from the managed care organization's plan. One can expect that a physician who has been de-credentialled will file a lawsuit against the managed care provider. He will claim that the decision to remove him from the plan has caused a great economic hardship to him and also a detriment to his patients. The de-credentialled doctor may often contend that a preliminary injunction should be granted to prevent the managed care organization from consummating the termination since it will cause him "irreparable harm." It will be contended that the managed care organization was unjustified in its actions and/or that it failed to follow proper procedures.

CLASS ACTION LAWSUITS

Managed care claims have also been central to huge class action lawsuits. A variety of issues were the driving forces in claims filed in different parts of the country. Among the key issues:

- A managed care organization's alleged engagement in fraud or even racketeering activities by utilizing undisclosed financial incentives and controls to limit the medical care patients receive.
- Physician lawsuits alleging that the HMO industry relies on faulty data to reduce reimbursements for medical services.

It is undetermined, as yet, the full effect which the Pegram decision of the United States Supreme Court will have on these types of cases. However, it is apparent that plaintiffs' attorneys will try and avoid ERISA pre-emption.

LIMITING THE POTENTIAL FOR MANAGED CARE CLAIMS BY PERSUADING THE PUBLIC (AND JURORS!) THAT HEALTHCARE WAS NOT COMPROMISED BECAUSE OF MANAGED CARE

Over the years, it has generally been considered that there were two factors more than anything else which helped to prevent medical malpractice lawsuits. One is obvious: the practice of good medicine. Healthcare providers who are knowledgeable, careful, diligent, prudent, and insightful will less often be the defendants in a lawsuit. Their mistakes will be minimal and their outcomes will usually be successful.

The second factor which has prevented lawsuits is just as important, and perhaps even more so in the era of managed care: good bedside manner. It is well know that those physicians who are perceived by their patients as being kind, caring, personal, interested and giving of their time will much less frequently be the target of medical malpractice lawsuits, even when their results are less than optimal.

In a managed care system, there is the potential for the practice of medicine to be perceived as more business-like and less personal, more inclined toward economic efficiencies than

toward total dedication to the interests of the patient. In this environment, it is essential for both the corporate entity – the managed care organization – and all of the involved healthcare providers to engage in the best "bedside manner" possible. Even when the HMO is not involved in hands on patient care, considerable effort should be undertaken to assure that the best public relations possible are fostered and that patients sense that the HMO is truly interested in their personal well being and not just in their plan membership. If this concept can be conveyed, the risks of enhanced liability from managed care lawsuits will be lessened considerably.

Even the best HMO will find itself to be a defendant in certain lawsuits, just as the most prudent doctor is undeservingly named as a defendant in a medical malpractice claim. However, if its subscribers have the impression that the HMO is on their side, that the healthcare providers furnished are of the highest quality, and that healthcare decisions are made because they make sense in the context of a careful analysis of a patient's healthcare needs—and not just because they make "economic sense"-- then it is less likely that the HMO or its providers will be involved in a greatly expanded number of lawsuits.

But, if managed care patients feel that they are being cheated by the care they are being provided or that finances dictate a diminished level of care, it is likely that the number of managed care lawsuits will greatly expand in the near future. If they do, the verdict potential is huge. It is predictable that the managed care organization and associated physicians will try hard to convince jurors of the HMO's good faith and that the HMO and its physicians made the right care decisions for the right reasons. But a problem they will face is that many of the jurors will have had problems with their own managed care.

It is incumbent upon both managed care organizations and the healthcare providers who are part of the system to demonstrate to the public that there is more than just a concern for economics, and that managed care *really* is a program designed to *enhance* healthcare to the *benefit* of the patient. When a case comes to trial, it will be essential to convince the jury that, managed care notwithstanding, a high degree of care and responsibility was exercised by physicians and the other healthcare providers involved, and that medical decisions were made *not* on the basis of economics, but were justified as part of a reasonable analysis of the appropriate level of care to be afforded to the patient.

There are several potential things that can be done to promote these goals. For example, a managed care organization can proactively work toward these goals by:

- Utilizing the media at every opportunity to educate the public about the advantages of managed care;
- Formulating reasonable and current policies regarding the use of new technology and advanced treatments;
- Engaging in meaningful credentialling;
- Consulting with legal counsel before making final decisions in high risk cases;

- Avoiding delayed decisions whenever possible;
- Documenting every request, denial and reason for denial of treatment;
- Boldly printing appropriate disclaimers in all contracts and handbooks;
- Developing expert testimony to emphasize the positive aspects of managed care.

Jurors do not expect that *everything conceivable* be done in caring for a patient. Jurors, despite the extraordinary verdicts often reported by the media, *are* in most cases inherently reasonable persons and responsible decision-makers. Jurors, will realize for example, that a physician cannot be stationed all day in every patient's hospital room; they appreciate that it is neither appropriate nor reasonable to perform *every test in the world* on a patient, especially if the physician believes that a proper diagnosis has been made with less than a complete battery of tests. But even these reasonable jurors will not respond favorably to flat-out assertions that something was just too expensive or that good medical care was sacrificed for someone's bottom line.

It is essential for both the managed care organization and all of the healthcare providers to engage in the best "bedside manner" possible. Even if the managed care organization is not involved in hands-on patient care, considerable effort should be undertaken to assure that positive public relations are fostered and that patients sense that the managed care organization is truly interested in their personal well being, and not just in their plan membership. If this concept can be conveyed, the risks of enhanced liability from managed care lawsuits will be lessened considerably.

Simultaneously, however, the managed care organization must be careful that it does not oversell itself, or make promises upon which it cannot deliver. There is the distinct potential for lawsuits premised upon the claims made in the advertisements and commercials of managed care organizations. Although it certainly is necessary for such an entity to market itself, it should be done with care, with legal advice, and, yes, even with some restraint. Managed care organizations should make certain that their promotional materials do not make misrepresentations, contain promises that they will not be able to keep, or advertise a level of care that the HMO and its providers will not be able to provide.

The careful credentialling of providers and the continuous monitoring of a managed care organization’s panel of physicians is also an essential component in reducing the potential for successful lawsuits against the HMO. The analysis most critical is one which is based on the clinical performance of the practitioner, as opposed to his meeting of economic targets or guidelines. If a physician is determined to have performed poorly, it is essential for the managed car organization to take corrective measures. If it fails to do so, and harm later results to a patient, the managed care organization clearly has liability exposure on the basis of a negligent credentialling claim.

Financial incentives should be disclosed to patients both by the managed care organization and by participating providers. This should be done

in a manner which is accurate, yet tactful. Consideration might be given, for example, to utilizing a well considered and legally reviewed form, preferably at the beginning of the relationship.

Managed care organizations and their providers should work together to develop the best health care plan possible. The goal is to assure that the managed care decisions which are made are not reasonably subject to criticism. And, when a case comes to trial, there must be an all out effort to demonstrate that the events which occurred – even if unfortunate – were neither caused by economic considerations nor a product of managed care's involvement. If these elements can be proven, the risk of an undeserved plaintiff's verdict or a runaway award will be greatly reduced.

CONCLUSION

For all participants in the managed care system, substantial legal liability lies ahead unless the public and the jurors it produces are convinced that the standard of care has not been tainted by the bottom line. It is incumbent upon managed care organizations and their affiliated healthcare providers to establish their credibility through day-to-day care, so that when cases inevitably reach the courtroom, it will be possible to prove convincingly that managed care was not at fault, that the care rendered to the patient was reasonable and appropriate, and that any discussion about financial factors is nonsense. Unless these themes are established, managed care liability will increasingly become an explosive courtroom issue.