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UPON FURTHER REVIEW: *RUSH PRUDENTIAL HMO, INC. v. MORAN* AND A NEW ERA OF MANAGED CARE ORGANIZATION LIABILITY

ALLEN D. ALLRED* AND DON L. DANIEL**

I. INTRODUCTION

As managed care organizations ("MCOs") assume an increasingly important role in the delivery of healthcare services to patients,[1] they find themselves prime targets of, among others, federal and state policymakers, plaintiffs' attorneys and consumer/patient rights activists. Many health care industry insiders believe the increased attention has had negative consequences for consumers of health care services. The president of the American Association of Health Plans ("AAHP"), for example, has stated that "reckless

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1. Studies indicate that as many as 170-180 million Americans are enrolled in MCOs. *See* National Conference of State Legislatures, *Managed Care Insurer Liability*, *at* http://www.ncsl.org/programs/health/liable.htm (last visited Oct. 6, 2002). *See also* Clive Riddle, *The Future of Managed Care: An Outline*, Managed Care On-Line, *at* www.mcareol.com/mcolfre1/cresem.pdf (last visited Oct. 6, 2002). Other surveys indicate that up to 88% of all Americans with private health insurance are enrolled in a managed care plan (up from just 27% in 1988). Alliance For Retired Americans, *Patients' Bill of Rights*, *available at* http://www.retiredamericans.org (last visited Dec. 26, 2002).

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litigation" is among the chief challenges facing the United States health care system,[2] and cites a recent AAHP-commissioned Pricewaterhouse Coopers analysis ("PWC Report") which concluded that 27 cents of every new dollar spent on health care in 2001 was "driven by litigation, government mandates and regulation and waste, fraud and abuse."[3] The net result, according to the survey, was an added cost to the health care system of approximately $18 billion in 2001.[4]

While it is clear that there are many factors which have led to increases in consumer health care costs, the extent to which any one factor is more responsible than others is certainly debatable. Nevertheless, a quick glance at the recent legal "headlines" leaves little doubt that MCOs are being forced to expend increasingly significant amounts of time and money in the defense of, among other things, complex medical malpractice and class action lawsuits.[5] In the span of just one month in early 2002, for example, "The medical societies of New Jersey, South Carolina and Tennessee filed separate lawsuits accusing some of the nation's largest health plans of engaging in illegal business practices."[6]

The dramatic increase in health care system regulation/litigation has had some incredible effects:

- During 2001-2002, employers' health care costs increased an average of 13.7%;
- Annual health care insurance premiums for employees and retirees increased an estimated 13% in 2001;
- The median malpractice award increased 43% in 2000 to $1 million; and

2. *HMO Trade Group Cites Challenges in Health Care System," Reckless Litigation" Among Them*, MEALEY'S MANAGED CARE LIABILITY REP., June 14, 2002, at 1.

3. *Id*.

4. *Id.* According to Karen Ignagni, President of AAHP, '"[These] resources alone could have provided coverage to 6.8 million Americans.'" *Id*.

5. *See* Acad. of Med. of Cincinnati v. Aetna Health, Inc., No. A0204947 (Ohio Cir. Ct., July 27, 2002); Acad. of Med. of Cincinnati v. Aetna Health, Inc., No. 02-C1-903 (Ky. Cir. Ct., July 27, 2002). The two previously cited cases are proposed class actions filed on June 27, 2002 alleging that four health plans participated in an "anti-competitive and illegal combination or conspiracy in restraint of trade" to fix physician reimbursement rates. *See also* Chester County Hosp. v. Independence Blue Cross, No. 02-CV-2746 (E.D. Pa., May 8, 2002) (a class action suit filed wherein a hospital alleges the region's largest insurer has violated antitrust and other laws by "abusing its dominant market power," and seeks more than $20 million in damages and other injunctive relief.)

6. Laura B. Benko, *States of Frustration; More Medical Groups Step Up Battle Against Insurers*, MODERN HEALTHCARE, May 20, 2002, at 16, 16 (2002).

- Malpractice insurance premiums increased from 20% to 100% for some providers.[7]

Indeed, large verdicts awarded under emerging theories of managed care liability have caused some to forecast managed care litigation as "the tobacco litigation of the turn of the century."[8]

The statistics set forth above tell only part of the story. Increased costs lead to fewer employers offering health benefits for employees, and many of those employers who continue to offer such benefits must demand additional contributions from employees to cover rising expenses. Ultimately all of this results in (a) fewer Americans having health insurance coverage (some estimate that 300,000 people lose coverage for every one-percent increase in premiums), and (b) shortages in quality medical care as physicians and other health care providers deal with skyrocketing malpractice premiums.[9]

Unfortunately for MCOs and benefit plan administrators, the surge in litigation (as well as the inevitable increase in litigation costs) coincides with an erosion of traditional protections from liability once afforded to such entities. Thus while MCOs struggle to find ways to control the costs of providing high quality medical care, the very mechanisms used to control such costs are increasingly being opened to scrutiny and attack in the courts and legislatures.

A recent and important example of the judiciary's newfound willingness to disregard liability protections once relied upon by MCOs can be seen in the Supreme Court's controversial 5-4 decision in *Rush-Prudential HMO, Inc. v. Moran.*[10] While this case will be discussed in greater detail in this Article's section on ERISA, it is sufficient to note for purposes of this Introduction, that whereas health plans and their medical directors were once granted a great amount of deference for discretionary medical coverage decisions, *Rush* appears to stand for the proposition that, under state law, independent physician reviewers can make medical necessity decisions that will be binding

7. Louise Kertesz, *What is Fueling the Increase in Health Care Costs?*, HEALTHPLAN MAG., Aug. 15, 2002, *at* http://www.aahp.org/Content/NavigationMenu/Inside_AAHP/Healthplan_Magazine/What. . .S.

8. Michael Higgins, *Second Opinions on HMOs*, A.B.A. J., Apr. 1999, at 60, 62. Interestingly enough, Richard Scruggs (the Pascagoula, Mississippi, lawyer who pioneered the "big tobacco" litigation), together with David Boies (who handled the federal government's case against Microsoft), are leading an assault on the HMO industry, charging several top managed care companies with racketeering.

9. *See* American Association of Health Plans, *Class Action Litigation Against the Managed Care Industry*, *at* http://www.classactioncenter.org/legal/litigation.htm (last visited Oct. 6, 2002). Medical care shortages are especially acute in areas where such care is needed most (for example, rural and economically depressed areas). *Id.*

10. Rush Prudential HMO, Inc. v. Moran, 122 S. Ct. 2151 (2002).

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on MCOs and licensed health insurers.[11] MCOs are now facing the prospect of having to adapt their medical management decision-making processes to account for physician review standards that may vary greatly among the states.[12]

Perhaps more disturbing for MCOs and benefit plan administrators than the actual decision in *Rush* is the fact that the decision appears to be just another step in a judicial trend of upholding state laws that negatively impact the ability of MCOs to administer health plans in a uniform manner across the states. The bottom line appears to be, of course, that MCOs, employers and, ultimately, consumers of health care services, can expect to see continuing increases in costs.

In this Article, we provide an analysis of significant ongoing liability issues for MCOs (especially in light of recent developments such as the *Rush* decision), as well as an outline of "emerging" areas of MCO liability. In Part II, we provide a brief summary of ERISA and an analysis of the courts' trend towards upholding state laws that once would have been preempted. Part III is an outline of "traditional" areas of MCO liability, including direct liability (for example, negligent supervision/retention of physicians), vicarious liability (for example, medical malpractice), tortious interference with contract and breach of warranty. Part IV focuses on RICO and the slew of class action claims filed against MCOs several years ago, as well as the status of certification of new classes. Finally, Part V examines the theories behind developing areas of MCO liability including antitrust, utilization review and provider de-selection.

II. IMPACT OF ERISA ON MCO LIABILITY

A. Overview of ERISA and the ERISA "Preemption" Clause

The Employee Retirement Income Security Act ("ERISA") was enacted in 1974 to protect the pension plan assets of American workers from misappropriation by corporate and union pension plan managers.[13] "ERISA applies to all employee pension, health, and other benefit plans established by private sector employers (other than churches) or by employee organizations such as unions."[14] As a result, virtually all privately-employed Americans who

11. Joel L. Michaels & Robin J. Bowen, *Rush to Judgment? An Analysis of* Rush Prudential HMO, Inc. v. Moran, HEALTH L. DIG., Aug. 2002, at 24, 28.

12. *Id*.

13. *See* SARA ROSENBAUM, AN OVERVIEW OF MANAGED CARE LIABILITY: IMPLICATIONS FOR PATIENT RIGHTS AND FEDERAL AND STATE REFORM, at ii (2001). *See also* Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 580-81 (2001).

14. PATRICIA A. BUTLER, ERISA PREEMPTION MANUAL FOR STATE HEALTH POLICY MAKERS 5 (2000).

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receive health benefits as part of their employment are covered by an ERISA plan.

ERISA does not require "employers to establish employee benefit plans," nor does it mandate the "benefits employers must provide if they to choose to offer such a plan."[15] While ERISA generally regulates the structure and operation of pension plans, employers are granted "broad discretion over the design of their health plans," including discretion over whether health care coverage for employees will be obtained through managed care companies.[16]

"[D]rafted . . . in reaction to an environment of failed [multi-state] pension plans and the economic dangers associated with mass forfeiture,"[17] ERISA was enacted in an effort to establish uniformity in the regulation of benefit plan administration. To accomplish this objective, Congress included in ERISA a "preemption" clause which provides that ERISA shall supersede "conflicting or inconsistent state and local regulations."[18] Peculiar in its strength, the ERISA preemption clause has been interpreted to preempt not only conflicting state laws that regulate ERISA health plans, but also state laws that merely "relate" to such plans.[19] As a result, ERISA historically has been held to displace even state regulation that is compatible with federal regulation of health care benefit plans.[20]

Obtaining ERISA preemption is important for MCOs (particularly in areas such as medical malpractice) because ERISA remedies are generally limited to either the cost of the denied benefit or injunctive relief.[21] ERISA precludes punitive damages and damages to make the beneficiary 'whole' from denial of medical treatment.[22] Further, if a plan participant dies as a result of an MCO's decision to deny benefits, there generally is no remedy available under ERISA.[23]

15. Pegram v. Herdrich, 530 U.S. 211, 266-27 (2000).

16. ROSENBAUM, *supra* note 13, at 8 (citing *Pegram*, 530 U.S. at 225-26).

17. Sharon Reece, *The Circuitous Journey to the Patients' Bill of Rights: Winners and Losers*, 65 ALB. L. REV. 17, 20 (2001).

18. Ochmann, *supra* note 13, at 581 (citing 120 Cong. Rec. 29, 197 and 29, 933 (1974) (quoting Sen. Williams)).

19. 29 U.S.C. § 1144(a) (2000).

20. Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 261 (1997) (citing Metro. Life Ins. Co. v. Travelers Ins. Co., 471 U.S. 724, 739 (1985); Shaw v. Delta Airlines, Inc., 463 U.S. 85, 98-100 nn. 18-20 (1983)).

21. *See* 29 U.S.C. § 1132 (2000).

22. June M. Sullivan, *Overcoming the ERISA Barrier to Recovery Against HMOs: Current Trends and Legislation*, 4 QUINNIPIAC HEALTH L.J. 245, 254 (2001) (citing Jane M. Mulcahy, *The ERISA Preemption Question: Why Some HMO Members are Dying for Congress to Amend ERISA*, 82 MARQ. L. REV. 877, 881 (1999)).

23. Mulcahy, *supra* note 22, at 883.

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It is important to clarify that ERISA specifically "saves" state insurance regulation but exempts employee benefit plans from regulation as insurance.[24] For example, the U.S. Supreme Court, in *Shaw v. Delta Airlines, Inc.*, held that New York's Human Rights Law forbidding discrimination in employee benefit plans on the basis of pregnancy, and its Disability Benefits Law requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy, were preempted by ERISA because they "relate to" employee benefit plans.[25] In contrast, the Supreme Court, in *Metropolitan Life Insurance Co. v. Massachusetts*, held that a Massachusetts statute requiring certain minimum mental-health-care benefits to be provided to Massachusetts residents insured under a general health insurance policy or employee benefit plan was not preempted by ERISA so far as it applied to the insurance policy and not the employee benefit plan itself.[26]

By the late 1980s, courts were broadly interpreting ERISA's "relate to" language to preempt state-based tort liability for tortious administration of employee benefits.[27] Examples include *Pilot Life Insurance Co. v. Dedeaux* (Supreme Court held that a Mississippi common-law cause of action arising from "improper processing of a claim for benefits" was preempted by ERISA),[28] and *Corcoran v. United Healthcare, Inc.* (U.S. District Court for Eastern District of Louisiana held that ERISA preempts a state-based tort claim against an MCO and limits recovery for the death of a newborn to the costs of the care recommended by the plaintiff's physician and denied by the utilization reviewer).[29]

With respect to the preemption of state-based tort claims against benefit plan administrators and MCOs, the *Corcoran* case established a standard that would hold for several years.[30] An example of the reach of the *Corcoran* rationale can be seen in the Eighth Circuit's holding in *Kuhl v. Lincoln National Health Plan*.[31] In *Kuhl*, the plaintiff was denied bypass surgery on the grounds that it was determined medically unnecessary.[32] The plaintiff was awarded benefits upon adjudication, but had progressed to the point of needing a transplant.[33] The plaintiff died while adjudicating the transplant issue, and

24. 29 U.S.C. § 1144 (2000).

25. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-98 (1983).

26. Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739-746 (1985).

27. Wayne Blackmon, *The Emerging Convergence of the Doctrine of Informed Consent and the Judicial Reinterpretation of the Employee Retirement Income Security Act*, 19 J. LEGAL MED. 377, 380 (1998).

28. 481 U.S. 41 (1985).

29. 965 F.2d 1321 (5th Cir. 1992).

30. Blackmon, *supra* note 27, at 381.

31. 999 F.2d 298 (8th Cir. 1993).

32. *Id.* at 300.

33. *Id.*

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the benefit plan was found liable only for costs of care denied.[34] By the time of the *Kuhl* case, ERISA had come to be recognized as a basis for dismissing state-based tort claims against plan administrators and MCOs that were based on wrongful denial of benefits or wrongful interference with benefits.[35]

B. Erosion of the ERISA Preemption

For over two decades, MCOs and plan administrators have relied on ERISA preemption and an almost literal interpretation of its "relate to" language to "insulate themselves from inflamed state court juries relying upon state statutory or common law bad faith doctrines and special interest groups or active insurance commissioners who sought to undermine the uniformity of the benefit programs of multistate employers."[36] While the ERISA preemption clause has received intense judicial scrutiny almost since its inception,[37] several Supreme Court decisions in the mid-1980s justified such reliance by virtue of their broad interpretation and application of the preemption.[38]

By the mid 1990s, however, the Court began indicating dissatisfaction with its previously liberal interpretation of ERISA's "relate to" language (as established in the *Shaw* line of cases), thus signaling the beginning of a gradual erosion of the ERISA preemption.[39] In three cases commonly referred to as the "Travelers Trilogy"[40]—*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,[41] *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*,[42] and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund* [43]—the Court seized upon language in *Shaw* indicating that "some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan."[44]

34. *Id.* at 300-01.

35. Blackmon, *supra* note 27, at 381.

36. Edward A. Scallet, *ERISA Preemption—Is it Still a Viable Doctrine?* (Jan. 6, 1999), *at* http://www.insurancelegal.com/erisa199.htm (last visited Oct. 6, 2002).

37. Ochmann, *supra* note 13, at 582-83. *See also* Torrin A. Dorros & T. Howard Stone, *Implications of Negligent Selection and Retention of Physicians in the Age of ERISA*, 21 AM. J.L. & MED. 383, 401 (1995). In 1992, Justice Stevens reported that "[a] recent LEXIS search indicated that there [were] . . . over 2,800 judicial opinions addressing ERISA pre-emption," District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 135 n.3 (1995).

38. Scallet, *supra* note 36 (citing Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) and Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1985)).

39. Blaire S. Osgood, Note, *The Treachery of the ERISA Preemption: Ceci N'est Pas Une Benefits Determination*, 81 B.U. L. REV. 867, 871 (2001).

40. *Id*.

41. 514 U.S. 645 (1995).

42. 519 U.S. 316 (1997).

43. 520 U.S. 806 (1997).

44. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983).

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First, in *Travelers*, commercial insurers of ERISA plans challenged a New York State rate scheme that imposed surcharges on hospital and HMO rates for ERISA plan participants for purposes of funding a Blue Cross rate program.[45] The Court rejected the Second Circuit's holding that the surcharges "related to" ERISA plans because they imposed an economic burden on plan administration,[46] and instead adopted the position that Congress did not intend to preempt state law and, therefore, "clear and manifest" congressional intent would be required before federal preemption of state action in areas of "traditional state regulation" would be allowed.[47]

Examining ERISA's "relate to" language, the Court in *Travelers* hypothesized that "really, universally, relations stop nowhere,"[48] and, as such, almost any state law could be deemed to relate to ERISA. That being the case, the Court determined that ERISA preemption should be determined in light of the "objectives" of the ERISA statute, rather than its "unhelpful" text.[49] Upon examination of the Congressional Record, the Court concluded that "the basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[50] Applying such rationale to the facts at hand, the Court concluded that the New York State surcharge on ERISA plan hospital and HMO rates was an indirect influence that could affect a benefit plan's shopping decisions, but the surcharge would not bind plan administrators to any particular choice. As such, the Court held that the New York State law did not "relate to" ERISA because the surcharge did not preclude uniform benefit plan administration or the provision of a uniform interstate benefit package if a plan wished to provide one.[51]

Two years later, the Court handed another victory to the states in *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*[52] Continuing its dramatic shift from a broad, literal interpretation of the term "relates" as used in Section 514 of ERISA, to a more narrow interpretation focused on the impact of state law on the structure and choices of an ERISA benefit plan,[53] the Court considered a California statute that permits contractors to pay less than the prevailing wage to apprentices

45. *Travelers Ins. Co.*, 514 U.S. at 649.

46. *Id*. at 654.

47. *Id*. at 654-55.

48. *Id.* at 655 (quoting HENRY JAMES, RODERICK HUDSON, at xli (1980)).

49. *Id*. at 656.

50. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995).

51. *Id.* at 659.

52. 519 U.S. 316 (1996).

53. Blackmon, *supra* note 27, at 381.

who are enrolled in state-approved apprenticeship programs.[54] The Court said that while the California law has an economic impact on ERISA plans, such economic impact is too tenuous a relationship to justify preemption of a state law.[55] Significantly, the Court's opinion in *Dillingham* advances the presumption that Congress did not intend to preempt state law in areas of traditional state regulation.[56]

Finally, in *DeBuono*, the Supreme Court went a step further and held that even a direct tax on an ERISA plan does not require a finding of preemption of state law.[57] According to the Court, the party advancing a theory of ERISA preemption "bear[s] the considerable burden of overcoming the starting presumption that Congress does not intend to supplant state law."[58] In stark contrast to pre-*Travelers* cases (where MCOs typically could rely on the courts to preempt claims of medical malpractice and negligence against MCOs based on the theory that such claims "related to" ERISA benefit plans), *DeBuono* reinforces the emerging commitment of the Court to preserve state law in areas of traditional state regulation, including the practice of medicine.[59]

The *Travelers* line of cases clearly represents a dramatic shift in the Court's application of ERISA preemption to state law. While one can justifiably conclude that, prior to the *Travelers* cases, courts began with a presumption that ERISA preempts state law, it seems clear that defendants in post-*Travelers* actions must present clear evidence that the state law at issue conflicts with ERISA in order to obtain preemption.

C. The Quality vs. Quantity Distinction

Injured patients seeking tort recovery from MCOs for the alleged actions or omissions of affiliated hospitals and/or physicians (that is, vicarious liability) have benefited from the continued weakening of the ERISA preemption clause.[60] In *Dukes v. U.S. Healthcare, Inc.*,[61] the Third Circuit consolidated two federal district court cases alleging medical malpractice.[62] One of the lower court cases involved a widowed spouse's claim that her

54. *Dillingham Construction*, 519 U.S. at 319. While apprenticeship programs are not traditionally thought of as a "benefit," ERISA specifically states that they are covered by the act, and subject to all its requirements.

55. *Id.* at 334.

56. *Id.*

57. DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund. 520 U.S. 806, 809 (1997).

58. *Id.* at 814.

59. Osgood, *supra* note 39, at 874.

60. Please note that vicarious liability, as a cause of action against MCOs, is discussed in greater detail in Part III of this Article.

61. 57 F.3d 350 (3d Cir. 1995).

62. *Id.* at 351.

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husband's death was due to the refusal of a hospital to perform a blood test,[63] and the other alleged that an MCO was vicariously liable for the failure of its network physicians to diagnose and treat a condition which caused an infant to be delivered stillborn.[64]

After U.S. Healthcare was sued under state law (in both lower court cases cited above), it removed the cases to federal court, arguing that each case was completely preempted by ERISA.[65] U.S. Healthcare contended that removal was proper because treatment had been provided as a benefit under an ERISA plan, and resulting state law claims relating to such plans must be completely preempted.[66] In each case, the district court agreed and dismissed the plaintiff's state law claims.[67]

Interestingly, the threshold issue considered in *Dukes* was procedural in nature. In determining whether it was proper to remove the state cases to federal court, the Court first considered whether the cases "arise under" federal law.[68] The Court noted that the question of whether a case arises under federal law is made by examining the plaintiff's complaint (the so-called "well-pleaded complaint rule"), and, therefore, removal based on a federal defense ordinarily would not be proper.[69] However, the Court went on to recognize that in certain circumstances, "Congress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character."[70] The Supreme Court has determined that the "complete preemption" doctrine applies to state law claims that "fit within the scope of ERISA's civil enforcement provisions."[71]

Next, continuing its trend of strong reliance on Congressional intent when examining ERISA preemption issues, the *Dukes* Court reasoned that Congress intended to preempt state law claims concerning denial of benefits under ERISA plans ("quantity of benefits"), but did not intend to regulate or control issues regarding the *quality of benefits* received.[72] Examining the facts of the consolidated cases, the Court concluded that the state law claims involved quality of care received rather than recovery of benefits due under the plan. As

63. Dukes v. U.S. Healthcare Sys., Inc., 848 F. Supp. 39, 40 (E.D. Pa. 1994).

64. Visconti v. U.S. Healthcare, 857 F. Supp. 1097, 1099 (E.D. Pa. 1994).

65. *Dukes*, 57 F.3d at 352-353.

66. *Visconti*, 857 F. Supp. at 1100-01.

67. *Dukes*, 848 F. Supp. at 42; *Visconti*, 857 F. Supp. at 1105.

68. *Dukes*, 57 F.3d at 353.

69. *Id.* at 353-54.

70. *Id*. at 353.

71. Phyllis C. Borzi, *Distinguishing Between Coverage and Treatment Decisions Under ERISA Health Plans: What's Left of ERISA Preemption?*, 49 BUFF. L. REV. 1219, 1249 (2001).

72. Karla S. Bartholomew, Note, *ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation*, 52 VANDERBILT L. REV. 1131, 1158 (1999) (citing *Dukes*, 57 F.3d at 356).

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such, the Court held that removal of the state law claims to federal court was improper because the cause of action was not completely preempted.[73]

Unfortunately for MCOs, the Court in *Dukes* did not offer guidance to distinguish claims for denial of benefits from quality of care claims.[74] Further, because the doctrine of "complete preemption" is inevitably raised each time an MCO seeks to remove a state law malpractice claim to federal court based on ERISA preemption, post-*Dukes* courts have increasingly relied on the ambiguous quality versus quantity distinction.[75]

As noted above, the ability of plaintiffs to avoid preemption of state malpractice claims opens the door to punitive and compensatory damage awards otherwise unattainable under ERISA. The "quality vs. quantity" distinction established in *Dukes*, as well as the failure of the Court to articulate a clear standard for making such a distinction, leaves MCOs exposed to malpractice liability in any number of circumstances, especially those where failure to provide a service can be characterized as either negligence ("quality of care") or benefit denial ("quantity of care").

D. Rush-Prudential HMO, Inc. v. Moran and its Implications for ERISA Preemption

The Supreme Court's recent decision in *Rush-Prudential HMO, Inc.* has been termed "perhaps the most important ERISA preemption case to ever come before the Supreme Court."[76] The *Rush* case "highlights the continuing struggle courts have in defining concise and predictable boundaries as to the scope of [ERISA] preemption of state laws,"[77] and "will encourage more state regulation and . . . trigger lawsuits on how far states can go to protect patients from [adverse MCO benefit decisions]."[78]

In a 5-4 ruling on June 20, 2002, the Court held that ERISA does not preempt an Illinois law requiring independent review when an HMO and a patient disagree over whether a course of treatment is medically necessary.[79] In a "major victory for HMO members and states' rights,"[80] the Court reasoned

73. *Dukes*, 57 F.3d at 356-57. The Third Circuit remanded the case to district court with instructions to send the cases to state court for trial on the issue of vicarious liability of the MCO for the actions of its health care providers. *Id.* at 361.

74. Bartholomew, *supra* note 72, at 1158.

75. *Id.* at 1158-59 (citing Schmid v. Kaiser Found. Health Plan, 963 F. Supp. 942, 944 (D. Or. 1997); Hoyt v. Edge, No. 97-3631, 1997 U.S. Dist. LEXIS 8846, at *4-7 (E.D. Pa. June 19, 1997); Roessert v. Health Net, 929 F. Supp. 343, 349-50 (N.D. Cal. 1996)).

76. Mark D. DeBofsky, Moran v. Rush-Prudential HMO, Inc.—*The New Paradigm of ERISA Preemption*, *at* http://www.debofsky.com/moran-article.html (last visited Dec. 26, 2002).

77. Michaels and Bowen, *supra* note 11, at 24.

78. Marcia Coyle, *HMO Outlook: More Court Action*, NAT'L L.J., June 24, 2002, at A1.

79. Rush Prudential HMO, Inc., v. Moran, 122 S. Ct. 2151, 2170-71 (2002).

80. *ERISA Preemption: Rush Prudential HMO v. Moran*, HEALTH L. LITIG. REP., June 2002, at 3.

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that independent state review panels are exempt from federal preemption because HMOs are insurance companies subject to state regulation.[81]

1. *Procedural Background.* In this case, Rush-Prudential HMO, Inc. denied coverage to Debra Moran, an Illinois resident, for a requested shoulder surgery procedure. Ms. Moran opted to obtain surgery through an out-of-network provider at her own expense, incurring medical expenses in excess of $94,000.[82] Ms. Moran then sued Rush in state court under the Illinois Health Maintenance Organization Act ("Illinois HMO Act") which requires HMOs to (a) submit to independent physician review where there is disagreement between plan and beneficiary over whether a course of treatment is medically necessary, and (b) to comply with the decision of the independent physician reviewer.[83]

Rush removed the case to federal court on the grounds that Moran's claim was preempted by ERISA and contended that the case should be decided in accordance with ERISA's civil enforcement provision. The district court remanded the case to state court, however, after ruling that Moran's request for independent physician review under state law would not require interpretation of the terms of the benefit plan (that is, it was not a "quantity" or "coverage" determination) and thus her cause of action was not "completely preempted."[84] On remand, the state court ordered Rush to submit to an independent physician reviewer in accordance with Illinois law, who in turn found that Ms. Moran's surgery was, in fact, "medically necessary" (based on the language of Ms. Moran's insurance certificate as well as the reviewer's own medical judgment).[85] Nevertheless, Rush's medical director rejected the decision of the independent physician review and denied Moran's claim.[86]

Next,

> Moran amended her complaint in state court to seek reimbursement for [her] surgery as "medically necessary" under [the Illinois] HMO Act, [whereupon] Rush [once] again removed [the case] to federal court [on the grounds] that Moran's amended complaint stated a claim for ERISA benefits (a "quantity" or "coverage" claim) and was thus completely preempted by ERISA's civil enforcement provisions.[87]

The federal district court granted Rush's motion for summary judgment and Moran appealed to the Seventh Circuit.[88]

81. *Rush*, 122 S. Ct. at 2160-62.
82. *Id*. at 2156-57.
83. *Id.* at 2157.
84. *Id*.
85. *Id*.
86. *Rush*, 122 S. Ct. at 2157.
87. *Id*. at 2157-58.
88. *Id*. at 2158.

The Court of Appeals for the Seventh Circuit acknowledged that ERISA "broadly preempts" state law which "relates to" employee benefit plans, but noted that state laws which "regulate insurance" are "saved" from ERISA preemption.[89] In reversing the lower court, however, the Seventh Circuit concluded that the state independent physician review provision was part of the insurance contract between Rush and Moran and did not constitute a forbidden "alternative remedy" to the civil enforcement provisions of ERISA.[90] The Court of Appeals reasoned that the Illinois HMO Act did not "authorize any particular form of relief in state courts; rather, with respect to ERISA [] health plan[s], the judgment of the independent reviewer is only enforceable in an action brought under ERISA's civil enforcement scheme."[91]

2. *Supreme Court Decision*. In a 5-4 decision, the Supreme Court affirmed the decision of the Seventh Circuit, holding that the Illinois HMO Act is not preempted by ERISA because: (a) the state law qualifies as a regulation of insurance and thus is specifically "saved" from preemption,[92] and (b) the Illinois HMO Act's independent physician review provision for coverage disputes regarding medical necessity does not provide a remedy that conflicts with those available under the civil enforcement provisions of ERISA.[93]

In determining that the Illinois HMO Act qualified as an insurance regulation, the majority opinion (written by Justice David H. Souter) spent significant time explaining that, while many HMOs act as both providers and insurers, nothing in the ERISA "saving" clause[94] requires an either/or choice between provider and insurer when considering questions of state law preemption.[95] As a result, if "providing insurance fairly accounts for [] application of [the] state law, the [ERISA] saving clause may apply" and preemption will not stand.[96] According to the majority, it is unrealistic to think of HMO-style organizations without their insurance element, and thus preemption of the Illinois law's independent review provision would be contrary to ERISA's "saving" clause.[97]

89. *Id*.

90. *Id*.

91. *Rush*, 122 S. Ct. at 2158.

92. *Id*. at 2160-63.

93. *Id*. at 2170. We should note that, in the wake of *Rush*, the Supreme Court already ordered the Fifth Circuit Court of Appeals to reconsider its decision regarding Texas' external review law in *Montemayor v. Corporate Health Insurance, Inc.*, 122 S.Ct. 2617 (2002). In June 2002, the Supreme Court "directed the Fifth Circuit Court of Appeals to reconsider its decision in [*Montemayor*]." *The U.S. Supreme Court Last Week Directed the Fifth Circuit Court of Appeals to Reconsider Its Decision in* Montemayor v. Corporate Health Insurance, Inc., MANAGED CARE WK., July 1, 2002, at 8.

94. See *supra* notes 14-35 and accompanying text.

95. *Rush*, 122 S. Ct. at 2160.

96. *Id*.

97. *Id*.

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Rejecting Rush's alternative argument that the Illinois law should be preempted on the grounds that it creates an impermissible alternative remedy that conflicts with ERISA's exclusive remedies (Rush actually argued that the independent physician review provision amounted to a de facto binding arbitration provision), the Court held that because the independent review is limited to medical necessity decisions, it is more akin to a second opinion and far removed from any notion of an enforcement scheme.[98] Further, the court argued that the state law does not create any form of ultimate relief that conflicts with the type of relief obtainable in an ERISA proceeding and, as such, the state law is not categorically preempted.[99]

3. *Analysis*. In his dissenting opinion, Justice Clarence Thomas warns that the ruling in *Rush* "eviscerates" the uniformity of ERISA remedies because some 40 other states have similar laws, though [such laws] vary as to applicability, procedures, standards, deadlines and consequences of independent review."[100] According to the dissent (joined by Chief Justice Rehnquist, Justice Scalia and Justice Kennedy), "allowing disparate state laws that provide inconsistent external review requirements to govern" a plan participant's claim to benefits "is wholly destructive of Congress' expressly stated goal of uniformity in this area."[101]

Indeed, it is interesting to note that in *Travelers*, the case which can be viewed as the beginning of the erosion of ERISA preemption, the Court specifically noted that Congressional intent would be the key to ERISA preemption decisions and that "the basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[102] Just as *Travelers* represented a departure from the *Shaw* line of cases (a move from a literal interpretation of ERISA's "relate to" language to a focus on Congressional intent), *Rush* appears to have established yet another framework for preemption decisions. Instead of focusing on Congressional intent, the key to preemption decisions now appears to be whether the state law at issue establishes a new cause of action or provides for a form of relief inconsistent with ERISA's civil enforcement provisions.[103] The only theme that appears to

98. *Id*. at 2168-69.

99. *Id*. at 2167.

100. *Rush*, 122 S. Ct. at 2178.

101. *Id*.

102. N.Y. State Conference Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655-57 (1995). For a full discussion of *Travelers*, see *supra* notes 45-51 and accompanying text.

103. To illustrate this point, though in a light considerably more favorable to MCOs, see *Sprecher v. Aetna U.S. Healthcare, Inc.*, No. 02-CV-00580, 2002 U.S. Dist. WL 1917711 (E.D. Pa. Aug. 19, 2002). In *Sprecher*, which was decided two months after the Supreme Court's decision in *Rush*, U.S. District Judge Ronald L. Buckwalter refused to follow a colleague's recent

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be consistent is that the courts will consistently force MCOs to overcome a strong presumption against preemption of state law.

While the long-term impact of *Rush* is still open for debate, many feel that the Supreme Court's decision will have a strong negative impact on managed care. Elliot B. Pollack, co-chairman of Pullman & Comley's health care section (Hartford, CT) states that "[t]he language of the decision is an open invitation to other forms of state legislation which, five years ago, one would have said would be trampling on ERISA proscriptions."[104] According to Sharon J. Arkin, an attorney who filed an amicus brief supporting Moran on behalf of the California Consumer Health Care Council, the *Rush* decision will impact state law in that it will give individual states an idea as to how far they can go with external review statutes. Ms. Arkin states that approximately 50% of independently reviewed HMO denials are reversed in California.[105] The Washington, D.C.-based Health Benefits Coalition, which represents employers, announced its opinion that the *Rush* decision deals "a blow in the battle to control the already soaring costs of health care."[106] After *Rush*, it is clear that MCOs and their medical directors will have to consider their standards for discretionary coverage decisions. Uniformity in plan administration, the stated goal of ERISA, appears to be unattainable in light of the courts' inability to adequately define the scope and parameters of ERISA preemption.

III. GENERAL THEORIES OF LIABILITY

Generally speaking, individuals or entities failing to exercise reasonable care in the medical treatment of patients can be held liable for injuries that result from such negligence.[107] Applying this principle in the managed care context, MCOs often can be held liable under state common law (qualified, of course, by ERISA's preemption clause) not only for their own negligence, but

decision allowing ERISA plaintiffs to pursue claims under Pennsylvania's bad faith statute. *Id.* at *3. Judge Buckwalter reasoned that the Pennsylvania bad faith law (which authorized punitive damages and interest penalties) "would significantly expand the potential scope of ultimate liability imposed upon employers by the ERISA scheme." *Id.* at *7. Buckwalter went on to hold that "because Pennsylvania's bad faith statute provides a form of ultimate relief in a judicial forum that adds to the judicial remedies provided by ERISA, it is incompatible with ERISA's exclusive enforcement scheme." *Id.*

104. Coyle, *supra* note 78, at A9.

105. *Id*.

106. David G. Savage, *A Second Opinion*, A.B.A. J., Aug. 2002, at 36.

107. Angela M. Easley, Comment, *A Call to Congress to Amend ERISA Preemption of HMO Medical Malpractice Claims: The Dissatisfactory Distinction Between Quality and Quantity of Care*, 20 CAMPBELL L. REV. 293, 303-04 (1998) (citing RESTATEMENT (SECOND) OF TORTS § 283 (1965)).

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also for the negligence of their health care providers.[108] The two main theories of MCO malpractice liability are direct liability and vicarious liability.[109]

A. Direct Liability

In direct liability causes of action, plaintiffs attempt to overcome ERISA preemption by seeking to hold MCOs liable for their own actions or omissions, as opposed to the actions or omissions of the MCO's agents.[110] Direct liability theories generally can be divided into two categories: (1) corporate negligence and (2) contract-based theories (including breach of contract, breach of warranty and fraud).[111]

1. Corporate Negligence

While common law principles of negligence have been applied to hospitals for quite some time,[112] only recently have courts extended the doctrine of institutional or corporate negligence to MCOs.[113] Underlying the tort of corporate negligence is a recognition of the comprehensive role of MCOs in the provision of health care services to their members, as well as a belief that MCOs should have "corresponding corporate responsibilities."[114]

In other words, corporate negligence is a theory that creates a non-delegable duty owed directly to the patient.[115] Under such theory, MCOs owe a duty of care to their patients "to maintain safe and adequate facilities and equipment; to select and retain competent[] [health care providers]; to oversee all persons who practice medicine; and to formulate, adopt and enforce adequate rules and policies to ensure quality care for its patients."[116] A plaintiff seeking to recover damages under a theory of corporate negligence must show that MCOs are, in effect, practicing medicine in that they (a) are active managers of patient care, and (b) have influence over "physicians'

108. *Id.* at 304.

109. *Id*.

110. Christine E. Brasel, Comment, *Managed Care Liability: State Legislation May Arm Angry Members With Legal Ammo to Fire at Their MCOs For Cost Containment Tactics . . . But Could it Backfire?*, 27 CAP. U. L. REV. 449, 464 (1999).

111. James F. Henry, Comment, *Liability of Managed Care Organizations After* Dukes v. U.S. Healthcare: *An Elemental Analysis*, 27 CUMB. L. REV. 681, 702 (1996)

112. *See, e.g.*, Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E. 2d 253 (Ill. 1965).

113. *See,e.g.*, Jones v. Chicago HMO Ltd. of Ill., 730 N.E.2d 1119, 1128 (Ill. 2000); Shannon v. McNulty, 718 A.2d 828 (Pa. Super. Ct. 1998).

114. *Jones*, 730 N.E.2d at 1128.

115. Richard C. Miller, *Breaking Down the Wall (ERISA): Theories of Recovery Against HMOs*, *at* http://www.mmmpalaw.com/CM/Articles/ articles27.asp (last visited Sept. 5, 2002).

116. Anna M. Bamonte & Linda S. Hackett, *HMO Liability Presents Risks to Physicians*, PHYSICIAN'S NEWS DIGEST (Jan. 1999), *at* http://www.physiciansnews.com/law/898.html (last visited Sept. 5, 2002).

medical treatment decisions." Plaintiffs also must prove that their injuries were caused directly by the negligence of the MCO.[117]

In the 1998 case *Shannon v. McNulty*, "Pennsylvania became the first jurisdiction to hold a managed care plan directly liable for its own . . . corporate negligence."[118] In *Shannon*, the plaintiff utilized an HMO-provided emergency care telephone service staffed by triage nurses to obtain advice regarding abdominal pains and other symptoms the plaintiff believed were associated with preterm labor.[119] After first ordering the plaintiff to consult with her Ob-Gyn, the HMO's telephone service staff responded to the plaintiff's repeated requests for additional treatment by directing her to undergo a back examination.[120] Ultimately, the plaintiff was admitted to a hospital for a back exam, but delivered a baby who died two days later due to severe prematurity.[121]

The plaintiff in *Shannon* brought suit against the HMO, asserting claims of vicarious and direct liability under the corporate negligence doctrine.[122] Specifically, the plaintiff alleged that the HMO breached its duty to oversee that the dispensing of advice by its telephone triage nurses would be performed in a medically reasonable manner.[123] The court relied on *Thompson v. Nason Hospital*[124] which, in the context of considering a hospital's negligence, stated four general areas of corporate liability including "a duty to oversee all persons who practice medicine within its walls as to patient care."[125] In extending this duty to MCOs, the *Shannon* court compared "the corporate hospital's role in the total health care of its patients" to the "central role played by HMOs in the total health care of its subscribers."[126]

Importantly, the court in *Shannon* held that when an HMO provides health care services, rather than just paying for those services, it has a non-delegable duty to render the medical decisions affecting a subscriber's care in a "medically reasonable" manner.[127] Further, when an MCO makes a decision to limit a subscriber's access to treatment, "that decision must pass the test of

117. Miller, *supra* note 115.

118. Emmanuel O. Iheukwumere, *Application of the Corporate Negligence Doctrine to Managed Care Organizations: Sound Public Policy or Judicial Overkill?*, 17 J. CONTEMP. HEALTH L. & POL'Y 585, 609 (2001). *See* Shannon v. McNulty, 718 A.2d 828 (Pa. Super Ct. 1998)

119. *Shannon*, 718 A.2d at 832.

120. *Id*.

121. *Id*.

122. *Id*. at 834.

123. *Id*.

124. 591 A.2d 703 (Pa. 1991).

125. *Id*. at 707.

126. *Shannon*, 718 A.2d at 835.

127. *Id*. at 835-36.

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medical reasonableness."[128] Perhaps most ominous for MCOs, however, the *Shannon* court stressed "HMOs may, under the right circumstances, be held corporately liable for *any* of the *Thompson* duties which causes harm to its subscribers."[129] The other *Thompson* duties are: (1) the duty to maintain "safe and adequate facilities and equipment" for patients; (2) the "duty to select and retain only competent physicians"; and (3) the "duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for patients."[130]

In 2000, the Illinois Supreme Court followed Pennsylvania's lead in *Jones v. Chicago HMO Ltd. of Illinois*, where plaintiff was insured through defendant Chicago HMO.[131] At the time of the incident at issue, plaintiff was assigned a particular primary care physician by her HMO, and such physician had undertaken treatment of plaintiff's infant daughter (despite the fact that the physician was the primary care physician for at least 6000 patients).[132] When plaintiff telephoned her physician (as instructed by her HMO) to describe symptoms her daughter had developed, the physician neglected to recommend hospitalization and instead advised giving castor oil to the child.[133] The next day, plaintiff took her daughter to an emergency room because the infant's symptoms had not improved.[134] The baby was diagnosed with bacterial meningitis and was permanently disabled as a result of the illness.[135]

The plaintiff in *Jones* filed complaints against both the primary care physician and the HMO, including a charge of corporate negligence against Chicago HMO for, inter alia, (1) negligently assigning an overloaded physician as the child's primary care physician, and (2) negligently adopting procedures that required plaintiff to contact her primary care physician before visiting his office or seeking emergency care.[136] Chicago HMO made no argument against the extension of corporate negligence to HMOs, and the court concluded that "the law imposes a duty upon HMOs to conform to the legal standard of reasonable conduct in light of the apparent risk."[137] To fulfill this duty, according to the *Jones* court, an HMO must act as would a "reasonably careful" HMO under the circumstances.[138]

Managed care organizations also need to be cognizant of legislative initiatives to negate ERISA preemption by extending direct liability to MCOs.

128. *Id*.
129. *Id*. at 836 (emphasis added).
130. *Id*. at 831.
131. *Jones*, 730 N.E.2d 1119, 1123 (Ill. 2000).
132. *Id*. at 1125.
133. *Id*. at 1123.
134. *Id*.
135. *Id*.
136. Jones v. Chicago HMO Ltd. of Ill., 730 N.E.2d at 1122-24.
137. *Id.* at 1129.
138. *Id*.

In California, for example, the Managed Health Care Insurance Accountability Act of 1999[139] (which applies to services rendered or treatments denied after January 1, 2001) has as its stated purpose the protection of "persons covered by employer-sponsored health and disability plans by ensuring that health care providers rather than HMOs are in charge of patient care."[140]

The California statute makes HMOs liable for their own coverage decisions as well as coverage decisions made by any party they contract with, such as third party administrators or doctors.[141] It imposes a duty of ordinary care upon the HMO to arrange for the provision of "medically necessary health services to its subscribers and enrollees, where the health care service is a benefit provided under the plan."[142] The plan also is

> liable for any and all harm legally caused by its failure to exercise ordinary care when both of the following apply: (1) the failure to exercise ordinary care resulting in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee; and (2) the subscriber or enrollee suffered substantial harm.[143]

The California statute does provide one safe harbor for HMOs. It requires the subscriber or enrollee to exhaust the HMO's independent review procedure prior to bringing suit unless he or she can demonstrate that substantial harm has occurred or will imminently occur prior to the completion of the independent review.[144] Alternatively, a participant may use California's independent review process for treatment denials that are based on medical necessity where the health care service is otherwise eligible for coverage under the plan.[145]

One area of direct liability which likely will see increased litigation is corporate negligence in provider selection or supervision (negligent credentialing and negligent retention of providers).[146] Credentialing is the means by which an MCO verifies a provider's qualifications and reputation prior to adding him or her to its provider panel and is one of many mechanisms utilized by MCOs to provide quality care while controlling costs. By instituting a thorough and complete credentialing system, MCOs minimize the risk that subscribers will look to it to collect damages when the subscriber is

139. CAL. CIV. CODE § 3428 (West Supp. 2002).

140. Beckman, Davis, Smith & Ruddy, L.L.P., *New Legislation and Statutory Amendments*, *at* http://www.beckmandavis.com/articles.htm (last visited Sept. 5, 2002).

141. CAL. HEALTH & SAFETY CODE § 1374.30(b) (West Supp. 2002).

142. CAL. CIV. CODE § 3428(a) (West Supp. 2002).

143. *Id.* § 3428(a)(1)-(a)(2).

144. *Id.* § 3428(k)(1).

145. *Id.*

146. Henry, *supra* note 111, at 701 (citing Joanne B. Stern, *Malpractice in the Managed Care Industry*, 24 CREIGHTON L. REV. 1285, 1289-90 (1991)). *See also* Thompson v. Nason Hosp., 591 A.2d 703 (Pa. 1991).

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injured due to the malpractice of a provider which the MCO held out to be qualified.

Negligent credentialing and supervision claims typically are brought together with ostensible agency claims for medical malpractice, "because to prevail in a claim of negligent . . . [credentialing] or [negligent] supervision, the plaintiff must first prove that the provider performed a negligent act."[147] Thus while a plaintiff generally will face a "double hurdle" of proving negligence by both the provider and the MCO,[148] courts have specifically held that MCOs have a duty to conduct "reasonable investigation[s]" of the physicians available to MCO enrollees to determine their competence and reputation in the medical community.[149] Further, at least one court has rejected an HMO's attempt to remove a negligent credentialing case to federal court via ERISA's preemption clause, finding that the negligent credentialing complaint "attacked the quality of services rendered" by the HMO, and that state court was a proper forum because the plaintiff's claim "fall[s] outside the scope of ERISA."[150]

MCOs also face potential liability from suits brought by providers claiming they were wronged in the credentialing process (wrongful termination of membership). Unlike other areas of corporate negligence, however, MCOs can find certain protections from this type of liability in federal and state credentialing laws. Such "peer review" immunity laws are a "powerful defense for credentialing entities and an almost insurmountable hurdle to individual health care providers."[151]

The primary source of peer review immunity is the Health Care Quality Improvement Act of 1986 ("HCQIA")[152] Enacted to encourage health care entities to conduct meaningful review of their providers, HCQIA provides almost complete immunity to claims for monetary damages arising from credentialing/peer review actions.[153] To qualify for immunity under HCQIA, not only must an MCO report certain adverse actions against providers to the

147. Henry, *supra* note 111, at 701.

148. *Id*.

149. McClellan v. Health Maint. Org. of Pa., 604 A.2d 1053, 1053 (Pa. Super. Ct. 1992).

150. Dykema v. King, 959 F. Supp. 736, 741 (D.S.C. 1997).

151. Michael J. Baxter, *A Potent Weapon: Federal Peer Review Immunity Under HCQIA*, *available at* http://www.bbsclaw.com/art_05.htm. (last visited Sept. 7, 2002).

152. *Id*. (citing 42 U.S.C. §§ 11101-11152). In addition to federal immunity under HCQIA, many states have peer review statutes providing corresponding immunities. In certain instances, state laws may confer even broader immunities than HCQIA (for example, the Indiana Peer Review Act confers confidentiality on records and determinations of peer review committees). Sherry A. Fabina-Abney & Christopher S. Sears, *Why Do Managed Care Organizations Do Credentialing*, NAT'L ASS'N MED. STAFF SERVICES J., Spring 1996, *available at* http://www.icemiller.com/resource_center/publications.html#health) (last visited Dec. 26, 2002).

153. Baxter, *supra* note 151.

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National Practitioner Data Bank,[154] but it must provide a complete array of due process rights to providers whose membership is denied, modified, suspended or terminated.[155]

An MCO's decision to deny, modify, suspend or terminate a provider's membership must be taken: (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved, and (4) in the reasonable belief that the action was warranted by the facts known after the investigation and hearing.[156] In addition, except for emergency situations, MCOs must provide certain notice and hearing procedures to physicians prior to making decisions which would adversely affect a provider's membership.[157]

The immunity provisions of HCQIA are extremely broad. It protects the MCO's credentialing committee members and any other MCO committee-members engaged in credentialing-related activities.[158] The immunity can "halt suits against an MCO by a physician adversely affected by a credentialing decision including suits for defamation, abuse of process, malicious prosecution, antitrust and tortious interference with contractual relations."[159] In fact, there is a statutory presumption of immunity which courts have indicated must be rebutted by the party opposing the motion raising the immunity defense.[160]

In light of the extension of corporate negligence to MCOs as evidenced by the decisions in *Shannon* and *Jones*, as well as the proliferation of various patients' rights initiatives throughout the United States, MCOs likely can expect further judicial and legislative efforts to extend corporate negligence principles traditionally applied to hospitals. While corporate negligence, as it applies to MCOs, is still the exception rather than the rule, MCOs should consider undertaking risk management initiatives in line with the duties

154. This is a national data bank established to store malpractice claim and disciplinary history for health care providers.

155. Fabina-Abney & Sears, *supra* note 152.

156. 42 U.S.C. § 11112(a) (1994).

157. Fabina-Abney & Sears, *supra* note 152. *See* 42 U.S.C. §§ 11112(b)-11112(c) (1994). These subsections essentially require that physicians be notified of a proposed adverse action. Such notice must indicate that the physician has the right to a hearing; and that the physician must be notified of hearing rights and which witnesses will be called. *Id.* These subsections also dictate who can be the decision-maker at the hearing, right to counsel and cross-examination rights. *Id.*

158. Jerry S. Sobelman, *Managed Care Credentialing of Physicians*, PHYSICIAN'S NEWS DIG., June 2001, *available at* http://physiciansnews.com/business/601sobelman.html (last visited Dec. 26, 2002). *See also* Fabina-Abney & Sears, *supra* note 152.

159. Fabina-Abney & Sears, *supra* note 152.

160. Baxter, *supra* note 151 (citing Goodwich v. Sinai Hosp. of Balt., 680 A.2d 1067 (Md. 1996)).

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enumerated in *Thompson v. Nason Hospital* (discussed *supra*), as well as ensuring that they comply with any availability "immunities" such as that set forth in HCQIA.[161]

2. Contract-Based Theories

The relationship between an MCO and its enrollees is essentially one of contract.[162] MCOs may be exposed to liability for breach of contract or warranty for failing to provide benefits or pay claims that the MCO is obligated to provide under the terms of the agreement between the MCO and the enrollee.[163] Breach of contract claims generally are brought by plaintiffs seeking to hold MCOs directly liable for provider negligence.[164] While the majority of direct negligence claims against MCOs assert some form of breach of contract claim, ERISA preemption has proven to be a major hurdle for plaintiffs.[165] Nevertheless, where plaintiffs are able to prove bad faith denial of bargained-for services, they may be successful in obtaining punitive and compensatory damages, attorneys' fees and interest.[166]

Courts have held that MCOs have a legal duty to "deal fairly and in good faith with [subscribers], and when [they] refuse to do so without proper cause, [they are] liable for damages flowing therefrom."[167] In *McEvoy v. Group Health Cooperative of Eau Claire*,[168] for example, the Wisconsin Supreme Court considered an HMO's denial of a subscriber's inpatient psychological care benefits, which were specifically provided for in the subscriber agreement.[169] The court noted that HMO subscribers are similar to insurance policyholders in that they are in a weak bargaining position vis-à-vis their HMO and, as such, may face bureaucratic and procedural hurdles in asserting their contractual rights.[170] Given such similarities between HMOs and traditional insurance companies, the court extended Wisconsin's common law tort of bad faith to HMOs in an effort to ensure that "HMOs do not give cost

161. *See supra* notes 122-30 and accompanying text.

162. Brasel, *supra* note 110, at 466.

163. Stephen S. Rosenfeld, *Managed Care Liability: Review and Update*, *available at* http://www.rosenfeld.com/Articles/mcl.htm, (last visited Sept. 3, 2002).

164. *Id*.

165. Ochmann, *supra* note 13, at 601.

166. *See, e.g.*, Williams v. Health Am., 535 N.E.2d 717 (Ohio Ct. App. 1987) (HMO can be liable for bad faith benefits decision); Birth Ctr. v. St. Paul Co., Inc., 787 A.2d 376 (Pa. 2001) (compensatory damages available).

167. Richard A. Spector, *Managed Health Care Liability Issues*, 32 CUMB. L. REV. 311, 325 (2001-2002) (citing Rederscheid v. Comprecare, Inc., 667 P.2d 766 (Colo. Ct. App. 1988)).

168. 570 N.W.2d 397 (Wis. 1997).

169. *Id*. at 400.

170. *Id*. at 402.

containment and utilization review such significant weight so as to disregard the legitimate medical needs of subscribers."[171]

The *McEvoy* court held that to prevail on a bad faith tort claim asserted against an HMO, a plaintiff must plead sufficient facts to show (1) "the absence of a reasonable basis for the HMO to deny a plaintiff's claim for [contracted services, and (2)] that the HMO, in denying such claim, either knew or recklessly failed to ascertain that the coverage or care should have been provided."[172] "When a bad faith breach occurs, the HMO is liable for any damages which are the proximate result of that breach."[173] Should the plaintiff prove by clear and convincing evidence that the HMO acted with fraud, oppression or malice, then punitive damages apply.[174]

Managed care organizations also should be aware that subscribers are not the only potential class of plaintiffs eligible to bring breach of contract claims against them. In *McLachlan v. Louisiana Health Service and Indemnity Co.*,[175] Judge Ivan L.R. Lemelle of the Eastern District of Louisiana held that a claim for breach of contract by a third-party medical provider does not arise under ERISA.[176]

In *McLachlan*, a physician brought a breach of contract claim against Blue Cross and Blue Shield of Louisiana ("Blue Cross"), alleging that Blue Cross refused to pay for services rendered by the physician.[177] Blue Cross removed the case to Federal District Court, claiming that it fell "within the scope of ERISA."[178]

In remanding the case back to the First City Court of Orleans Parish, Judge Lemelle reasoned that "ERISA [only] preempts the state law if the plaintiff's claim 'relates to' an employee benefit plan."[179] In this case, observed Lemelle, the plaintiff's claims for breach of contract against Blue Cross did not address a beneficiary's right to receive benefits under the terms of a plan.[180] Further, since plaintiff is a medical provider, his claim does not affect the relationship between traditional ERISA parties.[181] As such, Judge Lemelle held that the plaintiff physician's claim did not "relate to" an employee benefit plan and was not preempted by ERISA.[182]

171. *Id*. at 403.
172. *Id*. at 405 (citations omitted).
173. *McEvoy*, 570 N.W.2d at 405 (citations omitted).
174. *Id*.
175. No. 02-0424, 2002 U.S. Dist. LEXIS 12558 (E.D. La. July 3, 2002).
176. *Id*. at *5.
177. *Id*. at *1.
178. *Id*. at *2.
179. *Id*. at *5 (citation omitted).
180. *McLachlan*, 2002 U.S. Dist. LEXIS 12558, at *4.
181. *Id*. at *6-7.
182. *Id*. at *5.

Bad faith usually implies that an MCO should have performed a function or honored an agreement, but did not. The *McEvoy* case and others like it reinforce the importance of ensuring that coverage and contractual decisions are based on established policies and procedures that apply to all enrollees and providers, and that such policies are strictly followed. Services that are not covered should be communicated clearly in plan descriptions and other materials provided to enrollees, and only services that are covered and available under the plan should be promoted.

B. Vicarious Liability

Vicarious liability is an agency principle which makes the master liable for the tortious acts of his servant, despite the fact that the master has not himself acted negligently.[183] Particularly applicable to malpractice actions (as discussed briefly in our analysis of the *Dukes* case *supra*), vicarious liability can be subdivided into theories of respondeat superior and apparent/ostensible agency.[184]

1. Respondeat Superior

Under the doctrine of respondeat superior, an employer is vicariously liable for the tortious acts of an employee acting within the scope of his or her employment.[185] The general theory behind this doctrine is that if employers are held liable for the negligent acts of employees, employers will have an incentive to invest time and resources into exercising appropriate levels of supervision and control over their agents, or instituting prevention measures necessary to reduce risk to acceptable levels.[186]

A plaintiff seeking to hold an MCO liable for a physician's (or other provider's) malpractice on a theory of respondeat superior must prove that the physician was an employee of the MCO rather than an independent contractor and that the employee's tortious behavior fell within the scope of his employment.[187] While an MCO model which directly employs physicians, nurses and/or other healthcare workers (e.g., staff model HMO) is particularly susceptible to respondeat superior liability, courts generally will focus on the degree of control the MCO exercises over the provider (as opposed to whether

183. Brasel, *supra* note 110, at 460 (citing Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 452 (1997)).

184. *See supra* notes 61-75 and accompanying text.

185. RESTATEMENT (SECOND) AGENCY § 267 (1958).

186. Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, Class Actions and The Patient's Bill of Rights*, 30 J. LEGAL STUD. 625, 636-37 (2001).

187. Brasel, *supra* note 110, at 461 (citing William E. Milks, Annotation, *Liability of Health Maintenance Organizations (HMOs) for Negligence of Member Physicians*, 51 A.L.R. 5th 271 (1997).

an official 'employment" relationship exists) when determining whether respondeat superior liability is appropriate.[188]

Given the myriad of formal and informal "relationships" that may exist between healthcare providers and MCOs, it is not always easy for claimants to prove employment relationships for purposes of establishing MCO liability under a theory of respondeat superior. However, it is not necessary to prove that an MCO has "actual control" over a provider in order to be successful in a respondeat superior claim; rather, the MCO must be "in a position to control the physician."[189]

When deciding whether an MCO has the requisite amount of control over a provider such that respondeat superior liability would attach to the MCO, courts often will consider the manner of physician selection, physician discharge rights (that is, provider de-selection), quality control mechanisms instituted by the MCO, and the form of compensation paid to the provider.[190] Active and comprehensive utilization review mechanisms, for example, are evidence of an MCOs intent to exercise control over physician treatment decisions.[191]

With respect to compensation, and absent other mitigating factors, fee-for-service arrangements (payment for each service provided by the physician pursuant to a contract negotiated between the MCO and the physician at arm's length) are indicative of an independent contractor relationship.[192] In contrast, physicians receiving salary or capitation payment compensation from an MCO generally are regarded as employees. In a typical salary arrangement, such as a staff-model HMO, the managed care organization institutes certain cost-control mechanisms and physicians are motivated to adhere to such mechanisms in order to retain their jobs and salaries.[193] This degree of control over physician decision-making is also evident in capitation payment arrangements (fixed sum payment to physician for each patient per month in return for providing all medically necessary service), as physicians have an incentive to increase their profits by providing only truly necessary services.[194]

2. Ostensible Agency

Even where an independent contractor relationship is found to exist between an MCO and a provider, however, the MCO may, in certain circumstances, be found liable on an ostensible agency theory. This doctrine

188. *Id.* (citing O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047, 1049 (1995)).

189. *Id*. (citing Zamora, *supra* note 183, at 1050).

190. Henry, *supra* note 111, at 701. *See also* Sullivan, *supra* note 22, at 259.

191. Henry, *supra* note 111, at 701.

192. *Id*.

193. Sullivan, *supra* note 22, at 260.

194. *Id*. at 260-61.

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provides that, where an organization (an HMO or other managed care organization) "represents" that a healthcare provider is an agent or employee of the organization, and causes a patient to rely on that representation when submitting to care, the organization will be held liable for tortious acts of the healthcare provider, regardless of the fact that an independent contractor relationship actually exists between the organization and the provider.[195]

As opposed to respondeat superior claims, the key issue in ostensible agency matters is not the degree of control the MCO exercises over the provider, but rather how the relationship between the MCO and the provider is represented to the health plan member.[196] In *Boyd v. Albert Einstein Medical Center*,[197] for example, the court reversed a summary judgment order granted to an HMO on a state wrongful death claim, specifically noting that the HMO advertised its physicians as "gatekeeper[s] into the health care delivery system,"[198] and held itself out in printed materials as a "total care program which not only insures its subscribers, but *provides medical care, guarantees the quality of the care* and controls the costs of health care services."[199]

The leading vicarious liability case is *Dukes*, which involved an ostensible agency claim (as well as claims for corporate negligence in selecting, screening, monitoring and supervising personnel) alleging vicarious liability of an MCO for provider malpractice. As noted in our discussion of *Dukes* above, such malpractice claims may be viewed by courts as "quality of care" actions rather than denial of benefits (or, alternatively, "quantity of care") actions, and thus not subject to ERISA preemption. The impact of all of this is that plaintiffs can now use vicarious liability theories to expose MCOs to punitive and compensatory damages for the malpractice of affiliated health care providers.

C. Breach of Fiduciary Duty

Managed care organizations use a variety of mechanisms designed to control costs while at the same time ensuring that patients receive appropriate, high-quality medical care. Most MCO litigation results from the use of such

195. *See, e.g.*, Elsesser v. Hosp. of Philadelphia Coll., 802 F. Supp. 1286, 1290 (E.D. Pa. 1992).

196. *See* Epstein & Sykes, *supra* note 186, at 639. Epstein and Sykes state:

> The paradigm case here would be one in which the public is led to believe that an impecunious independent contractor is in fact an employee of another entity, so that the apparent employer's assets would be available to satisfy a judgment in the event of carelessness by the apparent employee.

Id.

197. 547 A.2d 1229 (Pa. Super. Ct. 1988).

198. *Id.* at 1235.

199. *Id.* at 1232 (emphasis added). It is interesting to note, however, that this statement was made in a marketing document aimed at employers, and not plan members. *Id.*

mechanisms (for example, use of utilization review systems to ensure that medical care is necessary; establishment of protocols for pre-authorization of medical services, and financial incentives paid to physicians for reducing costs).

When use of cost-control mechanisms results in denial of necessary medical care, MCOs can, in certain instances, be sued under a theory of vicarious liability. It is generally well-established that ERISA preemption is not applicable in medical malpractice (or "quality of care") cases.[200]

If an MCO's own corporate/administrative malfeasance leads to patient injury, MCOs could be subject to suit under various direct liability theories. However, as addressed previously, direct liability is still the exception rather than the rule (despite apparent trends indicating that this may not be the case for long), so plaintiffs face the hurdle of overcoming ERISA's preemption clause which was designed to provide health care plans with freedom in administrative decision-making.[201]

One more theory of MCO liability used by plaintiffs in their attempts to circumvent ERISA preemption of state law is that of breach of fiduciary duty.[202] In furtherance of its stated purpose of establishing uniform rules for benefit plan administration, ERISA includes certain fiduciary duty provisions.[203] For a plaintiff alleging breach of fiduciary duty to succeed in a case against an MCO, the plaintiff must establish that: (1) the MCO is a health plan fiduciary; (2) the MCO breached its fiduciary duty, and (3) "that a cognizable injury resulted."[204]

Fiduciary responsibility under ERISA is simply stated. The statute provides that fiduciaries shall discharge their duties with respect to a health plan "solely in the interest of the participants and beneficiaries."[205] A fiduciary is required to discharge his duties with respect to a benefit plan for the exclusive purpose of (1) providing benefits to participants and their beneficiaries, and (2) defraying reasonable expenses of administering the benefit plan.[206] In addition, fiduciaries must discharge their duties "with the care, skill, prudence, and diligence . . . that a prudent man acting in a like capacity . . . would use in the conduct of [a similar plan]."[207]

All of this, of course, begs the questions of whether an MCO can be considered a plan fiduciary under ERISA and, if so, what are the practical

200. *See, e.g.*, Dukes v. United States Health Care Systems of Pa., Inc., 57 F.3d 350 (3d Cir. 1995).

201. Edward P. Richards, *Pre-emption After* Pegram, NAT'L L.J., June 18, 2001, at B8.

202. Sullivan, *supra* note 22, at 256.

203. *See* Pegram v. Herdrich, 530 U.S. 211, 224 (2000).

204. Ochmann, *supra* note 13, at 602.

205. *Pegram*, 530 U.S. at 223 (citing 29 U.S.C. § 1104(a)(1) (2000)).

206. 29 U.S.C. § 1104(a)(1)(A) (2000).

207. 29 U.S.C. § 1104(a)(1)(B) (2000).

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implications for such organization? The leading case under the breach of fiduciary duty theory is *Pegram v. Herdrich*.[208] The decision in *Pegram* addressed the key issue of "whether treatment decisions made by [HMOs], acting through their physician employees, are fiduciary acts within the meaning of [ERISA]."[209] In the process of ruling that HMOs can provide certain financial incentives to network physicians without running afoul of ERISA's fiduciary provisions, the Court actually might have narrowed the scope of ERISA's preemption clause beyond the already stringent standard established in *Dukes*.[210]

The *Pegram* case arose out of treatment provided to Herdrich by Dr. Lori Pegram, a physician-owner of an HMO.[211] Dr. Pegram found a large mass in Herdrich's abdomen and concluded it was an inflamed appendix.[212] Rather than scheduling a diagnostic ultrasound at a local hospital, Herdrich alleged that Dr. Pegram was motivated by financial incentives to delay the procedure for eight days in order to have it take place in an HMO-owned facility more than fifty miles away.[213] In the interim, Ms. Herdrich's appendix ruptured.[214]

Specifically, the Supreme Court considered Herdrich's allegations that the HMO's practice of providing year-end bonuses to its physician-owners based on the difference between the cost of providing medical care and HMO revenues created an improper incentive for such physicians to limit treatment.[215] Herdrich, attempting to avoid ERISA preemption by suing under ERISA itself, argued that the HMO's bonus policy constituted an inherent or anticipatory breach by the HMO of an ERISA fiduciary duty, since the terms of the bonus policy created an incentive for physicians to make treatment decisions in their own self-interest, rather than in the exclusive interest of benefit plan participants.[216]

After undertaking an analysis of the core principles of managed care,[217] the Court recognized that no MCO "could survive without some [form of] incentive connecting physician reward with treatment rationing."[218] The Court went on to note that "inducement to ration care goes to the very point of any

208. *Pegram*, 530 U.S. at 211.

209. *Id.* at 214.

210. Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After* Pegram v. Herdrich: *The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 29 (2001).

211. *Pegram*, 530 U.S. at 215.

212. *Id*.

213. *Id*.

214. *Id*.

215. Louis Saccoccio, *Pegram's Significance for Managed Health Care*, YALE J. HEALTH POL'Y, L. & ETHICS 195, 196 (2001).

216. *Pegram*, 530 U.S. at 223.

217. *Id*. at 233-34.

218. *Id*. at 220.

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HMO scheme," and that "whatever the HMO, there must be rationing and inducement to ration."[219] Reasoning that Congress, through its encouragement of HMOs, had long sanctioned such rationing of care, the Court was unable to justify application of ERISA's fiduciary standards to rationing decisions.[220] If fiduciary standards were applied, according to the Court, any decision based on cost rather than the best interest of the patient would be a violation of ERISA.[221] Finding that there was no reason to believe that Congress intended such a result, the Court held that rationing decisions could not be subject to ERISA's fiduciary rules.[222]

After concluding that an MCO's provision of financial incentives to physicians in an effort to control costs could not be a fiduciary act under ERISA, the Court took up the question of whether, in the course of administering the health benefits plan, certain acts of the HMO physicians were fiduciary in nature and, if so, whether such actions were improperly motivated by the MCO's monetary incentive scheme.[223] In its analysis, the Court focused on two types of arguably administrative acts: (1) pure "eligibility decisions,"[224] which turn on the plan's coverage of a particular condition or medical procedure for its treatment, and (2) "treatment decisions," which are choices about how to go about diagnosing and treating a patient's condition.[225]

In the Court's majority opinion, Justice Souter notes that "eligibility" decisions often "cannot be untangled from physicians' judgments about reasonable medical treatment," and that "[eligibility and treatment] decisions are often practically inextricable."[226] The Court believed that the medical decisions made in Ms. Herdrich's case offered a prime example of such "mixed eligibility and treatment decisions."[227] In *Pegram*, the treating physician decided that "Herdrich's condition did not warrant immediate action" ("treatment decision"); the consequence of such decision was a medical determination that the HMO "would not cover immediate care" ("eligibility decision").[228] According to the Court, the eligibility and treatment decisions in *Pegram* were "inextricably mixed, as they are in countless medical administrative decisions every day."[229]

219. *Id*. at 221.
220. *Id*. at 228.
221. *Pegram*, 530 U.S. at 228.
222. *Id*. at 229.
223. *Id*. *See also* Borzi, *supra* note 71, at 1261.
224. "Eligibility" decisions are also often referred to as "coverage" decisions.
225. *Pegram*, 530 U.S. at 228-29.
226. *Id*.
227. *Id*. at 229.
228. *Id*.
229. *Id*.

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Turning once again to Congressional intent, the Court expressed doubt that Congress intended for MCOs to be treated as fiduciaries to the extent they make mixed treatment-eligibility decisions through their physicians.[230] Comparing common law fiduciary duties with the types of decisions involved in *Pegram*, the Court reasoned that common law "fiduciary duties characteristically attach to decisions about managing assets and distributing property to beneficiaries," while the types of decisions made by HMOs (through their physicians) typically involve whether or not to provide medical care.[231] "[W]hen Congress took up the subject of fiduciary responsibility under ERISA," according to the Court, "it concentrated on fiduciaries' financial decisions" rather than the types of fiduciary duties alleged by Ms. Herdrich.[232]

Based on the reasoning detailed above, the Court ultimately concluded that neither pure "treatment" decisions nor mixed treatment-eligibility decisions made by physicians are acts of plan administration and, therefore, ERISA's fiduciary rules did not apply to such decisions.[233] Only "pure eligibility" decisions will be considered subject to ERISA's fiduciary duty provisions.[234]

The practical effect of the *Pegram* decision is that most typical MCO functions remain beyond the reach of ERISA's fiduciary obligations.[235] While pure "treatment" decisions remain subject to state regulation (see this Article's analysis of medical malpractice actions set forth *supra*), state efforts to regulate MCOs in their capacity as plan administrator are preempted.[236]

At first glance, *Pegram* appears to be a major victory for MCOs (and some would argue that it is).[237] There is debate as to whether *Pegram* actually has narrowed the scope of ERISA's preemption of state laws regulating MCOs.[238] While the Court in *Pegram* found that financial incentives provided to physicians to control medical utilization and expenses are fundamental to the operation of managed care and thus are clearly allowed under ERISA, the "key issue may be how tightly the plan controls [physician] decision-making."[239] If, for example, an MCO utilized pre-approval mechanisms for the provision of

230. *Pegram*, 530 U.S. at 231.

231. *Id*.

232. *Id.* at 232.

233. *Id*. at 235-36.

234. *Id*. at 236. *See also* Borzi, *supra* note 71, at 1263.

235. Borzi, *supra* note 71, at 1263.

236. McLean & Richards, *supra* note 210, at 29.

237. S*ee, e.g.,* Saccoccio, *supra* note 215, at 195 (arguing that *Pegram* "is a significant victory for managed health plans, their network physicians, and their members," and "does not represent a shift in the law regarding HMO coverage decisions."). Mr. Saccoccio is General Counsel to the American Association of Health Plans.

238. *See, e.g.*, McLean & Richards, *supra* note 210, at 30 (arguing that *Pegram* "appears to be a Pyrrhic victory for the HMO industry").

239. *See* Richards, *supra* note 201, at B8.

medical care (or any other arrangement to prospectively affect the care of an individual), this could be seen as a direct intervention of the MCO into medical decision-making and would defeat ERISA preemption.[240] MCO's choosing to manage medical decision-making, either directly or through "branded" medical groups (i.e., medical groups held out by the MCO to be agents of the MCO), face the enormous administrative burden of dealing with fifty different state laws regarding medical malpractice and fiduciary duty.[241]

The ultimate reality of *Pegram*, then, is that it encourages MCOs to avoid direct management of individual patient care, instead transferring such responsibility to individual physicians. By shifting decision-making risk to the physicians, MCOs can take full advantage of ERISA preemption of state law. The question for MCOs, of course, is how best to transfer such responsibility without losing control over costs.[242]

IV. RICO AND MANAGED CARE CLASS ACTIONS

When Congress enacted the Racketeer Influenced and Corrupt Organization Act ("RICO")[243] in 1970, its primary goal was to utilize the law to eradicate organized crime from the legitimate business community. However, in the years following its enactment, RICO has been used against legitimate businesses that were not in any way connected with organized crime. The Supreme Court put its stamp of approval on this practice in *Sedima, S.P.R.L v. Imrex Co.*,[244] when it held ruled that RICO is not limited to organized crime and may be applied to legitimate businesses.[245]

Section 1962 of RICO prohibits any person from, among other things, acquiring or maintaining through a pattern of racketeering activity an interest in an enterprise affecting interstate commerce, conducting or participating in the conduct of the affairs of an enterprise affecting interstate commerce through a pattern of racketeering activity, or conspiring to participate in any of these activities.[246] In addition, section 1962(a) prohibits the investment or improper use of money obtained from racketeering activity.[247]

Racketeering is any scheme or artifice to defraud associated with a pattern of at least two predicate acts, which are interrelated and are not isolated events. Therefore, the courts require plaintiffs to show the existence of an enterprise in

240. *Id*.

241. McLean & Richards, *supra* note 210, at 30-31.

242. Some suggest that capitation payment is one effective means for transferring risk while maintaining cost control, because physicians have a set "per patient" budget which cannot be exceeded without penalty. *See* Richards, *supra* note 201, at B8.

243. 18 U.S.C. §§ 1961-1968 (2000).

244. 473 U.S. 479, 499 (1985).

245. *Id*. at 499.

246. 18 U.S.C. § 1962(a) (2000).

247. *Id.*

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proving that defendant(s) engaged in racketeering activity. An enterprise under RICO includes any group of individuals, partnerships, corporations, associations or other legal entities.[248] Generally, the enterprise "must exist independently from the racketeering activity that it engages in and must have some structure for the making of decisions and some mechanism for controlling and directing the affairs of the group on an on-going, rather than ad hoc, basis."[249] Typically, when the RICO defendant is a legal entity, the plaintiff can easily prove the existence of an enterprise because "proof that the entity in question has a legal existence satisfies the enterprise element."[250]

As in every other civil action, a plaintiff in a RICO claim must first establish standing to sue. A RICO plaintiff has standing when the plaintiff can demonstrate that, as a result of defendant's actions, plaintiff suffered an injury to business or property.[251] In addition, bringing suit under section 1962(b) requires the plaintiff to show that defendant's actions were indictable under a separate federal criminal statute.[252] On the other hand, in order to plead a 1962(a) claim, a plaintiff must allege that he or she suffered an injury as a result of defendant's use of racketeer income.[253] In both cases, defendant's action must have been the proximate cause of the plaintiff's injury.[254] Section 1962(c) of RICO authorizes recovery of up to treble damages for any prevailing plaintiff in a civil RICO action; any person injured in "his business or property by reason of a violation of section 1962" may bring a civil action in federal court against the violator.[255] In addition to the treble damage recovery, a private plaintiff that prevails on a RICO claim is also entitled to recover the cost of filing the suit and reasonable attorney's fees.[256] As such, RICO presents an attractive and very powerful tool to use against MCOs.

With the general onslaught of litigation against MCOs, class actions suit based on RICO claims were almost inevitable. In *Humana Inc. v. Forsyth*,[257] the Supreme Court opened the door for beneficiaries of MCOs to bring civil actions under RICO by holding that the McCarran-Ferguson Act did not bar

248. 18 U.S.C. § 1961(4) (2000).

249. Simon v. Value Behavioral Health, Inc., 208 F.3d 1073, 1083 (9th Cir. 2000).

250. Jaguar Cars, Inc. v. Royal Oaks Motor Car Co., 46 F.3d 258 (3d Cir. 1995) ("A corporation is an entity legally distinct from its officers or employees, which satisfies the enterprise definition.").

251. 18 U.S.C. § 1962(c); *Sedima*, 473 U.S. at 496.

252. *Sedima*, 473 U.S. at 497 ("any recoverable damages occurring by reason of a violation of 1962(c) will flow from the commission of the predicate acts"). *See also* Beck v. Prupis, 529 U.S. 494, 506-07 (2000).

253. *Simon*, 208 F.3d at 1083.

254. Holmes v. Sec. Investor Prot. Corp., 503 U.S. 258, 265-68 (1992).

255. 18 U.S.C § 1964(c) (2000).

256. *Id*.

257. 525 U.S. 299 (1999).

plaintiffs from bringing civil RICO claims against HMOs.[258] The reason for this, the Court stated, is that RICO typically provides stiffer penalties for fraud, namely, up to treble damages, and therefore, advances the interests of the states in combating insurance fraud.[259] The Court observed that the key factor for determining whether a RICO suit would impair state law in contravention of the McCarran-Ferguson Act was the existence of a state-sanctioned private right of action.[260] The state law in question in *Humana* allowed for private causes of action for insurance fraud.[261]

Following the *Humana* decision, there was a wave of class action suits filed against MCOs alleging RICO violations. The plaintiffs in these suits have experienced a number of difficulties in maintaining their suits against MCOs, including difficulties establishing standing, proving the predicate acts necessary to support a RICO claim, or—the *Humana* decision notwithstanding—showing that maintaining a private cause of action does not violate relevant state law.

A. The McCarran-Ferguson Limitation

American Chiropractic Association v. Trigon Healthcare, Inc.[262] involved a group of individual doctors and a chiropractic association who alleged extortion and conspiracy to eliminate the practice of chiropractic medicine by way of an MCO's exclusion of such services from its health insurance policies.[263] The plaintiffs then alleged violations of federal laws, including RICO, as well as violations of the Virginia Insurance Code.[264] The court found that the state law in question, unlike that in *Humana*, limited the private rights of action for insurance claims, and therefore, allowing the plaintiffs to bring a RICO cause of action against the insurance company "would not only 'impair' the [state] regulation but would [also] 'supercede' the state law at issue" in violation of the McCarran-Ferguson Act.[265]

B. Establishing Predicate Acts

In *Wagner v. Magellan Health Services, Inc*.,[266] the plaintiff was a psychiatrist who sued a managed care organization under a variety of theories, including RICO, claiming that he had been "blacklisted" by the defendant "because he insisted on procedures and treatments for patients [that the

258. *Id*. at 311.
259. *Id*. at 313, 314.
260. *Id*. at 310.
261. *Id*. at 303.
262. 151 F. Supp. 2d 723 (W.D. Va. 2001).
263. *Id.* at 727, 728.
264. *Id*. at 728.
265. *Id.* at 735 (quoting United States Dep't of Treasury v. Fabe, 508 U.S. 491, 501 (1993)).
266. 125 F. Supp. 2d 302 (N.D. Ill. 2000).

defendant MCO] did not [want] to cover."[267] To support his RICO claim, plaintiff alleged that defendant had committed extortion in violation of the Hobbs Act and wire fraud by threatening to cancel a contract with the hospital for whom plaintiff worked if plaintiff persisted in "making trouble."[268] In addition, plaintiff alleged that the defendant MCO pressured the hospital into using other psychiatrists, other than the plaintiff, for patients covered under defendant's insurance.[269] The court found that plaintiff's allegations failed to satisfy the requirement of the Hobbs Act because he had no right to treat any of the denied patients and thus no right to the fees that plaintiff claimed were being extorted through the MCO's threats of canceling its contract with the hospital.[270] The court, therefore, dismissed the case on motion since plaintiff could not establish the predicate acts to support the RICO claim.[271]

C. The Standing Issue

Among the first wave of cases filed after the *Humana* decision was *Maio v. Aetna Inc*.,[272] certified as a class action on behalf of "[then] present and former Aetna HMO members who, as a group, were targeted by Aetna and induced into enrolling in Aetna's HMO."[273] Although the plaintiffs alleged a variety of "criminal" acts to satisfy the requirements of RICO, their main allegation was that the defendant HMO had committed fraud (wire fraud and insurance fraud) by falsely representing that its members would receive "high quality health care from physicians who [would be] solely responsible for . . . maintaining the physician-patient relationship,"[274] when, in fact, the HMO's policy was to restrict a physician's ability to provide high quality health care. In addition, plaintiffs alleged that defendant HMO had misrepresented the extent of the coverage that would be provided under the plan and, as a result, plaintiffs were induced to enroll in defendant's health care plan.[275] The RICO injury, plaintiffs claimed, was the diminishment in the market value of the health care plans, as a result of defendants' undisclosed agreement with plaintiffs' health care providers restricting coverage.[276]

The court disagreed and dismissed the case on defendant's motion, and the trial court's decision was later upheld on appeal.[277] It found that plaintiffs had

267. *Id*. at 303.
268. *Id*. at 305.
269. *Id*.
270. *Id*. at 306.
271. *Wagner*, 125 F. Supp. 2d at 308.
272. 221 F.3d 472 (3d Cir. 2000).
273. *Id*. at 474 (internal quotations omitted).
274. *Id*. at 475.
275. *Id*. at 480.
276. *Id*. at 484.
277. *Maio*, 221 F.3d at 474.

not pleaded enough facts to support the allegation that they had suffered a present injury since plaintiffs could not point to specific instances where plaintiffs had "suffered negative medical consequences resulting from Aetna's enactment of the policies and practices at issue."[278]

In the court's view, plaintiffs' claims of injury rested solely on factual speculation as to whether their contracts would have been breached had they requested benefits.[279] The court found that plaintiffs' property interest in the HMO was "not a tangible property interest, like a plot of land," but rather was merely a "contractual right to receive benefits in the form of covered medical services."[280] The court cited Judge Kleinfeld's dissenting opinion in *Oscar v. University Students Co-Operative Association*[281] for the proposition that, where property interests are in the form of contractual rights, economic injury could not stem from a reduction in value.[282] The court held that plaintiffs' insurance policy was a contract, and, therefore, the court concluded that any injuries that plaintiffs might have suffered would have to be resolved under contract law.[283] Plaintiff could only prove an injury by alleging facts to show that the defendant HMO had breached its agreement with plaintiff by providing less service than they had contracted for.

In *Simon v. Value Behavioral Health, Inc.*,[284] the Ninth Circuit reached a similar conclusion to that of the Third Circuit in *Maio*. It found that plaintiff failed to allege sufficient facts to establish a claim under section 1962(a) of the RICO Act because plaintiff could not establish that he had been driven out of business or harmed in any direct way as a result of defendants' use or investment of income from racketeering activity.[285] Similarly, plaintiff's 1962(c) and 1962(d) claims could not stand because plaintiff did not allege, and could not establish the existence, of an enterprise among the defendants.[286] The court found that '"a conspiracy is not an enterprise for . . . purposes of RICO;'"[287] rather, plaintiff must prove that an enterprise existed independent of the racketeering activity and had a structure for controlling and directing decisions.

278. *Id*. at 487-88.
279. *Id*. at 495.
280. *Maio*, 221 F.3d at 488, 489.
281. 965 F.2d 783, 788 (9th Cir. 1992) (Kleinfeld, J., dissenting).
282. *See Maio*, 221 F.3d at 489-90.
283. *Oscar*, 965 F.2d at 789.
284. 208 F.3d 1073 (9th Cir. 2000).
285. *Id*. at 1083.
286. *Id*. at 1084.
287. *Id*. at 1083 (quoting Chang v. Chen, 80 F.3d 1293, 1300 (9th Cir. 1996)).

The violations alleged in *In re Managed Care Litigation*[288] are almost identical to those alleged in *Maio*. Unlike the *Maio* and the *Simon* courts, however, Judge Moreno, in *In re Managed Care*, found that the plaintiffs had alleged sufficient facts to establish standing to sue under the RICO Act.[289] Judge Moreno disagreed with the *Maio* court's "dichotomy between property interests and contracts and [the conclusion] that the subscriber plaintiffs . . . possessed only contractual [interests] . . . in their insurance coverage."[290] To Judge Moreno, "the *Maio* court took an overly restrictive view of property rights and overlooked the distinction between business-related torts and contract breaches."[291] Plaintiffs' claim was for fraudulent inducement, '"an independent tort in that it requires proof of facts separate and distinct from the breach of contract.'"[292] In the court's view "a person whose property is diminished by a payment of money wrongfully induced is injured in his [or her] property" as required by the RICO statute.[293] As for the speculative nature of plaintiffs' injuries, the court found that the tortious injury was suffered at the time they enrolled in the plans and that it was not necessary to wait until the defendant MCOs denied coverage before allowing the suit to stand.[294]

On February 20, 2002, Judge Moreno dismissed with prejudice all of the RICO claims for ten of the sixteen subscriber track plaintiffs.[295] While the court found that all of the plaintiffs had adequately pled claims under RICO, the court found that the McCarran-Ferguson Act required dismissal with prejudice of the claims of ten of the subscriber track plaintiffs because the Act prohibits federal lawsuits that encroach on state regulatory decision making.[296] Since the laws regulating the insurance industry in Florida, New Jersey, California and Virginia, where those ten plaintiffs lived, did not provide

288. 150 F. Supp. 2d 1330 (S.D. Fla. 2001). There have been a number of reported interim orders in this case on different issues; the latest decision was *In re Managed Care Litigation*, Nos. MDL 1334, 00-1334MDMORENO, 2002 WL 1359736 (S.D. Fla. Mar. 25, 2002).

289. *In re Managed Care*, 150 F. Supp. 2d at 1339.

290. *Id*. at 1338.

291. *Id.*

292. *Id.* (quoting HTP, Ltd. v. Lineas Aereas Costarricenses, S.A., 685 So. 2d 1238, 1239 (Fla. 1997)).

293. *Id*. (citing *Bennett v. Berg*, 685 F.2d 1053, 1058 (8th Cir. 1981), for the proposition that a plaintiff has standing to sue under RICO where plaintiff alleges an injury "not so much that the contractual terms have been breached, but that the value of the contract is different than appellants were led to expect through extracontractual statements and promises"). *See In re* Merrill Lynch Ltd. P'ships Litig., 154 F.3d 56 (2d Cir. 1998).

294. *In re Managed Care*, 150 F. Supp. 2d. at 1339.

295. American Association of Health Plans, *Judge Moreno Rules on Motions to Dismiss in Subscriber Track*, *available at* http://www.classactioncenter.org/legal/motions.htm (last visited Jan. 10, 2003).

296. *Id*.

private civil remedies for victims of insurance fraud, allowing the RICO claims of those plaintiffs in those states to go forward would encroach on those states' regulatory decision making.[297]

As a result of Judge Moreno's ruling, the remaining claims in the Subscriber Track Cases are

> (1) the RICO claims of those plaintiffs who reside in states that recognize a private cause of action for insurance fraud, (2) all of the ERISA claims alleging interference with physician-patient communication as a breach of fiduciary duty, and (3) the misrepresentation of "medical necessity" breach of fiduciary duty claims of those plaintiffs who no longer subscribe to the defendants' health care plans.[298]

In re Managed Care Litigation, nevertheless, remains a concern for MCOs in that Moreno seems to have disregarded earlier impediments to plaintiff standing. It would appear, then, that so long as RICO plaintiffs can overcome McCarran-Ferguson Act limitations, they have a legitimate chance to receive class certification.

V. EMERGING AREAS OF LIABILITY

Given the general trend towards increased liability for MCOs highlighted throughout this article, certain legal theories of liability which previously presented obstacles to plaintiffs seeking to recover damages from MCOs may receive additional attention from the plaintiffs' bar and the judicial bench. This section focuses on three such areas of "emerging" liability: antitrust, provider deselection and negligent credentialing.

A. Antitrust

Despite the dominance of managed care in a large number of markets, antitrust litigation directly concerning managed care represents only a small percentage of total medical antitrust cases resulting in opinions.[299] Generally speaking, courts have applied antitrust law so as to allow MCOs room to achieve their cost containment and management objectives.[300] There are

297. *Id*.

298. *Id*.

299. Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and The Courts*, 102 COLUM. L. REV. 545, 631 (2002) (Hammer and Sage conducted a comprehensive examination of health care antitrust enforcement between 1985 and 1999).

300. *Id*. at 633. *See, e.g*., Levine v. Cent. Fla. Med. Affiliates, Inc., 72 F.3d 1538 (11th Cir. 1996) (involving suit brought by a physician alleging antitrust violations against a PPO for denying provider panel membership); Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc., 123 F.3d 301 (5th Cir. 1997) (hospital terminated from PPO provider network alleges anticompetitive effects based on fact that PPO subscribers would no longer have the choice of the hospital's services).

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reasons to suspect, however, that managed care antitrust litigation will increase in the future.[301]

In their study of health care antitrust litigation, law professors William M. Sage (Columbia University) and Peter J. Hammer (University of Michigan) indicate that "waves of consolidation" within the managed care industry are leading to levels of horizontal concentration which are likely to draw increased antitrust scrutiny.[302] Furthermore, if economic conditions continue to worsen, MCOs may turn increasingly to exclusive provider networks, prompting heightened antitrust scrutiny even at relatively low levels of economic concentration.[303] Finally, the expansion of managed care into smaller communities and the resulting increase of market concentration likely will expose MCOs and their contracting partners to additional antitrust liability.[304]

One recent case which received a great deal of attention involved allegations of predatory pricing leveled by a health insurer, Coventry Health Care of Kansas, Inc., (hereinafter "Coventry"), against Via Christi Health System, Inc., a Wichita, Kansas based health system that owns a hospital, Via Christi Regional Medical Center, and a health insurer, Preferred Health Systems (hereinafter "Preferred").[305] The case, *Coventry Health Care of Kansas, Inc. v. Via Christi Health System, Inc.*, was heralded by some as "the beginning of a new wave of antitrust actions by health insurers seeking to challenge market conditions they considered disadvantageous."[306]

In *Coventry*, Raytheon Aircraft Company, the third-largest employer in Wichita, was informed by its health insurer, Coventry, that Raytheon's health insurance rates would increase 31% upon renewal of its health plan agreement with Coventry commencing January 1, 2002.[307] Facing such a stiff increase in premiums, Raytheon solicited bids for its health insurance account from Preferred and from Blue Cross of Kansas.[308] After considering all bids and further negotiation with Coventry, Raytheon ultimately awarded its account to Preferred at a cost savings to Raytheon (as compared to the Coventry proposal) of approximately $31 million.[309]

301. Hammer & Sage, *supra* note 299, at 635.

302. *Id*.

303. *Id*.

304. *Id*.

305. Coventry Health Care of Kan., Inc. v. Via Christi Health Sys., Inc., 176 F. Supp. 2d 1207 (D. Kan. 2001).

306. Memorandum from Gardner, Carton & Douglas, to Clients, Health Insurer's Monopolization Attack on Rival Health Plan Fails—Hospital's Lower Price to its Affiliate Health Plan Not Predatory (Jan. 2002) (on file with Saint Louis University Law Journal).

307. *Coventry*, 176 F. Supp. 2d at 1215.

308. *Id*.

309. *Id*. at 1216.

Fearing that its loss of the Raytheon contract would impair its ability to stay in the Wichita market, Coventry filed suit against Via Christi and Preferred challenging the award of the contract to Preferred.[310] Coventry argued that Preferred attempted to monopolize the Wichita "HMO/POS . . . benefit plan" product market,[311] and alleged that Via Christi engaged in predatory pricing by offering Preferred (a subsidiary of Via Christi) a "below cost" reimbursement rate.[312] According to Coventry, this predatory price allowed Preferred to win the Raytheon contract.[313]

In its decision, the *Coventry* court pointed out that a plaintiff claiming attempted monopolization by predatory pricing must prove: "(1) a relevant geographic and product market; (2) specific intent of the defendants to monopolize the market; (3) anti-competitive conduct by the defendants in furtherance of [such] attempt, and (4) the dangerous probability that the defendants will succeed in such attempt."[314] After reviewing a significant amount of evidence, and after considering the analysis of economic experts on each side, the court ultimately concluded that Coventry could not prove any of the four elements required to sustain a claim of predatory pricing, finding instead that Preferred's bid simply reflected, among other things, Preferred's "lower level of physician costs" and Coventry's "higher administrative costs."[315]

Coventry was unable to show antitrust injury by proving anticompetitive effect in the relevant market, as evidence showed that the Wichita area continued to be served by a variety of health insurers after the Raytheon contract was awarded to Preferred. In fact, Coventry remained a viable competitor after it lost the Raytheon contract. [316] Significant for integrated delivery systems, the court noted that despite the affiliation between Via Christi and Preferred, it found nothing unusual in the communications between the two affiliates with respect to the Raytheon contract which would suggest intent to monopolize.[317] Specifically, the court recognized the failure of Coventry to prove "backdoor" communications between Via Christi and Preferred, and noted that the affiliates appeared to operate "independently" and that boards of directors were kept distinct and separate (no overlap of members).[318]

310. *Id*. at 1225.
311. *See id*. at 1222.
312. *Coventry*, 176 F. Supp. 2d at 1223.
313. *Id*.
314. *Id*. at 1227.
315. *Id*. at 1235-36.
316. *Id*. at 1229.
317. *Coventry*, 176 F. Supp. 2d at 1229.
318. *Id*.

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It is clear from *Coventry* that plaintiffs claiming predatory pricing face significant evidentiary hurdles in proving such claims. As managed care encroaches into smaller markets which may be served by only a limited number of insurers, however, it may be easier for plaintiffs to prove anticompetitive injury and irreparable harm.

In a very recent case, *Women's Clinic, Inc. v. St. John's Health System, Inc.*, the Western District of Missouri followed the judicial trend apparent in *Coventry* by once again applying antitrust law in a manner which permitted the MCOs to contain costs and reach their management objectives.[319] Plaintiff, Women's Clinic, Inc. (hereinafter "Women's Clinic"), alleged that St. John's Health Systems, Inc., and St. John's Physicians and Clinics, Inc. (hereinafter "St. John's), a network of health care providers, engaged in anticompetitive behavior in violation of state and federal antitrust laws by integrating its health care network through exclusive contracts and by entering into a Business Covenant with Women's Clinic physicians which prohibited the Women's Clinic physicians from "investing in or operating surgical centers, birthing centers, mammography clinics, or other operations for which the physicians could charge a facility fee."[320]

In *Women's Clinic*, St. John's, in an effort to develop its multi-provider network, purchased Women's Clinic and made the plaintiff physicians employees of St. John's.[321] Pursuant to this agreement, the plaintiff physicians signed covenants not to compete with St. John's if the physicians should leave the St. John's network.[322] For several years, the relationship between the parties was favorable, and Women's Clinic benefited from their affiliations with St. John's.[323] During St. John's restructuring of its network in 1999, St. John's permitted Women's Clinic to repurchase the clinic, without the surgery center and the mammography clinic.[324] As part of the sale, the parties entered a Business Covenant which provided that "for a term of five years, plaintiff physicians could practice medicine in the Springfield area, but could not invest

319. No. 01-3245-CV-S-GAF, 2002 WL 3199212 (W.D. Mo. Nov. 12, 2002). The court's decision has been submitted by the court for publication. Attorney Allen Allred, one of the authors of this article, represented the defendants in this case.

320. *Id.* at *1-2. Through these activities, Women's Clinic claimed that St. John's inhibited competition within the Springfield, Missouri medical community. *Id.*

321. *Id.* at *6.

322. *Id.* The covenants provided that the physicians "would not practice medicine in competition with St. John's within a twenty-five mile radius from St. John's Regional for two years." *Id.*

323. *Id.* at *7. Pursuant to the agreement, Women's Clinic had access to the St. John's network. *Id.* at *6. This access to St. John's network provided Women's Clinic with patient referrals from payors who contracted with the network. *Id.* These payors provided financial incentives to individual patients enrolled in their plans "to see in-network physicians and financial disincentives to see out-of-network physicians." *Id.*

324. *Women's Clinic, Inc.*, 2002 WL 3199212, at *6.

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in or operate any ambulatory surgical center, birthing center, and freestanding lab or diagnostic service clinic including mammography and ultrasound."[325]

The *Women's Clinic* court granted summary judgment on all four counts in St. John's favor.[326] In response to Women's Clinic's first claim that St. John's "exclusive" vertical integration is an unlawful restraint of trade, the court held that Women's Clinic did not demonstrate the necessary showing that the "exclusive agreements between St. John's and its payors actually, detrimentally, impact[ed] competition" or that St. John's had sufficient market power.[327] The court relied on the fact that the agreements were not, in fact, "exclusive" because they did not prohibit its payors from paying individual enrollees for services they receive outside the network and they did not prohibit payors from leaving St. John's network to contract with a competitor network.[328]

The court denied Women's Clinic's second count that the Business Covenant between plaintiffs and St. John's acted as a horizontal market allocation in violation of antitrust laws.[329] According to the court, the Business Covenant was ancillary to the Transition Agreement associated with the sale of the clinic to plaintiffs, and was necessary for the plaintiff physicians to practice medicine and to "ensure a successful transition from employees to affiliates" for Women's Clinic.[330]

Further, Women's Clinic was unable to show antitrust violations under Missouri law, which considers a covenant not to compete to be unreasonable if, "in addition to being ancillary to a valid underlying agreement, the covenant is not reasonably limited in scope to protecting the covenatee's legitimate interest."[331] The essential fault with Women's Clinic's argument was that its claims were based on the erroneous notion that the relationship between plaintiffs and St. John's was an employee-employer relationship.[332] Women's

325. *Id.* at *7. Plaintiffs would not, however, be bound by the original covenants not to compete.

326. *Id.* at *10-25.

327. *Id.* at *10-11. Since the contract is not exclusive, this is not the type of activity that antitrust laws are intended to prevent. *Id.* St. John's only contracted with 31% of the OB-GYN physicians in the Springfield, Missouri region. *Id.* at *14. The court did not consider this percentage of the market share to demonstrate sufficient market power to violate antitrust laws. *Id.*

328. *Id.* at *12-13.

329. *Women's Clinic, Inc.*, 2002 WL 3199212, at *15. Horizontal market allocations are *per se* illegal under the Sherman Act. *Id.* at *15-16.

330. *Id.* at *17-18. The court specifically denied Women's Clinic's claims that the Business Covenant was a naked restraint on competition that was ancillary to the Employment Agreement.

331. *Id.* at *19.

332. *Id.* The relationship between St. John's and Women's Clinic was actually a buyer-seller relationship. *Id.* St. John's, as a seller, has a legitimate interest in protected its business interests. *Id.*

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Clinic was unable to persuade the court that declaratory relief was appropriate because Women's Clinic failed to request that the that court construe the terms of the affiliation agreement and that alternative remedies were available.[333]

Similar to *Coventry*, *Women's Clinic* demonstrates the difficulties placed in the paths of plaintiffs seeking to prove their claims of antitrust violations by managed care networks.

B. Provider Deselection

As managed care has evolved into the predominant form of healthcare delivery in the United States, physician-patient relationships have inevitably been affected by the business realities of the managed care framework.[334] The twin objectives of maximizing profit and controlling cost often force MCOs to terminate physician contracts in an effort to adjust their provider bases for efficient provision of care.[335] This is particularly true in the case of physicians who, in the judgment of MCO medical directors, over utilize managed care services or consistently appeal denial of care decisions.[336] This process of terminating physician contracts and removing such physicians from MCO provider panels is known as "deselection."[337]

333. *Id.* at *25.

334. Bryan A. Liang, *Deselection Under* Harper v. Healthsource: *A Blow for Maintaining Patient-Physician Relationship in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 799 (1997). *See also* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173 (1996).

335. *See* Liang, *supra* note 334, at 799. *See also* Julie A. Jacob, *Patients Protest Loss of Their Physicians*, AMEDNEWS.COM, Feb. 21, 2000, *at* http://www.ama-assn.org/sci-pubs/amnews/pick_00/mksc0221.htm (last visited Oct. 7, 2002) (describing patients' reaction to deselection of fourteen physicians from a managed care network in Northwest Arkansas); Ken Terry, *No-Cause Terminations: Will They Go Up in Flames?*, MED. ECON., Jan. 12, 1998, at 130 (observing that "doctors have also been dropped without cause for advocating on behalf of patients, noncooperation with health-plan rules, pursuing back payments too vigorously, questioning fee schedules or capitation rates, and criticizing plans to their patients").

336. Peter B. Jurgeileit, Note, *Physician Employment Under Managed Care: Toward a Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians*, 73 IND. L. J. 255, 256 (1997). *See also* David Lagala, *Credentialing Can Mean Double-Jeopardy for MCOs and Providers!*, CHIROPRACTIC ECON., *at* http://www.chiroeco.com/article/managed-care/double-jeopardy.html (last visited Oct. 7, 2002) (stating that "deselection of specific providers can occur as a result of cost cutting activities and/or economic credentialing resulting in a 'weeding out' process. Recently, MetLife cut 1,100 physicians in southern Florida, Blue Cross and Blue Shield dropped 3,000 physicians, including the providers deselected from these and other MCOs, over 5,000 physicians have experienced deselection, potentially resulting in an over-abundance of providers seeking membership to managed care panels.").

337. Richard S. Liner, *Physician Deselection: The Dynamics of a New Threat to the Physician-Patient Relationship*, 23 AM. J.L. & MED, 511, 513 (1997). *See also* Judith C. Brostron, *Physician Deselection in Managed Care Contracts*, *at* http://www.lashlybaer.com/itn/sfb/spring99html#physician (last visited Oct. 7, 2002).

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Provider deselection is based in contract and typically is accomplished through the use of "termination without cause" provisions.[338] Such "termination without cause" clauses, which are almost universally present in physician/MCO provider agreements, generally allow either party to terminate the contract at any time without reason.[339] This "at will" contractual relationship between physicians and MCOs provides MCOs with the ability to control healthcare costs by regulating their provider panels as needed.[340]

1. Physician Challenges to Deselection: The Harper Case

Until the New Hampshire Supreme Court's decision in *Harper v. Healthsource New Hampshire, Inc.*,[341] physicians who challenged termination without cause generally were denied relief on the grounds that, absent unfair procedures, such contract clauses were valid and enforceable.[342] In 1997, however, the *Harper* court reversed this trend, expressly supporting judicial intervention into MCO-physician relationships and allowing a physician to proceed with an action to invalidate the termination without cause provision of a provider agreement.[343]

In *Harper*, Dr. Paul Harper, a board certified surgeon, sued the HMO, Healthsource New Hampshire, Inc. ("Healthsource"), after Healthsource terminated their contractual relationship because Dr. Harper failed to satisfy the HMO's "recredentialing criteria."[344] At the time of the lawsuit, Dr. Harper had been a practicing physician with Healthsource for over ten years and approximately 30-40% of his patients were Healthsource related.[345]

338. Liner, *supra* note 337, at 513.

339. *See* Liang, *supra* note 334, at 801 (citing Howard Larkin, *You're Fired; Physician Termination*, AM. MED. NEWS, Feb. 13, 1995, at 17).

340. Jurgeleit, *supra* note 336 (citing Alan Somers, *What You and Your Physician Client Need to Know About Managed Care Contracts*, PRAC. LAW., Mar. 1996, at 15, 26-27). *See also* Lisa J. Bernt, *Wrongful Discharge of Independent Contractors: A Source-Derivative Approach to Deciding Who May Bring a Claim for Violation of Public Policy*, 19 YALE L. & POL'Y REV. 39 (2000)).

341. 674 A.2d 962 (N.H. 1996).

342. Liang, *supra* note 334, at 808 n.38 (stating that "many physicians have been reported to be deselected but there have been no successful published challenges to these terminations except under anti-discrimination laws.") (citing Ken Terry, *When Health Plans Don't Want You Anymore*, MED. ECON., May 23, 1994; Julie Johnson, *Hospital Medical Staffs: Next Managed Care Casualty?*, AM. MED. NEWS, Oct. 17, 1994, at 1). The decisions that granted relief generally focused on ensuring that deselected physicians received fair procedures. *See, e.g.*, Ambrosino v. Metro. Life Ins. Co., 889 F. Supp. 438 (N.D. Cal. 1995) (applying fair procedures theory to a provider deselected from a managed care company and ruling that a managed care company cannot terminate a provider for arbitrary or capricious reasons).

343. *Harper*, 674 A.2d at 966-67.

344. *Id.* at 963.

345. *Id.*

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The provider agreement between Dr. Harper and Healthsource contained a termination without cause provision pursuant to which the agreement could be "terminated by either party without cause upon six (6) months prior written notice."[346] After exhausting internal challenges of Healthsource's decision to terminate his provider agreement, Dr. Harper challenged his termination in court. Dr. Harper claimed that the termination without cause provision in the provider agreement was against public policy, and, thus, void.[347]

Citing previous application of public policy issues to hospitals,[348] the court in *Harper* extended the public policy argument to contractual relationships between HMOs and physicians.[349] The court observed that, as is the case with hospitals, the "public has a substantial interest in the relationship between health maintenance organizations and their preferred provider physicians. . . . This relationship is perhaps the most important factor in linking a particular physician with a particular patient."[350] The court went on to rule that public interest and fundamental fairness require that MCOs comply with an implied covenant of good faith and fair dealing when terminating provider agreements, and that such terminations not be contrary to public policy.[351] Accordingly, the court concluded that, while an MCO has a contractual right to terminate a provider agreement without cause, the terminated physician is entitled to a review of such decision if "the physician believes that the decision to terminate was . . . made in bad faith or based on a factor that would make the decision contrary to public policy."[352]

2. Post-Harper Developments

The *Harper* decision was seen by physicians as a victory against the termination of provider agreements by MCOs,[353] and it opened a new avenue of MCO liability by permitting challenges to physician deselection based on public policy arguments.[354] Subsequent to *Harper*, for example, in *New Jersey*

346. *Id.* at 964.

347. *Id.*

348. *Harper*, 674 A.2d at 966. (The court observed that "the public has a substantial interest in the operation of private hospitals and that of necessity in the public interest some measure of control by the courts is controlled for.") (quoting Bricker v. Sceva Speare Mem'l Hosp., 281 A.2d 589, 592 (N.H. 1971)).

349. *Id.*

350. *Id*.

351. *Id*. (observing that the "provider agreements must be 'fair and in the public interest'") (internal citation omitted).

352. *Id.* See also Liang, *supra* note 334, for a detailed analysis of the *Harper* decision.

353. Mark A. Kadzielski, *Provider Deselection and Decapitation in a Changing Healthcare Environment*, 41 ST. LOUIS L.J. 891, 903 (1997). *See also* Ken Terry, *supra* note 335 (discussing state level efforts to address deselection).

354. Kadzielski, *supra* note 353, at 904 (citing *New Hampshire Decision Could Inspire Suits Over "Without Cause" Exclusions*, 5 HEALTH L. REP., June 13, 1996, at d49). *See also* Liang

Psychological Association v. MCC Behavioral Care, Inc., providers terminated by the largest MCO in New Jersey challenged termination without cause provisions in their provider agreements.[355] The court compared the termination of qualified physicians by MCOs to hospital termination of physician staff privileges.[356] Finding that public policy considerations were similar in the two instances (MCOs delivery of healthcare to the public and MCO employment of physicians), the court held that physicians were entitled to a fair hearing before termination of their provider agreements by MCOs.[357]

Later, in *Potvin v. Metropolitan Life Insurance Co.*.,[358] a California obstetrician challenged his removal from a health plan's preferred provider list pursuant to a termination without cause provision.[359] Dr. Potvin argued that his removal from the preferred provider list was devastating to his practice as it substantially reduced his patient base.[360] In light of this allegation, the *Potvin* court observed that an insurance company may, in certain circumstances, have sufficient market power to "impair an ordinary, competent physician's ability to practice medicine . . . in a particular geographical area, thereby affecting an important, substantial economic interest."[361] Accordingly, the court held Dr. Potvin's termination without cause provision unenforceable and ruled that deselection, at least where the MCO has strong market presence, must be "both substantively rational and procedurally fair."[362]

It is important to note that treatment of the *Harper* and *Potvin* decisions has not been uniform. For instance, in *Grossman v. Columbine Medical Group, Inc.*,[363] the Colorado Court of Appeals rejected the *Harper* and *Potvin* public policy arguments, holding that the Colorado legislation on the issue was dispositive of the state's public policy.[364] The court noted that the Colorado law specifically allowing termination without cause provisions in provider agreements between MCOs and physicians was not applicable due to its

supra note 334; Jurgeilet, *supra* note 336; Julie A. Jacob, *Texas Physician Says His HMO Deselection Violates ADA—AMA/State Medical Society Litigation Center is Backing the Complaint*, AMEDNEWS.COM, Mar. 24-31, 1997, *at* http://www.ama-assn.org/sci-pubs/amnews/pick_97/pick0324.htm (last visited Oct. 7, 2002); Mary Chris Jaklevic, *AMA Fights Doc Ouster*: *Group Funds Battle Against Managed-Care "Deselection,"* MODERN HEALTHCARE, Apr. 14, 1997, at 24; Brostron, *supra* note 337.

355. N. J. Psychological Ass'n v. MCC Behavioral Care, Inc., No. 96-3080, 1997 U.S. Dist. LEXIS 16338, at *2-3 (D. N.J. Sept. 15, 1997).

356. *Id.* at *9-10.

357. *Id* at *10-12.

358. 997 P.2d 1153 (Cal. 2000).

359. *Id.* at 1155.

360. *Id.* at 1156.

361. *Id.* at 1161.

362. *Id. See also* Lagala, *supra* note 336 (discussing the *Grossman* decision).

363. 12 P.3d 269 (Colo. Ct. App. 1999).

364. *Id.* at 271.

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enactment subsequent to the termination of the contract in the current case.[365] However, the court found the statute instructive in its determination of public policy on the issue, and reasoned that the right to terminate without cause applies equally to both the MCO and the physician.[366] The court went on to reason that "the physician cannot rely on the implied duty of good faith and fair dealing to circumvent terms for which he expressly bargained,"[367] and, as such, the *Grossman* court denied the challenge of the termination without cause provision.[368]

3. Reducing Liability Exposure for Deselection Decisions

In light of the *Harper* and *Potvin* decisions, MCOs need to carefully consider and document their deselection decisions. While the *Harper* and *Potvin* decisions are not uniformly supported, they may indicate a trend of increased judicial scrutiny in deselection actions. In light of court decisions favorable to physicians, and given the very serious business, financial and professional ramifications that deselection can have on providers (including loss of income, decrease in established patient base and potential increases in malpractice insurance premiums), deselected physicians are likely to vigorously challenge MCO deselection decisions. [369]

A consistent pattern of physician deselection for over utilization of managed care resources is "an invitation for litigation," unless an MCO demonstrates other justifiable reasons for same.[370] To avoid costly and

365. *Id.*

366. *Id.*

367. *Id.* (citing Soderlun v. Pub. Serv. Co., 944 P.2d 616 (Colo. Ct. App. 1997)) (stating that the "covenant of good faith and fair dealing cannot limit an employer's right to discharge without cause unless there is an express or implied promise, independent of the covenant of good faith itself, restricting that right.").

368. *Grossman*, 12 P.3d at 272.

369. Bruce J. Goldstein & Mark D. Abruzzo, *Minimize Your Risk of Being Decredentialed*, PHYSICIAN'S NEWS DIG., Nov. 1999, *at* http://www.physiciansnews.com/business/1199goldstein.html (last visited Oct. 7, 2002). *See also* Kadzielski, *supra* note 353, at 905 (indicating that after the *Harper* decision, the "California Medical Association mailed letters to nineteen of the states' largest managed care health plans calling for a halt to without-cause terminations," arguing that "physicians on provider panels had 'vested significant economic interests' in their contractual relationships with Managed Care Organizations, which prohibited termination except for cause"); Blum, *supra* note 334, at 195-96. *But see* Liner, *supra* note 337, at 524-25 (arguing that deselection can benefit the public's interest in cost-efficient health care and protect physicians' reputations as it allows managed care companies to terminate incompetent physicians without entering their names into the National Practitioner Data Bank).

370. Bruce J. Goldstein & Mark D. Abruzzo, *Health Plans that Decredential Docs Must Do it Correctly or Expect a Fight* Managed Care, Sept. 1999, *at* http://www.managedcaremag.com/archives/9909/9909.legal.html (last visited Jan. 10, 2003) (The authors indicate that several factors lead to increased scrutiny of managed care companies when managed care companies make credentialing and decredentialing decisions, including pressure from physicians wishing to

prolonged litigation battles with terminated physicians, MCOs should first consider whether termination can be supported by a "termination with cause" provision in the provider agreement. If a termination without cause provision must be invoked, MCOs need to be prepared to: (1) demonstrate objective reasons for deselection; (2) show that the decision is not made in bad faith and is not contrary to public policy, and (3) follow a well-documented and objective termination process which will withstand judicial scrutiny if the termination decision is challenged by a physician.[371] It is also important that the deselection process be applied consistently to all physicians and that a deselected physician be given notice and reasons for deselection. Affected providers should be given an opportunity to meet with the MCO's governing body to discuss the situation before a final decision is made, and the deselection process should be thoroughly documented to prevent any future allegations of arbitrary or bad faith decisions to deselect.[372]

C. Utilization Review

One cost containment measure employed by MCOs to combat rising healthcare costs involves a process termed "utilization review," whereby MCOs or their agents (1) prospectively monitor and evaluate the medical necessity of a physician's prescribed treatments (including diagnostic evaluations or admission of patients to hospitals and other facilities), and (2) determine if the treatment is covered by the patient's policy.[373] Utilization

be part of the managed care company's network, negative financial impact decredentialing has on physicians, financial and organizational influences on managed care organizations leading to cutbacks among contracted providers, court rulings holding managed care organizations liable for acts of their contracted physicians, consumer pressure for stronger managed care companies accountability and better quality of care, heightened influence of accreditation organizations, unsettled law in the area of rights between MCOs and physicians and increased legislative efforts to address perceived managed care faults).

371. *See* Goldstein & Abruzzo, *supra* note 370 (advising that each physician be afforded proper due process upon deselection, that the credentialing process be formally adopted by the managed care company's governing body and that physician-members of the credentialing committee refrain from voting on deselecting physicians in their specialty areas).

372. *Id.* (stating that "All the due process in the world cannot protect against criteria that are wrongfully applied. Similarly, a decision to deselect for the right reasons will be subject to attack if the process is inadequate."). *See also* Susan Huntington, *Provider Terminations: Strategies for Risk Management*, HEALTHCARE FIN. MGMT., Mar. 1, 2000, at 35 (discussing strategies managed care companies can adopt to protect themselves from possible litigation due to deselection decisions).

373. *See* Sharon Reece, *The Circuitous Journey to the Patients' Bill of Rights: Winners and Losers*, 65 ALB. L. REV. 17, 31-33 (2001); David L. Trueman, *The Liability of Medical Directors for Utilization Review Decisions*, 35 J. HEALTH L. 105, 105-106 (2002) [hereinafter Trueman, *Liability of Medical Directors*]; David L. Trueman, *Managed Care Liability Today: Laws, Cases, Theories, and Current Issues*, 33 J. HEALTH L. 191, 220 (2000) [hereinafter Trueman, *Managed Care Liability Today*]. When determining whether the prescribed treatment is covered under a

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review generally is performed by medical personnel such as nurses or doctors employed by the MCO as case reviewers, with the MCO's medical director overseeing all determinations.[374] During the process of utilization review, if the MCO or its medical director determines that a particular treatment prescribed by the patient's treating physician is not "medically necessary," the MCO denies coverage for the treatment.[375] While MCOs argue that utilization review is solely administrative,[376] courts have recognized that, due to the cost of many medical procedures, the true effect of the MCO's decision to deny payment can be to "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."[377]

Litigation based upon utilization review is an emerging and highly unsettled area of the law.[378] This section aims to briefly describe the area of law as it stands today and to describe trends affecting MCO liability.

Most claims against MCOs with regard to utilization review are direct liability claims.[379] As with nearly all cases against MCOs, ERISA preemption provides an initial hurdle for any suit based upon utilization review. Only when the patient can successfully base his or her claim on the quality of medical benefits provided by the MCO, as opposed to the quantity of benefits owed to the patient under the MCO plan, will the suit survive ERISA preemption.[380]

While nearly all courts have held that ERISA preempts direct negligence claims based upon a denial of benefits through utilization review,[381] in 1999, the Third Circuit, in *In re United States Healthcare, Inc.*, [382] held that ERISA

patient's policy, the MCO and the reviewing agent will also determine if the treatment should be excluded from the policy due to its experimental nature. *See id.* at 220.

374. *See* Trueman, *Liability of Medical Directors*, *supra* note 373, at 105.

375. *See id.* at 106.

376. *See id.*

377. Shannon v. McNulty, 718 A.2d 828, 835 (Pa. Super. Ct. 1998).

378. *See* Trueman, *Managed Care Liability Today*, *supra* note 350, at 191.

379. *Id.* at 220.

380. *See In re* United States Healthcare, Inc., 193 F.3d 151, 161-62 (3d Cir. 1999).

381. *See* Danca v. Private Health Care Sys., Inc., 185 F.3d 1 (1st Cir. 1999); Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996); Tolton v. Am. Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995); Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993); Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992). In so doing, the courts relied on the ERISA analysis discussed in Part II of this Article and determined that each negligence claim against MCOs based on utilization review are in essence claims regarding the improper administration of benefits. *See supra* text accompanying notes 13-106. *See also* Martin V. Klein, Casenote, *Quality v. Quantity: Will ERISA Preemption Survive the Third Circuit Test of* In re U.S. Healthcare?, 34 CREIGHTON L. REV. 1069, 1103-05 (2001) (discussing cases that have confronted the issue of whether ERISA preempts direct negligence claims based upon a denial of benefits through utilization review).

382. 193 F.3d 151 (3d Cir. 1999).

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did not preempt a decedent's parent's direct negligence claim against an MCO which denied benefits after utilization review.[383] In this case, Michelle Bauman and her newborn daughter, Michelina, were discharged from the hospital twenty-four hours after Michelina's birth as required under their MCO plan.[384] One day later, Michelina contracted a virulent infection.[385] The treating physician failed to advise the Baumans to bring their daughter back to the hospital and U.S. Healthcare, the MCO, declined to provide a home visit from a pediatric nurse requested by Ms. Bauman.[386] Michelina died later that same day.[387]

The Baumans sued the physician, the hospital and the MCO based upon a number of legal theories, some of which were based upon the direct negligence of the MCO with regard to its various utilization review policies.[388] The court noted that an HMO may assume both a role as an administrator of the plan and a separate role as a provider of medical services.[389] The court acknowledged that ERISA completely preempts claims based upon an MCO's administrative activities, but determined that in this case, the decedent's parents were basing their claim upon the medical determination by the MCO of the appropriate level of care provided and not a claim that a certain benefit was requested and denied.[390] As such, the court actually attempted to follow the quality versus quantity distinction discussed earlier in this Article, but reached the opposite conclusion than that of other Circuits which have addressed the same issue.[391]

An in-depth discussion of all issues that might arise with regard to the direct liability of MCOs based upon utilization review is beyond the scope of this Article. However, assuming a plaintiff can successfully escape ERISA preemption by claiming a deficiency in the quality of medical care provided, the following causes of action have been successfully asserted, or could likely be successfully asserted sometime in the future, against MCOs for such claims.[392]

383. *Id*. at 162-63.

384. *Id.* at 156.

385. *Id.*

386. *Id.*

387. *In re United States Healthcare*, 193 F.3d at 156.

388. *See id.* at 155-57.

389. *Id.* at 162.

390. *See id.* at 163.

391. *See* cases cited *supra* note 381 and accompanying text.

392. *See generally* Trueman, *Managed Care Liability Today*, *supra* note 373, at 219-242. Dr. Trueman also provides an in-depth discussion of various other causes of action against MCOs not related to utilization review, some of which are briefly described elsewhere in this article, including: liability for negligent credentialing/selection/retention/supervision, misrepresentation, RICO claims, claims based on ERISA breach of fiduciary duty and claims based on vicarious liability through respondeat superior and ostensible agency. *See id.* at 229, 231-33, 234-42. *See also* William A. Helvestine, *Legal Implications of Utilization Review*, *in* CONTROLLING COSTS

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1. Negligence

In order to establish negligence against an MCO, a patient must show that the MCO "owed the [patient] a duty of reasonable care, that the [MCO] breached the duty, . . . that the breach proximately caused the [patient's] injury," and that the patient suffered actual damage as a result of the breach.[393] Whether the MCO owes a duty to the patient depends in great part on whether it is foreseeable that the patient may forego treatment if the MCO denies authorization.[394] Courts are likely to find that a duty exists and that the utilization review decision is often the decisive factor for the patient in determining whether the patient will forego treatment.[395]

There can be two separate duties of care applied depending on whether the alleged negligence is due to a defect in the MCO's procedures or in the MCO's substantive medical decisions. The standard of care applied for the procedural aspects of conducting the utilization review is likely to be based on the standard of care in the community of reviewing agents, and the "[utilization review] procedures must be sufficient to obtain enough information to make an informed decision and to enable a timely dialogue and/or appeal if the treating physician or patient disagrees."[396] Because MCOs use the expertise of physicians during utilization review to evaluate claims, the standard of care used to judge the substantive decision of whether or not a given treatment is medically necessary will likely be the same as for physicians generally.[397] The MCO should authorize treatment if a treating physician exercising the community standard of care would deem the treatment medically necessary.[398]

Negligence is probably the most common cause of action asserted by patients against MCOs with regard to utilization review,[399] and some courts have determined that a patient can successfully sue under such a theory.[400] For example, in *Wickline v. State*,[401] the MCO, through its utilization review process, allegedly influenced the treating physician's medical judgment, causing a premature discharge of a patient from the hospital that led to the

AND CHANGING PATIENT CARE?: THE ROLE OF UTILIZATION MANAGEMENT 169, 173-190 (Bradford H. Gray & Marilyn J. Field eds., 1989).

393. Helvestine, *supra* note 392, at 175; *see also* Trueman, *Liability of Medical Directors*, *supra* note 373, at 135.

394. Helvestine, *supra* note 392, at 175.

395. *Id.* at 175-76.

396. *Id.* at 176.

397. *Id*. at 177.

398. *Id*.

399. Helvestine, *supra* note 392, at 175; *see also* Trueman, *Managed Care Liability Today*, *supra* note 373, at 221 (noting that plaintiffs have brought direct negligence claims challenging all aspects of utilization review determinations).

400. *See, e.g.*, Trueman, *Managed Care Liability Today*, *supra* note 373, at 221-22.

401. 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

amputation of the patient's leg.[402] The court determined that the treating physician should bear ultimate responsibility for the loss of the patient's leg, and not the MCO, because the physician discharged the patient and did not protest the MCO's decision to deny payment for an extended stay in the hospital.[403] However, the court acknowledged that:

> Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost-containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.[404]

2. Breach of Contract

Policies between the MCO and patient are contracts, and as such, the wrongful denial of payment authorization through utilization review can subject the MCO to liability under contract theories such as breach of contract and breach of warranty.[405] However, if the patient argues only that the MCO breached its contract with the patient by wrongfully denying payment for treatments that should have been covered under the policy, the claim likely will be completely preempted by ERISA and dismissed as a state law breach of contract claim.[406] Moreover, even if the case were to escape ERISA preemption, the damages potentially available to the patient under a breach of contract theory are limited to those damages reasonably foreseeable from the breach.[407] Punitive damages are unavailable.[408]

3. Medical Malpractice

While the entire area of MCO liability based upon utilization review is an area of uncertainty,[409] states and courts are especially split on the front of whether MCOs can and should be liable to patients for medical malpractice.[410] For a patient to successfully assert a medical malpractice claim against a

402. *Id.* at 811.

403. *See id.* at 819.

404. *Id. See also* Wilson v. Blue Cross of S. Cal., 271 Cal. Rptr. 876, 877-80, 883-85 (Cal. Ct. App. 1990) (noting that the MCO could be held liable for negligence for its refusal to pay for extended hospital stay for a suicidal patient who subsequently committed suicide).

405. *See* Trueman, *Managed Care Liability Today*, *supra* note 373, at 233; Helvestine, *supra* note 392, at 179.

406. Trueman, *Managed Care Liability Today*, *supra* note 373, at 233.

407. Helvestine, *supra* note 392, at 180. However, the article does note, "[S]ince it is foreseeable that denying authorization will result in the patient foregoing medical services, the defendant potentially is liable for injury or death caused to the patient." *Id*.

408. Trueman, *Managed Care Liability Today*, *supra* note 373, at 233.

409. *See id.* at 191, 219.

410. *See* Trueman, *Liability of Medical Directors*, *supra* note 373, at 108-16.

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defendant, the patient must prove the four elements of general negligence[411] that there was a physician-patient relationship, and that the defendant was engaged in the practice of medicine.[412] The key issue then, in determining whether a plaintiff can successfully sue an MCO directly for medical malpractice, is whether utilization review is the practice of medicine.[413]

Historically, patients could not successfully sue MCOs for medical malpractice due to the "corporate practice of medicine doctrine," which has been codified in some states.[414] The doctrine generally bars corporations and other entities from the practice of medicine "because only a human being can have the [proper] education, training, and character necessary to receive a professional license and treat patients."[415]

However, the American Medical Association has stated, "utilization review decisions to deny payment for medically necessary care constitute the practice of medicine."[416] In recent years, the state medical licensing boards or attorneys general in California, Louisiana, Minnesota, South Carolina and Texas have all expressed a similar view.[417] In so doing, each state has potentially opened up an avenue for patients to sue the MCO directly for medical malpractice. In addition, there is strong support in these states for the position that physicians acting as medical directors in utilization review must be licensed to practice medicine in the state and that there will be significant penalties for those physicians who conduct utilization review without a license.[418]

Many states, however, have taken the opposing view. Arkansas, Kansas, Mississippi, North Carolina and Ohio have all seemingly relied on the

411. *See supra* note 393 and accompanying text (outlining four elements of a negligence cause of action).

412. Trueman, *Liability of Medical Directors*, *supra* note 373, at 135.

413. *Id*. at 108. It is also important to note that in certain states which have decided that utilization review is the practice of medicine, the MCO and its medical directors may not only be liable for traditional medical malpractice suits by plaintiff/patients, but would also be subject to review and discipline by the state's medical board. *Id.*

414. *Id.* at 136.

415. *Id*.

416. Trueman, *Liability of Medical Directors*, *supra* note 373, at 108 (citing AMA House of Delegates, H-285.939, Managed Care Medical Director Liability, *at* http://www.ama-assn.org/apps_pfonline/pf_online?f_n=resultLink&doc=policyfiles/HOD/H285.939.HTM&s_t= 285.939&catg=AMA/HOD&&nth=1&&st_p=0&nth=1& (last visited Jan. 17, 2002)).

417. *See id.* at 113-16. It should be noted that the authors have not engaged in a fifty state research of state medical licensing board opinions or attorneys' general opinions and have relied upon the cited reference in this determination. There may be additional states which share the same view.

418. *Id.* at 109.

traditional definition of medicine[419] and have determined that utilization review is not the practice of medicine.[420] The Ohio Medical Board went so far as to say that "the actions of a medical director must be the action of the corporation and therefore cannot be the practice of medicine."[421]

As noted above, while most cases against MCOs with regard to utilization review are direct liability claims, patients often attempt to assert vicarious liability claims against MCOs for medical malpractice and negligence of their physicians. Some courts have not allowed medical malpractice claims against MCOs to proceed for the same reason direct malpractice claims could not proceed: the court does not acknowledge that the MCO is practicing medicine. As such, these courts have held that the MCO cannot be held vicariously liable for medical malpractice, a cause of action for which the practice of medicine is an essential element.[422] However, if such a case is brought in a state which does consider utilization review the practice of medicine, the court would seemingly allow the vicarious liability medical malpractice case to proceed against the MCO.

4. Tortious Interference with Physician-Patient Relationship

In order to successfully bring a claim of tortious interference with the physician-patient relationship, the patient would need to prove the existence and the MCO's knowledge of the physician-patient relationship between the patient and a treating physician, the MCO's intentional interference with the relationship and actual breach of it, and damages caused to the patient because of such interference.[423] While no successful cases have apparently been brought under this cause of action based upon utilization review,[424] a patient

419. The traditional definition of practicing medicine only includes, for example, examining, "*diagnosing, operating on, prescribing for, administering to or treating* [a patient's] *ailment, injury or deformity*." *Id.* at 110 (citing 60 N.C. Op. Att'y Gen. 49 (1990)).

420. *See id.* at 109-13. It again should be noted that the authors have not engaged in a fifty state research of state medical licensing board opinions or attorneys' general opinions and have relied upon the cited reference in this determination. There may be additional states which share the same view.

421. Trueman, *Liability of Medical Directors*, *supra* note 373, at 137 (citing 1999 Ohio Op. Att'y Gen. No. 99-044, at 5 (1999), *available at* http://www.ag.state.oh.us/opinions/1999/99-044.htm).

422. *See, e.g.*, Dalton v. Peninsula Hosp. Ctr., 626 N.Y.S.2d 362, 364 (N.Y, Sup. Ct. 1995); Freedman v. Kaiser Found. Health Plan of Colo., 849 P.2d 811, 816 (Colo. Ct. App. 1993); Propst v. Health Maint. Plan, Inc., 582 N.E.2d 1142, 1143 (Ohio Ct. App. 1990).

423. Trueman, *Managed Care Liability Today*, *supra* note 373, at 230-31.

424. *See id.* at 230 (citing Drolet v. Healthsource, 968 F. Supp. 757, 757-58 (D. N.H. 1997) (tortious interference class action suit based upon materially false and misleading statements of the MCO which compromised the physician-patient relationship); Maltz v. Aetna Health Plans, 114 F.3d 9, 10, 12 (2d Cir. 1997) (ERISA based action claiming the MCO jeopardized the physician-patient relationship by forcing physician to either accept capitation or be dropped from

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could assert such a claim if the patient is harmed because the medical treatment the patient actually received was inferior to the treatment he or she would have otherwise received had the utilization review process not interfered with the physician-patient relationship.

As noted above, litigation based upon utilization review is an emerging and highly unsettled area of the law. Division among the states with regard to whether utilization review is the practice of medicine creates much of this uncertainty, although the trend appears to be moving toward treating utilization review as the practice of medicine.[425] If this trend continues, additional claims under many of the legal theories discussed above are likely to result. Moreover, the Third Circuit's decision in *In re U.S. Healthcare* to allow direct negligence claims against MCOs for utilization review remains the minority view and its effect is still uncertain. However, if *In re U.S. Healthcare* represents the beginning of a shift in the law, MCO liability pursuant to utilization review is likely to increase in the upcoming years.

CONCLUSION

Given the proliferation of managed care and the changing roles of health care providers and payors, courts struggle to balance common law theories of liability with ERISA's stated goal of uniformity in benefit plan administration. MCOs play an extremely important role in health care cost containment, and it appears that the haphazard manner in which courts approach managed care liability has only led to increases in health care costs.

Just over ten years ago, MCOs could take comfort in the knowledge that ERISA's preemption provisions stood as a significant bar to plaintiff recovery under state law for anything other than enforcement of rights guaranteed under contracts between the MCO and its subscribers. Now, with the Supreme Court's decision in *Rush*, MCOs are faced with the prospect of having to tailor their system-wide medical review policies and procedures to the requirements of individual states. Of course, the *Rush* decision is only the most recent advance in the continuing erosion of ERISA preemption. As noted throughout this Article, courts generally appear more willing to hold MCOs liable as providers of care, and have extended to MCOs theories of liability once reserved for hospitals.

MCOs and their legal counsel would be well advised to stay abreast of changes in managed care liability laws. It may be quite some time before the federal and state legislatures are able to coordinate appropriate measures to allow MCOs the latitude needed to control medical costs, while at the same time providing the appropriate degree of protection to MCO subscribers. That

the plan; Dr. Trueman analogizes arguments made in the case to those which would have to be made under a tortious interference cause of action)).

425. Trueman, *Liability of Directors*, *supra* note 373, at 105.

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being the case, it seems likely that courts will continue to approach managed care liability issues in an inconsistent, piecemeal fashion.