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**THE BENIGN HISTORY OF A SCAM:
THE HMO EXPERIENCE
(As Seen by a Health Lawyer)**

*Joanne B. Stern**

I. INTRODUCTION

When I began to practice health law in the early 1970s, Health Maintenance Organizations (HMOs) had been in existence for over thirty years. Yet, there was little known about HMOs and few people had actually enrolled in one. The concept seemed wonderful; by maintaining ones health rather than dealing with dire consequences if one failed to do so, both the HMO and the enrollee would reap enormous benefits. This arrangement allowed the HMO to continue to survive and thrive (most were non-profit entities), and the HMO member would be able to prevent health hazards before they occurred. Providers, for their part, would be utilized to counsel and inform patients, to help avert crises, and to intervene only when necessary to treat the ill.

Why were there so few HMOs in existence until 1980? Most likely, this was because of the medical establishment's antipathy toward them and because many state laws forbade the corporate practice of medicine, thus precluding HMO development and licensure. In addition, most providers (*i.e.*, physicians and hospitals) were hostile, because they conceived of HMOs as "a foot in the door of socialized medicine." These providers believed that working for an HMO would only diminish their income capacities since HMO physicians were ordinarily compensated based on capitation (*i.e.*, a prepaid fee for each member) and, thus, could not generally bill on a fee-for-service basis. Consequently, with both law makers and providers opposed, the lobbying against HMOs far

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outweighed, both in money and political influence, any lobbying in favor of them.

II.

My involvement with HMOs goes back to 1971 when the federal government saw the financial savings inherent in the HMO concept and attempted to convert neighborhood health centers, which provided free health care to the poor, into HMOs. A grant to develop model HMO contracts was given to the National Health Law Program, a legal services back-up center operating out of UCLA under the auspices of the Office of Economic Opportunity. Fresh out of law school with one year's experience at a large Los Angeles law firm, I was hired to research and draft model HMO contracts and was eager to do so. Moreover, under the administration of Governor Reagan in California, Medi-Cal funds were being siphoned to HMOs where it was thought that health care inflation could be better controlled, and health care costs for the eligible poor would be predictable and fixed.

From this vantage point I observed and studied the first large wave of HMOs which developed in the late 1960's and early 1970's in California. Most of these were sponsored by entrepreneurs; few providers were enthusiastic and/or desirous of participating. Though California law required that all HMOs be non-profit entities, astute businessmen (with the assistance of their attorneys and consultants) realized that substantial monies could be made by siphoning off a large percentage of the state funding they received into newly formed private corporations, such as management firms, real estate companies, pharmaceutical firms, and marketing enterprises wholly, or partially, owned by the HMO developer.

As a result of such creative HMO financing, scandal erupted.¹ Dozens of HMOs were started on a shoestring budget and marketed extensively, but for the most part provided minimal health care at best. Most of the Medi-Cal funding which was directed toward recipient care found its way to these private corporations, where hundreds of thousands of dollars of prepaid monthly fees were spent not on the provision of

¹ See Andrea Schneider & Joanne Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW U. L. REV. 90 (1975).

health care, but on the provision of profits to these entrepreneurs. In some cases, it was later found that only 15 percent of the health care monies provided by the state was actually utilized for patient care. It was also discovered that bribery and fraud had played a significant part in the contracting process and that various state officials had dispensed such contracts to parties who simultaneously agreed to utilize (and pay) consulting firms in which they had a financial interest. Similarly, employees were alleged to have sold "confidential" Medi-Cal lists for exorbitant fees to favored contractors.

Few Medi-Cal HMOs survived this initial wave once the practices of these so-called "pretzel factories" were exposed. The National Health Law Program initiated class action law suits against various HMOs and the state, claiming deceptive marketing practices, shoddy and sometimes even non-existent health care facilities. It was also discovered that since marketers were paid a fixed sum for each enrollee they signed up, numerous unethical and even fraudulent means were being employed to sign up as many enrollees as possible. Many Medi-Cal recipients who spoke no English were threatened, bribed, or thoroughly intimidated into signing a form they could not decipher. In some cases, Medi-Cal recipients were told by marketers, dressed up as nurses and physicians, that they would lose all their Medi-Cal benefits if they did not sign. In other cases, door-to-door marketers would offer free chicken dinners or raffle tickets for their signatures. Even more enterprising, were several prolific salesmen who claimed that the form they wanted signed was a referendum to recall Governor Reagan, an "enemy" of the poor.

Since HMOs could only make money by enrolling as many Medi-Cal beneficiaries as possible, their primary goal was to collect the monthly prepaid fees from the state and then provide as little service as possible. Consequently, once Medi-Cal enrollees were directed away from their current physician, they found some of the new entities they had signed up for were yet to be organized and/or built and that emergency numbers did not answer. This deception left beneficiaries out in the cold.²

When federal and state hearings ensued to look into allegations raised by subscribers, many of the HMOs folded. It was immediately clear that

² *Id.*

the provision of preventive care could easily lead to preclusion of services, thus enabling the entrepreneur-developer to reap substantial financial gains in a very short period. Various individuals who had been involved with the fledgling HMOs testified at those hearings, while others invoked their fifth amendment privilege against self-incrimination. None, however, were indicted. When Jerry Brown later became governor, most Medi-Cal HMOs were put out of business permanently. Knowledgeable health care reformers predicted the so-called "California Experience" had set back the acceptance of HMOs by at least a decade. These predictions, however, were not to come true.

III.

The major turning point in the national emergence of HMOs occurred during the Nixon administration when the HMO Act of 1973³ was passed. The Act provided significant incentives for HMO development and preempted many state laws that had precluded their existence. This was largely accomplished through financial incentives (grants, loans and loan subsidies) and a federal mandate requiring HMOs to be offered whenever an employer of twenty-five or more employees also offered a traditional health insurance plan to their employees. At a time when federal funds for health care development were generally drying up, this was the most significant legislation enacted to support and finance a new approach to health care delivery. It was also thought that by emphasizing health maintenance, HMOs could prevent health problems before they developed, and, thus, efficiently manage health care inflation, which was spiraling out of control.

With an eye toward potential abuses, the federal law was also written to include various provisions relating to accessibility, availability and quality of patient care. In addition, feasibility and planning grants were widely available. Because it was recognized that the beneficent purpose of the HMO could be totally undermined by a non-beneficent purpose of the sponsor-developer, the law and regulations promulgated thereto called for strict enforcement of rules and federal oversight of HMO development

³ 42 U.S.C. § 300 (1996).

and qualification. A similar law, the Knox-Keene Health Care Service Plan Act,⁴ was passed in California in 1976. This Act and its subsequent regulations, similarly required stringent enforcement of quality, as well as administrative and financial controls, and was purposefully aimed at preventing the problems that had plagued the Medi-Cal HMOs. Moreover, both federal and state laws, in recollection of the "non-profit" scams, chose to permit the development of for-profit entities.

As a result of these incentives, many new HMOs sought state licensure and federal qualification in the late 1970s and 1980s and most were determined to be profit-making businesses.⁵ Conversion from nonprofit entity to for-profit entity was extremely common in the mid-1980s, as was consolidation, mergers and buy-outs. Large HMOs were even listed on the national stock exchange. The "bottom line" became all-important to the HMO, but the hope and expectation was that the strict federal and state laws (and continuing oversight) would mitigate the abuses associated with the money-hungry, cash poor, under serving HMOs of the past.

Although the majority of providers were still resistant, in California the providers soon came to the realization that it was fruitless to fight. Large hospital-based "Individual Practice Associations" (IPAs) consisting of numerous physicians with a wide range of specialties were formed in order to contract with various HMOs in their areas. Some providers (as well as directors, consultants and attorneys) became very wealthy upon conversion to for-profit status by allocating stock to key players. (I know at least one twenty-eight-year-old MBA who retired to a life at sea upon conversion of his HMO). Today, there are HMO executives who are actually reap near-billion dollar packages and multi-million dollar annual salaries after HMO conversions and buy outs.⁶

⁴ CAL. HEALTH & SAFETY CODE, § 1340 (West 1996).

⁵ See Joanne Stern, *The Conversion of Health Maintenance Organizations from Nonprofit to For-Profit Status: Background, Methodologies and Problems*, 26 ST. LOUIS U. L. J. 711 (1982); Theresa McMahon, *Fair Value? The Conversion of Nonprofit HMOs*, 30 U.S.F.L. REV. 355 (1996).

⁶ A \$920 million buy-out pertaining to just one HMO executive discussion. See WALL ST. J., Apr. 2, 1996. See also AMERICAN MEDICAL NEWS, Feb. 5, 1996, at 3 (reviewing HMO executive salaries).

Once HMOs became large corporate entities, many prestigious law firms clamored to represent them. Consequently, much of the legal work in the 1980s consisted of HMOs interacting and negotiating with regulatory agencies in order to become licensed and qualified to expand their enrollee base and to extend their service areas and/or to convert to for-profit status. In the nineties, mergers, acquisitions, and buy-outs have dominated the financial and legal scene as multi-million dollar companies have come to dominate the managed care market.

IV.

In the mid-1970s, I served as a Consultant to the Department of Health and Human Services in formulating contracts, doing site visits, and reviewing feasibility and planning proposals pursuant to the HMO Act of 1973. In 1977, I served as a Special Consultant to a California agency called the Department of Corporations (Department), which was responsible for licensing, regulating and overseeing HMOs after the 1976 Knox-Keene state law was enacted.

The Department was a very strange agency to entrust with the regulation of HMOs since it was primarily involved with securities regulation and had little, if any, expertise in the health care area. However, it was widely believed that this particular agency had a generally good reputation and would not allow the Medi-Cal abuse problems which had developed under the Department of Health Services to occur. The Department of Insurance, of course, was inadequate to take on the role of a regulatory agency since it was widely viewed as "a revolving door to the industry."⁷ In any case, by 1978 I decided to become a full-time professor of health law at an emerging Southern California law school (Whittier) and believed my active involvement in the HMO industry was at its end. At that time, HMOs were just beginning to build a niche and it appeared they would remain a gradually developing alternative to traditional medicine.

⁷ Unfortunately, despite the confidence of the legislature, after twenty years of health care regulation, the Department of Corporations is becoming much the same revolving door as the Department of Insurance.

Contrary to my predictions, nothing could have been further from the truth. Few attorneys were familiar with HMO laws and regulations or with the "underground rules" which governed licensure and conversion. As the industry expanded and new federal and state laws were implemented, I consulted with numerous law firms on these matters. I cooperated and sometimes battled with the state and federal agencies whose approvals were necessary, and testified before state legislatures when hearings on new HMO laws were being considered. I wrote law review articles based largely on my HMO experiences and the potential problems that could develop when a health care system played the role of both insurer and provider. The complication that could develop ranged from meeting the duties, responsibilities and liabilities of HMO management, to the emerging areas of tort law that could be utilized to deter HMO abuse.⁸

By the late 1980s and early 1990s, HMOs had gained a very solid foothold in the U.S. health care system. Both Medicaid and Medicare allowed, and even encouraged, beneficiaries to enroll and most employers were mandated to offer the choice of an HMO to their employees who joined in increasing numbers. The cost of HMO coverage was considerably less than that of traditional insurance plans and the providers were generally well-qualified, though often disgruntled by the constraints imposed upon them. Few providers could get by financially without aligning themselves at least to some extent with HMOs. In California, for example, the vast majority of the insured population is currently enrolled in a managed care plan. Moreover, it is projected that within three years, approximately 60 percent of the national population will be similarly enrolled.⁹

It soon became clear, however, that excellent providers did not necessarily translate to excellent (or even adequate) care. The byword of the system and the way to make money for stockholders was "managed care," a system that required certain protocols including:

⁸ See Joanne Stern, *Potential Liability of the Board of Directors of a Health Maintenance Organization*, 3 WHITTIER L. REV. 1 (1981); Joanne Stern, *Bad Faith Suits: Are They Applicable To Health Maintenance Organizations?*, 85 W. V. L. REV. 911 (1983); Joanne Stern, *Malpractice in the Managed Care Industry*, 24 CREIGHTON L. REV. 4 (1991).

⁹ See J.P. Werner, *Forecasting the Effects of Health Reform on U.S. Physician Workforce Requirement: Evidence From HMO Staffing Patterns*, 272 JAMA 222, 230 (1994).

- (1) restricting primary physicians from referring HMO patients to specialists;
- (2) requiring prior approval before allowing referrals of patients to hospitals; and
- (3) closely monitoring hospital stays.

Many physicians felt hamstrung by these limitations, but since most HMOs were given bonuses and incentives to "come within or below budget," providers' overall income was in many ways significantly affected by their health care decisions. Basically, the more referrals they made, the less money they earned.

Some physicians also felt the fiduciary relationship between physician and patient had become severely compromised since decisions about each enrollee's health, as well as accessibility and availability of care, were strictly monitored by administrative personnel. Unfortunately, health "maintenance" in many HMOs meant the patient was given short shrift-- the least amount of services for the dollar. Because HMOs were run as a business, financial performance was paramount. Consequently, the question of how to cut down on spiraling costs while maintaining integrity in the system and insuring adequate patient care was of foremost concern to all parties.

V.

Thus, the era of litigation ensued. Failure to refer a patient to a specialist in some cases led to premature death. Limitations on hospital stays frequently resulted in dire consequences to the patient. Denial of benefits for expensive new procedures for potentially terminal patients also had ominous consequences. Although HMOs were not technically practicing medicine, a variety of causes of action were brought against them based on such legal theories as *respondeat superior*, ostensible agency, bad faith breach of contract, corporate negligence, tortious interference with the physician-patient relationship, and fraud and misrepresentation.¹⁰

¹⁰ For an excellent summary of such theories, see Diana J. Bearden & Bryan J. Meadgen, *Emerging Theories of Liability in the Managed Care Industry*, 47 BAYLOR L. REV. 281 (1995).

“Risk-management” also became a key word in most HMO organizations as executives pondered how the HMO could control the amount and extent of care afforded in given cases and simultaneously limit the risk of adverse consequences leading to increased morbidity and mortality rates. In addition, the HMO had to accomplish these goals while avoiding adverse public publicity and perceptions, greater governmental scrutiny, and explosive monetary awards. If compromise by the HMO was necessary, it was always a one-sided compromise, with little, if any, input from physicians and consumers. Although federally qualified HMOs were required to have a certain number of consumers on their boards, this requirement was easily met by choosing individuals they preferred and giving them enrollment cards, thus making them instant consumer “representatives.”

Why then did we hear so little about these HMO abuses? Why have so many HMOs escaped multi-million dollar verdicts even when their alleged failures have been so well documented, and sometimes proven? The paramount reason stems from the mandatory binding arbitration clauses included in most HMO contracts which prevents most patients who join HMOs from having access to the court system. Arbitration proceedings are typically held in private forums. The rationales for their findings are never spelled out and appeals are severely limited. In most states, the legality of binding arbitration has been upheld, even if the individual is totally unaware of his or her relinquishment of judicial rights.¹¹ As a result, confidentiality and lack of precedent in these HMO decisions has not allowed for public outcry. Unethical practices, violations of federal and state laws, and blatant abuses, if not condoned, were at least not publicized. Moreover, arbitrators have been known to award significantly less per case than juries, and punitive damages are not always available.

Even when court proceedings have been allowed, awards generally have been minimal. This is largely because the U.S. Supreme Court in the 1987 *Dedeaux v. Pilot Life Ins. Co.* decision,¹² determined that federal

¹¹ *Madden v. Kaiser*, 552 P. 2d 1178 (Cal. 1976).

¹² *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

employee retirement income security act (ERISA) laws¹³ overrode virtually all state law causes of action relating to insurance and HMOs. The vast majority of enrollees are covered by ERISA, a comprehensive law created for the main purpose of protecting employees' rights and benefits. HMOs can, therefore, request that virtually any alleged tort violation that may get to court be transferred to federal court, where extra-contractual tort damages, such as emotional distress and punitive damages are not permitted under ERISA. It has always been my belief that Congress never meant to restrict long-standing state tort actions against insurers and HMOs in cases such as these, but the Supreme Court's ruling (as interpreted by various lower courts) now governs such suits and since ERISA prevails, extra-contractual and punitive damages cannot be generally recovered.

Nevertheless, horror stories have abounded and have led both providers and patients rights advocates to press for reform and redress. In the last few years, two major HMOs have been sued for a "denial of services" in state courts because ERISA law is not applicable in such cases. In those cases, jury verdicts of \$45 million and \$89 million were rendered against the HMOs.¹⁴

In recognition of these abuses, various consumer protection proposals are now under consideration to eliminate the so-called "gag rules" in provider-HMO contracts, which severely limit what the physician can discuss with the HMO patient with regard to his or her treatment options.¹⁵ Pressure has also been placed on state agencies to more severely penalize the offenses that regularly occur in some HMOs.

These acts alone are not viable solutions to "rein in" the HMO abuses. Because HMO economic systems thrive on limiting resources and costs, not on preventing illness or maintaining health, they have tremendous incentives to enroll healthy people but, less incentive to care

¹³ The Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §1001-1461 (1988 and Supp. V 1993)).

¹⁴ Adams v. Kaiser Foundation Health Plan of Georgia, No. 93-V5-7985 E (Feb. 2, 1995); Fox v. Health Net, No. 21962 (Sup. Ct. of Riverside Cty., CA).

¹⁵ Unfortunately, since this article was written, California's attempt to regulate HMOs through the proposition process in the recent national election was soundly defeated. Enormous amounts of money spent by HMOs and insurance companies was successful in adversely influencing public opinion.

for them when they become ill. Furthermore, the HMO executives, who are only answerable to stockholders, receive huge salaries and bonuses to ensure profitability by continuing to do exactly what they have been doing. Conversely, state and federal reform is slow and even where physicians line up with the consumers, the major funding available for political and public relations purposes itself derives from "deep pocket" HMOs.

The managed care business is now consolidating, and mergers and buy-outs occur frequently. Even traditional insurance companies have become active participants, and billion-dollar corporations have lead the movement. In recent months, there have also been well-founded allegations of organized-crime involvement in the HMO industry.¹⁶ If this is true, capitalistic greed could be overshadowed by outright corruption. In either case, consumers and physicians are the losers.

VI.

I have been an expert witness in many HMO arbitration proceedings. Although these decisions are generally rendered in a much shorter period than judicial decisions, they receive no publicity and set no precedent. Moreover, the plaintiff's ability to "put on his case" may be thoroughly eclipsed by the formidable experts, high-profile attorneys, and much larger resources of the HMO. And, of course, if the HMO sees the "handwriting on the wall," even arbitration proceedings may not proceed to final judgment.

Perhaps a good example is one HMO arbitration in which I was involved. In this instance, the HMO in question had limited the medical coverage available to newborn infants to sixty days, despite the fact that state law specifically prohibited such a limitation. The parents of the infant involved in the case were school teachers forced to file for bankruptcy and suffer two years of extreme emotional turmoil in order to ensure that their infant, who eventually died, received the best care possible. The parents eventually sought help from an attorney who initiated a case against the HMO to recover both financial and emotional

¹⁶ Douglas McLeod, *New Jersey Probing Health Plan's Mob Ties*, BUSINESS INSURANCE, pg. 1 (Aug. 26, 1996).

damages. During discovery proceedings, the attorney found out from former disgruntled employees, that the HMO president had been actively involved in the decision-making process regarding this particular infant and had actually overridden the medical director's initial decision to provide full coverage. To avoid publicity and notoriety, the HMO settled the case for a large amount of money contingent upon the plaintiffs' execution of a confidentiality agreement prohibiting disclosure of both the facts of the case and its ultimate outcome.

In another case in which I was involved, an HMO so closely monitored its hospitalized members on a day-to-day basis that almost every physician felt pressured to release patients as soon as possible, even if it was against their better judgment. In this case, a young man had been admitted to the hospital with terrible abdominal pains. The physician in charge initially thought it could be a urinary tract infection, but was uncertain because the tests had not yet been completed. Because the hospital HMO nurse insisted the patient had already been hospitalized for as long as necessary, given the tentative diagnosis, the young man was sent home with antibiotics and pain killers only to drop dead that same night from a burst appendix.

Once the physician's insurance company had settled with the decedent's family, the physician was only too happy to testify quite angrily about the effects of the HMO's pressure on his decision in that case, as well as others. "If they're in this HMO," he stated bitterly, "the need for expedited, unwise release is always on my mind." By admitting this, the HMO physician was virtually guaranteeing his expulsion from any further HMO involvement. As a foreign medical physician, he at least had the opportunity to return to his country of origin.

An even more frightening scenario occurred several years ago in California, in a case that received wide attention when two physicians were actually charged with second degree murder for prematurely "pulling the plug" of a patient on a respirator.¹⁷ However, not enough attention was given to the physicians' reasons for doing so.¹⁸ Although there were allegations of poor medical judgment and malpractice cover-up, some

¹⁷ Barber v. Superior Court of Los Angeles Cty., 147 Cal. App. 3d 1006 (1983).

¹⁸ For an excellent review of this case, see Jonathan Kirsch, *A Death at Kaiser Hospital*, CALIFORNIA MAGAZINE, Nov. 1982, at 79.

HMO critics believe the real reason for the premature euthanasia, even when the patient still showed neurological hope, was to “free up” an expensive hospital bed. It is impossible to dismiss these medical implications of a system which thrives on minimizing medical bills.

It seems to me that it is absolutely necessary to allow regular judicial review of HMO abuse cases in order to reform and balance the legal system. Large damage awards and the concomitant publicity just might embarrass the industry to reform itself, as it has in many product liability cases. Furthermore, when an HMO's income is totally dependent on attracting subscribers, its ability to survive would be significantly diminished if major abuses and judicial decisions were well-publicized. Strict fiscal control over entitlement programs, and more effective federal and state regulation would also help. However, political and economic realities and the increasingly close relationships between HMO advocates and HMO regulators stand in the way of major legislative reform, especially in an era of budget-balancing restraint, and deregulation. Finally, the *Pilot Life* decision should be reconsidered, if not by the Supreme Court then at least by Congress. Otherwise, it is likely that managed care will come only to mean “restricted care,” and other than investors, HMOs will be answerable to no one.

While socialized medicine has been considered an anathema by various provider groups, insurance companies and other profit-oriented entities, unless managed care is managed well and with a fiduciary duty to the patient, it poses an even greater threat to the health care system in this country. If some significant changes are not made soon, we may all simply become part of a huge bureaucracy where the actual care provided is much less important than the capitalistic goals of the entities themselves.

