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# BEWARE HMOs: THE FUTURE OF HMO MEDICAL MALPRACTICE LIABILITY IS UNCERTAIN

*Neville M. Bilimoria*[*]

The face of health maintenance organization (HMO) delivery is in the process of dramatic change. HMOs, organizations that control costs and utilization of health care services through requiring prepayment by subscribers for services,[1] are growing in the United States.[2] The challenge for HMOs continues to be controlling costs and increasing access to health care while maintaining the quality of services provided.[3] Recent reports indicate some HMOs in the northeastern part of the country have begun to experience increased costs and are increasing the premiums they charge. More importantly, HMOs across the nation are beginning to feel the pressures of tort reform and other state laws which counter the HMOs' drive to reduce health care expenditures.

This article examines both HMOs' success in defending malpractice claims and the recent laws making HMOs more susceptible to malpractice lawsuits.[4] The article also analyzes possible strategies for HMOs to defend future malpractice suits. Section I will discuss the rise and current status of HMOs in the United States. Section II describes current HMO medical malpractice claims. In Section III, ERISA preemption of state HMO medical malpractice claims is examined. Section IV discusses the trend away from general immunity for HMOs, historically provided by ERISA. Finally, Section V will outline strategies that will permit HMOs to reduce the risk of liability.

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[1]Barbara Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1219 (1997).

[2]Ellyn Spragins, *Does Your HMO Stack Up?*, NEWSWEEK, June 24, 1996, at 56 (graphic showing enrollment in HMOs grew from six million in 1976 to 53.3 million in 1995).

[3]Noah, *supra* note 1, at 1220-21.

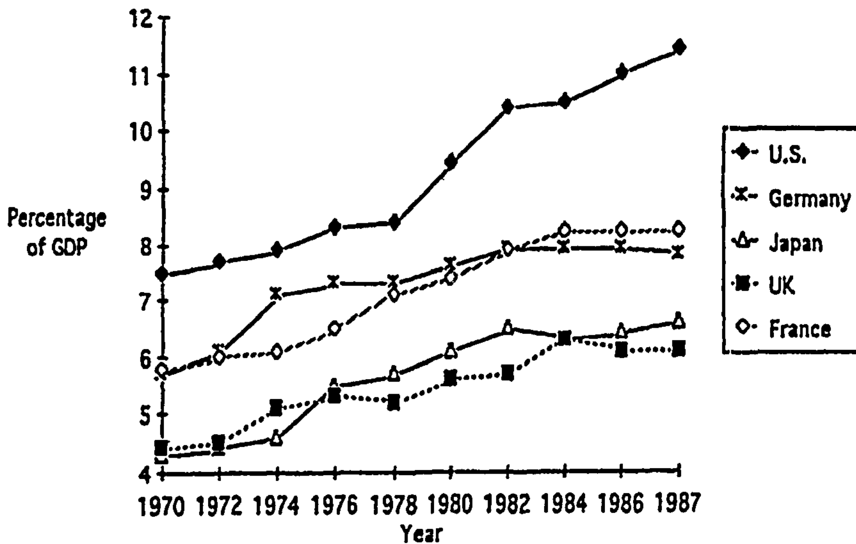
[4]Milt Freudenheim, *Baby Boomers Force New Rules for HMOs*, N.Y. TIMES, Nov. 27, 1997, at A1 ("[m]ore than 1,000 managed-care bills were introduced in state legislatures last year. Congress also enacted new requirements. These laws, called mandates, limit the ability of H.M.O.s to contain costs .... ")

## THE CURRENT STATE OF HMOs

Today there are over 65 million HMO members nationwide.[5] There are roughly 90 million other Americans enrolled in similar managed care organizations, such as preferred provider organizations (PPOs.)[6] While many criticize HMOs due to their bureaucracy and cost cutting incentives,[7] HMOs remain established institutions.

The impetus behind the proliferation of HMOs in the United States was the growth in health care expenditures compared with other countries. *See Figure 1.*[8]

**Figure 1: Expenditure on Health Care as Percent of GDP**

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[5]Michael Higgins, *Increased Exposure to HMOs*, 83 A.B.A. J. 24, 24 (Sept. 1997).

[6]Noah, *supra* note 1, at 1220.

[7]*See* Kenneth R. Pedroza, *Cutting Fat or Cutting Corners: Health Care Delivery and Its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 411 (1996) ("[t]he incentive structure created is for the [HMO] to use fewer resources per patient as a means of realizing a greater profit ... [W]hen physicians are pressured into underutilization, there is a danger that the quality of care provided will fall below the legally required standard.").

[8]Aki Yoshikawa et al., *How Does Japan Do It? Doctors and Hospitals in a Universal Health Care System*, 3 STAN. L. & POL'Y REV. 111, 115 (1991).

In fact, President Bill Clinton, one of the more ardent supporters of HMOs, has viewed the managed care organization as an efficient way to reduce the spiraling costs of health care in the United States.[9]

Undoubtedly, managed care organizations use cost cutting methods to stave off the enormous expenditures on health care. As a consequence, HMOs make decisions affecting the quality of care. It can be argued that HMOs are needed to avoid disastrous economic consequences;[10] however, efforts need to be taken to ensure HMO quality while allowing appropriate profits through cost cutting incentives. Unfortunately, the objective of reducing health care costs while increasing access to health care has thus far been unattainable.

Given the need for HMOs and the lack of alternatives, it is important to observe that the tension between quality and cost cutting is only minimally addressed by the legal system. Courts are now increasingly allowing medical malpractice suits against HMOs which will undoubtedly lead to large financial setbacks for even the most stable HMOs.

## HMO LIABILITY

HMOs are currently held liable for actions of doctors and nurses through the theory of "enterprise liability." This theory encompasses vicarious liability and actual or apparent agency theories against HMOs, much like the law applied in medical malpractice litigation against hospitals. These theories would result in HMO liability for the actions of provider physicians under their health plan.

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[9]Susan Garland, *Managed Care: Dr. Clinton Has Grim News*, BUS. WK., Jan. 18, 1993, at 35. In 1992, the nation spent $838.5 billion on health care. Health care expenses in 1992 amounted to 14 percent of the Gross National Product, up from 9.1 percent in 1981. *Id.*

Government spending on health care was a significant part of Clinton's health care reform campaign, which is largely responsible for the change to managed care organizations, like HMOs, today. Said Clinton, health care unreformed "is going to bankrupt the country."*Say Aargh For Reform*, ECONOMIST, Feb. 6, 1993, at 25.

Journalists agreed that health care reform was needed and HMOs became the answer: "The problem with hospital costs is not simply that they are high, but that they have been rising rapidly and consuming an ever larger fraction of gross national product." W.B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies*, 257 JAMA 220, 220 (1987).

[10]*Health Care Prognosis*, BUS. WK., April 7, 1997, at 8 (graphic depicting that by year 2005, national health care expenditures will constitute nearly 18 percent of the Gross Domestic Product even with slower growth).

Under the state law theories, HMO liability may be established by evidence of any of the following:

(1) that a patient was restricted to selecting a primary care physician (PCP) through an HMO-provider list;
(2) that patients under the HMO were treated by a specialist only after the negligently delayed referral (approval) of the selected PCP; or
(3) that the selected PCP was screened by the HMO through a defective credentialling process.[11]

In addition, HMO liability may be established through direct evidence contained within the HMOs' brochures which list physicians as being competent and pre-screened for periods of time before being selected for the health plan. The negligent credentialling claim is further bolstered when an HMO limits the choice of physicians. In all, these claims may likely be proven in light of the economically motivated procedures of the HMO, including granting financial incentives to PCPs for discouraging referrals and using less costly treatments.[12]

Recently, a Pennsylvania Court held the failure of HMOs to refer a young patient to a specialist in a timely manner, which ultimately lead to the patient's hearing loss, was enough to support a medical malpractice claim against the actual HMO.[13] This decision is particularly troubling for HMOs as they enter an era of ever increasing access to enrollment, which in turn, necessarily increases bureaucracy and the time for approval of referrals.

State law actions for breach of contract or breach of implied warranty are also possible claims against HMOs for injuries involving malpractice.[14] However, whether direct negligence, enterprise liability, or breach of contract, many HMOs today can take advantage of defenses provided by federal statutory law.

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[11]Allen D. Allred & Karen A. Carr, *Enterprise Liability Puts MCOs at Risk*, NAT'L L. J., Sept. 8, 1997, at B9.

[12]*Id.*

[13]Fitzgerald v. Mercy Catholic Medical Ctr., No. 02983 PHL 96, Pa. Super.

[14]*See, e.g.*, Raglin v. HMO Illinois, 230 Ill. App. 3d 642, 595 N.E.2d 153 (1992).

## HMOs and ERISA PREEMPTION

The medical malpractice liability of HMOs is largely limited through immunity provided by the Employee Retirement Income Security Act of 1974 (ERISA).[15] Congress enacted ERISA to provide a unified regulation of employee benefit plans. Generally, ERISA supersedes all state laws relating to employee benefit plans. For example, HMO coverage, as part of an employee benefit plan, would be covered under ERISA. The United States Supreme Court has given ERISA a very broad preemption interpretation[16] and thus, HMOs often avail themselves of immunity from state law claims for medical malpractice merely by asserting ERISA preemption. While currently viable, this ERISA immunity defense has been increasingly susceptible to erosion.

While ERISA provides two methods for preemption which are discussed below, attorneys must note ERISA preemption *only* applies to qualified health plans subject to ERISA. Therefore, HMOs not provided through an enrollee's employment are not able to utilize ERISA preemption as a defense. However, it is notable that most HMO enrollees (about 65 percent) are members as part of an employment benefit plan.

### Section 502(a) Complete Preemption

Preemption under Sec. 502(a)[17] of ERISA is referred to as "complete preemption"[18] and involves the federal court's removal jurisdiction. If a state law claim can be characterized as within the scope of ERISA's § 502(a) civil enforcement provisions, the state law claim is completely preempted and the federal court will retain jurisdiction.

Specifically, ERISA Sec. 502(a) provides a civil enforcement action can be brought for the following three reasons only:

(1) to recover benefits due in a plan;
(2) to enforce rights under a plan; or
(3) to clarify rights to future benefits under a plan.[19]

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[15]29 U.S.C.A. § 1001 - 1461 (West 1985 & Supp. 1997).
[16]*See, e.g.*,District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992).
[17]29 U.S.C.A. § 1132 (West 1985 & Supp. 1997).
[18]Thomas A. Moore and Matthew Gaier, *HMO Liability*, N.Y. L. J., Sept. 2, 1997.
[19]Schmid v. Kaiser Foundation Health Plan, 963 F. Supp. 942, 943-44 (D. Or. 1997).

If a state law claim falls within the scope of the Sec. 502(a) enforcement actions, the claim is recharacterized as a "federal claim" under ERISA, thus resulting in federal subject matter jurisdiction.

As a result of the operation of Sec. 502(a), plaintiffs are able to enforce rights under the terms of ERISA with the necessary extinguishing of all state law claims. In reality, plaintiffs are not truly preempted because they are allowed to recover only equitable relief through Sec. 502(a). However, Sec. 502(a) effectively limits damages a plan participant can recover. Therefore, if a plaintiff's malpractice claim against an HMO is categorized under Sec. 502(a), her suit is essentially preempted, allowing only equitable recovery such as for benefits denied (*i.e.*, cost of a denied hospital stay). Plaintiffs can sue for the cost of the treatment denied by the HMO, but are *unable* to collect damages for health problems resulting from not receiving the treatment.[20] State law negligence theories would therefore yield no damages to the plaintiff if "complete preemption" was found.[21]

**Section 514(a) Conflict Preemption**

Any state claim not falling within the purview of the civil enforcement provisions of ERISA may, nonetheless, be preempted by a second form of ERISA preemption under Sec. 514(a),[22] known as "conflict preemption." Therefore, HMOs may have this second line of defense to malpractice claims under ERISA if complete preemption does not apply.

Under conflict preemption, ERISA supersedes state laws which "relate to" an ERISA plan.[23] In the case of conflict preemption, it is important to ask whether the state law claim "has a connection with or reference to" the ERISA plan, namely the HMO plan.[24] Not all state laws are necessarily preempted, but the Supreme Court has directed courts to apply ERISA's preemption clause expansively.[25] In fact, courts must determine on a case by case basis whether the state medical malpractice law claims asserted by the plaintiff against an HMO "affect employee

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[20]Higgins, *supra* note 5, at 24.

[21]*Id. See* James Walker Smith and Christopher P. Hannan, *ERISA Preemption*, MED. MALP. L. & STRATEGY (March 1997).

[22]29 U.S.C.A. § 1144(a) (West 1985 & Supp 1997).

[23]*Id.*

[24]Shaw v. Delta Airlines, Inc., 463 U.S. 85, 96-97 (1983).

[25]*See, e.g.*, Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990).

benefit plans in too tenuous, remote, or a peripheral manner" to find that the state law does not "relate to" the plan.[26]

Unlike complete preemption, conflict preemption under Sec. 514(a) does not create federal question jurisdiction. Therefore, if a state malpractice claim against an HMO is not found under complete preemption, the case must be remanded to state court for lack of subject matter jurisdiction.[27] Consequently, the state law claims will survive in state court, but the HMO will still have Sec. 514(a) conflict preemption available as a defense rather than as a basis for federal jurisdiction. Commentators and case law show that when cases are remanded to state courts (when complete preemption cannot be shown), even though conflict preemption may be an available HMO defense, state courts are disinclined to offer immunity to HMOs based on Sec. 514(a).[28] It is clear that conflict preemption is broader than complete preemption because state law claims found under Sec. 502(a) are necessarily preempted by Sec. 514(a), as necessarily "relat[ing] to" the health plan. Conversely, state laws that do not fall within complete preemption may fall under conflict preemption for use by HMOs as a defense to medical malpractice liability.

## CURRENT TRENDS IN HMO LIABILITY

While state and other federal courts are struggling over the applicability and breadth of ERISA preemption clauses, some states are opening the door for medical malpractice suits against HMOs. Recent trends show the case law is eroding the ERISA preemption for HMOs and newly enacted laws are increasingly accepting of enterprise liability.

### Split in the Circuits

HMOs may find relief in the holdings of two recent decisions of the Seventh Circuit Court of Appeals. In *Rice v. Panchal*,[29] the Seventh Circuit found no complete preemption attached to a claim that would hold an HMO liable under a theory of vicarious liability for the actual or

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[26]*Shaw*, 463 U.S. at 100 n.21.

[27]Rice v. Panchal, 65 F.3d 637, 646 (7th Cir. 1995).

[28]*See, e.g.*, Pappas v. Asbel, 675 A.2d 711 (Pa. Super. Ct. 1996). *See* Smith & Hannan, *supra* note 21.

[29]*Rice*, 65 F.3d 637 (7th Cir. 1995).

apparent agent physician's malpractice.[30] The court in *Rice* held the state law claims of respondeat superior could be decided without the interpretation of an ERISA plan, and therefore, were not subject to preemption.[31] According to *Rice,* only the tenuous conflict preemption defense could be asserted in state court.

More recently in *Jass v. Prudential Health Care Plan,*[32] however, the Seventh Circuit revisited complete preemption for HMO malpractice liability. In *Jass,* plaintiff sued the HMO and an HMO-employed nurse for the nurse's determination that the plaintiff be discharged after knee surgery without the necessary rehabilitation.[33] The plaintiff also sued the physician who discharged her from the hospital claiming the HMO was vicariously liable for his malpractice.[34] In effect, *Jass* ruled direct negligence on the part of the HMO (through the nurse) was actually a claim for a denial of benefits, thus effectively preempted by Sec. 502(a).[35]

The *Jass* court retained federal jurisdiction based on diversity, and therefore, the Seventh Circuit was able to rule on the vicarious liability count against the HMO for the physician's negligence.[36] *Jass* held the vicarious liability claim was also preempted, but this time under Sec. 514 because the plan was the basis of the relationship between HMO and the physician.[37] Because the plan would need to be examined to determine whether there was vicarious liability, the state law claim was preempted.[38]

While the Seventh Circuit appears to provide ERISA preemption to state law claims alleging direct negligence against HMOs, other circuits are not as accommodating to preemption arguments. In *Dukes v. U.S. Healthcare,*[39] plaintiffs sued for injuries resulting from medical malpractice of HMO affiliated hospitals and physicians.[40] The Third Circuit ruled such state claims of direct negligence, *i.e.*, negligent hiring

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[30]*Id.* at 646.
[31]*Id.* at 645.
[32]Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996).
[33]*Id.* at 1485.
[34]*Id.*
[35]*Id.* at 1489 (stating plaintiff's claim against the nurse was really a "§ 502(a) denial of benefits claim").
[36]*Id.* at 1491-92.
[37]*Jass* 88 F.3d at 1493.
[38]*See id.* at 1492-95.
[39]Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995).
[40]*Id.* at 351.

by an HMO, are not completely preempted under Sec. 502(a) of ERISA.[41] *Dukes* reasoned that the complaint did not allege denial of benefits against the HMO, but rather asserted a claim for negligent care.[42] The Third Circuit drew a distinction between claims that focused on the "quantity" of benefits, which *would* be preempted, and claims that focused on the "quality" of benefits, which would not.[43] *Dukes* ruled Sec. 502(a) was not intended to control the *quality* of benefits received by plan participants, allowing for state law claims of medical malpractice against an HMO.[44]

The Third and Seventh Circuits are at apparent odds with each other regarding applicability of complete preemption to medical malpractice claims against HMOs. Unfortunately for HMOs, the Tenth Circuit in *Pacificare of Oklahoma v. Burrage*[45] held an action holding an HMO vicariously liable for malpractice of one of its physicians does not relate to the plan and does not entail conflict preemption under Sec. 514(a).[46] Seemingly in conflict with the Seventh Circuit in *Jass*, the Tenth Circuit court in *Pacificare* ruled state law claims holding an HMO potentially liable for a judgment, while carrying a potential economic impact, "is not enough to relate the action to the plan."[47] More dangerous for HMOs was the reasoning of the Tenth Circuit, which if adopted, could prove the end of ERISA preemption:

> Just as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent .... We agree with the district court that reference to the plan to resolve the agency issue does not implicate the concerns of ERISA preemption.[48]

Indeed the difference in reasoning behind the opinions in *Jass*, *Rice*, *Dukes*, and *Pacificare* indicates that "reasonable capable people may

[41] *Id.* at 351-52.
[42] *Id.* at 357.
[43] *Id.*
[44] *Dukes*, 57 F.3d at 357.
[45] Pacificare of Oklahoma, Inc. v. Burrage, 59 F.3d 151 (10th Cir. 1995).
[46] *Id.* at 155.
[47] *Id.* at 154 (quoting Airports Co. v. Custom Benefits Services of Austin, Inc., 28 F.3d 1062, 1065 (10th Cir. 1994)).
[48] *Pacificare* 59 F.3d at 155.

differ" as to the proper analysis regarding ERISA preemption of HMO medical malpractice claims.[49] While the Third, Seventh, and Tenth Circuits have each decided against preemption in at least one case,[50] the Seventh, Fifth, and Sixth Circuits have conversely ruled in favor of ERISA preemption for malpractice claims against HMOs.[51]

The most recent ERISA preemption decision came from the Eighth Circuit in *Shea v. Esensten.*[52] In *Shea,* the court held state tort claims against an HMO for failing to disclose that it provided incentives to deter its physicians from making referrals were preempted under Sec. 514(a).[53] In fact, *Shea* followed the Seventh Circuit's reasoning in *Anderson v. Humana*[54] where attacks on an HMO's incentive structure were deemed preempted.[55]

**United States Supreme Court Signal?**

Ultimately, the issue of HMO liability and ERISA preemption will have to be decided by the Supreme Court. However, the Supreme Court has indirectly hinted towards limiting ERISA preemption for HMO liability in the case of *California Div. of Labor Standards Enforcement v. Dillingham.*[56] Although *California Div. of Labor,* addressed a California wage law and not HMO liability, the Court's dicta appeared to signal that ERISA preemption is limited when preemption would limit a state's rights to control medical care quality standards. The Court seemed to side with the Tenth Circuit's decision in *Pacificare* finding mere economic impact on an ERISA plan does not warrant preemption:

> Indeed, if ERISA were concerned with any state action -- such as medical-care quality standards or hospital workplace regulations -- that increased costs of providing certain benefits, and

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[49]Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 185 (E.D. Pa. 1994).

[50]*See, e.g.,* Pacificare of Oklahoma, Inc., v. Burrage, 59 F.3d 151 (10th Cir. 1995); Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995); Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995).

[51]*See, e.g.,* Jass v. Prudential Health Care Plan, 88 F.3d 1482 (7th Cir. 1996); Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992) (holding a wrongful death action against an HMO based upon utilization review that hospitalization was not available was preempted under Section 514(a)); Tolton v. American Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995).

[52]Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997).

[53]*Id.* at 627.

[54]Anderson v. Humana, 24 F.3d 889, 891 (7th Cir. 1994).

[55]*Shea,* 107 F.3d at 628 (citing *Anderson,* 24 F.3d at 891).

[56]California Div. of Labor Standards Enforcement v. Dillingham, 117 S. Ct. 832 (1997).

> thereby potentially affected the choices made by ERISA plans, we could scarcely see the end of ERISA's pre-emptive reach, and the words "relate to" would limit nothing.[57]

Despite *California Div. of Labor*, however, the Supreme Court has yet to rule on the issue of HMO liability and ERISA preemption clauses.

### A Wave of State Laws

State legislatures across the country are now proactively moving to hold HMOs liable for malpractice, even if the new laws allow consumers greater tort protections against HMOs. For example, Texas Governor, George W. Bush signed four bills increasing consumer protections against malpractice by HMO plans.[58] Although these statutes took effect in September 1997, a suit has already been filed seeking to enjoin officials from enforcing the law, contending ERISA preemption.[59]

Florida passed legislation similar to that of Texas last year; however, the bill was vetoed by the governor. Arizona and Connecticut have passed statutes offering consumers the right to appeal HMO decisions to review boards. A Missouri statute attempts to remove HMOs exemption from liability for medical malpractice.[60] With this flood of state legislation, the Supreme Court will undoubtedly have to decide whether to extend ERISA preemption broadly against state HMO medical malpractice status.

## STRATEGIES FOR HMOs

Until the Supreme Court decides ERISA preemption and HMO liability, HMOs can follow a few guidelines in defense of HMO malpractice claims. First, an HMO should try to characterize the state law claim, no

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[57]*Id.* at 840.

[58]*See* TEX. CIV. PRAC. & REM. CODE ANN. § 88.001 – 88.003 (West 1997 & Supp. 1998) (section 88.002 of the statute provides that HMOs have the duty to exercise ordinary care when making treatment decisions and are liable for damages caused by failure to exercise such ordinary care. HMOs are also liable for damages proximately caused by decisions made by employees, agents, ostensible agents, or representatives acting on their behalf).

[59]*See* Corporate Health Ins., Inc. v. Texas Dep't. of Ins., H-97-2071 (D.S. Tex., filed June 16, 1997) (alleging this legislation is preempted by ERISA).

[60]1997 Mo. Legis. Serv. 302, 313 (West) *repealing* MO. REV. STAT. § 354.505(3) (deleting "[a]ny health maintenance organization authorized under sections 354.400 to 354.550 shall not be deemed to be practicing medicine and shall be exempt from the provisions of chapter 334 R.S. Mo.").

matter how artfully pleaded, as a denial of benefits claim within the scope of Sec. 502(a) or complete preemption. The *Jass* decision is an excellent reference for arguing that a plaintiff's complaint is in fact plead as a denial of benefits.[61] Of course, if complete preemption is unavailable, HMOs should look to categorize the state malpractice claim as being otherwise "related to" the plan under Sec. 514(a) or conflict preemption.

Furthermore, HMOs can make changes in infrastructure to combat potential state law malpractice claims. For example, HMO employees should be structured so that they serve only in an administrative capacity, not in a medical capacity. The more medically involved the HMO administrator becomes under a plan, the more likely a court will find a state claim to be a quality of care issue, similar to *Dukes*, where ERISA preemption may not apply.[62]

Finally, defense counsel should strive to characterize an HMO's actions as part of its administrative function, rather than the rendering of medical care. Such an effort will require examining the legislative history or longstanding case law on ERISA itself to determine applicability of ERISA preemption to the HMO's actual administrative practices. Again, the Seventh Circuit decision in *Jass* provides a good basis for such a defense argument.[63]

## CONCLUSION

The recent movement toward the erosion of ERISA immunity for HMOs may result in new standards of care in medical malpractice cases against HMOs. These standards will be determined by applicable state medical malpractice law. Enterprise liability will likely make HMOs accountable for most malpractice by HMO plans if ERISA preemption falls by the wayside. Ultimately, the Supreme Court may need to resolve the conflict between the various circuit court decisions involving HMO liability and ERISA preemption. For now, HMOs can only follow the current laws in their jurisdiction, with the hope that ERISA preemption is not further eroded by the Supreme Court.

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[61] *Jass*, at 88 F.3d at 1491 n.6.
[62] Smith & Hannan, *supra* note 22.
[63] *See Jass*, 88 F.3d at 1491.