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In Pursuit of Health

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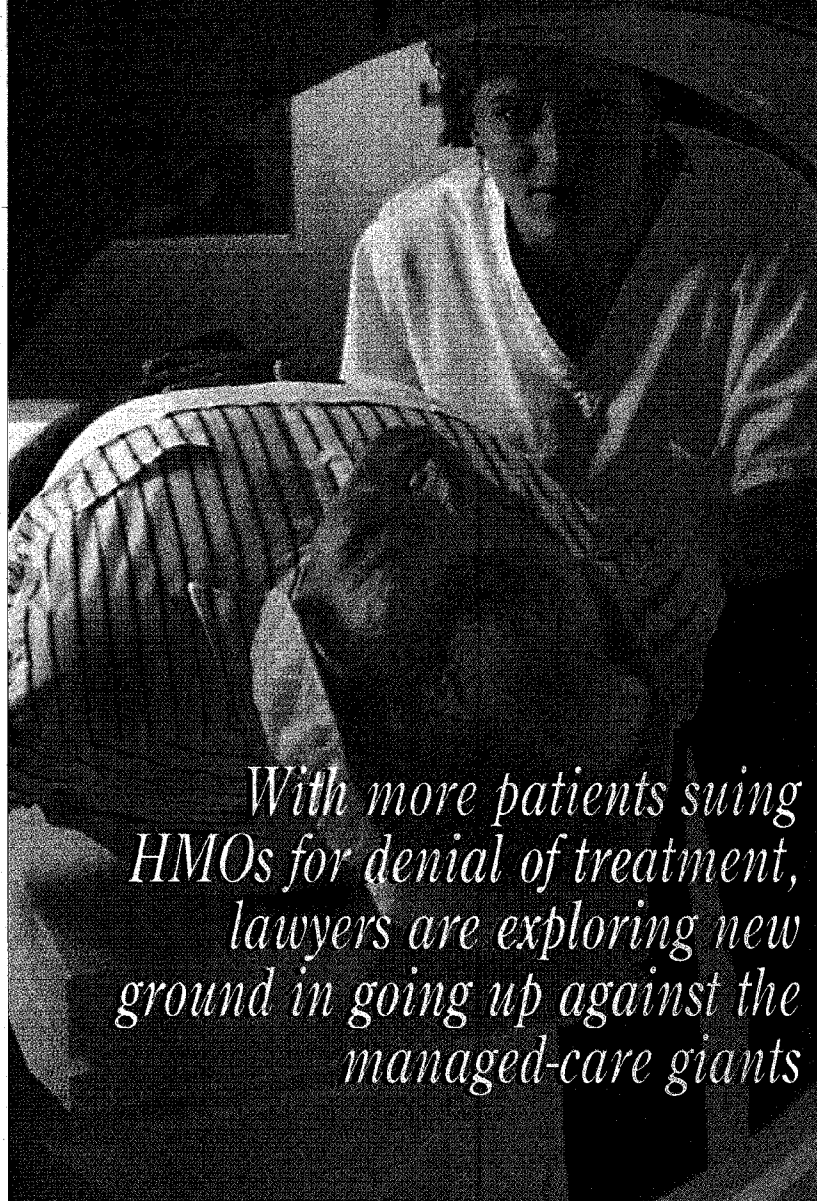
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Next month from ABA Connection

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In Pursuit of Health



With more patients suing HMOs for denial of treatment, lawyers are exploring new ground in going up against the managed-care giants

BY RICHARD C. REUBEN

California general practitioner Mark Hiepler thought that the problem could be resolved with a simple letter.

His sister, schoolteacher Nelene Fox, had breast cancer, and her doctor wanted her to have a bone marrow transplant. But her health maintenance organization, Health Net, refused to pay for the \$100,000 treatment, contending it was experimental at her advanced stage, and therefore not covered by her policy. Hiepler sent a letter questioning the decision, and then another, and another, each falling on deaf ears as his sister's condition worsened.

"I couldn't believe their arrogance," says a still-shocked Hiepler. "The policy language was clear, but they just didn't want to pay for the treatment, even though there was a reasonable chance it would have saved her life if it had been done when her treating physician asked."

Hiepler, then just five years out of Malibu's Pepperdine law school and shoehorning help for his sister into a busy associate's schedule, finally sued Health Net for refusing to provide treatment. He won an \$89 million jury verdict that stunned the managed-care industry, although it was later reduced in a settlement.

The award in 1993, however, came too late to help Fox, who had raised the money for treatment on her own but died eight months before the verdict.

Her now 34-year-old brother is still playing an Arthurian role. Hiepler's crusade includes more than 130 denial-of-treatment cases now pending and about 100 hours of pro bono work each month to field nearly 400 calls from disgruntled patients or attorneys seeking advice on how to handle the cases.

Since the Fox case made national headlines, media coverage of problems with HMOs and other managed-care entities has exploded. It has been stoked by a slow but steadily increasing stream of consumer complaints about delays in or denials of treatment as experimental, unnecessary or beyond coverage—and more multimillion-dollar plaintiffs' verdicts, including several key cases by Hiepler.

"We're far from the peak of this

kind of litigation," laments Dave Willett, a California medical-care defense lawyer, echoing other industry attorneys. In fact, some managed-care insurers have begun stoking their reserves in anticipation of a wave of denial-of-treatment-related claims, as the nation continues to undergo a fundamental shift in the way health care is funded, organized and administered.

"There is less personal association between the patient and physician, and when that personal relationship is gone, people don't feel as kindly as they did when things go wrong, making them more inclined to sue," says Willett of Hassard Bonnington in San Francisco.

But there are other forces building this tide, including the ever more cost-conscious treatment orders by managed-care decision-makers and the fantastic growth of the industry. Thanks largely to employer-sponsored plans, nearly 150 million Americans received their health care through HMO and other managed-care entities in 1995—an increase of more than a third from the 91.8 million enrollees in 1992, according to the American Association of Health Plans.

Similarly, more than half of this country's physicians now do at least some managed-care work. Both patient and physician enrollments are expected to grow.

Managed-care advocates praise its cost controls on treatments for beginning to tame the health care beast, which devoured nearly 14 percent of the nation's gross domestic product in 1994, according to the U.S. Department of Health and Human Services. Such belt-tightening is necessary to allocate health care dollars rationally, advocates con-

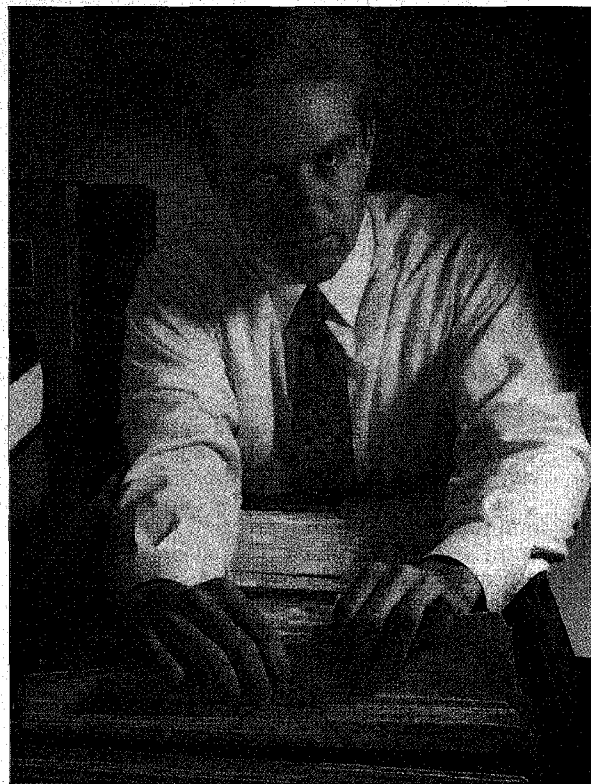
tend, pointing to direct patient costs as proof that a healthy balance has been achieved.

But critics contend that managed care is more about making money than saving it. Even though costs have gone down, they argue, premiums have remained high and corporate profits have soared. More significantly, they charge that managed care delivers second-class treatment because of the way doctors in the plans are compensated.

Because of a financing arrangement called "capitation," which sets a fixed fee per patient, and broad incentives to reduce costs, critics claim doctors have powerful inducements to scale back on treatments and hospital stays, and to limit referrals to specialists. Managed-care providers deny it.

For many sick patients, the decisions on treatment can be shocking, frustrating, painful and, in cases like Nelene Fox's, deadly. They can be equally vexing for doctors, who are often thrust into a Hobson's choice among potential malpractice for undertreatment, paying for treatment themselves if they have exhausted capitation amounts, or banishment from HMO rosters for overtreatment.

This in turn is breeding resent-



Mark Hiepler

HMOs use words like 'experimental' to label anything they don't want to pay for.

Richard C. Reuben, a lawyer, is a reporter for the ABA Journal.

ment among doctors for what they see as the usurpation of their judgment and independence by cost-conscious executives or, worse yet, nonmedical support staff.

The tension among the parties is becoming more palpable by the day, as lawyers for doctors, patients and managed-care entities are doing battle on a variety of fronts in the courts and legislatures—including questions of HMO liability, legal debates over medical judgments, and the prospect of physician actions against HMOs—that will establish the future contours of managed-care liability.

In the erstwhile fee-for-service era, lawsuits were relatively straightforward: The doctor performed the services and was the primary target for litigation when something went wrong. But managed care has changed that dynamic dramatically, and is beginning to replace the doctor as the deep pocket of choice in medical-care litigation.

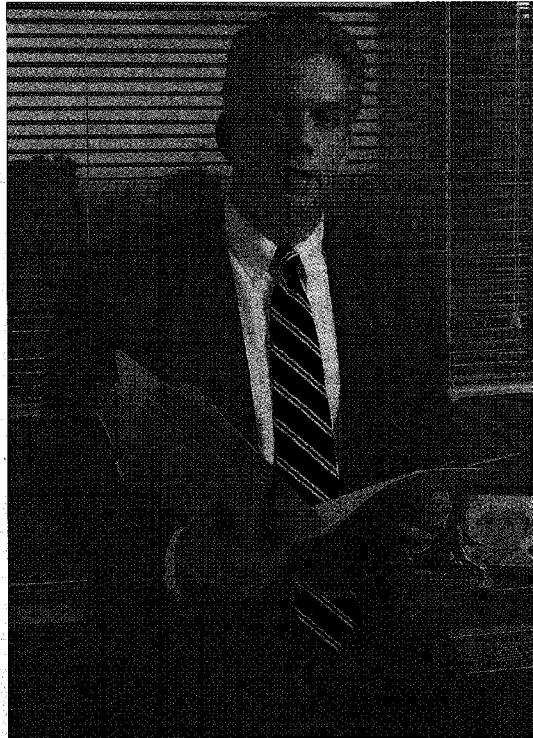
But it is a choice fraught with peril, as suing an HMO for the denial of treatment or payment for services is much more difficult and complex than yesterday's medical malpractice cases. Many HMOs require the mandatory arbitration of treatment and other claims, which keeps such matters out of court unless the arbitration provision can be trumped.

ERISA Pre-emptions

State law claims, moreover, are often pre-empted by the federal Employee Retirement Income Security Act, given the U.S. Supreme Court's broad view of ERISA pre-emption of legal issues "related to" employee benefit plans. This is significant because punitive damages generally are not available in actions governed by ERISA, and because federal courts are often considered to be friendlier to managed-care defendants than to plaintiffs.

While the trend for now appears to favor ERISA pre-emption of state law claims against HMOs aris-

ing from employee health plans, courts are still splintering on the details of an issue that is often one of the first points of contention in an HMO suit. Most experts say the U.S. Supreme Court will ultimately have to decide the scope of ERISA pre-emption in the HMO context to establish uniform rules.



Domenick DiCicco: The more control an HMO has over its doctors, the more its liability will increase.

Regardless of venue, however, managed-care entities have historically benefited from the so-called "corporate practice of medicine" doctrine. The doctrine essentially bars direct malpractice lawsuits against most types of HMOs and managed-care entities on the theory that they are not corporations formed to practice medicine; rather, they are formed like insurance companies just to pay for the treatments. Like ERISA pre-emption, the application of the doctrine is often an early battleground, as attorneys parse organizational charters and related facts to determine the scope of an HMO's legal authority.

With clients at their doors, plaintiffs' lawyers have used two other central theories to scale the often statutory corporate-practice-of-medicine wall—vicarious liability and corporate negligence—although the growing number of judicial deci-

sions on motions for summary judgment continue to conflict.

Domenick C. DiCicco Jr., a Philadelphia litigator who handles matters for CNA Insurance Cos., says a managed-care entity's agency liability is real, that it is going to depend on the nature of the relationship between the doctor and the entity.

"The more HMOs exercise control over their participating physicians, the more their exposure to liability for the torts of the doctors will continue to increase," maintains DiCicco, of Simasek, Ruzzi & McKee. "Many of the complaints are ridiculous and get dismissed rather easily, but other times you just have to wonder what [the HMO] was thinking," he says, calling the liability issue "a disaster waiting to happen."

HMOs that hire doctors as full-time employees have generally been found liable under a respondeat superior theory much as any other company would be liable for actions of its employees. Some courts, such as the U.S. Court of Appeals for the District of Columbia in *Schlier v. Kaiser Foundation Health Plan*, 876 F.2d 174 (1989), have extended this rationale to find HMOs vicariously liable for the negligence of consulting physicians.

The majority of HMOs present harder cases because the doctors are independent contractors rather than staffers. This means the HMO can only be held liable for a doctor's misconduct if the doctor was an "apparent" or "ostensible" agent of the HMO.

Experts agree this is an expensive, fact-intensive inquiry, which requires a plaintiff to show that he or she looked to the HMO rather than the individual physician for care, and that the HMO held out the physician as its employee, creating a reasonable presumption in the eyes of the patient that the physician was the agent of the HMO.

Advertising and marketing efforts can be crucial evidence in this determination, and can give rise to fraud as well as other forms of liability. In one case, for example, an HMO patient who had to have an arm amputated after a misdiagnosis based on a consulting radiologist's report was allowed to sue the HMO for malpractice largely because it promised plan members "complete health care services." *Decker v. Saini*, WL 277590 (Mich. Cir. Ct. 1991).

On the other hand, an Illinois HMO was able to avoid apparent agency liability, in part, by specifi-

cally informing patients that it does not provide medical services. *Raglin v. HMO Illinois, Inc.*, 230 Ill. App. 3d 642 (1992).

Larry R. Rogers Sr. of Powers, Rogers & Lavin in Chicago, who represented Gerik Raglin in a claim for damages arising from the troubled pregnancy of his mother, said the court's decision was driven by

HMOs since the late 1980s. *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58 (Mo. 1989).

As with apparent agency, this approach is costly, fact-intensive and unpredictable as courts work their way toward consensus rules. It may also be more difficult than the agency theory for plaintiffs, in that they have to show the HMO was legal-

County (Cleveland), Ohio, slapped an HMO with a \$1.25 million verdict on a corporate negligence theory for a doctor's failure to diagnose a cancerous lung tumor, and the verdict was affirmed on appeal. *Isbell v. Kaiser Foundation Health Plan*, 619 N.E.2d 1055 (Ohio Ct. App. 1993).

"The agency principle is a long-standing one, but corporate negligence is where it's really starting to come down," defense lawyer DiCiccio says. Recent trial court rulings, he adds, "have made it clear that HMOs are going to be on the hook for direct corporate negligence."

Paul Herrington III, insurance counsel for a national HMO, says most denial-of-treatment complaints against HMOs arise from two situations: Either the HMO considers a treatment experimental or unnecessary, or it is not covered by the HMO policy.

"You may really need eyeglasses or a stay in a rest home, but that doesn't necessarily mean that it's covered by the policy or that the HMO is going to pay for it as medically necessary," says Herrington, chair of the ABA's new Health Law Section.

Patients who disagree with a coverage issue can generally appeal within the HMO, which often resolves the problem. "A lot of people just think insurance covers everything," Herrington says. "When you show them why something wasn't covered by the policy, they tend to understand. They may not be happy, but they understand."

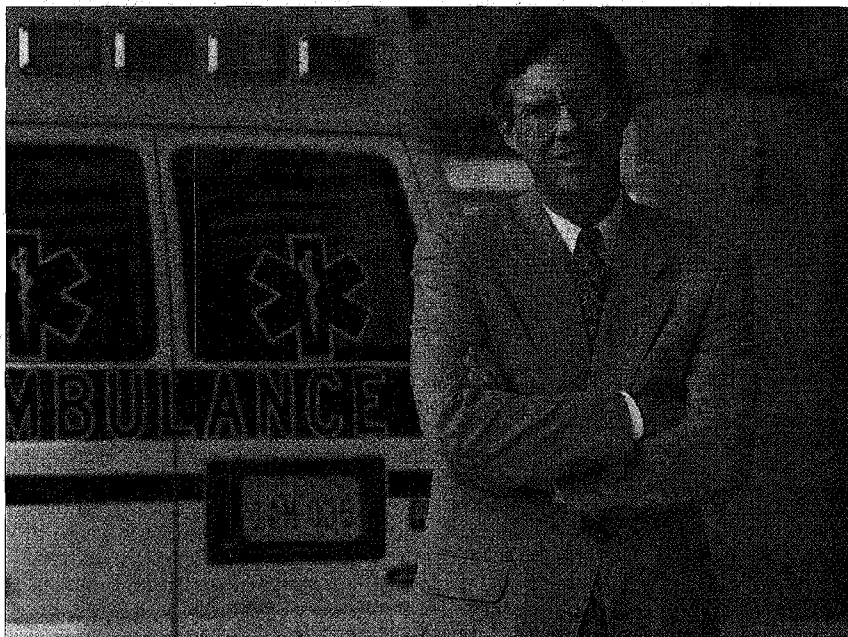
To safeguard consumer loyalty and goodwill, HMOs frequently cover matters that they don't have to, Herrington adds.

Into the Fray

Lawyers are increasingly being brought into play at the earliest stage, when internal review is sought for an HMO's decision to deny treatment on the basis of lack of medical necessity or experimental treatment—even though decision-making at this point tends to be driven far more by medical factors than legal considerations.

James Griffin, a Westbury, N.Y., solo practitioner who has handled several denial-of-treatment cases, says this stage is much like any other negotiation, requiring fact-gathering, phone calls, letters and strategies—except that speed is particularly important.

"This is about getting the pa-



Paul Herrington: People need to know that even though medical insurance doesn't cover every eventuality, they can still appeal within their HMO.

the corporate-practice-of-medicine doctrine. He also called "for an appropriate legislative remedy so HMOs cannot avoid liability by setting up corporations under acts that provide them the immunity from liability that they now enjoy."

In the past, employers have typically weighed competing health plans primarily by cost, rather than quality, according to plaintiff's lawyer Hiepler. "They're acting as a fiduciary for their employees when they select plans," Hiepler says. "But if they don't engage in a due diligence inquiry on quality, then they may be subject to liability."

While this theory of liability is just emerging, HMO liability for corporate negligence is further along. The idea is that HMOs owe a duty to patients to exercise reasonable care in ensuring the competence of physicians and staff they hire or approve, as well as in maintaining facilities. The theory has been applied to hospitals since the mid-1960s, and has been extended to

ly negligent in selecting its physicians and managing its staff and facilities, rather than that a physician was negligent in a given situation.

Still, experts see direct corporate negligence liability taking root with increasing speed. For example, a Pennsylvania appeals court upheld a corporate negligence action against an HMO for failing to properly screen a physician whose patient died of cancer after the doctor failed to get a biopsy or perform follow-up treatments.

In so doing, the court said an HMO that uses independent contract physicians owes its patients a duty to "select and retain only competent physicians" and to "formulate, adopt and enforce adequate rules and policies to ensure quality care" for its patients. *McClellan v. Health Maintenance Organization of Pennsylvania*, 442 Pa. Super. 504 (1995). Failure to meet such duties, the court said, will subject an HMO to direct corporate liability.

Indeed, a jury in Cuyahoga

Curing HMO ills by ballot

While litigation is a key battleground for determining who will control American health care, the fight is also being waged on political fronts throughout the nation.

Nowhere is that battle being more fiercely fought this autumn than in California, where tens of millions of dollars are expected to be spent on two November ballot initiatives that would rein in perceived HMO abuses.

One measure, Proposition 216, is being sponsored by the Ralph Nader-backed Foundation for Taxpayer and Consumer Rights and the California Nurses Association. The other, Proposition 214, is sponsored by the Service Employees International Union and the California Physicians Alliance.

Both measures ban financial incentives to doctors and nurses to deny care, bar so-called "gag orders" on doctors who want to give more information to patients and second opinions before recommended treatments could be denied. The Nader-backed initiative goes even further, imposing a tax on certain health care mergers, hospital closures and executive compensation; establishing a consumer watchdog agency to monitor HMO practices; and barring the mandatory arbitration of medical malpractice cases.

"Treatment should be determined by the care we need, not how much it costs," says Harvey Rosenfield, a veteran Nader's Raider who spearheaded California's massive auto insurance revolt, Proposition 103, in 1988.

While both California measures are hard-nosed, a pair of Oregon ballot initiatives go even further. One would bar HMOs from using capitation—or per patient, per month payments—as a means of compensating physicians. The other would permit patients to choose any kind of health care provider—from acupuncturist to neurosurgeon—rather than being limited to those on HMO-approved lists.

Proponents of such initiatives are expected to play on consumer frustration with HMOs, while the industry and employers are expected to argue that the initiatives will drive up medical costs and ruin the emerging managed-care system with too much government regulation.

Virtually all 50 states are considering legislation that would respond to consumer complaints about HMOs. New York state passed a sweeping managed-care reform measure earlier this year that broadens disclosure requirements, creates utilization and grievance review procedures, and bars HMOs from issuing physician "gag orders."

It also provides specific due process protections for doctors who are terminated by HMOs and makes it harder for HMOs to deny emergency room costs.

Blair Horner, legislative director for the New York Public Interest Research Group, says of the provisions, "The fact that they're all together in the same bill probably makes it the most comprehensive reform in the country."

So far, that is.

—Richard C. Reuben

tient the care that's necessary as soon as possible, not about ultimately winning a lawsuit," he says. His added advice: It's wise "to let the HMO know you are demanding review on an expedited basis because your client isn't getting the necessary treatment."

One common criticism of the review process is that the boards either are composed of business people or physicians who are personally or institutionally beholden to the HMOs, and therefore have a financial incentive to rule in favor of the HMOs. It is a criticism HMO attorneys strenuously deny.

Rather, they contend, debates over medical treatment by review boards simply mirror similar debates within the medical profession itself.

For example, women in the United States undergo hysterectomies at a rate about five times that of other developed countries. At an average cost of \$5,000 an operation, HMOs are increasingly scrutinizing requests for the surgery while looking at other treatment options.

How long women who have given birth should be allowed to remain in a hospital is another point of contention. After public outcries over widespread practices of discharging new mothers within 24 hours of delivery, more than 20 states this year have enacted statutes requiring hospitals to allow post-delivery stays of at least 48 to 96 hours.

But Herrington insists such instances are "not a question of bad faith." Rather, they reflect "serious, well-founded debate within the medical community" over proper medical care. Other examples of often requested, often denied treatments include bone marrow transplants, psychiatric-related therapy and temporomandibular joint surgery for headaches.

But Hiepler says the argument sweeps too far. "It's the best way for an HMO to ration care without saying so," he argues. "They do not want to specifically exclude anything, so they put in words like 'experimental' or 'investigational' or 'medically necessary' that have

no meaning, and can't be defined, to provide a label for anything they don't want to pay for."

Therein lies the gulf between the camps, and when the brawl spills over from the utilization review board into the courtroom, the results are predictable. Plaintiff's lawyers who have been successful in surviving the HMO's summary judgment motion ply juror emotions, while HMO lawyers battle a negative public image in contending that a treatment wasn't medically necessary or was experimental and, therefore, excluded from the policy.

In the end, "It's very much a battle of the experts," says medical defense litigator Davis Carr III of Carr, Alford, Clausen & McDonald in Mobile, Ala. "Denial-of-treatment cases are not unlike medical malpractice cases in that, in almost every case, you have the physician's judgment at issue, with someone disagreeing with or second-guessing someone else's judgment."

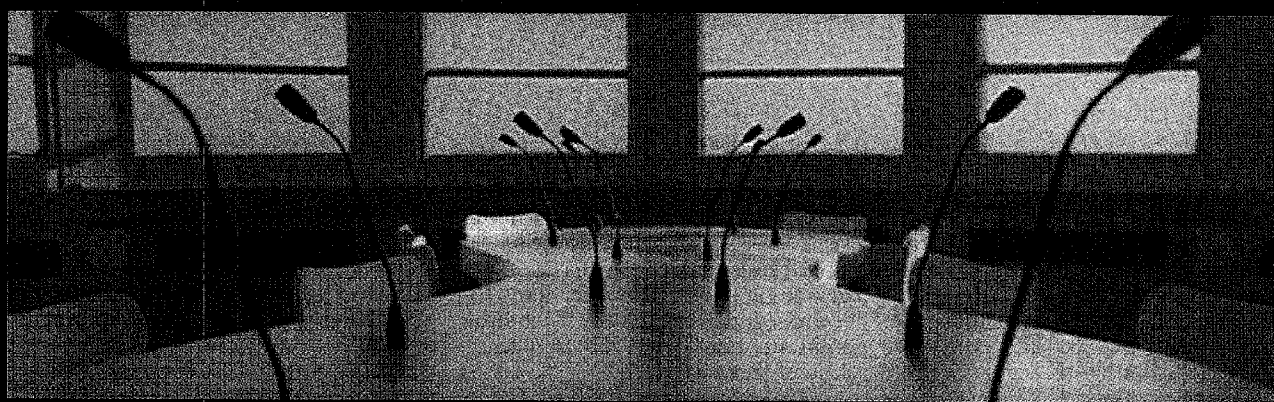
Doctors Suing HMOs

This "second guessing" is increasingly what gives rise to agency liability for HMOs, as well as a rising level of litigation unknown in the old fee-for-service system: doctors suing HMOs and other managed-care entities.

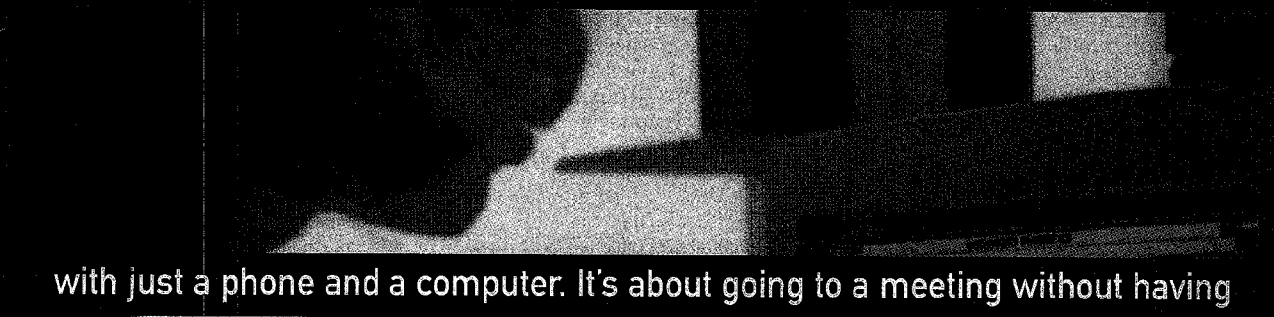
Doctors are, quite literally, caught in the middle in the battle over treatment between patients and HMOs. They are finding themselves in the position of being patient advocates when the HMO says no.

"We advise [doctors] it's imperative they properly document what they're asking for, and what led them to their conclusion that it's necessary," says Timothy A. Johnson of Gardner, Carton & Douglas in Chicago, a firm that represents both doctors and managed-care entities. "I, for one, believe that managed-care entities don't want the malpractice liability, the bad faith accusations, the bad publicity, and really just need for doctors to properly document what they're doing. Too often, that's just not done."

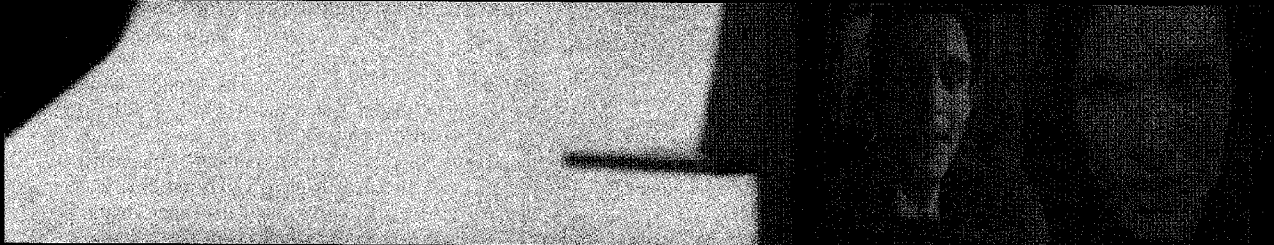
The issue of the impact of HMO decisions to deny treatment on medical malpractice standards is still largely uncharted territory. But most experts for now agree that the primary duty of care is that which a reasonable physician in the community would have provided, regardless of HMO decisions about payments for services.



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This puts the doctor in the awkward position of either going forward with a procedure that won't be reimbursed by the HMO or the patient, or being subjected to malpractice liability if something goes wrong for failing to carry out a treatment he or she wanted to do. Not surprisingly, many doctors prefer to reduce the risk by paying the costs of the denied treatment out of their own pockets.

As those costs continue to rise, however, some attorneys see the need for what may someday be called the "HMO made me do it" defense to a physician's malpractice liability.

"If a treatment decision is not made in good faith and is made for

care entities continues to rupture.

In the meantime, Goldring says physicians in such situations do have remedies. "I would try to bring the HMO into the original suit on a cross complaint and handle it there," he says. "The idea is, 'You turned me down, your decision was wrong, and I think you should stand up here with me and take some of this fault.'"

"Yet, doctors are timid about taking such a course of action, just as they are loathe to advocate too vigorously on their patients' behalf when the HMO denies treatment. HMOs, after all, have the power of the purse, and many physicians are openly fearful of making decisions

different HMOs, so a decision by the HMO to remove them from the list may not be that economically disastrous. "It depends on what percentage of practice is being terminated," says Goldring.

For example, he says, a physician who loses 5 percent of business after being released by one HMO for overutilization may not feel it's worth the fight to challenge that action. However, losing 50 percent or more of business might make litigation a necessity of survival—a prospect increasingly possible as the managed-care industry begins to consolidate.

Like patients denied treatment, however, such doctors are plaintiffs in search of a theory, as early-generation federal antitrust and RICO claims, and state law claims for tortious interference with prospective economic advantage by excluded doctors have generally failed to survive motions for summary judgment. *Hassan v. Independent Practice Associates*, 698 F. Supp. 679 (1989).

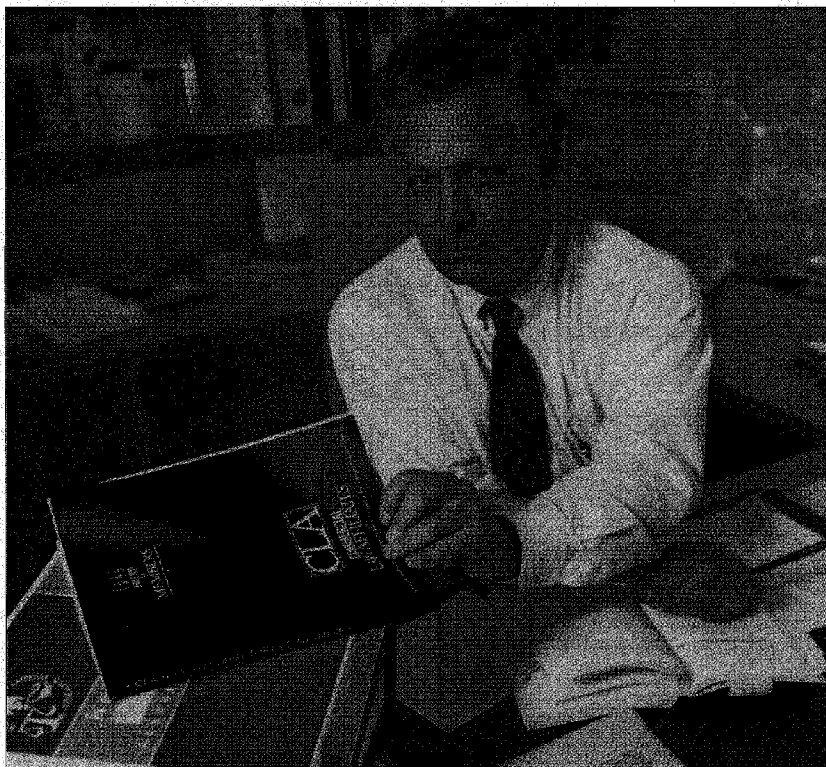
Most physicians or physician groups have contracts with HMOs that provide for periods in which either party can renew or terminate the relationship without cause.

But at least one state supreme court has ruled that the refusal to reappoint a surgeon to a panel after 10 years with the HMO could violate public policy, and permitted the surgeon to challenge the decision on the ground that the termination violated the implied covenant of good faith and fair dealing traditionally read into contracts. *Harper v. Healthsource New Hampshire*, 674 A.2d 962 (1996).

"I see this as a brand new area of litigation," says Hiepler. "You don't have state caps on punitive damages, you don't have to worry about possible ERISA pre-emption, you don't have any arbitration clauses."

And, he adds, "There is the potential for huge damages because you're able to argue to a jury that this is a doctor who just wanted to treat patients, but the HMO only wanted doctors who wouldn't give patients adequate treatment."

It likely won't be the last new area, as managed-care litigation only promises to expand, with issues yet to be conceived as plaintiff's lawyers work to get into HMO pockets—and managed-care lawyers fight to keep them out. ■



Michael Goldring: Physicians facing a malpractice suit may want to fall back on the 'HMO made me do it' defense, though that strategy can lead to their termination.

economic rather than medical reasons, there should be some form of redress for the physician," says Michael Goldring, a Fresno, Calif., lawyer who represents doctors and other medical care providers.

While such an argument may have emotional sway with a jury, no court is believed to have yet endorsed such a defense in a published decision. But that day may be coming as more such complaints are filed, and as the relationship between providers and managed-

or taking positions that would lead to them being cut off from the financial umbilical cord of approved-provider status," says Goldring.

"Doctors who are seen to be overutilizers are being tossed out of the plans, and as the numbers become more significant, those decisions will likely be litigated because they are about professional survival," says Jay Christiansen, an attorney with Faegre & Benson in Minneapolis, Minn.

Many doctors work with many