Litigating around ERISA to Quality Managed Healthcare: An HMO Can Breach Fiduciary Duties

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I. INTRODUCTION

Health maintenance organizations ("HMOs") have been broadly accepted across the country as a tactic to keep healthcare costs under control. The key issue emerging from widespread HMO adoption is what happens to the individual patient who suffers negligent medical assistance or surgery? This exact situation occurred when Patrick Shea died of heart failure at the age of forty, and his wife, Dianne, decided that the HMO that provided his medical coverage should be held responsible. The family physician, who was under contract with the HMO, ruled out sending Patrick to a cardiologist even though he...
had complained of chest pains and shortness of breath.\textsuperscript{2} Dianne, however, contended during litigation that the HMO was legally liable for her husband’s death since it provided financial incentives for the general practitioners not to refer patients to expensive specialists.\textsuperscript{3}

The HMO in this case, Minnesota-based Medica, responded with a familiar litigation strategy. Medica contended that since Patrick received his insurance from an employer-sponsored health plan via the HMO, Dianne could only proceed in federal court pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA").\textsuperscript{4} This seemingly trivial argument was an absolute catastrophe to Dianne Shea’s legal cause of action. It meant that the damages she could recover would be limited to the cost of treatment denied her husband, as opposed to compensation for wrongful death as tort law would typically allow. The key difference arises in that under state law, ERISA would not preempt the allowance of unexpected death damages. However, if the court concluded that ERISA controlled, then the damages would be limited significantly.\textsuperscript{5}

As a result, Mrs. Shea’s only option was to file a claim based on the argument that a fiduciary responsibility was created by the HMO’s

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\item[2.] See id. at 626. Medica’s primary care doctors received payments for not making referrals to expensive specialists. Mrs. Shea argued that had her husband known this, he would have paid for the cardiologist at his own expense and probably saved his life by doing so. See id. at 627.
\item[3.] See id. at 627. The issue of financial incentives was a focal point of the pleading battle between the two parties, as Mrs. Shea amended her initial complaint to uncover this fact and thereby argue the breach of fiduciary duties emanating from Medica as a result of ERISA. See Employment Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1002(21), 1104(a)(1) (1994). The district court dismissed the amended complaint holding that the undisclosed, behind-the-scenes compensation arrangements were not “material facts affecting a beneficiary’s interests.” See id. at 627.
\item[4.] See id. at 627. In language used in a number of similar HMO cases that involved the ERISA removal issue, the Eighth Circuit stated that “ERISA supersedes state laws insofar as they ‘relate to any employee benefit plan.’” Id. (quoting ERISA, 29 U.S.C. §1144(a). This language from the ERISA statute has been used in a number of cases to support similar HMO immunity arguments.
\item[5.] Mr. Shea’s damage recovery under ERISA would have been limited to the actual cost of the specialist treatment denied with no consideration of state tort claims, such as wrongful death. However, the district court was far more focused on the nature of the fiduciary relationship between Medica and the patients. The circuit court stated that “the duty of loyalty requires an ERISA fiduciary to communicate any material facts which could adversely affect a plan member’s interests.” Id. at 628 (quoting Varity Corp., 36 F.3d 746, 754 (8th Cir. 1994)). Quoting Eddy v. Colonial Life Ins. Co. of Am., 919 F.2d 747, 750 (D.C. Cir. 1990), the same court stated, “[t]he duty to disclose material information is the core of a fiduciary’s responsibility, animating the common law of trusts long before the enactment of ERISA.” Id.
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relationship with the physician and the patient. The chances of winning on this argument in state or federal court are not nearly as good as on a simple state tort claim because a fiduciary stands in high regard. Mrs. Shea, however, refused to let her lawsuit die. Medica settled the claim after the Eighth Circuit Court of Appeals set aside the District Court's decision upholding Medica's motion to dismiss on the bases of ERISA preemption and that the fiduciary issue was too novel a legal theory on which to base a claim.

A similar case, *Herdrich v. Pegram*, unfolded in the Seventh Circuit with a final decision rendered on August 18, 1998. In *Herdrich*, the patient, Cynthia Herdrich, complained to physician Pegram of abdominal pains. Pegram worked as a providing physician under the Carle Clinic Association, P.C., ("Carle"), an HMO that paid its participating physicians annual "cost containment" payments for keeping the total cost of medical care low. In Ms. Herdrich's case, Dr. Pegram made a grave malpractice error and elected to delay immediate further treatment that would have diagnosed her impending appendix rupture. Instead, Dr. Pegram sent Ms. Herdrich home where her appendix ruptured, and she contracted peritonitis as a result of Dr. Pegram's negligence.

Ms. Herdrich sued Dr. Pegram for negligence and malpractice. She also sued Carle for breach of fiduciary duty under the ERISA statute, since the HMO provided a cash incentive to its physicians. She ultimately received a malpractice settlement against Dr. Pegram. Carle chose to whisk the case into safe arms of an ERISA defense similar to that faced by Mrs. Shea in the case mentioned above, and to keep low-key the counter-argument that cost containment payments

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6. See Shea v. Esensten, 107 F.3d 625, 627 (8th Cir. 1997). However, the Eighth Circuit soon noted its disagreement with the district court's conclusion that there had been a breach of fiduciary duty:

ERISA supersedes state laws insofar as they 'relate to any employee plan.' 29 U.S.C. §1144(a). To this end, the language of ERISA's preemption clause sweeps broadly, embracing common law causes of action if they have a connection with or a reference to an ERISA plan. Here, Medica administered Seagate's employee benefit plan, and Mrs. Shea maintains Medica wrongfully failed to disclose a major limitation on her husband's healthcare benefits. Along these lines, we have held that claims of misconduct against the administrator of an employer's health plan fall comfortably with ERISA's broad preemption provision.

*Id.* (citations omitted).

7. See id. at 628-29.


9. See id. at 365.

10. *Id.* at 372-73.

11. See id. at 374.

12. See id. at 365.
do not constitute grounds for a breach of fiduciary cause of action. While little mention was made of the incentive nature of the program by Carle, Seventh Circuit Judge John L. Coffey saw the case differently and ruled that the "specter" of doctors receiving yearly kickbacks for withholding medical treatment cast a great shadow of doubt on whose interest the physician represented. The Herdrich case was argued before the United States Supreme Court on Wednesday, February 23, 2000, and promises to be a critical opinion in the managed care debate.

Clearly, the area of health law is increasingly becoming something of the Wild West with regard to coverages and whether or not health-care organizations are doing what they promised to do when they entered the scene ten to fifteen years ago. First, this article will examine the ERISA statute as a shield to HMO litigation and review a number of the common law tort theories used in various courts in medical malpractice cases against a managed care organization ("MCO"). In these latter cases, courts held that ERISA did not apply or could not be relied upon to restrict damages, thereby wrecking the absolute first-line HMO defense. Finally, some discussion will be offered regarding actions filed under the Americans With Disabilities Act ("ADA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and state legislative action taken to deal with this problem on an individual basis. To conclude, the HMO patients' fear that with a patchwork of case law and statutes put forward by legislatures and individual plaintiff's attorneys, the likelihood increases that what will emerge is a hodgepodge of solutions geared strictly to get around the ERISA preemption clause. As a result, this article theorizes that ERISA should be held as inapplicable to managed healthcare programs. This goal could be achieved either through an appropriate decision by the United States Supreme Court in Herdrich, a decision comparable to that in Morales v. Trans World Airlines, Inc., or an outright Congressional codicil to ERISA more strictly prohibiting its application to MCOs. Any of these would strip MCOs of their two

13. See id. at 380.
14. See id. at 373. The court stated: "Under the terms of ERISA, Herdrich most certainly has raised the specter that the self-dealing physician/owners in this appeal were not acting 'solely in the interest of the participants' of the Plan." Id. (quoting ERISA, 29 U.S.C. §1104(a)(1)). As ERISA points out very clearly, a fiduciary must put the interests of the participants ahead of all others. See id.
15. See infra Parts III, IV, V.
16. See infra Part VI.
17. 504 U.S. 374 (1992). In Morales, the Texas Attorney General, among others, asserted the right to regulate allegedly unfair and deceptive airline fare advertisements. The airline defendant argued that the term "relates to" in ERISA meant that anything related to "rates or routes" was governed by ERISA, and individual state regulation was preempted. The Supreme Court agreed with the defendant. Id. at 390.
most formidable defenses: removal to federal court and reliance on the preemption clause of ERISA.

By removing a cap on damages, HMOs will be held accountable for all malpractice actions, forcing them to realize that they are in a "life and death" business. The ERISA statute essentially works as a shield that must be stripped away in order to insure equity and fairness of care in the medical field. Medical professionals need to understand that HMO-provided health coverage does not protect against the garden-variety medical malpractice claim.

II. ERISA AS AN HMO LITIGATION SHIELD

ERISA's critical problem is that Congress did not pass it to deal with healthcare cases at all. Instead, Congress designed it to regulate retirement programs and ensure that individual companies properly funded and provided fair vesting requirements for employees' retirement programs. However, skillful lawyers have found ways to use the damages cap in the ERISA statute in ways in which Congress did not intend when it passed ERISA in 1974.

Why should Congress be so reluctant to pass healthcare legislation now, at a time when it is clearly long overdue? The political nature of this issue provides one answer. The issue of healthcare has been bounced around like a rubber ball. Republicans played healthcare turmoil, created by the Clinton Administration when the President attempted to have his wife solve the healthcare problem, to the political hilt. It quickly became clear that Congress lost all interest in finding a solution, and all that mattered was posturing for the 2000 elections. In short, healthcare is now a highly politicized issue, highly partisan in a presidential election year, and no one can expect a solution any time soon.

One bright spot on this cloudy horizon, however, should not be overlooked. A bill proposed by the House would have amended ERISA to add an external review allowing patients to challenge a denial of benefits and not effect ERISA's preemption of suits. Unfortunately, this proposal was narrowly defeated in the summer of 1999, and the Committee which brought the bill to the floor is uncertain whether similar action will occur during a presidential election year.

Senate Majority Leader Trent Lott, a Republican from Mississippi and resident Cheshire Cat in the healthcare debate, has made it clear

19. See infra Part III.
21. See Berkman, supra note 20.
that there will be no movement on this issue until after the election.\textsuperscript{22} He will apparently use any opportunity to preclude meaningful debate of the issue; resolution will not occur under his watch in order to avoid the appearance of a Democratic victory. In the meantime, the courts are clogged with cases that await resolution of this particular issue.\textsuperscript{23} If the question were left up to Douglas A. Hastings the answer would be quite simple. Mr. Hastings' article recently published in The National Law Journal, \textit{HMO Suits Threaten Efficiency}, states: "Let's face it, there is no plan B. We have to make managed care work . . . and the reality is that to deal with the daunting problem of the uninsured, we are going to have to continue to promote and support cost efficiency."\textsuperscript{24}

According to Mr. Hastings, the issue and the answer are obvious: allow HMOs to operate under the current ERISA statutory environment, unencumbered by any state tort claim that would permit individuals such as Patrick Shea to seek judiciary redemption. Clearly Mr. Shea deserves more than the Hastings Plan A, whatever that is. Mr. Hastings' conclusion is unconscionably callous in light of the fact that Congressional politics bog down the HMO issue. The answer here is quite clear. The time has come to bridle ERISA,\textsuperscript{25} either judicially or via statute, so that corporations understand that ERISA was not meant to protect them from corporate-managed answers where the bottom line looked profitable, or at least until the plan was implemented.

More specifically, ERISA was not intended to place caps on well-founded claims brought in medical healthcare cases. If federal courts want to take claims on a diversity basis that have their foundation in state tort claims, then those cases should be litigated relative to the merits of state common law. HMOs should be required to get out from behind the comfortable shield of ERISA and other statutory laws and defend their positions accordingly.

Mr. Hastings would like the federal government to take a more active role, "to focus on making Medicare work in a managed care environment."\textsuperscript{26} The federal government, however, has not made managed care work efficiently and apparently has no intention of doing so during this upcoming election year. Mr. Hastings' position may also be buttressed by his firm's representation of one or more large HMOs that stand to lose a multitude of state tort claim actions if

\textsuperscript{22} See Aronson, supra note 20, at A10.
\textsuperscript{23} See Berkman, supra note 20.
\textsuperscript{26} See Hastings, supra note 24 at A15.
stripped of their ERISA statutory shield. To counter Mr. Hastings' proposals, plaintiff patients' lawyers must shrewdly define their causes of action, such that they can remain intact within the confines of state tort law even though HMOs will remove the case to federal court under diversity jurisdiction. Again, this is no small undertaking, and state tort lawyers know that. Further, the ERISA federal court damages shield remains unanswered with the Herdrich decision outstanding.

Plaintiffs are also hampered by the reality that plaintiffs' lawyers with experience in state court may be uncomfortable or inexperienced in litigating federal cases. Consequently, as soon as removal to federal court via diversity jurisdiction occurs, the plaintiff's attorney may lose some zest and zeal in prosecuting the case to its conclusion. The large law firms know this, especially since they are well-staffed with individuals whose practices are highly specialized and include a federal litigation division. Consequently, the plaintiff's lawyer should draft the complaint in such a way that the state law cause of action will pass muster as a state tort law claim. This ties the federal court's hands and the HMO no longer gets the home field advantage, beyond the more extensive resources that an HMO's legal team tends to bring to the counsel table. If the plaintiff's attorney can overcome this hurdle, chances for settlement increase.

III. COMMON LAW CLAIMS

A. Negligence

Negligence, when dealing with a medical malpractice claim, is one of the most common tort claims. Therefore, a plaintiff's lawyer commonly looks first at an HMO health plan to see whether or not the plan has any room to enunciate a legal cause of action for plan negligence. Under this ideal cause of action, damages are essentially unlimited and the jury gets an opportunity to look at all treatment that the individual patient received, did not receive, or was denied. Unfortunately, the ERISA statute restricts this particular claim by limiting plaintiffs to contract damages only in federal court. This limitation was mentioned above with regard to not permitting the plaintiff to recover wrongful death damages.

Even though the majority still holds this view, the United States Department of Labor advocates an even narrower view of the ERISA

27. Author's prerogative. See Hastings, supra note 24.
28. See id. at A15.
29. See infra notes 50-55 and accompanying text.
30. Id.
31. See supra note 5.
preemption statute.\textsuperscript{32} Clearly, this position is even more anti-patient and anti-consumer than that which has been perpetrated by MCOs.\textsuperscript{33} Unfortunately for the United States Department of Labor and the HMOs, the judiciary has shown no signs of interest in this narrower preemption. Courts have held that quality of care suits ought not be preempted where the health plan procedure provides that the physician perform negligently and the only remedy is to have the cause go forward under the state law claim.

A 1998 Pennsylvania case last addressed this distinction. In \textit{Pappas v. Asbel},\textsuperscript{34} the Superior Court of Pennsylvania reversed a trial court's entry of summary judgment in favor of a third party, the United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare").\textsuperscript{35} Although the appellate court relied on different reasons from those enunciated by the Superior Court, it nevertheless preempted the claims made and affirmed the order of the Superior Court.\textsuperscript{36}

In \textit{Pappas}, Haverford Community Hospital admitted the patient to the emergency room late in the morning of May 21, 1991, complaining of paralysis and numbness in his extremities.\textsuperscript{37} During his admission, he was an insured of HMO-PA, an HMO operated by U.S. Healthcare.\textsuperscript{38} The emergency room physician concluded that the patient was suffering from an epidural abscess and, after consultation with a neurologist and a neurosurgeon who concurred, it was decided that Mr. Pappas' condition constituted a neurological emergency.\textsuperscript{39} Given these circumstances, the attending physician felt it necessary that it was in the patient's best interest to receive treatment at a university hospital.\textsuperscript{40} Dr. Dickter, the attending emergency room physician, made arrangements to transfer Mr. Pappas to Jefferson University Hospital.\textsuperscript{41} At about 12:40 P.M. on the afternoon of May 21, 1991, when the ambulance arrived and Dr. Dickter was prepared to transport Mr. Pappas to the receiving hospital, he received word that U.S. Healthcare denied authorization for treatment at Jefferson.\textsuperscript{42}

Shortly thereafter, Dr. Dickter contacted U.S. Healthcare to obtain authorization for his transfer and, at about 1:15 P.M., the HMO re-

\textsuperscript{32} See supra note 20.
\textsuperscript{33} See infra Part III.
\textsuperscript{35} See id. at 890.
\textsuperscript{36} See id.
\textsuperscript{37} See id.
\textsuperscript{38} See id.
\textsuperscript{39} See id.
\textsuperscript{40} 724 A.2d 889, 890 (Pa. 1998).
\textsuperscript{41} See id.
\textsuperscript{42} See id.
sponded to the inquiry. It advised that the authorization for treatment was still denied but that the physician could transfer the patient to Hahnemann University, Temple University or the Medical College of Pennsylvania. It advised that the authorization for treatment was still denied but that the physician could transfer the patient to Hahnemann University, Temple University or the Medical College of Pennsylvania. Hahnemann was immediately contacted and advised of the situation. It took until 2:20 P.M. for that institution to respond that it could not possibly be prepared to take him for at least a half hour. At that point the Medical College of Pennsylvania was contacted and within minutes it agreed to accept Pappas, who was ultimately transported there at 3:30 P.M. Not too surprisingly, as a result of the loss in precious treatment time, the patient suffered permanent injuries as a direct result of the compression on his spine by the abscess. Mr. Pappas and his wife filed suit against Dr. Asbel, his primary care physician, and Haverford claiming, respectively, medical malpractice and negligence for not arranging a timely transfer in order to handle his emergency. Haverford then filed a third party complaint against U.S. Healthcare, which joined Haverford as a third party defendant, for U.S. Healthcare’s refusal to authorize a transfer to the hospital selected by the Haverford physicians. The third party lawsuit also included a cross-claim against U.S. Healthcare seeking contribution and indemnity.

Consistent with the current jurisdictional custom, U.S. Healthcare came forth with a motion for summary judgment on the third party claims, alleging that ERISA preempted the claims. The Superior Court noted that one method of preemption U.S. Healthcare relied on was that the statute includes a clause providing for express preemption where states have statutes that “relate to” the issue at hand. The Supreme Court of Pennsylvania and the parties agreed that the United States Supreme Court has yet to speak directly to the issue of whether negligence claims against an HMO “relate to” an ERISA plan.

The Court has addressed this issue with regard to airline advertising in Morales v. Trans World Airlines. In Morales, the Attorney
General of Texas wanted to regulate airline advertising under the Texas Consumer Deception Act but could not because the Supreme Court found airline advertising to be the Federal Aviation Administration's prerogative.\textsuperscript{55} This ruling rested on the conclusion that airfares, routes and rates "relate to" the issue of aviation and airline regulation.\textsuperscript{56}

The Pennsylvania Supreme Court noted that briefs by U.S. Healthcare brought forth a number of these cases, obviously arguing that HMOs should be regulated accordingly.\textsuperscript{57} Fortunately, the Pennsylvania Court relied on the Supreme Court's \textit{Travelers} line of cases in which the Court purposely reined in the expansive view previously taken in the \textit{Morales} case.\textsuperscript{58} This is not to say that the \textit{Morales} decision was too broad, but the \textit{Travelers} line of cases is more limited in scope and suitable for application to MCOs. Perhaps the critical case in that line is the \textit{DeBuono}\textsuperscript{59} case, in which a hospital questioned the New York gross receipts tax as applied to hospitals that operated under ERISA plans.\textsuperscript{60}

The \textit{DeBuono} Court found the language "relates to" unhelpful and instead evaluated Congress' intent in enacting ERISA to determine whether state law indeed meant for the ERISA preemptive scope to cover this type of situation. The Court concluded that ERISA did not preempt the gross receipts tax since it was "one of myriad state laws of general applicability that impose some burdens of the administration of ERISA plans but nevertheless do not relate to them within the statute's meaning. . . ."\textsuperscript{61} Based on the strength of this language, and even though the Pennsylvania Supreme Court stated that it supported U.S. Healthcare's position that "the preemption provision" in ERISA should be read broadly, it had no choice but to follow the line of reasoning put forth in the \textit{Travelers} and \textit{DeBuono} case lines.\textsuperscript{62} The \textit{Pappas} court concluded that negligence claims against a health maintenance organization do not "relate to" an ERISA plan as supported by \textit{Travelers}.\textsuperscript{63}

\textsuperscript{56} See \textit{id}.
\textsuperscript{57} See 724 A.2d 889 (Pa. 1998).
\textsuperscript{59} See DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997).
\textsuperscript{60} 520 U.S. at 807.
\textsuperscript{61} \textit{Id}.
\textsuperscript{62} 724 A.2d at 893.
\textsuperscript{63} \textit{Id}.
In 1995, *Dukes v. U.S. Healthcare, Inc.* 64 first put forward the basic issues discussed in *Pappas v. Asbel.* *Dukes,* a Third Circuit case, involved two cases filed in state court against HMOs managed and run by U.S. Healthcare. 65 The plaintiffs in both cases claimed damages arising during medical procedures provided by HMO affiliated hospitals and personnel under a variety of theories. 66 U.S. Healthcare removed both of these cases to federal court pursuant to the ERISA statute and argued that, because the plaintiffs received employer provided welfare benefit plans, the federal statute preempted any state tort claim. 67 U.S. Healthcare went even further to argue that there was complete preemption pursuant to the "well pleaded complaint rule," and accordingly, the plaintiffs' claims were preempted by the respective district courts. 68

The Third Circuit held that the plaintiffs were not covered by employer benefit plans as envisioned by the ERISA statute, thereby eviscerating the preemption exception heavily relied upon by U.S. Healthcare. 69 It reversed the judgments of the district courts with respect to this particular issue and remanded each case to the appropriate district court with instructions that the cases be remanded to the state courts from which they had been previously removed. 70 Although the facts are extremely detailed and recount a variety of mis-treatments afforded several patients at the hands of the defendant, a recitation of the facts in each case is not necessary in order to fully appreciate the consolidated review provided by the Third Circuit. 71 The missing factual backgrounds are merely emblematic of those already reviewed in various other cases where the HMO possessed the superior litigation position, such as in *Shea* and *Herdrich.*

U.S. Healthcare's strategy in this case began with its strongest argument and moved to its weakest via interpretation of language within the ERISA statute. 72 First of all, with the direct preemption clause overruled and reversed outright, U.S. Healthcare fell back to its second position, in which they alleged that the district court lacked original jurisdiction since the claim had arisen from the Constitution and laws of the United States. 73 For U.S. Healthcare, as long as ERISA preemption worked, everything was fine. But as soon as the pre-emption argument failed, their next step was to attack the court's

64. 57 F.3d 350 (3d Cir. 1995).
65. See id. at 351.
66. See id.
67. See id.
68. See id.
69. See id. at 351-52.
70. 57 F.3d 350, 351-52.
71. See id.
72. See id. at 353-55.
73. See id. at 353.
jurisdictional base. The Court, citing *Metropolitan Life Insurance Company*, held that when a cause of action arises under a federal law and removal is proper, removal is based upon whether or not the plaintiffs’ petition properly presents a federal question.

The Third Circuit stated that “a federal defense to a plaintiffs’ state law cause of action ordinarily does not appear on the face of the well pleaded complaint, and, therefore, usually is insufficient to warrant removal to federal court.” This statement meant that U.S. Healthcare’s second defense did not justify removal to federal court. In these particular cases, the district courts found that the state law claims against U.S. Healthcare fell within the scope of § 502(a)(1)(B) of the statute, thereby triggering the *Metropolitan Life* “complete pre-emption doctrine”.

The Third Circuit disagreed. First, it analyzed the state law claims, considering whether or not they fell within the scope of section 502; the court determined that they did not. Second, the HMO argued that the medical care received by the patients was itself the plan benefit and this brought the ERISA statute into play. The court also rejected this argument. Finally, the court considered U.S. Healthcare’s characterization of the plaintiffs’ state court complaints as attempts to enforce their “rights under the terms of the respective welfare plans.” This constituted yet another effort to bootstrap the language of ERISA within the purview of section 502, thus bringing it within coverage of the *Metropolitan Life* case. The Circuit Court noted that no plan-created right existed that was implicated by the plaintiffs’ merely having a state medical plan, nor could state law medical malpractice claims be ignored simply because a state employer provided the plan as a benefit. The court’s analysis concluded with the finding that the plaintiffs were not really trying to define new rights. They were simply attempting to enforce rights that already existed under a state law-recognized benefits plan.

75. 57 F.3d 350 at 353.
76. *See id.*
77. *Id.* at 356.
78. *See id.* at 354.
79. *See id.* at 356.
80. *See id.*
81. *See id.* at 356-57.
82. 57 F.3d 350 at 357.
83. *See id.*
84. *See id.* at 358.
85. *See id.*
B. Agency Theory

Plaintiffs have achieved almost as much success in pursuing claims against healthcare organizations under common law theories of agency as they have in using negligence. Some plaintiffs might even argue that they have had more success arguing apparent authority and vicarious liability when seeking damages under agency theory. This article not only reviews the various state claims and federal statutory claims that a plaintiff might use in a healthcare case, but also briefly summarizes some of the various theories used in successful actions against HMOs. This section summarizes cases where plaintiffs successfully used the agency theory to establish a valid cause of action able to withstand the ERISA preemption claim.

The State of Illinois has been especially successful in fostering lawsuits based upon the theory of vicarious liability, apparent authority, and agency theory against HMOs during the past five years. The Illinois Supreme Court has exercised extremely broad latitude when deciding upon damages for patients who have been injured as a result of actions by health organizations. This has been particularly true when the HMO held itself out as being the provider of the healthcare, but did not inform the patient that the care was given by an independent contractor physician, who was under a contractual relationship with the HMO. To this extent, the patients “justifiably relied” on the HMO’s conduct and they looked to the organization, instead of the particular physician involved, to provide a high level of medical care. As a result, plaintiffs have been making cases for implied authority since they could demonstrate that the HMO exerted control over the doctor and negated any independent contractor status that the individual physician may have exercised on an outward basis to a third party patient.

In Petrovich v. Share Health Plan of Illinois, the plaintiff brought a medical malpractice action against a physician for failure to timely diagnose oral cancer. However, the plaintiff also included the HMO in the complaint, arguing that the company was vicariously liable for its independent contractor’s negligence pursuant to agency law. Plaintiff premised the malpractice claim on both apparent and implied

87. See id.
88. See id.
89. Id.
90. See id.
91. 719 N.E.2d 756 (Ill. 1999).
92. See id. at 760.
93. See id.
authority concepts of agency law.\textsuperscript{94} The trial court ruled in favor of defendants while the intermediate appellate reversed.\textsuperscript{95} The Illinois Supreme Court upheld the HMO's leave to appeal, and then ruled that the plaintiff was entitled to a trial on the merits of vicarious liability as prescribed under apparent and implied authority.\textsuperscript{96}

C. Breach of Fiduciary Duty

One of the most interesting common law claims employed to avoid ERISA preemption has been breach of fiduciary duty, despite its shortcomings relative to trustee standards. The Introduction above briefly discussed this claim as applied in the \textit{Shea} and \textit{Herdrich} cases where the plaintiffs argued that the HMO established a fiduciary duty between itself and the providing physicians by exercising so much control over the procedures that had to be followed, as well as providing a monetary incentive to keep medical costs low.\textsuperscript{97} For example, quality medical treatment was delayed for Patrick Shea, who was suffering from chest pains but was not referred to a cardiac specialist. Mrs. Shea argued that the delay occurred because the physician had an incentive to keep costs low, and thus was a fiduciary of the HMO when there was a failure to render a correct medical judgment. This triggered the breach of duty argument under common law and concomitant potential liability on the part of the HMO.\textsuperscript{98}

This theory now looms large on the horizon as a result of the Supreme Court having heard the Seventh Circuit Court of Appeals case, \textit{Herdrich v. Pegram}\textsuperscript{99} on February 23, 2000. \textit{Herdrich} arose when Cynthia Herdrich filed a complaint against Lori Pegram, M.D., and the providing HMO, the Carle Clinic Association, P.C., alleging that her ruptured appendix and peritonitis resulted from professional medical malpractice.\textsuperscript{100} Given that the physician was part of an HMO plan, the case was argued in federal court with the HMO using the usual ERISA preemption as its primary line of defense, which the court did not receive favorably.\textsuperscript{101} The major issue in the case was fiduciary duty, which got a boost when the Seventh Circuit endorsed it. Carle appealed to the Supreme Court.\textsuperscript{102}

\textsuperscript{94} See id. The court stated: "We hold that the plaintiff has presented sufficient evidence to entitle her to a trial on whether Share [the HMO] is vicariously liable under the doctrines of apparent and implied authority." \textit{Id.}

\textsuperscript{95} See id.

\textsuperscript{96} See id.

\textsuperscript{97} See supra notes 6-11 and accompanying text.

\textsuperscript{98} See supra notes 1-5 and accompanying text.

\textsuperscript{99} 154 F.3d 362 (7th Cir. 1998).

\textsuperscript{100} See id. at 365.

\textsuperscript{101} See id. at 366.

\textsuperscript{102} See id.
Herdrich's legal counsel made all the proper common law tort and statutory claims imaginable but included one that was somewhat unique. In count three, the complaint asserted that the defendants acted as fiduciaries to the plan and, as a result of operating as fiduciaries pursuant to the ERISA statute, the plaintiff should be given wide latitude with regard to recovery.\textsuperscript{103} The plaintiff bolstered this argument with references to the ERISA statute's legislative history as well applicable case law.\textsuperscript{104} This represented a significant change from other claims that had been argued not only in this complaint but in other cases as well, since it proposed that a significant trustee-like relationship existed between the HMO and the physician providing the medical care. The Seventh Circuit concluded "that the defendants are fiduciaries under ERISA" and then next considered whether or not there had been a breach of fiduciary duty.\textsuperscript{105} Again, the court examined the ERISA statute carefully with regard to the requirements necessary for such a breach to occur. The court noted that the single most important requirement set forth by ERISA is that the court look with an eye to promoting the interests of the participants and the beneficiaries, in accordance with judicial guidance.\textsuperscript{106}

The \textit{sine que non} for the Seventh Circuit was that Herdrich alleged a flaw that "springs from the authority of physician/owners of Carle to simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals."\textsuperscript{107} The Court viewed this as raising the possibility of self-dealing between the HMO and physicians and thereby triggering the breach of fiduciary duty possibility.\textsuperscript{108} The Herdrich case represented a major departure from other cases that have been reviewed in this article. Herdrich's attorneys did not include this departure in their complaint, knowing that it could create cross-claims and counterclaims that might be difficult to fend off in litigation.\textsuperscript{109} However, the handful of cases utilizing this theory have been successful, and now there is a string of cases for attorneys to rely

\textsuperscript{103} See id. at 366-67.
\textsuperscript{104} See id. at 366-69; 120 Cong. Rec. 3877, 3983 (Feb. 25, 1974) reprinted in 2 Legislative History of the Employee Retirement Income Security Act 3293.
\textsuperscript{105} See \textit{Herdrich}, 154 F.3d at 370; see \textit{ERISA}, 29 U.S.C. §1002(21) for the definition of fiduciary.
\textsuperscript{106} See 154 F.3d at 370.
\textsuperscript{107} Id. at 373.
\textsuperscript{108} Id. The court stated:

Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of 'loyalty' to his own financial interests. Tolerance, in other words, has its limits.

\textsuperscript{109} See id. at 374-375.
upon as precedent to press this claim forward to an even higher level.¹¹⁰

This particular theory, however, has not always met with such success. In *Weiss v. Cigna Healthcare*,¹¹¹ a New York District Court decided that even though a fiduciary duty existed between the physician/HMO and the patient, the HMO did not violate its fiduciary duties when it gave physicians financial incentives to lower their patients' rates of hospitalization and referrals to specialists.¹¹² Clearly, this issue goes to the very core of the general acceptance of managed healthcare and the reason why the judiciary must embrace the breach of duty cause of action. When managed organizations actually provide financial incentives for physicians not to make costly referrals, the patient inherently distrusts the equity of the entire healthcare network system.¹¹³ The key question will be which of the two approaches the Supreme Court will choose to take in *Herdrich*. One member of the Supreme Court even questioned during oral argument whether this is an issue better left to the legislature and not the courts.¹¹⁴

IV. AMERICANS WITH DISABILITIES ACT

Given the strictures of the ERISA preemption provision, attorneys have looked for creative ways to get around it. One Texas attorney represented a number of health plan members in a lawsuit filed under the American With Disabilities Act ("ADA").¹¹⁵ The patients and two physicians filed an action against an HMO pursuant to the ADA, seeking compensatory and punitive damages as well as other appropriate relief under Texas state law.¹¹⁶ The defendants filed a motion to dismiss, as well as a motion for summary judgment.¹¹⁷ The District

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¹¹⁰. See id.
¹¹². See id. at 743-755.
¹¹³. See *Herdrich v. Pegram*, 154 F.3d 362, 375 (7th Cir. 1998). The *Herdrich* court quoted a well-known medical journal:

> The specter of money concerns driving the healthcare systems, says a group of Massachusetts physicians and nurses, 'threaten[s] to transform healing from a covenant into a business contract. Canons of commerce are displacing dictates of healing, trampling our professions' most sacred values. Market medicine treats patients as profit centers.'


¹¹⁷. See id. at 438.
Court denied both motions because the plaintiffs raised a genuine issue of material fact in suggesting the possibility of discrimination.118 The plaintiffs alleged that the pressure on physicians who participated in the managed care plan to keep costs under control discriminated against disabled patients, placing them in a relationship with their physicians that directly violated the ADA.119 The plaintiffs further claimed that this denied them full and equal enjoyment of medical treatment and services in violation of the discrimination statute, section 504 of the Rehabilitation Act.120 The defendants' primary defense was that the plaintiffs did not exhaust their administrative remedies pursuant to the Medicare Act before bringing this litigation in federal court. The District Court held that remedy exhaustion was not required as a prerequisite to bringing an ADA suit, and that any HMO member was eligible to bring such litigation if he or she was dissatisfied with the health service he or she received.121 The key to this particular issue was that the state law claims that were sheltered under the ADA did not "arise under" the act itself.122 The District Court also noted that even if it agreed with the defendants' argument, the payment of benefits retrospectively would not remedy the plaintiffs' claim made under the Act.123

The court also denied Humana's claim that the plaintiffs had no standing to seek monetary relief, since the HMO argued that the plaintiffs had no right to seek monetary relief and could not prove that there was any likelihood of an immediate or substantial risk of discrimination in the future.124 These are statutory requirements of ADA. Obviously, by making these arguments the HMO was hoping to get the case back to where it could engage the ERISA preemption statute and pay nothing in the process.125 Unfortunately, as the court pointed out, "it is defendants' burden to demonstrate there is no reasonable expectation the wrong will be repeated."126

Finally, the HMO argued that the plaintiffs failed to state a claim upon which relief could be granted pursuant to the ADA.127 For good measure, the defendant HMO also argued that the Texas Medical Practices Act "forbids the corporate practice of medicine and plaintiffs cannot recover under a joint venture theory of recovery."128 If defend-

118. See id. at 440.
119. See id. at 439.
120. See id.; ERISA, 29 U.S.C. § 794.
121. Quezada, 34 F. Supp.2d at 440.
122. See id.
123. See id.
124. See id. at 441.
125. See id.
126. Id. at 441.
127. See id. at 444.
128. Id.
ants wish to have plaintiffs' complaint dismissed on the theory that medicine cannot be practiced via a corporate or joint venture entity in the State of Texas, then how is medicine being practiced in that State at the present time? On its face, this seems to be a somewhat self-defeating argument. Nevertheless, Humana moved forward and the Court denied this defense.129

Because of the sophisticated nature in which the healthcare organizations had been assembled for Humana to own Health Texas, it operates offices within the State of Texas in a manner sufficient to validate the control element claim that the plaintiffs made in their complaint pursuant to the ADA.130 Put another way, the District Court concluded that the plaintiffs did not make a joint venture claim and, therefore, such a claim was not available for dismissal or summary judgment. However, the plaintiffs were prohibited from asserting any type of joint venture argument later in the proceedings.131 The real travesty of this defense argument is that the seamless web referred to in the pleadings is most often concocted by those firms representing the HMOs.132 In summary, the Texas District Court held that a properly pleaded complaint alleging compensatory and punitive damages pursuant to the ADA and requesting relief under state law could stand muster against an HMO and not necessarily be preempted by the ERISA statute.133

V. RICO

One extremely powerful theory supporting a patient-plaintiff's claim against an HMO can be employed under the Racketeer Influenced and Corrupt Organizations Act ("RICO").134 As a litigation remedy, RICO has not been tested in civil actions in the area of managed care liability. However, in at least one case the way has been cleared for a RICO case to be brought against an MCO. In Humana v. Forsyth,135 the plaintiff argued that the health plan engaged in a pattern of wrongdoing by overcharging members relative to co-payments.136 The attorney who represented approximately sixty plan members on a pro bono basis noted that the healthcare field is a new

129. See id.
130. See id. at 444-445.
131. See id. at 445.
132. See id. at 444-445.
133. See id. at 445-446.
136. See 827 F. Supp. at 1501-02.
area for the type of large-scale wrongdoing that RICO intended to deter.\textsuperscript{137}

The case that opened the door essentially held that the McCarran-Ferguson Act,\textsuperscript{138} which protects insurance companies from federal laws impairing a state's ability to regulate insurance, was not effective.\textsuperscript{139} Consequently, the patient could bring a civil RICO action against the managed care company, as could her similarly situated co-members.\textsuperscript{140} Admittedly, a RICO claim in a complaint against a managed care company is a long shot. Defense attorneys argue that it equates with simply throwing any available theory at the HMO and seeing what will hit the target.\textsuperscript{141} These lawyers should understand, however, that in any case where the plaintiffs can show a large scale active fraud by a managed care company that adversely affects all policyholders and rises to a racketeering level commensurate with that of similar cases, courts may allow RICO to reach the healthcare field. Also, remembering that this article presents theories and claims under state law or federal law that escape the ERISA preemption, finessing the subtle nuances of RICO will be well worth the effort should it prove to be successful in reaching an equitable settlement in one healthcare case.

VI. STATE ACTIONS

As Congress wrestles with the question of HMO liability, the states are not standing idly by with respect to taking legislative action on their own. These types of state statutes encompass a wide variety of liability legislation, such as guaranteeing minimum benefits.\textsuperscript{142} For example, an HMO would be required to cover at least two days for certain procedures instead of one.\textsuperscript{143} Perhaps the most hotly contested issue in this particular area is the one versus two-day coverage question for women who have just had babies. Mothers and obstetricians want a second day of hospital time while HMOs would treat childbirth on an outpatient basis, if they could. Achieving this change required much uproar.

Another approach gaining a high degree of acceptability and preference among the various states is one that guarantees health plan members the right to appeal any decision made by an HMO regarding

\begin{itemize}
\item \textsuperscript{138} 15 U.S.C. § 1012(b).
\item \textsuperscript{139} See id.
\item \textsuperscript{140} 119 S. Ct. 710, 718-19 (1999).
\item \textsuperscript{141} See infra note 151; Quezada, 34 F. Supp.2d 433.
\item \textsuperscript{142} See infra note 151.
\item \textsuperscript{143} See, e.g., Corporate Health Ins., Inc. v. Texas Dep't of Ins., 12 F. Supp.2d 597, 602-03 (S.D. Tex. 1998).
\end{itemize}
the medical necessity of a particular treatment. The problem lies in establishing the review mechanism and determining its cost coverage as well as any appeal rights. Also, choosing and qualifying mediators or arbitrators poses a problem. This could create an additional layer of bureaucracy that may make as many problems as it solves.

HMOs fear most that the state legislatures will pass bills that permit or guarantee patients the right to sue HMOs. Managed care will not admit it, but this type of action brings with it the possibility of bankruptcy, the very essence of corporate failure in the legal environment of managed care. At this point, only Texas has passed this type of statute and HMOs have attacked the law via the ERISA statute's preemption provision. Essentially, the managed care industry argues that ERISA preempts the State of Texas from setting up any type of mandatory independent review. On the other hand, Judge Gilmore, in the initial court decision, found that in addition to the right of review, the State also had the right to guarantee the patient's right to sue. This case is on appeal to the Fifth Circuit, and most other states are waiting to see the outcome prior to going down the same legislative path.

Undoubtedly, if the Fifth Circuit upholds Texas statute, states will be less likely to wait for another appeal to the Supreme Court before taking comparable action on their own. The advantage of having a circuit court opinion to use in fashioning a state's "Right to Sue an HMO" bill is priceless in terms of fending off attacks by the managed care industry. Congress holds the key as to exactly how far states will be able to go in writing statutes allowing patients to take action outside the ERISA preemption provision. With the stroke of a pen, a federal bill amending ERISA could include reform to accomplish exactly that, and there does appear to be some inclination on the part of several members of Congress to achieve that end.

On the other hand, many members of Congress feel that ERISA ought not to limit patients and are touting a variety of bills aimed at increasing patient rights and quality care access. These statutes would guarantee the patient an opportunity to have an independent review of any managed care decision, and if the patient felt that it

144. See id.
145. See id.
146. See id. at 628.
147. See id. at 626-628.
148. See id. at 629-30.
149. See Michael Higgins, Second Opinions on HMOs, A.B.A. J., April 1999, at 60, 64-65; Geyelin, supra note 140.
150. See H.R. Res. 2990, 106th Cong. (1999), sponsored by Charles Norwood (R-Georgia) and John D. Dingell (D - Michigan), which would make cost-efficiency illegal in the name of patient protection.
resulted in liability for which damages were due, there would exist a right to sue.151 All of these statutes are slated for discussion on Capitol Hill this year, and an intensive battle has unfolded between the supporters of managed care and patient consumer advocates. The latter believe that managed care promotes saving money over providing quality healthcare, while the former argue otherwise. Invariably, managed care companies are large corporations, and must be in order to provide the kind of cost-wise care that they offer, as well as to meet the demands of stockholders. This question involves a perceived social right: does the typical big company MCO have the best interests of the American consumer in mind or those of the corporate stakeholder?

VII. CONCLUSION

The current primary issue in the healthcare industry is policy preference. Although medical and economic considerations buttress this issue, the question still boils down to the manner in which healthcare should be provided and the limits, if any, that should be placed on the patient in taking action to hold physicians accountable. The ERISA statute, standing alone, provides an excellent forum for the opponents of managed care to argue that the healthcare industry is unaccountable.

Whether or not a patient can litigate his or her way to quality healthcare by circumventing ERISA will be answered in the Herdrich case. The healthcare corporate industry argues that imposing any additional potential liability possibilities on MCOs will drive up premiums and make healthcare more difficult to provide, while consumer and patient advocates argue the opposite. No matter how you cut it the average patient does not have the clout or the understanding of the system to go up against a highly financed, highly skilled MCO with a federal statute expressly protecting its level of liability.

Business-oriented proponents also argue that the more flexibility taken away from HMOs and MCOs, the greater the reduction in their ability to manage care and keep costs down. This was, after all, the very reason that HMOs were created. One possible solution is the implementation of a binding mediated or arbitrated appeal and settlement between the patient and the healthcare provider.152 The mechanics of this procedure will be contentious, and the solution may not arrive in time, especially with all the delays built into litigation procedure and used optimally by MCOs.

In reality, litigation in a managed environment will not likely achieve quality care, but the real hope must be that Mr. Hastings in-

151. See id.
152. See Higgins, supra note 151.
correctly stated that there is no "Plan B." If managed care is the only cost control option, the whole political landscape of this issue will change quickly in this century. Citizens may have a myriad of misgivings about tax policy in this country but the provision of quality, universal healthcare at an affordable price is not one of them. Consequently, only the MCOs see no "Plan B," since that is the position of maximum profit. Plan B will be developed for managed care proponents as they watch in dismay. Accordingly, it would be wise if they simply make hay while the sun shines and observe, despite their best efforts to keep it from happening, the development of a universal healthcare provision system by those who consider more than just cost in making hard decisions. Because, regardless of the decision in Herdrich v. Pegram, the electorate will likely force any judicial solution to be displaced by a more comprehensive legislative approach.

154. 154 F.3d 362 (7th Cir. 1998).