The FTC has recently held the first in an unprecedented series of workshops on healthcare competition law and policy. This month’s Health Law Analysis, written by Robert F. Leibenluft, of Hogan & Hartson, in Washington, DC, examines the implications of the FTC’s new emphasis on healthcare antitrust for healthcare providers, health plans, and pharmaceutical companies.

SPECIAL FEATURE

Selected Liability Issues For Managed Care Organizations

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I. Introduction

Managed care was created as part of the Health Maintenance Organization Act of 1973. The Act was adopted as a response to the escalating cost of medical care, which was blamed, in large part, on fee for service providers ordering unnecessary medical care. The Act was designed to create competition among health plans and financial incentives among providers to reduce the delivery of what was perceived as unnecessary medical care thereby reducing the cost of medical care.

To reduce unnecessary medical care, health plans would:

- credential and review providers on their panels;
- eliminate unnecessary costs by:
  - shifting some of the risks for cost of care to providers;
  - creating financial incentives to providers to deliver high quality care at reduced cost through mechanisms of capitation and provider bonuses;
  - utilizing pre- and post-care utilization review;
  - providing benefit packages to patients and employers designed to reflect premium cost.

The Act was successful in reducing medical cost inflation. However, as managed care became a significant part of healthcare, it has been increasingly under attack from patients, providers, Congress, and state legislatures. Consequently, managed care is in a period of great uncertainty. There is even concern about whether managed care will survive and, if so, in what form. This article outlines several expanding theories of liability against managed care organizations, and the current status of class action lawsuits.

II. Theories Of Corporate Liability For Network Physicians

Traditional theories of corporate liability against managed care developed from hospital medical malpractice cases. Hospital cases established the principle that a hospital has a direct responsibility for the quality of care provided by non-employed independent medical staff members. Courts reasoned that if the hospital breached its duty of responsibility for the quality of care provided by non-employed independent medical staff members, there was a foreseeable risk of harm to its patients.

A. Credentialing

Courts across the country have held that managed care organizations have a duty to ensure that competent physicians render care to health plan enrollees. To fulfill its duty, a managed care organization must carefully select the physicians it has in its panel of providers and it must carefully monitor the care those physicians provide. Courts reason that the failure to investigate a physician’s qualifications creates a foreseeable risk of harm to patients. Moreover, courts also note that this duty should be extended to managed care organizations because they are making choices for their enrollees by limiting the choice of providers and thereby requiring or encouraging enrollees to be cared for by those providers. For example, in Harrell v. Total Care Healthcare, Inc., a patient was referred by her primary care physician to a plan urology specialist. Under the plan, the primary care physician was solely responsible for referral decisions. The patient was injured when the urologist performed negligent surgery. The patient sued the urologist and the health plan. She alleged the health plan was negligent in credentialing and selecting the urologist as a preferred provider. After reviewing the health plan selection process for specialists, the court held that the health plan had a duty to conduct a reasonable investigation of plan physicians to ascertain their reputation in the medical community for competence. The court also noted that the health plan collected from the patient a premium for the expenses of medical care and then limited the patient’s choice to physicians acceptable to the plan. Accordingly, the court reasoned that there would be an unacceptable risk of harm to plan enrollees if the physicians provided by the health plan included unqualified or incompetent physicians.
Similarly, in *McClellan v. Health Maintenance Organization of Pennsylvania*, the patient was a member of a health plan that contracted with physicians on an independent contractor basis. The patient’s primary care physician removed a mole from her back, but did not submit it for pathology evaluation. After the patient died of malignant melanoma, the patient’s family sued the health plan, alleging that the health plan negligently selected and retained the primary care physician and made misrepresentations about the competency of its physicians and the availability of specialists. The court held that the health plan had a non-delegable duty to select and retain only competent primary care physicians and to formulate, adopt, and enforce adequate rules and policies to ensure quality care for its enrollees. It noted that liability for direct negligence could be established under Section 323 of the Restatement (Second) of Torts on the basis that one who undertakes to render services to another for the protection of that person, is subject to liability to that person for physical harm resulting from the failure to exercise reasonable care in rendering services when the failure increased the risk of harm or harm is suffered due to the other person’s reliance on the services.\(^6\)

Today many managed care organizations have credentialing and recredentialing policies and procedures that follow the statutory guidelines for accreditation or accreditation organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); JCAHO Accreditation of Health Care Networks; JCAHO Accreditation of Preferred Provider Organizations; National Committee for Quality Assurance (NCQA); Accreditation Association for Ambulatory Health Care (AAAHC); American Accreditation Health Care Commission (AAHCC); or the Quality Improvement System for Managed Care (QISMC).

Nevertheless, a credentialing plan was recently part of a settlement between Keystone Health Plan East Inc. and the United States Attorney for the Eastern District of Pennsylvania. On February 12, 2003, Keystone agreed to a stringent policy for verifying the credentials of its network providers. The new thirty-six page policy, which the government believes will serve as a model for other managed care organizations and provides significant new protection for patients, covers verification of credentials, and requires the health plan to perform numerous audits to ensure that appropriate verification procedures have been followed.\(^9\)

**B. Respondeat Superior**

Under this doctrine, an employer is liable for the negligence of its employees. In many managed care arrangements, the providers are independent contractors, and the managed care organization will not be vicariously liable for a negligent provider. However, courts will look at the degree of control that the managed care organization has over a provider. The degree of control is generally fact specific to the particular case, and if sufficient, a court may hold a managed care organization vicariously liable for a provider despite a contract stating that the provider is an independent contractor.\(^10\)

**C. Ostensible or Apparent Agency**

When no employment relationship exists between a managed care organization and the provider, the managed care organization may still be vicariously liable for independent contractor physicians under the doctrine of ostensible or apparent agency. This doctrine will apply if the patient reasonably looks to the managed care organization, rather than the individual physician, as the source of care, and the managed care organization engages in conduct that leads the patient to reasonably believe that it is the source of care or that the provider is its employee.\(^11\)

**III. Class Actions**

Beginning in 1999, providers, state medical associations, state attorneys general, and managed care organization subscribers began bringing class action lawsuits against managed care organizations such as Aetna, CIGNA, PacificCare, Prudential, Humana, United Healthcare, and others.\(^12\) The theories of liability and damages requested vary depending upon the plaintiff, the forum, and the basis for suit. A common goal is to change how managed care tries to eliminate unnecessary costs by creating financial incentives and other mechanisms to reduce medical care and the reimbursement to providers for providing medical care.

**A. Class Action Allegations**

Subscriber class actions generally include allegations that managed care organizations have (1) violated the Racketeer Influenced and Corrupt Organizations Act (RICO) and/or the Employee Retirement Income Security Act of 1974 (ERISA), (2) committed common law conspiracy, and (3) have breached contractual and fiduciary obligations to subscribers by failing to disclose physician incentives and narrow coverage criteria.\(^13\) Provider class actions generally include allegations that managed care organizations have conspired to defraud providers, violated RICO and state prompt pay laws, misused market power, unjustly enriched themselves, forced providers to accept harmful managed care practices, and systematically delayed and denied payments owed physicians by manipulating payment codes in order to downcode and bundle claims.\(^14\)

The subscriber classes generally seek to recover the difference in market value between the coverage they were promised and the value of the coverage actually purchased as a result of the managed care organizations’ restrictions on access to care and denial of treatment. They also seek treble damages and full disclosures of managed care operating
practices and provider financial incentives. The provider classes, many of which are represented by state medical associations, also request treble damages for RICO violations, but their primary goal is to obtain changes in managed care operating procedures, in particular the definition of medical necessity and payment practices. Some provider class actions also seek to recover money for denied or underpaid claims.

B. Multidistrict Litigation

On April 13, 2000, the Federal Judicial Panel on Multidistrict Litigation consolidated and transferred for pretrial many class actions to the United States District Court for the Southern District of Florida before United States District Judge Federico A. Moreno. The multidistrict litigation is known as In Re Managed Care Litigation.

The multidistrict cases have been divided into the subscriber and provider track cases. Early litigation for both tracks has concerned procedural issues of class status and standing, and the legal sufficiency of the theories of liability alleged.

Judge Moreno’s rulings have, and will continue to, generate controversy and appeals to the Eleventh Circuit and the United States Supreme Court.

The significant rulings to date are discussed below.

C. Class Certification

Providers, consisting of approximately six hundred thousand doctors from across the United States, have been granted class certification under the requirements of FED. R. CIV. P. 23. A Petition for Review filed by defendants has been granted by the Eleventh Circuit.

The providers demonstrated to Judge Moreno’s satisfaction commonality on such issues of law and fact as:

- the common practice of failing to place patients on physicians’ capitation roles until treatment is sought;
- whether the failure to pay a claim or the downcoding of a claim according to a standard other than medical necessity is a breach of contract;
- whether the managed care organizations have agreed to lower reimbursement rates and/or slow payment plans in a conspiracy to keep reimbursements low.

The subscribers, consisting of millions of enrollees, demonstrated commonality on such issues of law and fact as:

- whether capitation arrangements were concealed;
- whether coverage determinations were made on undisclosed cost-based criteria that are different or more restrictive than the factors included in the defendant’s medical necessity definition;
- whether the value of the policies as represented was worth more than the policies as implemented;
- whether “gag clauses” in contracts with providers are an improper interference with the physician-patient relationship.

The subscribers also met other R. 23(a) requirements, but failed to satisfy R. 23(b) requirements that the managed care organizations acted on grounds generally applicable to the class as a whole. The court held that the subscribers failed to demonstrate that managed care organizations had a “uniform scheme” of behavior generally applicable to the class as a whole. Therefore, the court held that the merits of the ERISA subclass subscribers’ claims depend on the defendants’ individual dealings with each plaintiff. Similarly, the court found that the RICO class subscribers’ claims require case specific inquiries both in discovery and at trial concerning the representations allegedly made by the managed care organizations, the representations relied upon by each plaintiff, and the additional information and knowledge available to each plaintiff at the time. Therefore, the RICO class also failed to demonstrate that (1) common issues of law or fact predominate over individual issues, and (2) that a class action is a superior method of deciding the dispute. The court reached the same conclusion on the ERISA subclass subscribers’ claims for misrepresentation of the medical necessity definition and for all “gag clause” claims.

D. Motions to Dismiss

Both tracks have been subject to several rounds of motions to dismiss. On June 12, 2001, Judge Moreno granted the managed care organizations’ partial dismissal without prejudice of the subscriber track cases for RICO claims on the basis that the subscribers failed to properly plead the predicate acts of
mail and wire fraud with particularity, and for their ERISA claims on the basis that the subscribers failed to comply with ERISA’s exhaustion requirement. Judge Moreno also noted that the subscriber track “coverage benefit” theory of damages is “uncharted legal territory” and this theory “resembles an unripe breach of contract claim.” The Judge invited the subscribers to re-plead specific claims that were wrongly denied by the managed care organizations.

The subscribers amended their complaints, and a second round of motions to dismiss were filed by the managed care organizations. On February 20, 2002, Judge Moreno dismissed many of the subscribers’ RICO, ERISA, and state law claims on various grounds, including that the McCarran-Ferguson Act prohibits federal lawsuits that encroach upon the state regulatory decision-making process, state law pre-emption of RICO claims of subscribers in certain states, failure to exhaust ERISA administrative procedures, and failure to state a claim for common law civil conspiracy, and state unjust enrichment. As a result, the only remaining subscriber claims were for non-subscribers who reside in states that recognize a private cause of action for insurance fraud, all claims alleging interference with the physician-patient relationship, and the claims of misrepresentation of medical necessity for subscribers who are no longer participants in the defendants’ health plans. On March 25, 2002, Judge Moreno amended his order to allow an interlocutory appeal to the Eleventh Circuit on the issue of whether a subscriber who has not actually been denied care (a requirement in the Third Circuit) can state a RICO claim. However, the Eleventh Circuit denied the defendants’ petition to appeal. In contrast to the subscribers, most of the providers’ claims remain intact.

E. Arbitration of Provider Claims

On December 12, 2000, Judge Moreno granted in part defendants’ motions to compel arbitration of disputes for those providers who have arbitration clauses in their provider contracts. However, he also ruled that those arbitration clauses that exclude punitive damages are unenforceable for RICO claims, and an arbitration clause may not be invoked to compel arbitration of an aiding-and-abetting charge regarding a provider’s contractual rights.

The Eleventh Circuit affirmed the trial court’s decision, and the United States Supreme Court granted a Writ of Certiorari filed by the defendants. On February 24, 2003, the United States Supreme Court heard oral argument, and a decision is pending.

F. A Challenge to Multidistrict Jurisdiction

Judge Moreno’s jurisdiction was recently challenged by CIGNA Corporation in Kaiser v. CIGNA Corp. Kaiser is a provider class action in federal district court in Illinois. CIGNA reached a proposed settlement with the providers that was set for an approval hearing. However, the settlement, which would have allowed physicians to recoup money for denied claims and required CIGNA to put explanations of its claims coding and payment policies on its Web site, was opposed by medical societies from nineteen states on the basis that CIGNA would still be able to use financial criteria to overturn treating physician decisions when determining whether a particular treatment is medically necessary.

Judge Moreno issued a preliminary injunction to prohibit the settlement without his approval when some of the class members were also participants in the Multidistrict Litigation. On February 21, 2003, this decision was upheld by a seven judge Judicial Panel on Multidistrict Litigation. It ruled that the Southern District of Florida Multidistrict Litigation is the proper forum for evaluating the merits of the proposed settlement and ordered the case transferred to Multidistrict Litigation. Both plaintiffs and CIGNA have filed petitions in the Eleventh Circuit for review of Judge Moreno’s decision.

IV. Conclusion

Over the last five to ten years, managed care organizations have seen their exposure to liability expand to include vicarious liability for independent contractors, and a duty to credential and thereby insure that subscribers receive quality care. At the same time, the systems developed to reduce the
cost of medical care are under attack with federal and state legislation for patient protection and prompt pay laws and class action lawsuits. The outcome of the class actions will likely involve a decision by the United States Supreme Court on the various pending procedural issues of class certification and arbitration. If the plaintiffs are successful procedurally, the class action claims will likely be ripe for settlement.

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End Notes

3 Id.
4 Id.
5 See Darda v. Charleston Community Mem’l Hosp., 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966) (whether hospital was negligent in permitting a general practitioner to perform orthopedic surgery in its emergency department); Purell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972) (hospital has a duty to prevent an independent contractor physician from practicing at its hospital when it knew or should have known of the physician’s incompetence); Blanton v. Moses H. Cone Mem’t Hosp., Inc., 319 N.C. 372, 354 S.E.2d 455 (1987) (hospital owed a duty to assure that independent contractor physicians were qualified to perform surgery).
6 718 S.W.2d 58 (Mo. 1989).
8 604 A.2d at 1059.
9 See http://pubs.bna.com/ip/BNA/hce.nsf/is/a0a6m3a4c2.
12 Some class actions have been filed by a group of class action lawyers who call themselves the REPAIR Team (RICO and ERISA Prosecutors Advocating for Insurance Industry Reform).
14 Id.
15 Id.
16 Id.
17 MDL No. 1334, Master File, D.C. Docket No. 00-1334-MD-Moreno In re: Managed Care Litigation.
18 See supra note 13.
19 The Global class consists of all doctors who provided services to any person insured by any defendant over a twelve-year period for claims of conspiracy to violate RICO, and for aiding and abetting violations of RICO. The national subclass consists of doctors who provided services to any person insured by a defendant, and has a claim against the defendant that is not subject to arbitration for claims of breach of contract, quantum meruit, RICO violations, unjust enrichment, and state prompt pay claims. The California subclass consists of doctors who provided services to any person insured in California by a defendant and is not subject to arbitration for claims under California law.
20 Order Granting Provider Track Class Certification and Denying Subscriber Track Class Certification, MDL No. 1334, Master File No. 00-1334-MD-Moreno, In re: Managed Care Litigation, filed September 26, 2002, at 33-34 (Certification Order).
21 Aetna v. Klay, No. 02-90039-B, petition to appeal granted (11th Cir. Nov. 20, 2002).
22 Certification Order at 33-34.
23 Subscribers consist of a RICO class and an ERISA subclass. The RICO class consists of persons who purchased or received coverage. The ERISA subclass consists of persons who received coverage through an employee welfare plan.
24 Certification Order at 9-10.
25 Id. at 13-15.
26 Id. at 17-27.
27 Id. at 29-31.
29 Id. at 42.
30 Id.
31 Order Granting in Part and Denying in Part the Defendant’s Motions to Dismiss the Amended Complaints, MDL. No. 1334, Master File No. 00-1334-MD-Moreno, In re: Managed Care Litigation, filed February 20, 2002.
32 Id.
33 Order Granting Defendants Joint Motion to Amend Dismissal Order to Include Certification for Interlocutory Appeal, MDL. No. 1334, Master File No. 00-1334-MD-Moreno, In re: Management Care Litigation, filed March 25, 2002.
34 See Maio v. Aetna, 221 F.3d 472 (3d Cir. 2000) (claims asserting wrongful coverage practices must be based on actual denials of medically necessary treatment).
37 Civil Action No. 02-1170-6PM (S.D. Ill.).
38 Order Granting Plaintiffs’ Motion for Preliminary Injunction, MDL. No. 1334, Master File No. 00-1334-MD-Moreno, In re: Managed Care Litigation, filed December 12, 2002.
39 Id.
40 See http://pubs.bna.com/ip/BNA/hce.nsf/is/a0a6m8w9q6.