

An Overview of Legal Developments in Managed Care Case Law

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Introduction

This analysis provides an overview of recent legal developments in managed care case law. Three types of cases are reviewed: claims brought by managed care enrollees against managed care companies and health plans; cases related either directly or indirectly to managed care and brought by both beneficiaries and managed care organizations against State Medicaid agencies and other public agencies engaged in the purchase of managed care; and cases brought by individual health professionals against managed care organizations.

As used in this analysis, the term managed care is meant to denote any health coverage arrangement in which a single entity contracts both to provide third party coverage to members and deliver covered services to members through a network of providers selected and controlled by the entity.¹ Managed care has become the central means by which privately insured workers and their families are covered and receive care. Approximately half of all Medicaid beneficiaries, including a significant proportion of non-institutionalized non-elderly beneficiaries with disabilities are required to enroll in some form of managed care as a condition of coverage. Finally, approximately six million Medicare beneficiaries were voluntarily enrolled in Medicare managed care plans as of 1999.

Not surprisingly perhaps, as managed care has become a dominant form of health care and health coverage, litigation against managed care companies and (in some cases) public and private managed care group sponsors has grown. The case law is rapidly evolving, as courts apply longstanding common law (i.e., judge-made law) liability principles to health maintenance organizations (HMOs) and other managed care organizations (MCOs). Just as HMOs are hybrid entities, the liability theories that courts apply span both medical liability theory (i.e., malpractice and medical negligence) and theories related to the insurance aspects of MCO conduct (i.e., negligence in the administration of such traditional insurance functions as utilization management and coverage determination procedures). As will be discussed below, whether or not an MCO can face liability under these various theories can turn on whether the group health plan sponsor is a private employer covered by the Employee Retirement Income Security Act (ERISA) or a public agency or non-ERISA-covered employer (such as a State or local government).

¹ Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY, 1997; 2000-2001 supplement), Ch. 2J.

All cases discussed in this overview are summarized in accompanying Tables 1-3. Interestingly, many of the leading cases in the field involve some aspect of behavioral health care. This fact is probably not surprising, since managed care appears to have had a particularly dramatic effect on both access to behavioral health care and the amount of care that individuals receive.² The particularly strong effect of managed care on the consumption of behavioral services may have given rise to greater levels of litigation on the part of both plans and providers. In addition, evidence from around the country suggests that the establishment and operation of publicly funded behavioral health systems has been comparatively contentious, with complaints from patients and advocacy organizations regarding the elimination of services and with protests by losing bidders against the awarding of contracts.³

Claims Brought Against Managed Care Organizations By Members and Patients: Leading Cases

Table 1 sets forth the principal theories and leading cases in recent years involving claims against managed care organizations. Claims can vary by group sponsor; thus, for example, individuals enrolled in a Medicaid managed care arrangement may have special legal rights that differ in certain respects from persons enrolled through an ERISA-covered employer-sponsored plan. Indeed, one company that does business with an array of group sponsors (private employers, public employers, Medicare, Medicaid) may face different types of liability depending on a particular patient's sponsor.⁴ However, although plan sponsorship can affect the legal claims available to plan members, certain types of claims against managed care organizations appear to apply regardless of plan sponsorship.

Taken together, the cases appear to support the following conclusions:

- Where liability for professional medical negligence is concerned, depending on the law of a State, an MCO can face medical liability for its own professional negligence or that of its network providers. Furthermore, medical liability can exist regardless of plan sponsor (i.e., regardless of whether membership in the MCO was purchased by Medicare, Medicaid, or an ERISA-covered employer. Professional liability is a concept that applies

² Surgeon General's Report on Mental Health (HHS, Washington D.C., 2000).

³ See accompanying synopsis of Medicaid behavioral health care legal developments in D. Richard Mauery, Sara Rosenbaum, and Joel Teitelbaum, "Selected Case Studies of Legal Developments in State Contracting for Managed Behavioral Health Services."

⁴ Since 1997, Congress has debated legislation to regulate the managed care industry. This legislation is commonly referred to as the "Patients' Bill of Rights." See, e.g., H.R. 2990, Bipartisan Consensus Managed Care Improvement Act of 1999; S. 1344, Patients Bill of Rights Plus Act. While these measures, if enacted, would make Federal regulation of managed care more uniform, they would by no means eliminate differences by sponsorship because of underlying differences in underlying Federal laws that authorize or fund the provision of managed care. For example, ERISA imposes almost no content requirements on employer sponsored health plans. Medicare and Medicaid, on the other hand, entitle beneficiaries to defined benefits, to be furnished in accordance with Federal requirements. As a result, Medicare and Medicaid managed care products operate within unique legal frameworks that are not applicable to employer-sponsored or privately purchased products.

to the managed care industry as a whole in its *health care* capacity. It represents an extension of the same corporate and vicarious liability legal theories that have been held to apply to hospitals since the mid-1960s.⁵ Courts have consistently held, as Table 1 illustrates, that Federal law does not displace longstanding principles of professional liability law. The law of health care quality continues to be governed by State common law and statutory law.

- Under concepts of professional liability, an MCO can be considered *vicariously* liable under State medical liability law for the negligence of its network physicians if their negligence is proven and if the company is shown to have an actual or ostensible agency relationship with the provider.⁶
- Similarly, an MCO can be held corporately (i.e., directly) liable under State common law or statutory law for engaging in substandard professional practices that bring the provision of covered services below professional standards. Thus if a company operates its health care programs in accordance with substandard professional guidelines and these guidelines are shown to be a proximate cause of a member's injury or death, the company may be directly liable for the harm produced.⁷ Similarly, if an MCO fails to maintain a network with a sufficient supply of physicians or fails to oversee the practices of its physician network, it may be liable for death or injury, just as a hospital would be liable for failing to police its medical staff.⁸
- Medical liability for the use of professionally substandard practice guidelines, either to guide the provision of covered services or to compensate health professionals, may be among the most important emerging medical liability case law. This is because most MCOs today make extensive use of guidelines. To the extent that guidelines that are used by MCOs are not evidence based and reliable and even if so, are applied in cases in which they are not relevant (e.g., because the individual circumstances of a patient's case warrant a different approach to treatment) an MCO may face professional liability, depending on the State in which the case is brought.
- The fact that enrollment in an MCO is sponsored by an ERISA-covered employer or the Medicare program does not insulate an MCO and its providers from either corporate or vicarious professional liability. Numerous ERISA cases, and a growing number of Medicare cases, hold that injury claims related to professional medical practice and medical quality fall outside of the scope of Medicare or ERISA preemption.
- While ERISA and Medicare do not preempt injury claims under State law arising from professional negligence, the cases on Table 1 indicate that they do have a preemptive impact on injury claims based on State laws applicable to insurance administration and practices. For example, State law may make insurers liable for bad faith breach of contract, fraud, mal-administration of insurance utilization management systems, and

⁵ Law and the American Health Care System, *op. cit.*, Ch. 3.

⁶ Table 1: *Boyd v Albert Einstein Medical Center*, *Shannon v McNulty*, *Petrovitch v Share Health Plan*).

⁷ Table 1, *Moscovitch v Danbury Hospital*; *In re U.S. Healthcare*; *Lazorka v Penn Hospital*.

⁸ Table 1, *Jones v Chicago HMO*.

other negligent practices related to policy administration.⁹ However, where a claim is against a managed care company for negligence in how it administers an ERISA plan or a Medicare-sponsored health plan, Federal law preempts (i.e., precludes the individual) from recovering under State law.¹⁰

- *Pegram v Herdrich* (Table 1) appears to draw a critical distinction between cases in which the injury is related to an act involving the exercise of medical judgement by plan physicians and those in which the injury claim is predicated on negligent benefits administration not involving medical judgement. This distinction is one that is just beginning to emerge in the law.¹¹ If the distinction set forth in *Pegram* is followed by the lower courts broadly (and a recent decision by the Court of Appeals for the Third Circuit indicates that courts may begin to take this approach),¹² then the range of cases that remain covered by State medical liability law will grow, with all medical judgement cases – regardless of whether they focus on coverage or quality of care – subject to available State law remedies for the negligent exercise of professional medical judgement. A more narrow reading of the *Pegram* case would preserve the quality/quantity distinction first drawn in the *Dukes* case. Under this distinction, cases in which the complaint focuses on the quality of care actually received would be governed by State medical liability law, while ERISA and Medicare would continue to provide an exclusive remedy (i.e., would preempt State common law and statutory remedies) for injuries flowing from the denial of coverage for care.
- Cases brought by plan members against MCOs under the ADA to date involve three types of claims. The first is that the MCO as a health provider is a public accommodation and has a duty to serve individuals in a non-discriminatory manner.¹³ This may be a particularly powerful claim given the fact that MCOs under their contracts agree to actually furnish health care (not merely cover it) to members. Thus, an MCO cannot simply refuse to serve a member with physical or mental disabilities but would have to make reasonable accommodations.¹⁴ A second category of claims involves incentive arrangements that discriminate against persons with disabilities and providers that treat persons with disabilities.¹⁵ The third involves challenges to contractual, across-the-board coverage limitations that pertain to a specific disability (e.g., limitations on otherwise covered services in the case of persons with HIV/AIDS or ARC). The leading case in this area places the *design and content* of health insurance (i.e., substantive coverage limits that apply to all enrollees) beyond the reach of the ADA, while simultaneously making clear that were an insurer to treat a person with a disability differently from others with respect to *covered* services, the ADA would offer protection.¹⁶

⁹ Table 1, *McEvoy v Group Health Cooperative of Eau Claire*; *Wickline v State of California*; *Wohlens v Bartgis*.

¹⁰ Table 1 *Pegram v Herdrich*; *Ardary v Aetna Health Plan*.

¹¹ Table 1, *Pegram v Herdrich*.

¹² Table 1, *Lazorka v Penn Hospital*.

¹³ Table 1, *Woolfolk v Duncan*.

¹⁴ There are as yet no Federal guidelines from the Office for Civil Rights as to what the reasonable accommodation duty under the ADA would require.

¹⁵ Table 1, *Zamora-Quesada v Humana Health Plan*.

¹⁶ Table 1, *Doe v Mutual of Omaha*.

- Certain laws create additional rights against managed care plans. While ERISA preempts certain injury actions against MCOs, an MCO can be found liable for breach of fiduciary duty for failure to disclose its physician incentive plans.¹⁷ Furthermore, an individual can recover benefits from his or her plan if he or she can demonstrate that the plan's decision to withhold covered care in a particular case was arbitrary and capricious (i.e., not grounded in evidence).¹⁸ However, where the plan's denial is based on coverage limits that are built directly into a plan contract, then a court has no authority to override the plan. To the extent that companies build practice guidelines directly into their agreements with purchasers, they may be able to avoid liability for care denials, since the only covered services are those set forth in the guidelines. At the same time, the medical liability cases suggest that MCOs may risk medical liability for substandard care if their guidelines are negligently applied or professionally substandard.

Cases Brought Against State Medicaid and Other Public Agencies

Table 2 sets forth cases brought against State Medicaid agencies and resulting from either their own alleged violation of law or violations committed by their managed care contractors. Table 2 also shows cases against Medicaid agencies and other public agencies brought by MCOs. Taken together, the cases suggest the following:

- Courts see MCOs as agents of State agencies, and their actions as "state action" for purposes of Federal civil rights protections. Thus, when a Medicaid MCO contractor fails to follow federally prescribed timely and adequate notice and pre-termination hearing requirements, a State Medicaid agency is liable for violations of Federal law, including both statutory requirements and constitutional law.¹⁹
- Current and prospective MCOs have Constitutional as well as Federal and State statutory and regulatory rights against State Medicaid agencies and mental health and other public agencies. Thus, where a State agency fails to follow Federal procurement regulations it may face liability under Federal law.²⁰ Similarly, an agency may be liable under State law for failure to follow its own State procurement practices.²¹ Finally, a State Medicaid agency may violate the Federal due process rights of its MCOs by summarily terminating

¹⁷ Table 1, *Shea v Esensten*.

¹⁸ Table 1, *Bedrick v Travelers Insurance*.

¹⁹ Table 2, *J.K. v Dillenberg; Perry v Chen; Rodriguez v Chen; Daniels v Wadley*. A similar result was reached under Federal Medicare law in *Grijalva v Shalala* F. 3d ____ (1998). However, the opinion was vacated and remanded for further consideration in light of the Supreme Court's decision in *American Manufacturing v Sullivan*, ____ U.S. ____ a case involving State action in a State unemployment compensation law context. The Secretary and the plaintiffs subsequently settled the case; as a result there is as yet no definitive Supreme Court decision regarding whether State action exists in the case of managed care contractors working for State and Federal public agencies pursuant to Federal laws governing the purchase and administration of managed care.

²⁰ Table 2, *Value Behavioral Health v Ohio Department of Mental Health*.

²¹ Table 2, *Medco Behavioral Care v Iowa Dept. of Human Services*.

their contracts without advance notice and the opportunity for a hearing on alleged violations.²²

- Courts are willing to hold States accountable to beneficiaries for the substandard health care access performance of their managed care contractors, at least in those cases in which a State has acknowledged its obligations pursuant to a consent decree to oversee contractor performance.²³

Cases Brought Against Managed Care Organizations by Health Professionals

Table 3 sets forth cases brought against managed care organizations by health professionals. These cases suggest the following:

- Courts will save from ERISA preemption State “any willing provider” and “anti-discrimination” statutes that require health insurers to include in their networks licensed health professionals who are willing to adhere to a company’s rules of operation and can legally furnish covered benefits under the terms of their licenses.²⁴
- At least one State (California) recognizes in a managed care context the concept of fair process, an approach to private conduct that has been applied to hospital staff privilege decision-making.²⁵ Under this concept, “at will” termination clauses in provider agreements are unenforceable because of their potential to significantly impair a health professional’s ability to engage in his or her profession. While other State courts may not yet recognize this concept as a common law right, other States may be willing through legislation to provide for minimum due process protections, even if termination at will clauses are not prohibited, as was the case in *Harper v Healthsource* (Table 3).

Conclusion

These cases illustrate both the evolution of managed care case law as well as the evolving thinking within the courts about the relative rights and responsibilities of the various stakeholders within the health care system: managed care companies, public and private sponsors of managed care products, health professionals, and patients and members. These decisions both establish new law (as in the extension of professional liability concepts to the managed care industry) and reinterpret existing law in new ways (e.g., the growing body of ERISA case law distinguishing between injuries caused by poor medical judgement and other injuries). One can expect that, as courts increasingly enter the managed care policy-making process through judicial decisions that apply existing legal principles to the modern health system, both Congress and State legislatures will draw from these cases general rules of practice that apply to the industry as a whole.

Even in a deregulated health system, the evolution of case law carries important implications not only for members of health plans, but for purchasers of managed care. This is

²² Table 2, *Medcare HMO v Bradley*.

²³ Table 2, *Frew v Gilbert*.

²⁴ Table 3, *Stuart Circle Hospital v Aetna; Washington Physician Services Ass’n v Gregoire*.

²⁵ Table 3, *Potvin v Metropolitan Life Insurance*.

particularly true for Medicaid agencies, which have a general duty under Federal law to assure the adequacy of quality services. Taken together these cases suggest that purchasers may wish to pay particular attention to the following matters:

- A contractor's claims regarding the sufficiency of its network, the process used to select and monitor the quality of care of its network providers, and the methods used by the contractor to ensure that no individual provider has more than a professionally sound number of patients.
- The practice guidelines that the contractor uses to incentivize its network providers and to measure the quality of the services it covers. The guidelines should be examined not only for their validity (i.e., the soundness of the evidence on which they rest) but their application, since medical liability can flow not only from the flawed design of practice but also from using the wrong diagnostic and treatment techniques on patients given their individual medical conditions. Practice guidelines, like compensation incentives themselves, are part of the managed care design. However, the liability cases suggest that they should be used as beginning guidelines only and not as conclusive evidence regarding how an individual patient should be managed.
- The contractor's ability to comply with notice and hearing requirements applicable to Medicaid agencies when care and services are denied, terminated, or reduced. Notices should be verified for adherence to Federal standards, procedures for continuing care in cases in which pre-action hearings are requested should be in place, and the contractor should have a mechanism for verifying its adherence to Federal requirements.
- The use of compensation arrangements that treat all providers similarly, that do not provide for additional payments for providers that treat patients with disabilities, and that contain incentives that could be interpreted as encouraging the under-diagnosis or under-treatment of persons with disabilities.
- The procedures the contractor has in place to ensure that its provider network members do not discriminate against persons with physical or mental disabilities through the use of inaccessible locations, the refusal to serve certain patients, or practices that discourage certain patients from receiving care.