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ARE WE PROTECTED FROM HMO¹ NEGLIGENCE?: AN EXAMINATION OF OHIO LAW, ERISA PREEMPTION, AND LEGISLATIVE INITIATIVES

I. INTRODUCTION

A California woman suffering from breast cancer is denied a bone marrow transplant by her Health Maintenance Organization (HMO).² Despite the fact that her physician recommended the transplant, the HMO deemed the treatment “experimental” and refused to pay.³

A Louisiana woman’s obstetrician ordered twenty-four hour hospitalization during her last term of pregnancy.⁴ Her HMO refused to authorize the stay, instead it authorized ten hours of home nursing care per day.⁵ While the woman was home alone, her fetus went into distress and died.⁶

A Missouri man suffered a heart attack.⁷ His primary care physician recommended heart surgery at a specialized facility.⁸ His HMO denied precertification since the facility was not within the HMO’s service area.⁹ Instead, the HMO required that the man schedule his surgery at a “participating facility,” which could not perform the surgery until nearly two months later.¹⁰ The man’s heart deteriorated to such a state that surgery could not be performed.¹¹ The man died while he waited on the heart transplant list.¹²

1. Although there are many forms of managed care organizations, each with liability concerns, this comment will focus on health maintenance organizations (HMOs) since they usually provide the most restrictive plans. See discussion *infra* note 37.

2. *Fox v. Healthnet*, No. 219692 (Cal. Super. Ct., Riverside Cty. 1993). Despite the fact that *Fox* was an unpublished case, it received a great deal of national attention. See, e.g., Robert J. Conrad, Jr. & Patrick D. Seiter, *Health Plan Liability in the Age of Managed Care*, DEF. COUNS. J., April 1995, at 193; Richard C. Reuben., *In Pursuit of Health*, A.B.A. J., Oct., 1996, at 55; Ellyn E. Spragins, *Beware Your HMO*, NEWSWEEK, Oct. 23, 1995, at 54.

3. Reuben, *supra* note 2, at 55. Mrs. Fox eventually was able to raise enough money for her treatment. *Id.* However, she died eight months prior to the jury verdict which awarded \$89 million. *Id.* The verdict was later reduced in a settlement. *Id.*

4. *Corcoran v. United Healthcare*, 965 F.2d 1321, 1322 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).

5. *Id.* at 1324.

6. *Id.* Although the court acknowledged that the HMO’s decision “may have been a serious mistake,” the Justices held that the claim was preempted by ERISA. *Id.* at 1338. For a further discussion of ERISA preemption, see *infra* Section IV. For further discussion of the *Corcoran* case in the context of ERISA preemption, see *infra* note 115 and accompanying text.

7. *Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 300 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994).

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

A Pennsylvania man was diagnosed with an abscess which was compressing his spinal cord.¹³ The emergency physician who diagnosed the condition recommended immediate transfer to a facility that specialized in neurosurgery.¹⁴ Despite being informed that the patient could have permanent nerve damage if not transferred to a specialized facility, the patient's HMO refused the transfer on the basis that the recommended facility was not an "approved facility."¹⁵ The patient's treatment was delayed and, as a result, the patient suffered permanent paralysis.¹⁶

These cases represent a small sample of individuals who have suffered personal injuries in the name of HMO approval requirements during recent years.¹⁷ Why? Because recent changes in the structure of our nation's health care system allow HMOs to make critical treatment decisions which patients and their physicians once made.¹⁸ With HMOs providing health care for at least fifty-eight million Americans,¹⁹ these organizations' liability for treatment decisions has become a matter of national concern.²⁰

12. *Id.* Like the *Corcoran* court, the court in *Kuhl* found the claim against the HMO to be preempted by ERISA. For further discussion of this case in the context of ERISA preemption see *infra* note 115 and accompanying text.

13. *Pappas v. Asbel*, 675 A.2d 711, 713 (Pa. 1996).

14. *Id.*

15. *Id.*

16. *Id.* This case was held not to be preempted by ERISA and was remanded for decision on the merits. *Id.* at 718. For further discussion of this case in the context of ERISA preemption, see *infra* text accompanying notes 123-125.

17. See *Conrad & Seiter*, *supra* note 2, at 191 ("[A] litigation earthquake has been building"); see also Rachel Kreier, *Playing the Liability Lottery Studies Cite Higher Costs, More Managed Care Suits*, AM. MED. NEWS., Apr. 15, 1996, available in 1996 WL 7990257 (citing a RAND corporation study which showed that 5 of the top 10 jury verdict awards of 1995 were cases against managed care entities).

18. See, e.g. *Conrad & Seiter*, *supra* note 2, at 191 (noting that cost containment measures associated with managed care organizations may directly affect the medical care received by patients thereby increasing the liability potential for plan providers); Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L. J. 1297, 1314 (1994) ("[T]he new mechanisms for encouraging more cost-effective medical practice directly intrude into what the tort law has traditionally considered 'medical authority' and reshuffle the values balanced in the concept of 'malpractice'"); Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 PUGET SOUND L. REV. 1, 5 (1993) ("[T]he patient may be medically injured not by conduct of the physician, not because of the physician's own decision, but because of a third-party payor's guidelines, with which the physician is trying to comply."); David D. Griner, Note, *Paying the Piper: Third Party Payor Liability For Medical Treatment Decisions*, 25 GA. L. REV. 861, 869 (1991) ("As a result of increasing cost constraints, external reviewers are now examining decisions that were once the exclusive province of the doctor and patient.").

19. *Nearly 150 Million Americans Now Enrolled in HMOs and PPOs*, HEALTH CARE STRATEGIC MGMT., Sept. 1, 1996, available in 1996 WL 7903916 (reporting results from a 1995 survey by the American Association of Health Plans).

While many states have analyzed the extent to which HMOs should be liable for medical treatment decisions, the body of case law in Ohio remains sparse.²¹ Since recent statistics report that 1.88 million Ohioans have health insurance through Health Maintenance Organizations,²² it is extremely important for Ohio's citizens and attorneys to be aware of the current state of the law in Ohio and other jurisdictions.

This comment discusses the various theories of HMO liability that are emerging in other jurisdictions as well as the extent to which current Ohio law bars several of these theories.²³ In addition, this comment also discusses ERISA's preemption of state laws related to HMO liability.²⁴ Finally, this comment analyzes legislative initiatives and other forms of regulation aimed at protecting consumers from HMO abuses.²⁵

II. THE CHARACTERISTICS OF MANAGED CARE AND HEALTH MAINTENANCE ORGANIZATIONS

A. History

Early managed care organizations, which strongly resemble today's HMOs, emerged into mainstream health maintenance during the 1930s.²⁶ Like HMOs, these plans relied heavily upon prepayment of health care coverage and only allowed members to visit participating health care providers.²⁷

HMOs were formally introduced by Congress during the 1970s²⁸ as a re-

20. See generally Griner, *supra* note 18; Randall, *supra* note 18; Spragins, *supra* note 26.

21. See discussion *infra* section III.

22. Anne Marcus, *Ohio: Market Forces Lead the Way*, BUS. & HEALTH, Sept. 1, 1995, available in 1995 WL 12099661.

23. See discussion *infra* section III.

24. See discussion *infra* section IV.

25. See discussion *infra* section V through VI.

26. Elk City, Oklahoma is believed to be the home of the first community-based prepaid health care plan which was initiated in 1929. Randall R. Bovberg, et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L. MED. & ETHICS 141, 143 (1993). In 1938, Edgar Kaiser and his father, Henry, set up a prepaid health plan for the work force building the Grand Coulee Dam. MANAGED CARE RESOURCE GUIDE: FOR SOCIAL WORKERS IN AGENCY SETTINGS §2.1 (Vivian H. Jackson, ed., 1995). Later, the Kaisers organized a plan for workers at their shipyards. *Id.* During this time period, several other HMO-like plans developed such as the Health Insurance Plan in New York, the Group Health of Puget Sound in Seattle, Group Health Association in the District of Columbia, and the Ross-Loos Plan in California. Bovberg, *supra*, at 143.

27. Bovberg, *supra* note 26, at 143.

28. CHARLES G. BENDA & FAY A. ROZOVSKY, *MANAGED CARE AND THE LAW: LIABILITY AND RISK MANAGEMENT, A PRACTICAL GUIDE* §1.1 (1995). ("[I]t was not until the 1960's and 1970's that they began to grow dramatically in recognition and use, under the newly

sponse to the Nixon administration's attempt to control rising health care costs.²⁹ The Health Maintenance Organization Act³⁰ provided governmental assistance in the formation of qualified HMOs.³¹

The 1980s brought about an alarming increase in health care expenditures. The percentage of the national gross product consumed by health care jumped from 8.4% in 1980 to 12.6% in 1990.³² This "health care crisis"³³ further encouraged HMO growth³⁴ until, by the 1990s, HMOs had become firmly entrenched

coined name 'health maintenance organization' or HMO.").

29. Ralph O. Bischof & David B. Nash, *Managed Care: Past, Present, and Future*, MED. CLINICS OF N. AM., March 1996, at 226 (noting that the passage of Medicare legislation gave providers an incentive to do more procedures and brought to light the problems with traditional "fee for service" health care delivery). "Ellwood coined the term health maintenance organizations in the 1970s, as the Nixon administration looked for answers to the problems of the health care system." *Id.* at 227.

30. *Id.* The Health Maintenance Organization Act is codified at 42 U.S.C. §300e (1996).

31. BENDA & ROZOVSKY, *supra* note 28, at §1.1. The Act promoted HMO growth in the following ways: (1) by defining characteristics for federally funded HMOs; (2) by offering grants and loans to assist in the development of such HMOs; (3) preempting any state law which would prohibit or limit the growth of such practice plans; (4) requiring employers to offer a federally qualified HMO as an option to employees if a qualified HMO was available in their region. *Id.*

32. The percentage of the United States's gross domestic product (GDP) that was consumed by health care expenditures was 5.9% in 1965, 7.4% in 1970, 8.4% in 1974, 9.3% in 1980, 10.8% in 1985, 12.6% in 1991, 13.2% in 1992, 13.6% in 1992, and 13.9% in 1993. *Tearing U.S. Apart Part 6: Health Care*, ATLANTA J. & CONST., July 26, 1996, at A16. This is significantly higher than the percentage of the GDP which is consumed by health care in other industrialized nations. Bischof & Nash, *supra* note 29, at 565. For example in 1991, Germany spent 8.5% of its GDP on health care, Japan spent 6.8%, and the United Kingdom spent 6.6%. *Id.* Despite the fact that the United States spends considerably more of its GDP on health care than these countries, the life expectancy in the United States is lower. William J. Serow, *Demographic Dimensions of Health Care Access in the United States: 1990 to 2020*, 1993 KAN. J.L. & PUB. POL'Y 53, 66 (1993).

33. Richard Nixon was the first to declare a "health care crisis" in 1970. Eli Ginzberg, Book Review *Resolving the Crisis in U.S. Health Care*, L.A. TIMES, Mar. 18, 1996, at 5. Bill Clinton's proposed health care reform was also aimed at remedying the "health care crisis." *The Debate: Is There a Health Care Crisis?*, HEALTH LINE, Jan. 25, 1994, available in LEXIS, Nexis Library, Med. & Health News File. Bob Dole, in a widely criticized statement, argued that "our country has health care problems, but not a health care crisis." Thomas J. Brazaitis & Tom Diemer, *President Took Reagan's Best Lines, GOP Claims*, PLAIN DEALER (Clev.), Jan. 27, 1994, at 1A. Critics of Dole's statement pointed out that in 1971 Dole had lauded President Nixon's recognition of "the present health care crisis in our nation." Jon Meacham, *The GOP's Master Strategist*, WASH. MONTHLY, Sept. 1, 1994, available in 1994 WL 13662800. Again in 1991, Dole spoke of the "health care crisis" in addressing the Senate. *Id.* See also *Debate Challenge Goes Out to Dole*, PLAIN DEALER (Clev.), Feb. 12, 1994, at 2B (criticizing Senator Dole's statement regarding the lack of a health care crisis and challenging him to tour a Cleveland area free clinic).

34. Bischof & Nash, *supra* note 29, at 227 ("The 1980s saw the true coming of age in managed care, as employers witnessed soaring health care costs. Enrollment in HMOs and preferred provider organizations (PPOs) exploded from roughly 10 million at the beginning of the decade to approximately 55 million by its end.").

as front runners in the mainstream of our nation's health care delivery system.³⁵

B. Definitions and Characteristics

HMOs are a type of managed health care organization.³⁶ A managed health care organization is a general term used to define any health care insurer which seeks to "manage" the health care decisions of its patient/insured and physician/provider.³⁷ This type of plan differs significantly from traditional "fee for service" plans. Under "fee for service" plans, the insurer does not have any input in the medical decision making process.³⁸

HMOs attract employers because of the HMO's ability to administer health care services in a more cost-effective manner.³⁹ A look at the basic characteristics of an HMO not only demonstrates how these organizations cut costs, but also demonstrates why HMOs are the target of many lawsuits.⁴⁰ First, HMOs offer the services of a restricted group of providers who are responsible for providing health care to the plan's insureds.⁴¹ Second, HMOs provide health care for a fixed fee per insured.⁴² Finally, they employ a variety of methods to control health care costs such as "utilization review," "gatekeeping," and "physician incentives."⁴³

35. Marcus, *supra* note 22 (survey results show that 19.6% of the national population is enrolled in an HMO). See also Mel Van Howe, *The Death of Managed Care*, HEALTHCARE INFORMATICS, Aug., 1996, at 104 (noting that more than 70 percent of the insured population is in some form of managed care organization).

36. Bischof & Nash, *supra* note 29, at 225. Managed care plans fall into three major categories: HMOs, Preferred Provider Organizations (PPOs), and (Point of Service) POS plans. *Id.* at 230. HMOs are the most restrictive type of plan. *Id.* They cover services only when the service is provided by a specified network of physicians and hospitals. *Id.* Patients are usually unable to access specialists until referred by their primary care physician. *Id.* PPOs generally allow patients to select from a larger network of physicians and may allow patients direct access to specialists. *Id.* POS plans allow patients to access physicians and hospitals outside of their network, but do assess penalties such as higher co-payments and deductibles. *Id.* There are many variations of these three basic categories. *Id.* One commentator estimates that there are as many as 30 million permutations on managed care payment models. Bill Childs, *Managed Care: Does it Have to Be This Difficult?*, HEALTHCARE INFORMATICS, Aug., 1996, at 6.

37. BENDA & ROZOVSKY, *supra* note 28, at § 1.2

38. *Id.* at § 1.2. In traditional "fee for service" plans, patients could choose any physician or hospital. *Id.* Furthermore, the providers and the insurers operated as separate entities. *Id.* HMOs, by creating an integrated network, act as both provider and insurer. *Id.*

39. BENDA & ROZOVSKY, *supra* note 28, at § 1.1 ("Employers . . . have embraced these organizations and approaches as ways of providing health benefits in a more efficient and less costly manner than that provided through traditional indemnity insurance.").

40. 1 BARRY R. FURROW ET AL., HEALTH LAW § 8.1, at 480 (1995).

41. *Id.*

42. *Id.*

43. *Id.*

C. *Methods of Controlling Costs*

1. Utilization Review

“Utilization Review” refers to methods by which an insurer determines whether or not health care services are medically necessary.⁴⁴ Traditionally, insurers performed utilization review *after* the patient received treatment.⁴⁵ While these “retrospective” utilization reviews would sometimes result in an insurer’s refusal to pay the health care provider, the review never affected the patient’s access to health care.⁴⁶ On the other hand, HMOs typically employ “prospective” or “concurrent” utilization review.⁴⁷ Prospective utilization review requires patients to obtain approval for treatment from the HMO *prior* to the provider’s administration of services.⁴⁸ Concurrent utilization review continuously monitors medical treatment and the length of stay to determine whether the care provided is necessary.⁴⁹

2. Gatekeeping and Physician Incentives

“Gatekeeping” is another method of controlling the use of medical services.⁵⁰ Gatekeepers are primary care physicians who provide basic medical care to patients.⁵¹ These individuals also determine when further medical care, such as hospitalization or specialist referral, is necessary.⁵²

44. Randall, *supra* note 18, at 27. For further discussion of utilization review and the liability concerns associated with it, *see generally* Randall, *supra* note 18; Peter H. Minaly, *Health Care Utilization Review: Potential Exposures to Negligence Liability*, 52 OHIO ST. L.J. 1289 (1991); Clifton Perry, *When Medical Need Exceeds Medical Resource and When Medical Want Exceeds Medical Need*, 21 W. ST. U.L. REV. 39 (1993).

45. Conrad & Seiter, *supra* note 2, at 191. This type of utilization review is known as “retrospective” utilization review. Randall, *supra* note 18, at 27.

46. Conrad & Seiter, *supra* note 2, at 191. *See also* Minaly, *supra* note 45, at 1289 (“[W]hile a retrospective payment denial may lead to heated disputes over who will pay the doctor or hospital, it usually does not have a significant impact on the patient’s care.”). Minaly also points out that retrospective review is not as effective at controlling costs:

[W]hile retrospective utilization review might reduce costs on an individual payor level, it is generally unsatisfactory as a cost containment device on a broader, societal level. The care has already been given by the time review is undertaken, and the question at that time is not whether the care will be paid for, but who will pay.

Id. at 1289 n. 4.

47. Conrad & Seiter, *supra* note 2, at 191.

48. Randall, *supra* note 18, at 27. An example of prospective utilization review is the requirement of preadmission review for scheduled hospitalizations. *Id.*

49. *Id.* Concurrent utilization review also includes admission review for unscheduled hospitalizations. *Id.*; *see also* Margaret Gilhooley, *Broken Back: A Patient’s Reflections on the Process of Medical Necessity Determinations*, 40 VILL. L. REV. 153, 153-161 (1995) (discussing one law professor’s experience with concurrent utilization review and determinations of “medical necessity” following a traumatic injury).

50. BENDA & ROZOVSKY, *supra* note 28, at §2.3.

Gatekeepers are often given economic incentives to prevent over utilization of medical services.⁵³ These incentives usually take the form of reimbursement incentives, penalties, and "risk sharing" or "capitation" arrangements.⁵⁴ In risk sharing, or capitation arrangements, a portion of the primary care physician's reimbursement is withheld by the HMO.⁵⁵ If, at the end of the contract year, the physician did not overutilize the services of specialists or other medical facilities, the HMO releases the withholdings to the physician.⁵⁶

III. THEORIES OF LIABILITY

A. Direct Liability for Negligent Utilization Review

Claims based upon HMO negligence in the utilization review process usually arise from review decisions made within prospective and concurrent systems of utilization review.⁵⁷ A negligent decision denying precertification of care or denying the continuation of care can lead to serious injury or even death.⁵⁸

51. *Id.*

52. Randall, *supra* note 18, at 19.

53. *Id.* Since gatekeeping physicians are also the primary caregiver and generally trusted by the patient, this aspect of managed care poses a potential threat to the typical concept of the patient/physician relationship. David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 149 (1995). Orentlicher notes that "[T]here is an increasing conflict between the personal financial interests of physicians and the needs of patients. For example, managed care plans typically pay physicians bonuses for keeping their spending on patient care low." *Id.* For a discussion on legislative efforts to either prevent or force disclosure of such financial incentives, see *infra* section V-C.

54. See Randall, *supra* note 18, at 19. See also BENDA & ROZOVSKY, *supra* note 28, at §2.3.

55. BENDA & ROZOVSKY, *supra* note 28, at §2.3.

56. *Id.*

57. See, e.g., Tolton v. American Biodyne Inc., 48 F.3d 937 (6th Cir. 1995) (challenging a prospective utilization review decision which refused to authorize psychiatric treatment for a man with suicidal thoughts); Corcoran v. United Healthcare, 965 F.2d 1321, 1322 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992) (challenging denial of precertification of hospitalization for perinatal monitoring, further discussed *supra* notes 4-5 accompanying text); Wilson v. Blue Cross of Southern California, 271 Cal. Rptr. 876 (Ct. App. 1990) (challenging refusal under concurrent utilization review process to discontinue benefits for inpatient psychiatric care after which the patient committed suicide); Wickline v. State, 239 Cal. Rptr. 810 (Ct. App. 1986) (challenging a prospective utilization review decision which refused to preauthorize an extended hospital stay, further discussed *infra* note 59). A claim may be brought based upon negligence in retrospective utilization review, but these cases are generally attempts on the part of hospitals or individuals to recover losses based upon a denial of coverage by the insurer. See e.g., Gulf South Med. and Surgical Inst. v. Aetna Life Ins. Co., 39 F.3d 520 (5th Cir. 1994) (brings claim challenging insurer's denial of coverage); Weaver v. Phoenix Home Life Mut. Ins., 990 F.2d 154 (4th Cir. 1993) (challenging refusal of insurer to compensate him for son's psychiatric care).

58. In *Wickline*, one of the earliest cases to address negligence in the utilization review process, a California court recognized the increased potential of harm to the patient in a

Numerous jurisdictions have applied traditional negligence theories to HMOs' utilization review decisions.⁵⁹ These courts have required that HMOs conform to the standard of care established by the health care industry.⁶⁰ However, Ohio is one of many jurisdictions which grants HMOs a certain degree of statutory protection against civil liability.⁶¹ For instance, Section 1742.30 of the Ohio Revised Code provides that "[a]ny health maintenance organization autho-

prospective utilization review process as opposed to the harm sustained in a retrospective review process:

The stakes, the risks at issue, are much higher when a prospective cost containment review process is utilized than when a retrospective review process is used. A mistaken conclusion about medical necessity following retrospective review will result in the wrongful withholding of payment. An erroneous decision in a prospective utilization review process, on the other hand, in practical consequences, results in a withholding of necessary care, potentially leading to a patient's permanent disability or death.

Wickline, 239 Cal. Rptr. at 812.

59. See, e.g., *Wickline*, 239 Cal. Rptr. at 810. Mrs. Wickline was a patient who underwent vascular surgery of the lower extremities. *Id.* at 812. Following the surgery, Mrs. Wickline developed complications. *Id.* at 813. Although her surgeon believed it was "medically necessary" to prolong her stay for the purposes of observation, the state's managed care health provider refused to authorize the extension of her stay. *Id.* Mrs. Wickline experienced further complications while at home and eventually lost her leg. *Id.* at 816. Although the *Wickline* court ultimately held the physician liable since he did not protest the third party payor's decision, the court acknowledged in dicta that a third party payor could be held liable "when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden." *Id.* at 819. See also *Wilson v. Blue Cross of Southern California*, 271 Cal. Rptr. 876 (Ct. App. 1990). *Wilson* was decided by the same court as *Wickline* and held that the third-party payor could be held liable for utilization review decisions. *Id.* at 883. See also *Pappas v. Asbel*, 675 A.2d 711 (Pa. 1996). *Pappas* is discussed in further detail *supra* notes 12-15 and accompanying text and *infra* notes 124-126 and accompanying text.

60. The court in *Wilson* held that the recipient was entitled to "the usual standards of medical practice in the community." 271 Cal. Rptr. 876, 880 (quoting *Wickline v. State*, 239 Cal. Rptr. 810 (Ct. App. 1986)). Standards of care to be applied to an HMO might arise from such areas as accreditation requirements, advertising, books and treatises, bylaws, practice guidelines, critical pathways, contracts, testimony of expert witnesses, scholarly articles, the HMO's membership handbook, regulations, and statutes. BENDA & ROZOVSKY, *supra* note 28, at § 6.2.

The Utilization Review Accreditation Commission (URAC) was organized in 1990 to accredit and set standards for reviewing organizations. FURROW ET. AL, *supra* note 40, at 498. The Agency for Health Care Policy and Research (AHCPR) was also recently formed by the federal government for publishing clinical practice guidelines. *Id.* The American Medical Association estimates that there are over 1,300 guidelines, protocols and parameters currently available for utilization review. *Id.*

61. OHIO REV. CODE ANN. §1742.30 (Banks-Baldwin 1996). For examples of other jurisdictions with similar statutes see ALA CODE §27-21a-23(c) (Michie 1996); DEL. CODE ANN. tit. 16, §9112(a)(1995); GA. CODE ANN. §33-21-28(c)(1996); HAW. REV. STAT. ANN. §432D-19(c) (Michie 1996); ME. REV. STAT. ANN. tit. 24-A, §4222(3) (West 1995); MO. ANN. STAT. §354.505(3) (West 1996); NEB. REV. STAT. §44-32,170 (1995); NEV. REV. STAT. §695C.050(3) (1995); N.J. STAT. ANN. §26:2J-25(c) (West 1996); N.C. GEN. STAT. §58-67-170(c) (Michie 1995); TENN. CODE ANN. §56-32-221(c) (1996); For a general

rized under this chapter shall not be considered to be practicing medicine.”⁶² In *Probst v. Health Maintenance Plan*,⁶³ the plaintiff attempted to hold an HMO directly liable for medical malpractice and negligence for exercising “substandard care” in arranging her medical care.⁶⁴ The First District Court of Appeals of Ohio held that since HMOs can not practice medicine, the defendant HMO could not be held liable for medical malpractice.⁶⁵

B. Direct Liability for Breach of Contract

In *Williams v. HealthAmerica*,⁶⁶ the Ninth District Court of Appeals of Ohio demonstrated that a breach of contract theory of recovery has a high chance of success against Ohio’s HMOs.⁶⁷ In *Williams*, the plaintiff’s primary care physician (“gatekeeper”) allegedly refused to refer Williams to a specialist.⁶⁸ When Williams complained to the HMO, it refused to review her complaints in accordance with its contractually established grievance procedure.⁶⁹

discussion of this type of statute see FURROW ET. AL., *supra* note 40, § 8-6, at 494.

62. OHIO REV. CODE ANN. §1742.30 (Banks-Baldwin 1996). Section 1742.30 establishes the applicability of laws governing insurance and health care professionals to Health Maintenance Organizations:

Except as otherwise specifically provided in this chapter or Title XXXIX of the Revised Code, provisions of Title XXXIX of the Revised Code shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer licensed and regulated pursuant to Title XXXIX of the Revised Code except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

For the purposes of clarifying jurisdiction under the “Bankruptcy Reform Act of 1978,” 92 Stat. 2549, 11 U.S.C.A. 101 and recognition of the right of this state to regulate domestic insurance companies under the “McCarran-Ferguson Act,” 59 Stat. 33 (1945), 15 U.S.C.A. 1011, a health maintenance organization is deemed to be a domestic insurance company.

Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health care professionals.

Any health maintenance organization authorized under this chapter shall not be considered to be practicing medicine.

Id.

63. *Probst v. Health Maintenance Plan*, 582 N.E.2d 1142, 1143 (Ohio Ct. App. 1990), *motion overruled by*, 562 N.E.2d 898 (Ohio 1990).

64. *Id.*

65. *Id.* This is the only published case which has cited section 1742.30 of the Ohio Revised Code. Search of Westlaw, Shepard’s Ohio Statutes (November 1996). Also, *Probst* has not been cited as support for any other published case.

66. *Williams v. HealthAmerica*, 535 N.E.2d 717 (Ohio Ct. App. 1987).

67. See Shelly L. Hansen, *HMO Liability: Two Theories of Recovery*, HEALTH L. J. OH., Sept./Oct., 1989, at 51.

68. 535 N.E.2d 717, at 718.

69. *Id.* at 720. When Mrs. Williams approached HealthAmerica’s representatives concerning

In reversing the trial court's grant of summary judgment,⁷⁰ the court relied on previous Ohio cases where tort liability was imposed upon insurers for "breach of a positive legal duty imposed by law."⁷¹ The *Williams* Court found that Section 1742.14 of the Ohio Revised Code, which requires HMOs to "establish and maintain a complaint system,"⁷² placed a positive legal duty on the HMO to review *Williams*' claims.

C. *Direct Liability for Negligent Selection, Retention, Supervision, and Credentialing*

Ohio's courts have routinely held hospitals liable for negligent selection, retention, supervision, and credentialing of staff physicians.⁷³ However, even though other state courts have extended this liability to HMOs, Ohio's courts have not addressed the issue.⁷⁴ Nonetheless, commentators have noted that

her complaints, she was told that referral decisions were "strictly up to Dr. Monroe" (her primary care physician under the plan). *Id.* HealthAmerica's grievance procedure was listed in a Service Agreement: "A Member may at any time, process a written complaint with HealthAmerica. If a Member's complaint is not resolved within sixty (60) days by informal action, then he may request a hearing before a committee designated by Health America." *Id.*

70. *Id.* at 722.

71. *Id.* at 721 (quoting *Hoskins v. Aetna Life Ins. Co.*, 452 N.E.2d 1315, 1320 (Ohio 1983)).

72. OHIO REV. CODE ANN. §1742.14 (A) (Anderson 1996) provides:

A health maintenance organization shall establish and maintain a complaint system that has been approved by the superintendent of insurance to provide adequate and reasonable procedures for the expeditious resolution of written complaints initiated by enrollees concerning any matter relating to services provided, directly or indirectly, by the health maintenance organization including, but not limited to, claims regarding the scope of coverage for health care services, and denials, cancellation, or nonrenewals of enrollees coverage.

Id.

For further discussion of OHIO REV. CODE ANN. §1742.14 (Anderson 1996), see *infra* note 194.

73. See, e.g., *Albain v. Flower Hosp.*, 553 N.E.2d 1038, 1046 (Ohio 1990) ("We hold that a hospital may be held directly liable for the malpractice of an independent physician with staff privileges . . ."), *overruled in part by Clark v. Southview Hosp. & Family Health Ctr.*, 628 N.E.2d 46 (Ohio 1994); *Browning v. Burt*, 613 N.E.2d. 993 (Ohio 1993).

74. See, e.g., *McClellan v. Health Maintenance Org.*, 604 A.2d 1053, 1059 (Pa. 1992).

It thus follows that a complaint . . . must contain factual allegations sufficient to establish the legal requirement that the HMO has undertaken (1) to render services to the plaintiff subscriber, (2) which the HMO should recognize as necessary for the protection of its subscriber, (3) that the HMO failed to exercise reasonable care in selecting, retaining, and/or evaluating the Plaintiff's primary care physician, and (4) that as a result of the HMOs failure to use such reasonable care, the risk of harm to the subscriber was increased.

Id. It is important to note that the *McClellan* decision did not rely on the application of the corporate negligence doctrine. *Id.* The theory of corporate negligence holds health care organizations to a heightened standard of care, imposing upon them a "duty to . . . ensure the 'competency of its medical staff and the quality of medical care provided through prudent

since HMOs restrict patient choices even more significantly than hospitals, an extension of "negligent selection" liability to HMOs makes for sound public policy.⁷⁵

As with claims for direct negligence related to utilization review,⁷⁶ it is possible that Ohio Revised Code Section 1742.30 might bar HMO liability for negligent selection, retention, supervision, or credentialing.⁷⁷ For example, an Illinois court construing a statute which exempted HMOs from negligence, held that the statute protected HMOs from claims of negligent credentialing.⁷⁸ On the other hand, the Illinois statute contains very specific language which exempts HMOs from liability for "injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice . . . on the part of any person . . . rendering health services to . . . beneficiaries."⁷⁹ Conversely, the Ohio Revised Code merely prevents a finding that an HMO is "practicing medicine."⁸⁰

Furthermore, the Supreme Court of Ohio has determined that a claim against an HMO based upon negligent credentialing is not "a claim based upon malpractice" or a "medical claim" for the purposes of determining the appropriate statute of limitations.⁸¹ In light of this decision, it is very likely that Ohio's

selection, review and continuing evaluation of the physicians granted staff privileges.'" FURROW ET. AL., *supra* note 40, § 8-3, at 489. The corporate negligence doctrine was rejected by the Ohio Supreme Court in *Albain*. 553 N.E.2d at 1046. "This expansion of a hospital's duties . . . has progressed in varying degrees, under the moniker of 'corporate negligence,' towards imposing strict liability upon hospitals . . . We are not convinced of the wisdom of such expansive liability." *Id.*

75. FURROW ET. AL., *supra* note 40, § 8-3 at 490.

The logic of a direct duty imposed on MCOs to properly select providers is even stronger for an MCO than for a hospital. In the hospital setting, the patient usually has selected the physician By contrast, in a managed care program the patient has chosen the particular program, but not the physicians who are provided The patient thus explicitly relies on the MCO for its selection of health care providers.

Id.

76. *See, supra* notes 61-65 and accompanying text.

77. For text of statute, *see supra* note 62.

78. *Moshe v. Anchor Org. For Health Maintenance*, 557 N.E.2d 451 (Ill. Ct. App. 1990).

79. *See* 32 ILL. COMP. STAT. ANN. 620/26 (West 1988):

A health services plan corporation shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any officer or employee of the corporation, or on the part of any person, organization, agency or corporation rendering health services to the health services plan corporation's subscribers and beneficiaries.

Id. This statute, which was enacted in 1951, was amended in 1988 to remove this immunity. *See, Moshe*, 557 N.E.2d at 46.

80. OHIO REV. CODE ANN. §1742.30 (Banks-Baldwin 1996). For full text of statute, *see supra* note 62.

81. *Browning v. Burt*, 613 N.E.2d 993, 1004 (Ohio 1993). *See* OHIO REV. CODE ANN. §2305.11 (Banks-Baldwin 1996) (defining "medical claim" as a claim that "arises out of the

courts might also refuse to define “negligent credentialing” as the “practice of medicine” within the meaning of Ohio Revised Code Section 1742.30.⁸²

D. Vicarious Liability Based Upon Agency Principles

An injured plaintiff may also attempt to hold an HMO vicariously liable for the negligent acts of its member physicians. Under the vicarious liability theory, the plaintiff attempts to establish that the physician was acting as an agent for the HMO.⁸³ The success of this theory depends largely upon the HMO’s structure and its relationships with member physicians.⁸⁴ If an HMO’s physicians are found to be employees, the HMO should be held vicariously liable for the physician’s negligence under the doctrine of *respondeat superior*.⁸⁵ Many courts allow this theory of recovery, reasoning that the degree of control exerted over the physician by the HMO should determine whether or not an employee/employer relationship exists.⁸⁶

Even if the courts do not find an express employee/employer relationship

medical diagnosis, care, or treatment of a person.”)

82. See *Browning*, 613 N.E.2d at 1004 (“If a negligent credentialing cause of action is not a claim for malpractice or a medical claim, the obvious question becomes: What is it? It is, simply a claim for bodily injury arising out of negligence.”) For a general discussion on credentialing liability, see generally BENDA & ROZOVSKY, *supra* note 28, at §7.1-§7.7.

83. For a discussion of cases addressing agency principles see *infra* notes 86 and 88. Many courts faced with vicarious liability claims against HMOs, never reach the merits of the claim because of ERISA preemption. See discussion *infra* section IV-B.

84. Conrad & Seiter, *supra* note 2, at 195. HMOs can be classified into five types depending on the relationship between the providers and the organization. BENDA & ROZOVSKY, *supra* note 28, at §2.4.1. In a staff model HMO, the physician is actually employed by the HMO and receives a fixed salary as well as bonuses from the organization. *Id.* A group model HMO contracts with multi-specialty group practices of physicians. *Id.* While the physicians in the group model are technically employed by the group practice, the group receives compensation from the HMO. *Id.* A network model HMO is very similar to the group model but instead of contracting with one multi-specialty group, it contracts with multiple groups of various specialties. *Id.* An Independent Practice Association (IPA) HMO contracts with an association of individual physicians who continue to maintain their own private practices and may see patients outside of the HMO. *Id.* Finally, a direct contract model HMO is very similar to the IPA model but allows the HMO to contract directly with independent physicians. *Id.*

85. See, e.g., *Dunn v. Praiss*, 606 A.2d 862 (N. J. Sup. Ct. 1992), *aff’d by*, 656 A.2d 413 (N.J. 1995); *Sloan v. Metro. Health Council of Indianapolis*, 516 N.E.2d 1104 (Ind. Ct. App. 1987).

86. The *Dunn* court focused on the following observations in making its decision that an agency relationship existed:

Neither he nor his group was paid on a fee-for service basis; rather they were paid on a per capita basis, based upon the number of subscribers to the HMO. They were not free to accept or reject a particular patient. Additional referrals were at the HMO’s option. They examined the decedent at the HMO’s office, as did Dr. Blumenthal, a full-time employee of the HMO . . . the overall control exercised by the HMO over both physicians clearly caused Dr. Marmar to be both actually and apparently the agent of the HMO.

between physician and HMO, courts have found that a plaintiff might be able to establish HMO liability pursuant to the "agency by estoppel" doctrine⁸⁷ or "apparent agency" doctrine.⁸⁸ Although slightly different in theory, commentators often refer to these two doctrines synonymously, as both are concerned with the degree to which an HMO has held the provider out as its agent.⁸⁹ In

606 A.2d at 868.

87. All 50 states have an agency or "partnership by estoppel" statute; *See, e.g.*, ALA. CODE § 10-8A-308 (Michie 1996); ARIZ. REV. STAT. § 29-216 (1996); ARK. STAT. ANN. § 4-42-308 (1995); ALASKA STAT. § 32.05.110 (1996); CAL. CORP. CODE § 15016 (1996); COL. REV. STAT. § 7-60-116 (1996); DEL. CODE ANN. TIT. 6, § 1516 (1995); D.C. CODE § 41-115 (1996); GA. CODE ANN. § 14-8-9 (1996); HAW. REV. CODE ANN. § 425-116 (Michie 1996); IDAHO CODE § 53-316 (1996); ILL. COMP. STAT. ANN. TIT. 805 § 205/16 (1996); BURNS IND. STAT. ANN. § 23-4-1-16 (1996); IOWA CODE § 486.16 (1995); KAN. STAT. ANN. § 56-316 (1995); FLA. STAT. § 620.635 (1995); KY. REV. STAT. ANN. § 362.225 (Michie 1995); MISS. CODE ANN. § 79-12-31 (1996); MINN. STAT. §323.15 (1996); ME. REV. STAT. TIT. 31, § 296 (1995); MD. CODE ANN. § 9-308 (Michie 1996) (Corporations and Associations); MASS. ANN. LAWS CH. 108A, § 16 (1996); MONT. CODE ANN. § 35-1-534 (1995); MI. STAT. ANN. § 20.16 (1996); MO. REV. STAT. § 358.160 (1995); N.D. CENT. CODE § 45-06-08 (1995); N.C. GEN. STAT. § 59-46 (1995); N.Y. CONS. L. SERV. PARTN. § 27 (1996); N.H. REV. STAT. ANN. 304-A:16 (1995); N.M. STAT. ANN. § 54-1-16 (1996); NEV. REV. STAT. ANN. § 87.160 (Michie 1995); N.J. STAT. § 42:1-16 (1996); NEB. REV. STAT. ANN. § 67-316 (Michie 1996); OHIO REV. CODE ANN. § 1775.15 (Baldwin 1996); OKLA. STAT. TIT. 54, § 216 (1995); OREGON REV. STAT. § 68.280 (1995); PA. CIV. STAT. TIT. 15, § 8328 (1996); R.I. GEN LAWS § 7-12-27 (1995); S.C. CODE ANN. § 33-41-380 (1995); TENN. CODE ANN. § 61-1-115 (1996); TEX. REV. CIV. STAT. ART. 6132b, § 16 (1996); UTAH CODE ANN. § 48-1-13 (Michie 1996); VA. CODE ANN. §50-16 (Michie 1996); VERMONT STAT. ANN. TIT. 11, § 1208 (1995); WASH. REV. CODE ANN. § 25.04.160 (Michie 1995); W.V. CODE ANN. § 47B-3-8 (Michie 1996); and 26 V.I.C.A. § 48 (1994).

88. *See, e.g.*, *Boyd v. Albert Einstein Medical Center*, 547 A.2d 1229 (Pa. Super. 1988); *Decker v. Saini*, 14 Empl. Ben. Cas. 1556, 1991 WL 277590 (Mich. Cir. Ct. 1991); *Kearney v. U.S. Healthcare*, 859 F. Supp. 182 (E.D. Pa. 1994) (recognizing cause of action for ostensible agency and remanding to state court); *Elsesser v. Hosp. of the Phila. College of Osteopathic Med.*, 802 F. Supp. 1286 (E.D. Pa. 1992) (recognizing cause of action for ostensible agency and remanding to state court). *But see Raglin v. HMO III, Inc.*, 595 N.E.2d 153 (Ill. Ct. App. 1992) (granting summary judgment to defendant HMO on "apparent agency" claim). "Ostensible agency" is another name for "apparent agency." Jim M. Perdue & Stephen R. Baxley, *Cutting Costs - Cutting Care: Can Texas Managed Health Care Systems and HMOs Be Liable for the Medical Malpractice of Physicians?*, 27 ST. MARY'S L. J. 23, 32 (1995).

89. *See Perdue & Baxley, supra* note 88, at 32-34 (1995). Most courts and commentators agree that "agency by estoppel" is defined by the Restatement of Agency §267 and that "apparent agency" is defined in the Restatement of Torts §429. *Jackson v. Power*, 743 P.2d 1376, 1380 (Alaska 1987); Cassandra P. Priestly, *Hospital Liability for the Negligence of Independent Contractors: A Summary of Trends*, 50 J. MO. B. 263, 265 (1994); Colleen Moran, Note, *Clark v. Southview Hospital: Ohio Follows the Nationwide Trend of Using Agency by Estoppel to Impose Strict Liability On Hospitals*, 9 J.L. & HEALTH 319, 322 (1995) Section 429 provides:

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

Clark v. Southview Hospital & Family Health Center,⁹⁰ the Ohio Supreme Court used the agency by estoppel doctrine to hold a hospital liable for the actions of a consulting physician.⁹¹ Similarly, a Michigan court, applying reasoning very similar to that used by the *Clark* Court, held that the agency by estoppel could also be used against an HMO.⁹²

However, it is possible that Ohio Revised Code Section 1742.30 might also bar an agency by estoppel theory of liability against HMOs.⁹³ For instance, a Colorado court, in *Freedman v. Kaiser Foundation Health Plan of Colorado*,⁹⁴

RESTATEMENT (SECOND) OF TORTS §429 (1965). THE RESTATEMENT OF AGENCY Section 267, on the other hand, provides that:

One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

RESTATEMENT (SECOND) OF AGENCY Section 267 (1958). This is arguably a stricter standard than that created by the Restatement of Torts, since it requires a showing of actual reliance by the patient. *Jackson*, 743 P.2d at 1380. Commentators have criticized the Ohio court for having blurred the distinction between these two types of agency. *Perdue & Baxley, supra*, at 88; *Moran, supra*, at 333. In *CLARK V. SOUTHVIEV HOSP. & FAMILY HEALTH CENTER*, the Ohio Supreme Court stated that it was applying the doctrine of “agency by estoppel.” 628 N.E.2d 46, 53 (Ohio 1994). However, the court did not require the element of “induced reliance.” *Id.* at 50. Commentators have pointed out that this is a required element of “agency by estoppel” under the RESTATEMENT OF AGENCY §267. *Moran, supra*, at 333. For further discussion of these two agency theories see Bradford C. Kendall, Note, *The Ostensible Agency Doctrine: In Search of the Deep Pocket?*, 57 UMKC L. REV. 917, 924 (1989). Kendall notes, “Despite its wide acceptance and apparent simplicity, the doctrine has evoked confusion, and many courts have used different language to describe the same phenomenon.” *Id.*

90. *Clark*, 628 N.E.2d 46 (Ohio 1994).

91. *Id.*

92. *Decker v. Saini*, 1991 WL 277590 (Mich. Cir. Ct. 1991). The *Decker* court applied the test for “apparent agency” from a Michigan Supreme Court case, *Grewe v. Mt. Clemens Gen. Hosp.*, 273 N.W.2d 429 (Mich. 1978). *Id.* at 3. The *Grewe* test required the finding of three elements:

- (1) The person dealing with the agent must do so with belief in the agent’s authority and this belief must be a reasonable one;
- (2) such belief must be generated by some act or neglect of the principal sought to be charged;
- (3) and the third person relying on the agent’s apparent authority must not be guilty of negligence.

Id. (quoting *Grewe v. Mt. Clemens General Hosp.*, 273 N.W.2d 429 (Mich. 1978)). Note the similarity of the *Grewe* test to the Ohio Supreme Court’s test for “agency by estoppel” as stated in *Clark*:

A hospital may be held liable under the doctrine of “agency by estoppel” for the negligence of independent medical practitioners practicing in the hospital if it holds itself out to the public as a provider of medical services and in the absence of notice or knowledge to the contrary, the patient looks to the hospital, as opposed to the individual practitioner, to provide competent medical care.

Clark, 628 N.E.2d at 444.

applied a statute with language nearly identical to Ohio Revised Code Section 1742.30, to hold that the statute precluded recovery against an HMO for the actions of its contracting physicians.⁹⁵ The *Freedman* court reasoned:

Because an HMO is specifically precluded from practicing medicine, no HMO can direct the actions of the independent physicians with whom it contracts. Thus, we conclude that the concept of *respondeat superior* cannot be invoked to make an HMO responsible for the medical malpractice of those independent contractor physicians that it is statutorily precluded from directing or controlling.⁹⁶

Whether or not Ohio's courts would strictly interpret Section 1742.30 remains to be seen. However, a review of the case law suggests that Colorado's courts have interpreted the Colorado statute (C.R.S. §10-17-125(3)) to afford HMOs greater protection from liability than Ohio's court have afforded under Section 1742.30. For example, Colorado's courts have held that C.R.S. §10-17-125(3) precludes a breach of contract claim against an HMO,⁹⁷ while Ohio's courts have held that Section 1742.30 does not bar the same claim.⁹⁸

On the other hand, the New Jersey Superior Court has held that New Jersey's corresponding statute, which states that an HMO should "not be deemed to be practicing medicine,"⁹⁹ does not preclude a claim against an HMO based upon agency theory.¹⁰⁰ The New Jersey court did, however, rely on additional language in the statute which provides that "[n]o person participating in the arrangements of a health maintenance organization other than the actual provider of health care services . . . shall be liable for negligence . . ." ¹⁰¹ The

93. For text of Section 1742.30 of the Ohio Revised Code, see *supra* note 62.

94. *Freedman v. Kaiser Found. Health Plan of Colo.*, 849 P.2d 811 (Colo. 1992). The Colorado statute provides that an HMO "shall not be deemed to be practicing medicine and shall be exempt from the provisions of laws relating to the practice of medicine." *Id.* at 816 (quoting the Colorado Health Maintenance Organization Act, COLO. REV. STAT. ANN. § 10-17-125(3) (West 1996)). Note the similarity to section 1742.30 of the Ohio Revised Code which provides that "Any health maintenance organization authorized under this chapter shall not be considered to be practicing medicine." OHIO REV. CODE ANN. §1742.30 (Banks-Baldwin 1996).

95. *Id.*

96. *Freedman*, 849 P.2d at 816.

97. *Evans v. Colo. Permanente Medical Group, P.C.*, 902 P.2d 867 (Colo. 1995). The court in *Evans* held that, "In Colorado, a breach of contract or tort claim may not be brought against an HMO . . . for negligently providing or failing to provide medical services . . ." *Id.* at 877.

98. *Williams v. HealthAmerica*, 535 N.E.2d 717 (Ohio Ct. App. 1987).

99. N.J. STAT. ANN. §26:2J-25(c) (West 1996) provides: "Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine." *Id.*

100. *See, Robbins v. HIP of N.J.*, 625 A.2d 45,46 (N.J. Super. L. 1993); *See also Dunn v.*

court interpreted this language to mean that the legislature intended to immunize individuals involved with administrative duties, but not the HMO itself.¹⁰²

IV. ERISA'S PREEMPTIVE EFFECT ON NEGLIGENCE CLAIMS

A. Introduction to ERISA Preemption

It is impossible to discuss the potential liability of HMOs without discussing the effects of the Employee Retirement Income Security Act (ERISA).¹⁰³ Congress adopted ERISA in 1974 to promote the growth of private employee health care and pension plans.¹⁰⁴ The act created a uniform set of minimally restrictive governmental guidelines which cannot be undermined by state regulation.¹⁰⁵ Since ERISA plans represent a majority of the nation's health care plans,¹⁰⁶ ERISA's preemption provisions bar state courts and legislatures from holding HMOs liable for negligence.¹⁰⁷

This result is a product of ERISA's very limited remedial scheme.¹⁰⁸ A

Praiss, 656 A.2d 413, 415 (N.J. 1995) (noting that the language of Section 26:2J-25(c) of the New Jersey Statute does not preclude medical malpractice claims brought against an HMO).

101. *Robbins*, 625 A.2d at 46 (quoting N.J. STAT. ANN. §26:2J-25(d) (West 1996) which provides: "No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies.").

102. *Id.*

103. 29 U.S.C. § 1001 *et seq.* (1996).

104. Robert L. Roth, *Recent Developments Concerning the Effect of ERISA Preemption on Tort Claims Against Employers, Insurers, Health Plan Administrators, Managed Care Entities, and Utilization Review Agents*, THE HEALTH LAWYER (The ABA Forum on Health Law), Early Spring 1996, at 3; For further discussion regarding the history and purpose of ERISA with respect to health plans, see FURROW ET. AL., *supra* note 40, § 8-8, at 504-07; David L. Bacon, *ERISA Preemption and Health Care*, 23 BRIEF 16, 17 (1994); Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 52-57 (1996); Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 357-62 (1994).

105. Roth, *supra* note 101, at 3. Congress was concerned with "inconsistent state regulatory schemes that could increase inefficiency and potentially cause benefit levels to be reduced by diverting available benefit dollars to satisfy additional administrative costs." *Id.* 29 U.S.C. § 1144(a) (1996) provides:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

Id.

106. Roth, *supra* note 104, at 3. Some plans that would not be covered by ERISA include governmental plans, church plans, unemployment compensation plans, worker's compensation plans, disability compensation plans, and unfunded excess benefits plans. 29 U.S.C. § 1003 (1996). See also BENDA & ROZOVSKY, *supra* note 28, at §4.3; Fred J. Hellinger, *The*

person who claims injury as a result of the actions of an ERISA plan's administrators is only entitled to recover the benefits or rights which were due under the HMO plan.¹⁰⁹ Unfortunately, these remedies do not include monetary relief for incidental damages or a jury trial.¹¹⁰

In determining whether ERISA preempts a claim, the courts look to three key ERISA provisions: (1) the preemption clause; (2) the "savings clause"; and (3) the "deemer clause."¹¹¹ ERISA's preemption clause, 29 U.S.C. §1144 (a), states that "this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ."¹¹² Whether or not a state claim "relates to" an employee benefit plan has been the subject of frequent litigation and liturgical discussion.¹¹³

ERISA's "savings clause," 29 U.S.C. §1144(b)(2)(a), provides that the act shall not be "construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."¹¹⁴ This clause would appear to "save" HMOs from preemption.¹¹⁵ However, the "deemer clause," 29

Expanding Scope of State Legislation, 276 JAMA 1065, 1066 (1996) (noting that in 1993 approximately 44 million people were enrolled in self-funded employee health plans governed by ERISA).

107. BENDA & ROZOVSKY, *supra* note 28, at §4.3.

108. *Id.* Remedies provided by ERISA are found in 29 U.S.C. § 1132 (1996). See also *Cannon v. Group Health Service of Ok. Inc.*, 77 F.3d. 1270, 1272 (10th Cir.), *cert denied*, 117 S.Ct. 66 (1996). (upholding lower court's finding that ERISA provides only for payment of "medical expenses actually incurred, when that is the benefit provided by the plan".)

109. 29 U.S.C. § 1132(a)(1)(b) (1996) provides: "A civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." *Id.* Plaintiffs might also be able to recover attorney's fees and court costs. See BENDA & ROZOVSKY, *supra* note 28, at §4.3, n. 11; Roth, *supra* note 104, at 3 ("Beneficiaries who believe that they have been harmed by torts committed by ERISA plan entities have brought suits against these entities seeking damages under state tort law – relief that clearly exceeds the remedies available under ERISA.").

110. BENDA & ROZOVSKY, *supra* note 28, at §4.3.

111. Roth, *supra* note 104, at 3.

112. 29 U.S.C. § 1144 (a) (1996).

113. See, e.g., *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 96-97 (1983) ("A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan."). For a general discussion of the preemption clause as related to health maintenance organization and other managed care entities, see generally Torin A. Dorros & T. Howard Stone, *Implications of Negligent Selection and Retention of Physicians in the Age of ERISA*, 21 AM. J. L. & MED. 383 (1995); Michael S. Gordon, *Managed Care, ERISA Pre-emption, and Health Reform – The Current Outlook*, HEALTH CARE POL'Y REP., Apr. 17, 1995; David H. Sculnick, *HMO Liability and ERISA Preemption for Medical Malpractice*, THE HEALTH LAWYER (The ABA forum on Health Law), Early Spring 1996, at 8.

114. 29 U.S.C. § 1144 (b)(2)(a) (1996). See *Metropolitan Life Ins. v. Mass.*, 471 U.S. 721 (1985) (holding that a Massachusetts statute which requires general health insurance policies to provide for a minimum amount of mental health care is a law which "regulates insurance"

U.S.C. §1144(b)(2)(b), prevents this interpretation by mandating that self-insured employee benefit plans qualified under ERISA cannot “be deemed to be an insurance company or other insurer.”¹¹⁶

B. Case Law Addressing ERISA Preemption

The success of ERISA preemption defenses depends largely upon the jurisdiction and the theory upon which the plaintiff pursues his or her claim.¹¹⁷ Most courts have held that ERISA preempts claims based upon a direct negligence theory for negligent utilization review or denial of benefits.¹¹⁸ For instance, the United States Court of Appeals for the Sixth Circuit followed this trend in *Tolton v. American Biodyne, Inc.*¹¹⁹ In *Tolton*, the Sixth Circuit upheld the District Court for the Northern District of Ohio’s ruling that ERISA preempted a claim for negligent utilization review.¹²⁰ However, a recent United States Supreme Court decision, *New York State Conference of Blue Cross & Blue Shield Health Plans v. Travelers Insurance*,¹²¹ arguably narrows the scope of ERISA’s preemptive effect on state liability claims against HMOs.¹²² *Travelers* involved a New York statute rather than common law; still, the issue was whether the statute “related to the employee benefit plan.”¹²³ The *Travelers*

and thus not preempted by ERISA). *But see* *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41 (1987) (holding that common law tort and contract claims against an insurer for improper processing of claims are preempted by ERISA and do not “regulate insurance” within the common sense meaning of the savings clause).

115. Roth, *supra* note 104, at 3.

116. U.S.C. § 1144(b)(2)(b) (1996) provides:

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company, or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts; banks, trust companies, or investment companies.

Id.

117. *See*, Sculnick, *supra* note 113, at 11; Conrad & Seiter, *supra* note 2, at 197 (“To make sense of the conflicting results and rationales presented by the case law, it is important to determine the factual basis of the claim . . .”).

118. *See* *Kuhl v. Lincoln Nat’l. Health Plan*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992).

119. *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995).

120. *Id.* at 944. The plaintiffs in *Tolton* were survivors of a man who committed suicide after being denied inpatient psychiatric care for his suicidal thoughts. *Id.* at 940. The denial was a result of the health plan’s utilization review process. *Id.*

121. 115 S.Ct. 1671 (1995).

122. *See* Karen A. Jordan, *Travelers Insurance: New Support For the Argument to Restrain ERISA Pre-Emption*, 13 YALE J. ON REG. 255, 322 (1996) (arguing that *Corcoran* and *Kuhl* would have a different result under the analysis set forth in *Travelers*). *Travelers* was decided

Court observed that

[f]or the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.¹²⁴

At least one court has adopted *Travelers*' language to find that ERISA does not preempt a direct negligence claim.¹²⁵ In *Pappas v. Asbel*,¹²⁶ the Pennsylvania Supreme Court borrowed from the *Travelers* decision in its analysis of Congress' preemptive intent with regard to direct negligence claims against HMOs.¹²⁷ The *Pappas* court reasoned that

[c]onsiderations of cost containment of the type which drive the decision making process in HMOs did not exist for employee welfare plans when ERISA was enacted. It cannot therefore be argued that the type of recovery sought here was deliberately excluded from the Congressional schema in order to it protect ERISA plans from conflicting directives which would, in attempting to control expenses, affect medical judgments.¹²⁸

However, in *Chagervand v. Carefirst*,¹²⁹ the United States District Court for the District of Maryland found that the language in *Travelers* did not necessarily alter Maryland precedent, stating that ERISA preempts direct negligence claims.¹³⁰

Although the Sixth Circuit has not yet addressed a direct negligence claim in light of *Travelers*, that court has addressed a claim for bad faith breach of contract.¹³¹ In *Schachner v. Blue Cross and Blue Shield of Ohio*,¹³² the Sixth Circuit held that ERISA preempted a bad faith breach of contract claim against an HMO insurer.¹³³ However, the precedential value of *Schachner* seems suspect in light of the fact that it was decided after *Travelers*, but did not make any mention of the *Travelers* opinion.¹³⁴

two months after *Tolton*.

123. 115 S.Ct. at 1671.

124. *Id.* For a discussion of the court's failure to rely on Congressional intent in interpreting ERISA see generally Fisk, *supra* note 104. Fisk states that the *Travelers* decision is a "step in the right direction." *Id.* at 93.

125. *Pappas v. Asbel*, 675 A.2d 711 (Pa. 1996).

126. 675 A.2d 711 (Pa. 1996).

127. *Id.* at 715.

128. *Id.* at 716.

129. 909 F. Supp. 304 (D. Md. 1995).

130. *Id.* at 309. (citing *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 184-85 (E.D. Pa. 1994)).

131. *See, Schachner v. Blue Cross & Blue Shield of Ohio*, 77 F.3d. 889 (6th Cir.), *cert.*

In claims based upon either negligent credentialing, supervision, retention, or vicarious liability theories, the courts are sharply divided with regard to the scope of ERISA's preemption clause.¹³⁵ The Sixth Circuit has yet to address the issue. However, the District Court for the Eastern District of Michigan recently distinguished a claim based upon "ostensible agency" and "negligent credentialing" from *Tolton*'s "negligent utilization review" claim.¹³⁶ In *Fritts v. Khoury*,¹³⁷ the District Court for the Eastern District of Michigan held that ERISA does not preempt ostensible agency and negligent credentialing claims.¹³⁸ In reaching its decision, the court relied upon *Dukes v. U.S.*

denied, 117 S.Ct. 173 (1996).

132. 77 F.3d 889 (6th Cir.), *cert. denied*, 117 S.Ct. 173 (1996).

133. *Id.* at 897. ("The Ohio common law right to a tort action for an insurer's bad faith breach of an obligation to pay a claim is preempted by ERISA").

134. *Schachner*, 77 F.3d. 889. *See also* *Zuniga v. Blue Cross & Blue Shield of Mich.*, 52 F.3d. 1395 (6th Cir. 1995). *Zuniga* involved a breach of contract claim brought by a physician who had been rejected by a health plan for overutilization of services. *Id.* at 1397. The majority of the court held that the claim was preempted by ERISA. *Id.* at 1402. The dissent, however, argued that the majority had ignored the recent *Travelers* decision. *Id.* at 1403 (Nelson, J., dissenting). The dissent went on to argue:

As we have seen, and as *Travelers* confirms, "[t]he basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." Enforcement of Dr. Zuniga's settlement agreement with Blue Cross would not, in my view, subject ERISA plans to a "multiplicity of regulation," and I am not persuaded that Congress intended to preempt state contract law in its application to this agreement.

Id. at 1405 (Nelson, J., dissenting) (citation omitted).

135. *Compare* *Dukes v. U.S. Health Care Inc.*, 57 F.3d 350 (3rd Cir.), *cert. denied*, 116 S.Ct. 564 (1995); (holding that neither claims for negligent credentialing nor vicarious liability are pre-empted by ERISA), *Pacificare of Ok., Inc. v. Burrage*, 59 F.3d. 151 (10th cir. 1995) (vicarious liability claim not preempted by ERISA); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995) (holding that claim based upon respondeat superior was not preempted by ERISA); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996) (vicarious liability claim not preempted by ERISA); *Frappier v. Wishnov*, 678 So.2d 884 (Fla. Ct. App. 1996) (vicarious liability claim not preempted by ERISA); and *Schachter v. Pacificare of Ok. Inc.*, 923 F. Supp. 1448 (N.D. Ok. 1995) (vicarious liability claim not preempted by ERISA) *with* *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994) (claims for negligent retention or selection should be preempted, but claims for vicarious liability are not) and *Kearney v. U.S. Healthcare*, 859 F. Supp. 182 (E.D. Pa. 1994) (claims for negligent selection preempted but claim for ostensible agency not) *with* *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th cir. 1992), *cert. denied*, 506 U.S. 1033 (1992); *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994) (claims for negligent credentialing and supervision, as well as claims for vicarious liability are pre-empted by ERISA); and *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61 (D. Conn. 1990) (claims for negligent credentialing are preempted by ERISA). For a general discussion of ERISA preemption of negligent selection and retention claims, see *Dorros & Stone*, *supra* note 113.

136. *Fritts v. Khoury*, 933 F. Supp. 668 (E.D. Mich. 1996). In *Fritts*, the court distinguished the case from *Tolton*, discussed *supra* notes 119-20:

Defendant's reliance on *Tolton v. American Biodyne, Inc.* . . . is misplaced. In *Tolton*, unlike the present case, the plaintiffs' claims specifically included a claim

Healthcare, Inc.,¹³⁹ a Third Circuit Court of Appeals case, which held that ostensible agency and negligent credentialing claims do not “relate to” the administration of an HMO plan’s benefits. Rather, the *Dukes* Court held that these theories of recovery relate to the quality of benefits received.¹⁴⁰

In summary, ERISA’s preemption clause produces uncertain, and often times inequitable results. In response, courts,¹⁴¹ commentators, consumer groups, and lobbyists alike are urging Congress to consider an amendment to ERISA.¹⁴²

for the “negligent and intentional refusal to authorize inpatient treatment . . . in reckless disregard of [the decedent’s] safety and in violation of the insurance policy” and for insurance bad faith Plaintiff’s present complaint does not allege any improper denial or refusal of benefits.

Id. at 672.

137. 933 F. Supp. 668 (E.D. Mich. 1996).

138. *Id.* at 671.

139. *Dukes*, 57 F.3d 350.

140. *Id.* at 357. The court stated:

Nothing in the complaints indicates that the plaintiffs are complaining about their ERISA welfare plans’ failure to provide benefits due under the plan Instead of claiming that the welfare plans in any way withheld some quantum of plan benefits due, the plaintiffs in both cases complain about the low quality of the medical treatment that they actually received and argue that the U.S. Healthcare HMO should be held liable under negligence and agency principles.

Id. at 356-57. See also *Chagervand v. Carefirst*, 909 F. Supp. 304 (D. Md. 1995). Although the *Chagervand* court did not view the *Travelers* decision as having any effect on the preemption of direct negligence claims, as discussed in *supra* note 124 and accompanying text, the court did rely on *Travelers* to support its contention that the plaintiffs vicarious liability claims were not preempted by ERISA:

[T]he common law principles of negligence are principles of general applicability which seek to compensate for any harm caused by the carelessness of others. While exposing HMOs to potential liability for the negligence of its participating physicians may, in the long run, increase the costs of operating a benefit plan, *Travelers* makes clear that an indirect economic influence, standing alone, does not mandate preemption.

Id. at 311.

141. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 506 U.S. 1033 (1992). In striking down a plaintiff’s negligence claim on the basis of ERISA preemption, the court noted:

While we are confident that the result we have reached is faithful to Congress’s intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the *Corcorans*’ position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.

V. STATE AND FEDERAL HMO REGULATION

Since people have become more concerned with the quality of their health care, but the legal remedies available to compensate for injuries due to negligent health care decisions have been steadily disappearing, health care consumers are beginning to turn to their legislatures for assistance.¹⁴³ In fact, pro-consumer health care legislation is being advanced at both state and federal levels through the lobbying efforts of a variety of interest groups, including the American Medical Association¹⁴⁴ and other consumer protection groups.¹⁴⁵

Id. at 1338-39. For further discussion of the *Corcoran* case, see *supra* notes 4-6.

142. See, e.g., *ERISA Shields Health Plans - Not Their Doctors*, MED. ECON., Apr. 10, 1995, at 34 (“[T]he AMA and state government officials are now pushing Congress to modify ERISA to enable the states to regulate health plans and enact health care reform.”); Conrad & Seiter, *supra* note 2, at 199. (“This difference in outcomes, based solely on whether benefits were provided through a privately sponsored ERISA plan or a publicly sponsored non-ERISA plan, begs for legislative resolution.”); Dorros & Stone, *supra* note 113, at 416 (“ERISA could be amended to exempt from preemption “run of the mill” state law claims); Fred Nepple, *ERISA: A Call For Reform*, J. INS. REG., Fall 1995, at 3-26.

143. See, e.g., Spencer Rich, *Managed Care, Once an Elixir, Goes Under Legislative Knife; Cost-Cutting Focus Feared Harmful to Patients*, WASH. POST, Sept. 25, 1996, at A01; 40 *States Trying to Bandage HMO Ills*, COLUMBUS DISPATCH, Mar. 15, 1996, at A01.

144. The American Medical Association (AMA) has been opposed to Health Maintenance Organizations from their inception. See John K. Inglehart, *The Struggle Between Managed Care and Fee-for-Service Practice*, 331 NEW ENG. J. MED. 63, 63 (1994) (“Against the fierce opposition of the AMA, but with surprising support from the Nixon Administration, the HMOs persuaded Congress to require many employers to offer their workers such insurance coverage, if available, as part of the Health Maintenance Act of 1973”). The following satirical poem illustrating the shortcomings of HMOs appeared in the Oct. 2, 1996 issue of the Journal of the American Medical Association’s Poetry and Medicine column:

Employers got nervous with just fee for service,
 their medical bills were too high
 So they gave up their voice and physician choice
 to give HMOs a try.
 But how we now cringe that this rationing binge
 has sidetracked good care and health
 Which today is replaced by a shiny new face;
 the accumulation of wealth.
 What we hope now prevails is a lifting of veils
 to reveal the HMOs’ greed,
 To see through the sell and pull out of hell
 subscribers who are truly in need.
 With HMOs – well, who really knows,
 since data collections not done;
 Now they are aware the data are there,
 it’s just a function they shun.
 It’s hard to take looks at their open books,
 there’s little they must disclose;
 So what really occurred is oddly obscured
 and lines pockets for their CEOs.
 They limit access while alleging success
 and to customers they state
 How much has been saved by excesses they’ve shaved

A. "Any Willing Provider" Legislation

One type of legislation which has received a great deal of attention recently is "any willing provider" legislation.¹⁴⁶ This type of legislation seeks to compel an HMO to accept any provider who is qualified to provide the health care and willing to accept HMO's terms and conditions.¹⁴⁷ Thus, these "freedom of choice" laws would allow consumers to obtain access to any provider, whether or not the provider is a member of the HMO plan.¹⁴⁸ In 1993-94 the Ohio General Assembly introduced, but failed to pass, an any willing provider statute.¹⁴⁹ However, a new bill is currently pending in Ohio which would require employ-

and then they raise the rate.
 But God save your soul if you've a bad mole
 or are losing your body hair,
 Or a cyst pilonidal or you're suicidal
 and need a specialist's care
 If you've a strange rash, then you'd better have cash
 for a skin doc you'll never see;
 You'll first be deterred from being referred
 for medical necessity.
 It takes a magician to get past that physician,
 your primary care designee,
 Who must be a whiz to manage the biz
 and is called a PCP.
 On them you depend, but they must defend
 the profit; on them is the onus
 To keep the costs low (as to treatment you go)
 so executives share in a bonus.
 Now physicians who care feel great despair
 that they must so closely ration,
 But if they want work, they should act like clerks
 and try to stifle all passions.
 If they want to be good, then like Robin Hood
 they steal from the lords of the risk pools.
 It's not treating disease or suffering to ease,
 it's the almighty dollar that rules.

Deborah Smith Parker, *With HMOs — Well, Who Really Knows*, 276 JAMA 1006, 1006 (1996).

145. See, *State Legislation: States to Target MCO Arrangements With Providers*, *Clinical Mandates*, BNA HEALTH CARE DAILY, July 18, 1996.

146. See, e.g., *Any Willing Provider*, WASH. POST, May 29, 1994, at C6; Allison Bell and Diane West, *Kassebaum Bill Likely to Dominate State Sessions*, NAT'L UNDERWRITER, Jan. 6, 1997, at 38; Donald E. Johnson, "Any Willing Provider Laws" Will Backfire, HEALTH CARE STRATEGIC MGMT., 1995; Apr. 1995; Greg Muirhead, *Not So Willing: Any Willing Provider Laws Found to be No Cure-all*, DRUG TOPICS, Mar. 6, 1995, at 27; *Ohio Coalition Formed to Fight Any Willing Provider Law*, NAT'L UNDERWRITER, Oct. 3, 1995, at 28; Michael Pretzer, *Do Any Willing Provider Laws Really Help Doctors?*, MED. ECON., Mar. 13, 1995, at 108; Charles E. Schmidt, *Any Willing Provider Laws Threaten to Sink Managed Care*, BEST'S REV.-LIFE-HEALTH INS. ED., Jan., 1996, at 60; Matthew P. Schwartz, *Battle Over Any Willing Provider Laws Intensifying*, NAT'L UNDERWRITER, Apr. 17, 1995, at 4.

147. Hellinger, *supra* note 106, at 1066.

148. *Id.*

149. See "Any Willing Provider Laws" Proliferate at State Level, *AMCRA Finds*, BNA

ers to offer a plan that allows employees their choice of health care providers.¹⁵⁰ Under this proposed legislation, if the employer fails to comply, the state could levy an income or franchise tax on all employee health care expenses provided by that employer.¹⁵¹

B. "Minimum Length of Stay" Legislation

Many states have also enacted statutes which require minimum length of stay requirements.¹⁵² For instance, in July 1996, the Ohio General Assembly passed a bill designed to end so called "drive through deliveries."¹⁵³ This legislation will force HMOs and other insurers to pay for forty-eight hour maternity stays for normal births and 96-hour maternity stays for cesarean births.¹⁵⁴ In addition, at the federal level, President Clinton recently signed the Newborn and Mothers' Health Protection Act of 1996.¹⁵⁵

HEALTH CARE DAILY, Dec. 2, 1994. The bill as introduced would have enacted section 3924.46 of the Ohio Revised Code to provide:

(A) [N]o third-party payer shall deny a beneficiary the right to choose a provider of health care or dental services, if the following conditions are met:

(1) The provider accepts the standard terms and conditions offered by the third-party payer to other providers, and any hospital or other health care facility to which a beneficiary may be referred by the provider accepts the standard terms and conditions offered by the third-party payer to other health care facilities

1993 OH H.B. 639. See also *AWP Fight Heats Up As 1996 Legislative Session Opens*, MANAGED CARE OUTLOOK, Jan. 12, 1996 (Talking about the coalition formed to fight "Any Willing Provider" legislation expected to be brought before legislature during 1996 session).

150. 1995 OH H.B. 58. The bill would enact Section 3924.62 of the Ohio Revised Code to provide the following:

Each employer shall do either of the following:

(A) Provide, or offer as an option among a choice of health care plans, an any-willing-provider plan meeting the requirements and conditions set forth

(B) Add the total amount it spends on employee health care during the taxable year to its net income . . . or its adjusted gross income . . . as applicable to the employer's filing status.

Id.

151. *Id.*

152. Hellinger, *supra* note 106, at 1068.

153. *Ohio: Voinovich Signs Bill Requiring Coverage for Post-Natal Hospital Stays*, BNA HEALTH CARE DAILY, July 26, 1996.

154. Ohio Senate Bill 199 enacted Ohio Revised Code § 1742.45 (A) to read:

Notwithstanding section 3901.71 of the Revised Code, each individual or group health maintenance organization contract delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of the inpatient care and follow-up care for a mother and her newborn as follows: (1) The contract shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical,

C. *Legislation to Force Disclosure of or Prevent Financial Incentives*

The United States Legislature enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to regulate the use of physician incentive plans by

educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

1996 OH S.B. 199.

155. The Newborns' and Mothers' Health Protection Act of 1996 is found in Title VI of the VA-HUD Appropriations Bill, H.R. 3666, 104th Cong. (1996). The Act amended ERISA to include the following:

(a) Requirements for minimum hospital stay following birth

(1) In general

A group health plan, and a health insurance issuer offering group health insurance may not —

(A) except as provided in paragraph (2) —

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefit for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) Exception

Paragraph (1) (A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) Prohibitions

A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan may not —

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in a manner inconsistent with this section; or

HMOs which participate in Medicare.¹⁵⁶ In order for an HMO's physician incentive plan to meet OBRA 90 requirements, the plan must not limit the medical care available to any specific individuals.¹⁵⁷ Furthermore, the plan cannot

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3) of this section, restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) of this section in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

29 U.S.C. §1185 (1996). See Rich, *supra* note 143. Hillary Clinton spoke of the importance of having an equivalent law at the federal level in her remarks at the signing of the bill:

I was in Cleveland yesterday at Lakewood Hospital talking with doctors about this provision, and they pointed out one of the reasons why this needed to be a federal law: because even though a number of states had taken action — Ohio being one . . . insurance companies often determined their rules based on the states where the policy was written or where it was first taken out or where the employer's main headquarters was so that even if a state had passed such a law the insurance company might argue it was not bound by that.

Remarks by President Bill Clinton, First Lady Hillary Rodham Clinton, Vice President Al Gore and Mrs Tipper Gore at the Signing of the VA/HUD Appropriations Bill, FED. NEWS SERV. WASH. PACKAGE, Sept. 26, 1996.

156. Pub. L. No. 101-508 (codified as amended at 42 U.S.C. §1395mm(i)(8)(A) (1996)). 42 U.S.C. §1395mm(i)(8)(A) provides:

Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan . . . unless the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization —

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

Id. The Act defines "physician incentive plan" as "any compensation arrangement between

create a "substantial financial risk"¹⁵⁸ for the physician unless the HMO provides stop-loss protection¹⁵⁹ and conducts periodic patient satisfaction surveys.¹⁶⁰

an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization." 42 U.S.C. § 1395mm(i)(8)(B) (1996). The Omnibus Budget Reconciliation act of 1986 prohibited all incentive payments for the purposes of reducing services to Medicare and Medicaid recipients. Pub. L. No. 99-509, 100 stat 1874 (1986). However, before this Act was implemented, it was repealed by Pub. L. No. 101-508, 104 stat 1388 (1990). See also Julie Forster, *California: Reflecting National Trend, Assembly Passes Bill to Restrict HMOs*, WEST LEGAL NEWS, June 13, 1996, available in 1996 WL 316825.

157. 42 U.S.C. § 1395mm(i)(8)(A)(i) (1996).

158. 42 U.S.C. § 1395mm(i)(8)(A)(ii) (1996). The Health Care Financing Administration (HCFA) has defined the general rule for determining when a physician or physician group has been placed at "substantial financial risk":

Substantial financial risk occurs when the incentive arrangements place the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services. Amounts at risk based solely on factors other than a physician's or a physician group's referral levels do not contribute to the determination of substantial financial risk. The risk threshold is 25 percent.

42 C.F.R. § 417.419 (e) (1996).

159. 42 U.S.C. § 1395mm(i)(8)(A)(ii)(I) (1996). Stop-loss protection is a method by which an HMO limits the degree of financial risk being undertaken by the physician. Orentlicher, *supra* note 53, at 168. This can be accomplished either by limiting financial responsibility per year (aggregate) or per patient. *Id.* The standards developed for stop-loss protection by HCFA are discussed in 42 C.F.R. section 417.419 (g)(2) (1996):

(i) If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services (beyond allocated amounts) that exceed 25 percent of potential payments.

(ii) If the stop-loss protection provided is based on a per-patient limit, the stop-loss limit per patient must be determined based on the size of the patient panel . . . Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient limit. The per-patient stop-loss limit is as follows:

(A) Less than 1,000 patients — \$10,000.

(B) 1,000 to 10,000 patients — \$30,000.

(C) 10,000 to 25,001 patients — \$200,000.

(D) Greater than 25,000 patients —

(1) Without pooling patients — none; and

(2) As a result of pooling patients — \$200,000

(iii) The HMO or CMP may provide the stop-loss protection directly or purchase the stop-loss protection, or the physician or physician group may purchase the stop-loss protection. If the physician or physician group purchases the stop-loss protection, the HMO or CMP must pay the portion of the premium that covers its enrollees or reduce the level at which the stop-loss protection applies by the cost of the stop-loss.

In addition, OBRA 90 requires that HMOs which operate physician incentive plans must disclose sufficient information to the Secretary of Health and Human Services. Upon disclosure, the Secretary determines whether the incentive plan complies with OBRA 90 requirements.¹⁶¹ These regulations, which are enforced by the Health Care Financing Administration, were implemented on January 1, 1997.¹⁶²

D. "Anti-gag Clause" Legislation

Other pending federal legislation is aimed at eliminating "gag" clauses.¹⁶³ Gag clauses are designed to prevent physicians from communicating certain information to their patients, such as financial incentives, treatment options not covered by the plan, and the availability of specialists or facilities not covered

160. 42 U.S.C. § 1395mm(i)(8)(A)(ii)(II) (1996). HCFA requires that the surveys:

(i) Include either all current Medicare/Medicaid enrollees in the HMO or CMP and those who have disenrolled (other than because of loss of eligibility in Medicaid or relocation outside the HMO's or CMP's service area) in the past 12 months, or a sample of these same enrollees or disenrollees;

(ii) Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

(iii) Address enrollees/disenrollees satisfaction with the quality of the services provided and their degree of access to the services; and

(iv) Be conducted no later than 1 year after the effective date of the incentive plan, and at least every 2 years thereafter.

42 C.F.R. § 417.419(g)(1) (1996).

161. 42 U.S.C. § 1395mm(i)(8)(A)(iii) (1996). Detailed instruction of information to be disclosed to HCFA is contained in 42 C.F.R. § 417.419(h) (1996). Information must also be disclosed to medicare/medicaid beneficiaries if they so request. *Id.* at § 417.419(h)(3) (1996).

162. See, Andrew B. Wachler & Phyllis A. Avery, *Physician Plan Regulations: Implications for Managed Care Organizations and Providers*, THE HEALTH LAWYER. (The ABA forum on Health Law), Late Spring 1996, at 1. See also Bruce Fried, *Notice to: Managed Care Plans and State Medicaid Agencies*, (last modified 11/8/96) <<http://www.hcfa.gov>>. For detailed discussion of the final rules, including responses to comments and questions, see 61 Fed. Reg. 13430 (1996).

163. H.R. 2976, 104th Cong., 2d Session (1996) would provide for the following:

An entity offering a health plan . . . may not provide, as part of any contract or agreement with a health care provider, any restriction on or interference with any medical communication . . . includes communications concerning —

(A) any tests, consultations, and treatment options,

(B) any risks or benefits associated with such tests, consultations, and options,

(C) variation among any health care providers and any institutions providing such services in experience, quality, or outcomes,

(D) the basis or standard for the decision of an entity offering a health plan to authorize or deny health care services or benefits,

by the plan.¹⁶⁴

In Ohio, House Bill 97, if enacted, would “prohibit contractual limitations or adverse actions related to a physician’s or health care provider’s statements relating to insurers or their practices.”¹⁶⁵ The proposed bill would also “hold

(E) the process used by such an entity to determine whether to authorize or deny health care services or benefits,

(F) and any financial incentives or disincentives provided by such an entity to a health care provider that are based on service utilization.

Id.

164. *Id.* For a discussion of the pros and cons of forcing disclosure of financial incentives see generally Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821 (1995). See also, *Issues and Standards for Managed Care: Hearings on H.R. 2976 Before the Subcomm. on Health and Environment of the House Committee on Commerce* 104th Cong., 2d. Sess. (1996) (statement of Robert E. McAfee, M.D. on behalf of the American Medical Association). Dr. McAfee stressed the AMA’s concern with HMO interference in the physician/patient relationship:

In short, the AMA believes that these clauses undermine a physician’s ability to provide his or her patients with the best possible care. The inclusion of “gag clauses” in contracts between physicians and managed care entities also raises, we believe, significant ethical concerns and creates a potential conflict of interest for physicians. We maintain that patients should receive the most complete information available about their health care options from their physician without interference from third parties. The AMA believes that these onerous medical “gag clauses” violate sound public policy and should be made unenforceable and legally null and void.

Id. The effect of managed care intrusion into the doctor patient relationship has been credited as having a significant effect on informed consent:

Physicians’ behavior is controlled by economic incentives and threats. Physicians who do not conform to managerial expectations ultimately may be removed from the list of approved practitioners or dismissed as employees. Physicians who limit the use of specialists and hospitals may receive substantial bonuses or incentive payments. All these administrative practices are designed explicitly to control physicians’ behavior in the direction of reduced use of resources. Since the threats and blandishments used to induce physicians to meet managerial expectations are covert, the process of informed consent is undermined.

Norman G. Levinsky, *Social, Institutional, and Economic Barriers to the Exercise of Patients’ Rights*, 334 N. ENG. J. MED. 532, 534 (1996). But see *Issues and Standards for Managed Care: Hearings on H.R. 2976 Before the Subcomm. on Health and Environment of the House Committee on Commerce* 104th Cong., 2d. Sess. (1996) (statement of William J. Osheroff, M.D., Medical Director, Pacificare of California) (arguing that restriction of gag clauses is not necessary and that requiring a physician to discuss options with a health plan doctor first does not undermine the physician/patient relationship).

165. OH H.B. 97. 121st Gen. Assembly (1995) (introduced to the House Committee on Health, Retirement, and Aging on 2/9/95). The bill would amend §1742.52 of the Ohio Revised Code to state:

(A) As used in this section, “physician” means a person authorized under chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B) No health maintenance organization shall impose a fine or other monetary

insurers and health maintenance organizations liable for their negligent acts or omissions resulting in the denial of prescribed testing or procedures"¹⁶⁶

E. Other "Patient Protection" Legislation

Other "patient protection" bills before the Ohio Legislature would prohibit HMOs from excluding certain types of treatments. For instance, House Bill 790 would "require all HMO organization contracts and all policies of sickness and accident insurance that provide coverage for a mastectomy to also provide coverage for breast reconstructive surgery incidental to the mastectomy."¹⁶⁷ In addition, Senate Bill 107, which was recently signed into law, "prohibits health care corporations, health maintenance organizations . . . from limiting or excluding coverage of a federally-approved drug on the basis that the drug has not received federal approval for treatment of the particular indication for which the drug is prescribed."¹⁶⁸ Also, Senate Bill 153 would prohibit insurers from re-

penalty, charge, or assessment on any physician with whom the organization enters into a contract on or after the effective date of this section for the provision of health care services because the physician's choice of a treatment for an enrollee to a health care facility is either contrary to specific directions given to the physician by the organization or contrary to the organization's guidelines for treatment or admission.

166. *Id.* The bill would also amend sections 3924.31 and 3924.32 of the Ohio Revised Code as follows:

Sec. 3924.31, as used in sections 3924.32 to 3924.34 of the Revised Code would read:

(A) "Insurer" means a health maintenance organization or sickness and accident insurer authorized to do business in this state.

(B) "Physician" means a person authorized under chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

Sec. 3924.32 would read:

If a physician or other health care provider prescribes for an insured a medical test or procedure covered by the insured's policy, contract, or health plan, and the insurer that issued the policy, contract, or health plan refuses to cover the test or procedure based upon a utilization review using information submitted by the physician or provider, the insurer shall be liable in damages in a civil action for its negligent acts or omissions resulting in the denial of coverage for the test or procedure.

OH H.B. 97, 121st Gen. Assembly (1995).

167. OH H.B. 790, 121st Gen. Assembly (1995) was introduced on Aug. 26, 1996 and was sent to the House committee on Health, Retirement, and Aging on Sept. 11, 1996. The bill would enact section 1742.46 of the Ohio Revised Code to provide:

(A) Notwithstanding section 3901.71 of the Revised Code, on or after the effective date of this section, individual or group health maintenance organization contract providing coverage for a mastectomy may be delivered, issued for delivery, or renewed in this state, unless the contract also provides for breast reconstructive surgery incidental to the mastectomy.

quiring a referral prior to seeing a dermatologist.¹⁶⁹

F. Effects of ERISA on State Regulation of HMOs

Besides preempting state common law claims, as discussed earlier,¹⁷⁰ ERISA preemption is an important consideration when discussing state enacted legislation aimed at regulating HMOs.¹⁷¹ In *Cigna v. Louisiana*,¹⁷² the Fifth Circuit Court of Appeals recently struck down Louisiana's any willing provider law by holding that it was preempted by ERISA.¹⁷³ This case is extremely important because the court analyzed Louisiana's any willing provider statute under the guidance set forth by the United States Supreme Court in *New York Conference of Blue Cross & Blue Shield Health Plans v. Travelers Insurance*.¹⁷⁴

(B) The coverage required by division (A) of this section shall include coverage for one or more prostheses.

Id.

168. OH S.B. 107, 121st Gen. Assembly (1995) (enacted). Section 1738.30(A) of the Ohio Revised Code now reads:

Notwithstanding section 3901.71 of the Revised Code, no individual or group health care corporation contract that provides coverage for prescription drugs shall limit or exclude coverage for any drug approved by the United States food and drug administration on the basis that the drug has not been approved by the United States food and drug administration for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia specified in division (B)(1) of this section or in medical literature that meets the criteria specified in division (B)(2) of this section.

OHIO REV. CODE ANN. §1738.30 (Anderson 1996)

169. OH S.B. 153, 121st Gen. Assembly (1995) (Introduced on May 4, 1995 was sent to Senate Committee on Financial Institutions, Insurance and Commerce May 9, 1995). This bill would enact Section 1742.302 of the Ohio Revised Code to read:

(A) As used in this section:

(1) "Dermatological Services" means services ordinarily and customarily rendered by a physician specializing in the practice of dermatology.

(2) "Primary Care Physician" means a physician who is board certified or board eligible and practices in general internal medicine, pediatrics, obstetrics, gynecology, or family practice.

(B) No individual or group health maintenance organization contract for health care services that is delivered, issued for delivery, or renewed in this state on or after the effective date of this section, and that covers dermatological services, shall require as a condition to the coverage of dermatological services that an enrollee first obtain a referral from a primary care physician.

170. See discussion *supra* section IV.

171. See Gordon, *supra* note 113; Christine C. Rinn, *ERISA and Managed Care: The Impact of Travelers*, THE HEALTH LAWYER (ABA forum on Health Law), Early Spring 1996, at 19; Gary A. Francesconi, Note, *ERISA Preemption of "Any Willing Provider" Laws — An Essential Step Toward National Health Care Reform*, 73 WASH. U. L.Q. 227 (1995).

172. *Cigna Healthplan of La. v. Louisiana*, 82 F.3d. 642 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996).

In *Travelers*, the Court upheld a New York statute requiring hospitals to collect a surcharge from patients insured by commercial insurers.¹⁷⁵ The *Cigna* Court differentiated Louisiana's "any willing provider" statute from New York's statute as follows:

Unlike the New York statute at issue in *Travelers*, Louisiana's Any Willing Provider Statute specifically mandates that certain benefits available to ERISA plans must be construed in a particular manner. In other words, the Louisiana statute does not merely raise the cost of the implicated benefits; it delineates their very structure.¹⁷⁶

G. Arguments Against Increased Regulation of HMOs

Managed care proponents refer to pro-consumer legislature as being "anti-managed care."¹⁷⁷ These commentators express concern that legislative restrictions on HMOs will increase the costs of health care.¹⁷⁸ For instance, in Ohio, HMOs have been credited for significantly reducing health care expenditures over the past six years.¹⁷⁹ One way that Ohio has reduced health care costs is by implementing mandatory HMO enrollment for Medicaid patients.¹⁸⁰

173. *Id.* at 649.

174. N. Y. State Conf. of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 115 S.Ct. 1671 (1995). See Rinn, *supra* note 171 at 19. ("A key issue for the court to decide [in the *Cigna* case] will be whether the Supreme Court's decision in *Travelers* requires a different result than that reached by the district court ["any willing provider law" preempted by ERISA].")

175. *Travelers*, 115 S.Ct. 1671 (1995). For further discussion of the *Travelers* case, see *supra* text accompanying notes 121-28.

176. *Cigna*, 82 F.3d. at 649.

177. See generally Bruce D. Platt & Lisa D. Stream, *Dispelling the Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of Care Provided by Health Maintenance Organizations*, 23 FLA. ST. U. L. REV. 489 (1995).

178. *Id.* at 490. Concern for increased health care costs was a large factor in the November 1996 election, where pollsters from both Oregon and California rejected "anti-managed care" legislation. Janet Firshein, *Anti-Managed-Care Initiatives Soundly Beaten at US Polls*, THE LANCET, Nov. 16, 1996, available in LEXIS, Nexis Library, Genmed File.

179. See Harcus, *supra* note 22, at 41. "In six years, Cleveland has slipped from its No. 3 ranking among U.S. cities with the highest health-care costs, to No. 33. Throughout the state, employers have been using their purchasing clout to rein in health-care costs." *Id.* But see, *Dual Mission for Ohio: Buying Health Care Wisely Means More Than Saving Money: Medicaid HMOs Must Be Able to Do Their Job*, PLAIN DEALER (Clev.), Jan. 11, 1997, at 108 ("Ohio's pilot Medicaid HMO program in Montgomery County cost more than the state expected without any increase in quality"). On a national level, managed care has been credited for the fact that 1993-1995 showed the lowest growth rate of health care costs in more than 30 years. *HHS Study Finds Health Care Spending Rose 5.5% in 1995*, CAP. MKT. REP., Jan. 27, 1997. Managed Care has also been credited for decreasing the cost of state employee's health costs. *Employee Benefits: State Employee Plans See Costs Slow*, HEALTH LINE, Apr. 14, 1995, available in LEXIS, NEXIS LIBRARY, Genmed file. During the time period that the state employees experienced this reduction in health care costs, they also experienced an increase in managed care enrollment. *Id.* Another study conducted at Georgetown University on Washington showed that between 1984 and 1993 average hospital costs per

Furthermore, managed care proponents argue that legislative restrictions on HMOs are unnecessary because HMOs have not adversely affected quality of care¹⁸¹ and patient satisfaction.¹⁸² However, while some studies have shown that managed care does not adversely affect quality of care,¹⁸³ recent studies have reached an opposite conclusion; especially with regard to elderly, poor,¹⁸⁴

admission rose only 8.3% in areas with a high level of HMO participation and 11.2% in areas where fewer patients are covered by HMOs. Louise Kertetz, *Depending on the Study, Enrollees Love or Hate Managed Care Plans*, MODERN HEALTHCARE, July 24, 1995, at 8.

180. See *Ohio: Managed Care Medicaid Expanded to Four Additional Counties*, BNA HEALTH CARE DAILY, July 5, 1996. Ohio Department of Human Services Director, Arnold Tompkins described the managed care program for Medicaid recipients:

OhioCare, authorized under a waiver received from the U.S. Department of Health and Human Services in Jan., 1995, is shifting the state from a third-party payer of direct services to a "value purchaser of health care" . . . the end result will benefit Medicaid recipients and taxpayers alike, he said, since HMOs control medical expenses and head off costly medical procedures by providing routine and preventative health care services.

Id.

181. See Platt & Stream, *supra* note 177, at 491. Platt & Stream, upon reviewing medical studies measuring the effectiveness of managed care organizations reached the conclusion that patients of managed care entities have as good as, if not better outcomes, than those patients of fee for service providers. *Id.* See also discussion of studies *infra* notes 183-85.

182. See discussion *infra* note 163 for studies showing both satisfaction and dissatisfaction among HMOs.

183. Bischof & Nash, *supra* note 29, at 232. "Studies confirmed the superiority of managed care-based services for older patients with acute myocardial infarction and men with advanced prostate cancer. A review of 24 studies of diagnostic test use in HMOs concludes that despite lower testing rates, quality of care is not harmed." *Id.* See also Sheldon Greenfield, Et Al., *Outcomes of Patients With Hypertension and Non-insulin Dependent Diabetes Mellitus Treated By Different Systems and Specialties*, 274 JAMA 1436 (1996). The study's findings were as follows:

No meaningful differences were found in the mean health outcomes for patients with hypertension or NIDDM, whether they were treated by different care systems or by different physician specialists. Although prepaid medicine relies more heavily on generalist physicians than does fee for service, there is no evidence from these analyses that the quality of care of moderately ill patients with these two common diseases was adversely affected. These findings must be viewed in light of the historically higher costs of fee-for-service medicine and of subspecialty physician practice.

Id. Another study resulted in similar findings with respect to patients suffering from rheumatoid arthritis: "We could find no evidence that persons with RA in fee-for-service and prepaid group practice settings received different quantities of health care or experienced different outcomes on either an annual or long-term basis." Yelin, Et. Al., *Health Care Utilization and Outcomes Among Persons With Rheumatoid Arthritis in Fee-for-Service and Prepaid Group Practice Settings*, 276 JAMA 1048, 10 (1996). A study of patients undergoing cardiac surgery actually showed more favorable outcomes among HMO patients: "The outcomes of our HMO group of patients were compared with those of our patients treated on a fee-for-service basis . . . Since 1985, the operative mortality for HMO patients has been consistently lower than for FFS patients." Starr, et al., *Is Referral Source A Risk Factor For Coronary Surgery? Health Maintenance Organization Versus Fee-For-Service System*, 111

and chronically ill populations.¹⁸⁵ Furthermore, some consumer satisfaction studies suggest that patients prefer “fee for service” plans over HMOs.¹⁸⁶

VI. OTHER POSSIBLE METHODS OF PROVIDING COMPENSATION FOR INJURIES

A. *Enterprise Liability*

Numerous commentators suggest that legislatures should remove medical malpractice claims from the traditional tort system and invoke a system of “enterprise liability” for health care providers.¹⁸⁷ The enterprise liability theory is based upon the premise that the party who benefits from the risk is in the best position to bear the risk.¹⁸⁸ Enterprise liability is the concept behind strict prod-

J. (THOR. & CARDI. SURG.) 708 (1996).

184. See Ware et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 JAMA 1039, 1039 (1996) (“[E]lderly and poor chronically ill patients had worse physical health outcomes in HMOs than in FFS systems.”); These findings are particularly troubling in light of the fact that commentators have predicted that managed care is most likely to have a negative effect on poor populations. See Louise G. Trubek, *The Social HMO for Low-Income Families: Consumer Protection and Community Participation*, 26 SETON HALL L. REV. 1143, 1143-47 (1996); Note, *The Impact of Managed Care on Doctors Who Serve Poor and Minority Patients*, 108 HARV. L. HEALTH CARE DAILY. 1625 (1995).

185. See Ware, *supra* note 184; Anna Lee-Feldstein, et al., *Treatment Differences and Other Prognostic Factors Related to Breast Cancer Survival*, 271 JAMA 1163, 1163 (1994). “Survival rates varied by hospital type for patients with localized disease, with significantly better rates at large community hospitals and significantly worse rates at HMO hospitals in comparison with small hospitals.” *Id.*

186. See Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1686 (1994) (citing a 1993 federally sponsored report which found “widespread dissatisfaction” with HMOs). See also Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-offs*, 32 HOUS. L. REV. 1321, 1323 (1996) (“[R]ecent surveys indicate that many individuals enrolled in MCOs are dissatisfied with the services they receive and that the public image of managed care is not positive.”). *But see HMO Members More Satisfied When Compared to Fee-For-Service and PPOs*, HEALTH CARE STRATEGIC MGMT, May 1995 (citing national study of 64,000 consumers which showed that 83% of HMO customers were either satisfied or very satisfied with their national health plans, as opposed to only 77% for those in fee-for-service plans); Kertetz, *supra* note 175 (citing one study which showed greater dissatisfaction with HMOs than with fee-for-service plans and one study which showed similar satisfaction levels for both types of services); Porter Et Al, *Consumers Rate HMOs*, OH. HEALTH L. UPDATE, Aug. 1995 (citing study among federal employees which showed that 89% of HMO enrollees are satisfied with the care they receive under their plan).

187. See generally Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J. L. & MED. 7 (1996); William M. Sage & James M. Jorling, *A World That Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL L. REV. 1007 (1994); *But see* Michael C. Thornhill & William H. Ginsburg, *Enterprise Liability: Cure or Curse*, 16 WHITTIER L. REV. 143 (1995) (outlining problems with enterprise liability and arguing that tort reform is a better means of reducing health care costs). The

uct liability and Worker's Compensation systems.¹⁸⁹ The rationale for invoking this type of liability in the health care industry is that, like manufacturers, health care providers are in the best position to prevent and spread the risk of health care related injuries.¹⁹⁰ Enterprise liability would impose strict liability on health plans for injuries related to providing or withholding health care services.¹⁹¹ To regulate claims, the state or federal legislatures could establish a system of adjudicating disputes with preset procedural guidelines and caps on compensation.¹⁹²

theory of enterprise liability was also a component of President Clinton's proposed health care reform plan. *Id.*

188. Kilcullen, *supra* note 187, at 10. The theory was developed as a response to large scale industry. *Id.*

189. *Id.*

190. *Id.* at 14. In comparing the medical industry to products liability, Kilcullen states:

Medical treatment is the product of a network of trained individuals, many of whom have no contact with the patient. Thus the individuals may not have a traditional duty of care toward the patient, yet their negligence can have devastating consequences. In addition, patients lack the bargaining power to negotiate all aspects of treatment, where, for example, they may consent to procedure without full comprehension of the procedure and its risks. Consequently, the medical enterprise is superiorly placed to manage both the risks and to distribute its costs in compensating anyone injured from its well-intended efforts.

Id.

191. Kilcullen, *supra* note 187, at 48. Kilcullen suggests that consumers should not need to prove negligence, instead they must show only that their injury a causal relationship between their injury and the plan's actions or failure to act. *Id.* Kilcullen notes that the forces which drove the creation of enterprise liability for consumer products (strict liability) is equally applicable in the health care arena:

The three arguments compelling the application of enterprise liability to consumer products apply equally to health care. First, HMO health care plans are immensely more powerful than even educated consumers in directing innumerable aspects of the care those consumers receive. The technical level of design and delivery of health care services is no less daunting than in the manufacture of automobiles, with the consumer equipped with only crude indicators of quality. Thus, consumers will never achieve a true position of market parity. Second, spreading risk through professional liability insurance for the plan's providers is already part of health care delivery . . . Finally, the cost of safety should be internalized to the plan and not, as under ERISA, externalized to the injured patient.

Id.

192. *Id.* at 49. Kilcullen suggests that the system could be modeled after that established by the National Childhood Vaccine Injury Act of 1986, which establishes jurisdiction in the Federal Courts for claims to be heard by special masters. *Id.* The act also established a table of side effects for which compensation could be obtained. *Id.* Decisions are appealable to the United States Court of Appeals. *Id.* at 50. Sage & Jorling argue that Enterprise Liability would be more effective as a voluntary contractual agreement between HMOs and their member physicians. See Sage & Jorling, *supra* note 187, at 1019. They argue that such an agreement would increase physician loyalty which would result in an increase in cooperation among the organization for quality assessment and improvement activities. *Id.* at 1020. Sage & Jorling

B. Grievance and Appeal Procedures/Consumer Advocacy Groups

Other commentators suggest that better regulation of appeal and grievance procedures would help prevent patient injuries resulting from HMO negligence.¹⁹³ Although both state¹⁹⁴ and federal laws¹⁹⁵ require HMOs to maintain complaint systems, HMO complaint systems are often difficult to access and,

also note that such an arrangement would increase efficiency in grievance processes and adjudication, since only one party would be involved as a defendant. *Id.* at 1021.

193. See generally, Gilhooley, *supra* note 49; Carol S. Jiminez, *Medicare HMOs: A Consumer Perspective*, 26 SETON HALL L. REV. 1195 (1996); Rodwin, *supra* note 182; Stayn, *supra* note 182.

194. Section 1742.14 of the Ohio Revised Code provides for the following:

(A) A health maintenance organization shall establish and maintain a complaint system that has been approved by the superintendent of insurance to provide adequate and reasonable procedures for the expeditious resolution of written complaints initiated by enrollees concerning any matter relating to services provided, directly or indirectly, by the health maintenance organization including, but not limited to, claims regarding the scope of coverage for health care services, and denials, cancellation, or nonrenewals of enrollees coverage.

(B) A health maintenance organization shall provide a timely written response to each written complaint it receives. Responses to written complaints relating to quality or appropriateness of care shall set forth a statement informing the complainant in detail of any rights the complainant may have to submit such complaint to any professional peer review organization or health maintenance organization peer review committee that has been set up to monitor the quality or appropriateness of provider services rendered. Such statement shall set forth the name of the peer review organization or health maintenance organization peer review committee, its address, telephone number, and any other pertinent data that will enable the complainant to seek further independent review of the complaint. Such appeal shall not be made to the peer review organization or health maintenance organization peer review committee until the complaint system of the health maintenance organization has been exhausted. Copies of complaints and responses shall be available to the superintendent and the director of health for inspection for three years.

(C) A health maintenance organization shall establish and maintain a procedure to accept complaints over the telephone or in person. These complaints are not subject to the reporting requirement under division (B) of section 1742.19 of the Revised Code.

OHIO REV. CODE ANN. §1742.14 (Anderson 1996).

195. The Federal HMO Act provides that:

Each health maintenance organization shall . . . be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization”

42 U.S.C. §300e (c)(5) (1996). Medicare recipients receiving health care from HMOs are also entitled to a hearing before the Secretary for disputes of greater than \$100. 42 U.S.C. §1395mm(c)(5)(B) (1996). In disputes involving amounts greater than \$1000, recipients are entitled to judicial review of the Secretary’s final decision. *Id.* Health plans providing medical assistance to Medicaid recipients must “provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under

in most cases, do not conform to due process standards.¹⁹⁶ To remedy this problem, some commentators suggest that consumer advocacy groups could play an important role in both assisting consumers in the grievance process and demanding an adequate appeal system.¹⁹⁷ However, that solution would only complicate the current problem by creating a second level of bureaucracy as a precedent to the plan's appeal system.

VII. CONCLUSION

It appears that managed care organizations such as HMOs have established a foothold in the mainstream of America's health care system. In short, HMOs are here to stay. With governmental health care reform at an apparent stand still,¹⁹⁸ our nation's health care consumers have, and will most likely continue to rely on managed care organizations to decrease health care costs. However, because HMOs' cost containment methods also have the potential to adversely impact on the patient's treatment, patient injuries will continue to increase.¹⁹⁹ Unfortunately, many of these injuries will go uncompensated because both state and federal laws protect HMOs against liability.

Under Ohio law, the tortious breach of contract theory is a tried and true theory of establishing liability against an HMO.²⁰⁰ However, if the HMO is an ERISA-governed plan, ERISA will almost certainly preempt the plaintiff's claim.²⁰¹ On the other hand, some Ohio plaintiffs have used agency by estop-

the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. §1396a(a)(3) (1996).

196. See, e.g., Jiminez, *supra* note 193, at 1211 ("The long and drawn out appeals process is grossly inadequate to meaningfully address quality of care and access to care problems and claims."); Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301, 327 (1996) (arguing that grievance procedures must include prompt decisions by an unbiased decision maker, as well as representation available for the patient). Rodwin, *supra* note 182, at 1379 (arguing that these grievance procedures lack oversight by agencies not affiliated with the HMO, are difficult to access, and do not conform to the requirements of due process); Stayn, *supra* note 186, at 1719 (arguing that Medicare recipients should be given assistance in grievance procedures, possibly by a physician not affiliated with the patient's health plan).

197. Rodwin, *supra* note 186, at 1347-1358 (arguing that consumers should join together in advocacy groups, alliances, or cooperatively arranged MCOs to ensure that adequate grievance procedures are available).

198. For a discussion of the failure of Clinton's health care reform plan in Congress, see generally, Manish C. Shah & Judith M. Rosenberg, *Essay: Health Care Reform in the 103rd Congress — A Congressional Analysis*, 33 HARV. J. ON LEGIS. 585 (1996).

199. See discussion *supra* section II-C.

200. See *supra* section III-B.

201. See *supra* section IV-B.

202. See *supra* sections III-C and III-D.

203. See *supra* section IV-B.

pel theories, as well as the theories of negligent selection, credentialing, supervision, and retention, to impose liability on hospitals.²⁰² If the courts extend the scope of these theories to include HMOs, plaintiffs will have another avenue of recourse against their HMOs. Moreover, considering the current course of decisions in the Sixth Circuit, it is also probable that these types of claims would survive ERISA's preemption clause.²⁰³

Although HMOs may play a valuable role in increasing access to health care by reducing health care costs, a balance must be struck between cost containment and consumer safety. To that end, state and federal legislatures must continue to assess the need to increase regulation of managed care organizations. In addition, Congress should amend ERISA so that state attempts to regulate HMOs, and state common law claims against HMOs are not preempted.²⁰⁴

In the meantime, consumers should form advocacy groups to demand increased governmental regulation of health maintenance organizations. Hopefully, the strength of numbers will directly impact upon the practices of Health Maintenance Organizations and create fairness in HMO grievance and appeal procedures.

AMY K. FEHN

204. *See supra* notes 139 and 140.