HMO Liability for the Medical Negligence of Member Physicians

Domenick C. DiCicco Jr.
RAPID increases in the cost of health care have forced the public and their representatives to seek alternatives to the traditional method of health care delivery. As a result, there has been a dramatic rise in the number of health maintenance organizations (HMOs) during the past twenty years. Moreover, the tight fiscal controls exercised by HMOs, the attractiveness of a prepaid fee to the customer and federal legislation have made the health maintenance organization the dominant organization in the health care delivery system. Not surprisingly, the dominance of
HMOs in the health care market has spawned litigation by consumers who are attempting to hold HMOs liable for malpractice committed by its health care providers. This Article will briefly review the history of HMOs and explore the current state of the law regarding the liability of HMOs.

II. Emergence of the HMO

The generally accepted definition of an HMO is an organization that provides health services to members in specific geographic areas in return for periodic, fixed prepayment. Such a prepaid system is legally charged with the responsibility for providing health care benefits to those enrolled in such programs.

Although HMO-type prepaid systems have only recently become popular, the concept of prepaid health care "is as old as the health-insurance industry." In fact, the first prepaid health plan began as a cooperative in Elk City, Oklahoma in 1927. Then, during the 1930s, further prepaid greater benefits and fewer hassles for physicians and patients); see also Barbara A. Noah, The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?, 48 MERCER L. REV. 1219, 1219 (1997) (noting that three-quarters of physicians in United States now practice within some form of managed care organization or treat some managed care patients).


[A] potential exists for HMOs to be held liable for medical malpractice based on one or more of several tort theories: (1) vicariously liability on the basis of respondeat superior or ostensible agency; (2) corporate negligence based upon negligent selection and negligent control of the physician; and (3) corporate negligence based upon the corporation’s independent acts of negligence, e.g. in the management of utilization control systems. Contract law might also be utilized to hold HMOs liable for malpractice based on breach of contract or breach of warranty.

Id. The recent attempts of consumers to hold HMOs liable for the medical malpractice of its member physicians is partly attributable to public discontent with the effects of cost cutting on patient care. See Noah, supra note 2, at 1220.

4. See 42 U.S.C. § 300e(a) (defining "HMO").

5. See Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GA. L. REV. 419, 430-31 (1997) (noting that people who join HMO buy more than health insurance). In discussing the theory and practice of HMOs, Dean Furrow states that:

HMOs have a contractual responsibility to provide or arrange for the facilities and physicians through which their members receive care. When people join an HMO, they are not just buying health insurance. They are buying access to a health care system and have a contractual right to medically necessary services.

Id. (citation omitted); see James & Nash, supra note 1, at 204 (noting that concept of managed health care allows business community to hold provider groups accountable for cost and outcome of its employees’ health benefits).

6. James & Nash, supra note 1, at 207; see Furrow, supra note 5, at 428 (stating that principles of managed care date back to previous century).

7. See James & Nash, supra note 1, at 207; see also Brian P. Battaglia, The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilisation Management and Financial Incentive Arrangements Between Health Care Providers and Payers, 19
plans developed around major construction projects. For example, Kaiser Industries, in response to a shortage of medical facilities for construction workers, created an HMO.

The American Medical Association (AMA) slowed the development of managed care in the late 1930s, however, by labeling the concept socialized medicine or communism. The AMA's hostility to this new concept eventually lead to the passing of restrictive state laws that effectively barred managed care plans from operating. Despite these restrictive state laws, the growth of these systems continued throughout the 1940s and 1950s, and other plans such as Group Health Cooperative of Puget Sound, the Health Insurance Plan of Greater New York and the Group Health Association of Washington, D.C. were formed.

8. See James & Nash, supra note 1, at 207 (noting that prepaid plans developed around construction projects such as Hoover Dam); see also Battaglia, supra note 7, at 159 (noting that railroad companies were far ahead of other businesses in providing health care services to employees as result of expansion of railroads in isolated areas of western United States in 1930s); Allison Faber Walsh, Comment, The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations, 31 J. MARSHALL L. REV. 207, 212 (1997) (noting that concept of HMO emerged in late 1920s and early 1930s when industrial groups began to offer prepaid health care to their employees).

9. See 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, 21 n.79. The original Kaiser HMO started as a series of capitation agreements with area physician groups that were paid $1.50 per month for each covered employee. See id. "As of March 1988, [Kaiser] was the largest prepaid plan in the United States with 4,904,768 members in five states." See id. (citing Jack F. Monohan & Michael Willis, Special Legal Status for HMOs: Cost Containment Catalyst or Marketplace Impediment?, 18 STETSON L. REV. 353, 359 n.21 (1989)).

10. See Randall, supra note 9, at 20; see also Battaglia, supra note 7, at 160 (noting that American Medical Association (AMA) objected to practice of cooperative medicine in 1930s in campaign to stop unlicensed and unregulated corporate practice of medicine).

11. See Randall, supra note 9, at 20 (citing Starr, supra note 7, at 302); see also Battaglia, supra note 7, at 160 (discussing AMA's objections to cooperative medicine). The AMA undertook a vigorous campaign to stop "unlicensed, unregulated health insurance and the corporate practice of medicine." Id. One such campaign began in 1937 and was directed at the Group Health Association (GHA), a nonprofit health care cooperative of government employees. See id. The GHA arranged for medical care and hospitalization for its subscribers and their dependents on a risk-sharing prepayment basis. See id. In an effort to provide reduced cost medical services, GHA collected dues from subscribers that were used to employ salaried physicians and a medical director. See id. As a result, the AMA launched an effort to prevent GHA from performing services by threatening doctors who joined GHA with disciplinary action. See id. Additionally, the AMA threatened hospitals with retaliation for permitting GHA physicians to use their facilities. See id.

12. See James & Nash, supra note 1, at 207 (discussing growth of HMOs despite AMA hostility); see also Battaglia, supra note 7, at 162 (noting that developments during World War II led to greater incentive to provide health care).
When skyrocketing health care costs became front page news in the 1970s, however, the AMA position weakened. Moreover, Democrats, lead by Senator Edward Kennedy, attempted to shift public sentiment toward the development of a national health insurance in the 1970s. The Republican response was to encourage private enterprise to develop prepaid plans. This response lead to the adoption of the Health Maintenance Organization Act of 1973. This act not only provided grants for development, but also federal loans to subsidize the initial operating deficits of new HMOs. The impact of the law was dramatic. In 1972, there had been fewer than forty HMOs, with approximately three million mem-

13. See Randall, supra note 9, at 20 (discussing weakening of AMA hostility to managed care organizations); see also Furrow, supra note 5, at 429 (noting that United States was perceived to face a national crisis in health care in 1970s because of escalating costs of fee-for-service medicine).

14. See James & Nash, supra note 1, at 207 ("In the early 1970s, under the influence of Senator Edward Kennedy, public sentiment toward the development of a national health-insurance system arose.").

15. See id. In the 1970s, the Nixon administration consulted with Paul M. Ellwood, Jr., an advocate of the restructuring of financial incentives in the private health services area. See Furrow, supra note 5, at 429. Ellwood's strategy, including a financing system that would reward health maintenance through prepayment for comprehensive care, appealed to a Republican administration that was hostile to big government. See id. Republicans viewed this new strategy as self-regulating and believed that they did not need a new federal bureaucracy to manage it. See id.

16. 42 U.S.C. §§ 300e to 300e-17 (1994). Congress passed the Health Maintenance Organization Act in response to increasing pressure. See Randall, supra note 9, at 21. The act requires businesses with more than 25 employees to offer their employees at least one federally qualified HMO as an alternative to conventional insurance. See id.

17. See 42 U.S.C. § 300e-4. The statutory provision providing for government funding for HMOs reads in relevant part:

   The secretary may—
   (1) make loans to public or private health maintenance organizations to assist them in meeting the amount by which their costs of operation during a period not to exceed the first sixty months of their operation exceed their revenues in that period;
   (2) make loans to public or private health maintenance organizations to assist them in meeting the amount by which their costs of operation, which the Secretary determines are attributable to significant expansion in their membership or area served are incurred during a period not to exceed the first sixty months of their operation after such expansion, exceed their revenues in that period which the secretary determines are attributable to such expansion; and
   (3) guarantee to non-Federal lenders payment of the principal and the interest on loans made to private health maintenance organizations for the amounts referred to in paragraphs (1) and (2).

Id.

18. See Randall, supra note 9, at 21 (noting that HMO industry experienced steady but significant growth between 1974 and 1983 because of federal grant and loan money made available by Health Maintenance Organization Act of 1973).
bers. The number of HMOs rose, however, to 648 between 1983 and 1988 and enrollment expanded to thirty-one million members.19

The enactment of this federal law, combined with the need to find an alternative to traditional health care delivery, lead to the explosive growth of HMOs during the late 1970s through the present. Once considered anomalies in the health care delivery system, plans such as the Kaiser Permanent System, Group Health Cooperative of Puget Sound, the Health Insurance Plan of Greater New York and the Group Health Association of Washington D.C. have grown to become giants of the industry.20 This increased growth has also lead to the significant and recent consolidation of the industry, which should continue for the next several years.21

III. HMO Models

The form of the HMO may be the determinative factor to courts in their analysis of liability. Thus, it is necessary to understand the three basic forms of HMOs presently in operation.

A. The Staff Model

The staff model is the traditional form of the HMO.22 In this model, the participating physicians are employees of the HMO, the facility in which the physicians practice is owned by the HMO and the personnel who help run the practice are employees of the HMO.23

19. See id. (noting 25% increase per year in number of HMOs and HMO members between 1983 and 1988).

20. See James & Nash, supra note 1, at 207 (noting that of these HMOs, Kaiser Permanent System is “grand daddy” of prepaid health plans in United States).

21. See Randall, supra note 9, at 22 (noting that, although recent market consolidation has resulted in actual decrease in number of operating HMOs, overall enrollment continues to climb); see also James & Nash, supra note 1, at 208 (predicting that greater emphasis on efficiency will result in consolidation of HMOs in late 1980s and 1990s).


23. See James & Nash, supra note 1, at 211 (noting that, in staff model, participating physicians function as salaried employees, responsible for providing total care for their patients); see also William A. Chittenden III, Malpractice Liability and Managed Health Care: History and Prognosis, 26 Tort & Ins. L.J. 451, 452 (1991) (noting that staff model HMO directly employs salaried physicians and usually owns or leases its own health care facilities); Sharon M. Glenn, Comment, Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability, 29 Wake Forest L. Rev. 305, 312 (1994) (noting that staff model physicians are employees of HMO, do not operate private practices and are compensated through salary, not fee-for-service, basis); Michael Kanute, Comment, Evolving Theories of Malpractice Liability for HMOs, 20 Loy. U. Chi. L.J. 841, 842 (1989) (noting that, in staff model, HMO administrative body directly employs physicians and compensates by salary).
The theory behind this model is that it frees the physicians from the responsibilities of the day-to-day management of a practice and, therefore, they are able to concentrate on providing the best possible care for their patients.\(^2\) Because the health care providers are employees of the HMO, the HMO will, in most cases, be susceptible to liability under the traditional theory of respondeat superior.\(^2\)

**B. The Group Model**

In the group model, a group of physicians incorporate themselves and then contract as a group with the HMO to provide care for the members of the HMO.\(^2\) Depending upon the terms of the contract, the physician group may be forced to limit its practice exclusively to members of the HMO, or may be permitted to treat fee-for-service patients as well.\(^2\)

The theory behind the group model is that the negotiating power of a group of physicians, as opposed to the physician employees in the staff model, gives the physicians more power.\(^2\) Additionally, the group model allows the physicians to generate additional income by treating fee-for-service patients.

Critics of the group model, however, charge that there is an inherent conflict in this structure.\(^2\) A physician has greater financial incentive to

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24. See James & Nash, supra note 1, at 211 (noting that freeing physicians from administrative duties, such as office management, billing and collections, may breed "clinic mentality" among staff model physicians); see also Jordan, supra note 22, at 902 (noting that staff model is most complete level of integration of both health care delivery and financing because services are provided within system and HMO fully finances provision of care to enrollees on prepaid basis).

25. See BLACK'S LAW DICTIONARY 1311 (6th ed. 1990) (defining respondeat superior as "[[I]et the master answer"). Under this doctrine, "an employer is liable for injury to person[s] . . . proximately resulting from [the] acts of [an] employee done within the scope of [employee's] employment in the employer's service." Id. at 1312.

26. See James & Nash, supra note 1, at 216; see also Battaglia, supra note 7, at 183 (noting that group model originated in 1970s to provide individual practitioners vehicle within which to compete with prepaid group practice plans). In this model, the HMO generally contracts with pre-existing partnership or corporation of physicians, who then provide health care services to participating members. See Mark G. Cooper, Comment, A "New" Approach to Medical Malpractice: The Liability of HMOs for Member Physician Negligence, 1994 DET. C.L. REV. 1263, 1264-65 (1994).

27. See James & Nash, supra note 1, at 216; see also Chittenden, supra note 23, at 452 (noting that physicians in group models "may treat only HMO subscribers or may treat HMO subscribers along with their regular fee-for-service patients"); Kanute, supra note 23, at 843 (noting that group model differs from staff model in that former has both prepaid and fee-for-service components to its practice).

28. See James & Nash, supra note 1, at 216 ("Advocates of the group model point to physician cohesiveness as a major advantage over the staff model."); see also Jordan, supra note 22, at 903 (noting that HMO does not directly make selection decisions as to individual physicians in group model HMO, rather, medical group controls selection process).

29. See James & Nash, supra note 1, at 216 ("Critics of the group model emphasize its bipolar priorities.").
favor fee-for-service patients and, therefore, may not devote the proper
time and treatment to prepaid patients. Additionally, prepaid patients
provide more income to the group if the physicians provide fewer ser-
ices. Conversely, fee-for-service patients bring in more income by gener-
ating internal referrals and increasing the use of laboratory and hospital
services.

C. The Network Model

The network model provides prepaid health care for members
through contracts with individual physician groups or entities having pro-
vider employees. Thus, instead of one group of physicians serving the
members of the HMO, several groups provide services. Although these
broad categories cover most of the HMOs currently operating in the
United States, there are other models which, for the sake of economy, will
not be discussed here.

IV. Theories of Liability

HMOs exercise more and more control over physicians. Thus, HMO
liability for the torts of their participating physicians also continues to in-
crease. This Article will now discuss the theories of HMO liability that
have developed.

30. See Kanute, supra note 23, at 842 (noting that group model physician
“may or may not devote a majority of [his or her] time serving the needs of HMO
[subscribers].”).

31. See James & Nash, supra note 1, at 216 (noting that financial dichotomy
can result in group model physicians resenting prepaid patients and viewing them
as drain on income).

32. See id. (“This dichotomy of financial rewards is problematic for many phy-
sicians in group-model HMOs.”).

33. But see Chittenden, supra note 23, at 452 (noting that distinction between
group model and network model has faded as industry has developed and both are
generally referred to as group model HMOs).

34. See Cooper, supra note 26, at 1265 (noting that three major types of HMOs
should only serve as guidelines); see also Gregory G. Binford, Malpractice and the
distinctions in HMO models). One commentator noted:

It should be recognized that while all three terms are commonly bandied
about in HMO parlance, the labels do not always carry the same defini-
tions. Within the extremes of the three basic models exist all forms of
HMOs exhibiting characteristics of one or all three models. The applica-
tion of this analysis to these “hybrid” models will require care, depending
upon the degree of similarity between the model in question and forms
discussed here . . . . [T]he informed reader should be careful to look
beyond the “label” of the HMO with which he or she may be dealing in
order to ensure correct application of the principles presented.

Id.
A. Vicarious Liability

The most popular and persuasive theory of liability is that based upon vicarious liability. Depending on the model employed, the theory of vicarious liability can be pursued via ostensible or actual agency. Naturally, however, the theory of actual agency is most persuasive when employed against the staff model HMO.

1. Actual Agency

Actual agency is generally used synonymously with the doctrine of respondeat superior. This well-known principle of law provides that an employee may be held vicariously liable for the negligent acts of an employee conducted in the course and scope of employment.

The case of Sloan v. Metropolitan Health Council of Indianapolis, Inc. provides a good illustration of the application of this theory to a medical malpractice claim. In Sloan, a husband and wife brought an action against Metropolitan, a staff model HMO, for the negligence of its physician employee. The trial court entered summary judgment for the HMO, holding that a corporation cannot be vicariously liable for the malpractice of a physician in its employment. The appellate court disagreed, holding that Metropolitan could be held vicariously liable for malpractice via the doctrine of respondeat superior. In finding such liability, the court noted that the staff physicians were under the control of Metropolitan's

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35. See Noah, supra note 2, at 1237 (explaining that HMO may be held liable for negligence of its physician employees if HMO exerts substantial control over them); see also Cooper, supra note 26, at 1266 (noting that agency theory is more widely recognized theory of liability for HMOs than general contract theory).

36. See Noah, supra note 2, at 1237 (noting that staff model HMOs are most susceptible to vicarious liability because they directly employ their physicians).


"The tort liability of the principal expressed in the doctrine of respondeat superior is based not upon the agency relationship . . . but upon the employer-employee relationship. Thus, the touchstone of the principal's liability for the tortious acts of his agent is merely whether they are done within the course and scope of the employment."

Id. (quoting Estate of Mathes v. Ireland, 419 N.E.2d 782, 785-86 (Ind. Ct. App. 1981)); see Noah, supra note 2, at 1237 (noting that doctrine of respondeat superior depends on existence of employer-employee, or closely analogous, relationship and generally does not apply to acts of independent contractor); see also Cooper, supra note 26, at 1270 (noting that courts will look for facts that indicate HMO "asserted control over . . . actual day-to-day activities of its member physicians" to establish liability based on respondeat superior).


39. Id. at 1104 (explaining that plaintiffs sued health care provider for failure of its physician to properly diagnose injury).

40. See id. at 1106.

41. See id. at 1109 (holding that "where the usual requisites of agency or an employer-employee relationship exist, a corporation may be held vicariously liable for malpractice for the acts of its employee-physicians").
medical director, who policed medical services and established policy.\textsuperscript{42} As such, the court found that an employer-employee relationship existed between the physician and Metropolitan.\textsuperscript{43}

In \textit{Gugino v. Harvard Community Health Plan},\textsuperscript{44} the Massachusetts Supreme Court held that a community health plan could be vicariously liable for the injuries sustained by a patient as a result of the malpractice of a plan physician and nurse.\textsuperscript{45} The patient, a member of the defendant health plan, had a Dalkon shield inserted in 1972.\textsuperscript{46} In 1974, after reading several articles questioning the safety of the device and experiencing bleeding, plaintiff sought the advice of her physician.\textsuperscript{47} The physician, an employee of the health care plan, assured plaintiff that the device was safe.\textsuperscript{48} The patient eventually suffered severe injuries which resulted in her undergoing a total hysterectomy.\textsuperscript{49} The court noted that the health plan could be liable under the theory of respondeat superior if the plaintiff could establish a factual basis for inferring that the health plan had a power of control or direction over the physician's and nurse's actions.\textsuperscript{50}

In \textit{Schleier v. Kaiser Foundation Health Plan},\textsuperscript{51} the court also held that an HMO could be vicariously liable for the actions of an independent consulting physician based upon the theory of respondeat superior.\textsuperscript{52} The

\textsuperscript{42}. See id.

\textsuperscript{43}. See id. ("We see no reason why Metro should be exempt from the doctrine of respondeat superior . . . .").

\textsuperscript{44}. 403 N.E.2d 1166 (Mass. 1980).

\textsuperscript{45}. Id. at 1168 (finding sufficient evidence that failure of physician and nurse to conform to good medical practice resulted in harm to patient). The court also found sufficient evidence that the negligent physician and nurse were under the control of the defendant health care plan at the time of the negligence. See id.

\textsuperscript{46}. See id. at 1167 (noting that Dalkon Shield is intrauterine contraceptive device).

\textsuperscript{47}. See id. (noting that physician was assigned to plaintiff by defendant health care plan). The defendant physician who was assigned to the plaintiff in 1974 was not the physician who inserted the intrauterine device. See id. The patient's claim against the physician who inserted the device was voluntarily dismissed without prejudice. See id.

\textsuperscript{48}. See id. (noting that defendant physician advised plaintiff that "he knew of no pregnancy or infection problems associated with the device"). Nine months after speaking to her assigned physician, the plaintiff spoke to a health plan nurse who also failed to notify her of the dangers and risks involved with the device and additionally, recommended inappropriate treatment for her symptoms. See id.

\textsuperscript{49}. See id. (noting opinion of plaintiff's expert that delay in issuing proper diagnosis increased likelihood that hysterectomy would be necessary).

\textsuperscript{50}. See id. at 1168.

\textsuperscript{51}. 876 F.2d 174 (D.C. Cir. 1989).

\textsuperscript{52}. Id. at 176 (finding that independent consultant was under control of health care provider physicians). In \textit{Schleier}, a patient contacted his HMO after experiencing chest pain and was admitted to a hospital by an HMO physician. See id. At the hospital, an independent cardiologist, who was not an HMO physician, but an outside consultant, misdiagnosed the patient. See id. The physician determined that a heart attack had not occurred and that there were no signs of heart disease. See id. The patient died soon thereafter from heart failure. See id.
court, perhaps stretching the theory of vicarious liability, found that when an HMO employee-physician requests a consultation by an independent physician, the HMO can be liable for the actions of the independent physician if a "master-servant" relationship existed between the HMO employee-physician and the independent consulting physician.53

A New Jersey appellate court, in Dunn v. Praiss,54 held a group model HMO liable under the theories of respondeat superior and ostensible agency for the negligence of a specialist who was retained by a patient's primary care HMO physician.55 Although not distinguishing between actual and apparent (ostensible) agency, the appellate court noted that the chief indications of the agency relationship were present.56 The court stated that "the overall control exercised by the HMO over both physicians clearly caused the [retained specialist] to be both actually and apparently the agent of the HMO."57

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53. See id. at 177 (finding requisite "master-servant" relationship between independent consultant and health care provider). The court held that the independent consultant was an agent of the health care provider because (1) the consultant was brought in by a physician employee of the provider and (2) the provider had the ability to control the consultant because the consultant answered to an HMO physician who decided whether or not the consultant remained active in this particular patient's case. See id.

The Schleier court noted that the determining factor in holding the HMO liable, based on the doctrine of respondeat superior, was the HMO's power over its physicians' conduct. See id.; see also O. Mark Zamora, Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact, 19 NOVA L. REV. 1047, 1050 (1995) (noting that both Sloan and Schleier courts found that "degree of evidence of control may be enough to find vicarious liability," although neither court "specified degree or manner of control necessary to find vicarious liability").


55. Id. at 868 (finding defendant health care plan liable for negligence of physician on principal-agent theory).

56. See id. (noting facts that establish agency relationship). The court noted that some of the chief indications of the agency relationship were as follows:

Neither [the defendant physician] 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 decedent at the HMO's office . . . .

Id. The appellate court noted that the facts of this case required a finding that the defendant physician was an agent of the HMO. See id. at 869. The court also stated, however, that "from these facts, he might also have been considered a direct employee when he performed his services at the HMO offices for payments based upon the number of HMO subscribers." Id.

57. Id. at 868; see Noah, supra note 2, at 1239 (noting that finding of agency relationship was based on capitation payments to group, physicians' use of HMO's facilities in delivering care to enrolled patients and HMOs control over referrals to physicians).
2. *Ostensible Agency*

Ostensible agency is the relationship that arises when a principal represents or creates the appearance that a person is his or her agent and a third party reasonably relies on that representation. To sustain a cause of action based on this theory, the plaintiff will have to prove that (1) the patient looks to the HMO, rather than the individual physician for care and (2) the HMO "holds out" the physician as its employee. When the

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58. See *Restatement (Second) of Torts* § 429 (1964) (discussing employer liability for negligence of independent contractors); see also *Restatement (Second) of Agency* § 267 (1957) (defining apparent or ostensible agency). Section 267 of the *Restatement (Second) of Agency* provides:

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.


59. See *Boyd*, 547 A.2d at 1234 (listing two factors relevant in finding existence of ostensible agency); see also Dukes v. United States Health Care Sys. of Pa., Inc., 848 F. Supp. 39, 42 (E.D. Pa. 1994) (relying on ostensible agency factors as delineated in *Boyd*), rev'd on other grounds, 57 F.3d 350 (3d Cir. 1995); Furrow, *supra* note 5, at 455-57 (discussing *Boyd* case and factors considered in determining existence of ostensible agency). *But see Williams* v. Goodhealth Plus—Healthcare Am., 743 S.W.2d 373 (Tex. Ct. App. 1987) (noting that this was first case in which patient sought to hold HMO liable for acts of its physicians under theory of ostensible agency). In *Williams*, the defendant, a group model HMO, contracted with the plaintiff's physician group to provide medical services to the plaintiff and other HMO members. *Id.* at 374. The plaintiff was examined by her treating physician group for an infection of her right thumb nail. *See id.* The thumb nail eventually became so infected that it had to be surgically removed. *See id.* The plaintiff brought suit against her HMO, seeking damages for negligence in treatment. *See id.* The court, relying on Texas statutory law, determined that a corporation cannot, as a matter of law, practice medicine. *See id.* at 375. The statute the court relied on provides in relevant part:

(e) It shall be unlawful for any individual, partnership, trust, association, or corporation by the use of any letters, words, or terms as an affix on stationary or on advertisements, or in any other manner, to indicate that the individual, partnership, trust, association, or corporation is entitled to practice medicine if the individual or entity is not licensed to do so.

*Tex. Health & Safety Code Ann.* § 3.07(e) (1993). The court also noted that the physicians who formed the group model HMO were not employees of the HMO under an actual agency theory. *See Williams*, 743 S.W.2d at 377. Furthermore, the court granted the HMO's motion for summary judgment on the issue of ostensible agency noting that the defendant HMO exercised no right of direction of control over the physicians involved in the treatment of the plaintiff or the medical group that selected the physician. *See id.*
HMO holds out the physician as its employee, it thereby creates a reasonable presumption in the eyes of the patient that the physician was the apparent agent of the HMO.60

*Boyd v. Albert Einstein Medical Center*61 is particularly instructive. In *Boyd*, a Pennsylvania court applied the theory of ostensible agency to a group model HMO.62 The plaintiff sued his HMO on the theory of vicarious liability via ostensible agency for the medical negligence of the HMO physicians and the resultant death of his wife.63 The trial court granted the HMO's motion for summary judgment, finding the plaintiff failed to establish the factors required for ostensible agency.64

On appeal, the court remanded, holding that the HMO could be held vicariously liable for the specialist's actions based on the theory of ostensible agency.65 The court listed several factors which indicated that the HMO may have held out its providers as employees.66 Particularly, the court noted that the plaintiff and his deceased spouse were required to follow the mandates of the HMO and did not directly seek the attention of the specialist, thus creating an inference that the decedent looked to the HMO for care and not solely to the physicians.67 Additionally, the court

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60. See Capan, 430 A.2d at 649 (noting that HMO holds out a physician “when the [institution] acts or omits to act in some way which leads the patient to a reasonable belief he is being treated by the [institution] or one of its employees”).
62. Id. at 1235.
63. See id. at 1231. The plaintiff and his deceased wife participated in a group model health plan offered by his employer. See id. at 1230. One of the primary care physicians detected a lump in the decedent's breast and referred her to a specialist, who was also a participating HMO health care provider. See id. During the surgery, the specialist perforated the decedent's chest with a biopsy needle, causing her to sustain a left hemothorax. See id. In the weeks following, the decedent complained to her primary care physicians of pain in her chest wall and eventually went to the hospital. See id. The chest pain continued after the decedent was released from the hospital and she again called her primary care physicians who prescribed a pain medication without further examination. See id. The decedent was discovered dead in her bathroom that same afternoon as a result of a myocardial infarction. See id.
64. See id.
65. See id. at 1235 (quashing order granting summary judgment and remanding to determine if physicians were ostensible agents of HMO).
66. See id. (listing factors that indicate issue of material fact as to whether participating physicians are ostensible agents of HMO). The court listed the following factors as instructive:
HMO covenanted that it would provide health care services and benefits to [m]embers in order to protect and promote their health . . . [HMO] operates on a direct service rather than an indemnity basis. Appellant paid his doctor's fee to HMO, not to the physician of his choice. Appellant selected his primary care physicians from the list provided by HMO . . . Moreover, those . . . physicians are screened by HMO and must comply with a list of regulations in order to honor their contract with HMO.
67. See id.
noted that the HMO advertised itself as a "total care program" that exercised care in the selection and accreditation of its members.68

Another example of a successful ostensible agency claim against an HMO is *Decker v. Saini*.69 In *Decker*, the plaintiff sued his physicians and HMO, contending that all three were negligent in failing to diagnose a cancerous tumor, resulting in an otherwise unnecessary amputation.70 The court, in denying the HMO's motion for summary judgment, concluded that the HMO could be liable for the medical malpractice of its member physician and a nonmember physician on the theory of vicarious liability via ostensible agency.71 The court noted that

[a]s a matter of public policy . . . imposing vicarious liability on HMOs for the malpractice of their member physicians would strongly encourage them to select physicians with the best credentials. Otherwise, HMOs would have no such incentive and might be driven by economics to retain physicians with the least desirable credentials, for the lowest prices. In the interest of encouraging high standards of health care it behooves the Courts to hold HMOs liable for the conduct of their participating physicians, when the facts so merit.72

68. See id. at 1232-33 n.6. The HMO advertised itself in a brochure as a "total care program" and as "an entire health care system." See id. The court relied on this advertisement as a representation from which a subscriber could conclude that the physicians of the HMO were its employees. See id.


70. See id. at *1. In *Decker*, the minor plaintiff sought treatment by his primary care physician for soreness in his arm. See id. The primary care physician referred the plaintiff to a nonmember physician for Xrays. See id. The nonmember physician concluded that the soft tissue in the minor's arm appeared normal and that the X-ray results were negative. See id. at *2. Several months later, the plaintiff was diagnosed with cancer and his arm was amputated. See id.

71. See id. at *4. The court noted that enough proof was brought forward to sustain a viable cause of action under the theory of ostensible agency. See id. The court stated that the evidence submitted in this case support each of the three elements of ostensible agency as follows: (1) plaintiffs reasonably believed that the doctor was the HMO's agent; (2) that belief was generated by the representations of the HMO's primary care physician; and (3) plaintiffs' reliance was not negligent. See id.

72. Id. As to the HMO's potential liability for the nonmember physician, the court also stated:

As a practical matter, this Court notes that it would be against public policy to allow HMOs, as a matter of law, to escape liability for their members' treatment by simply referring them outside the HMO plan. This would be an unscrupulous practice in cases where the HMO collects a membership fee based on the representation that it will provide the member with complete health care services. It would also allow HMOs to escape liability for cases gone awry, by simply referring them to a physician outside the plan. Consequently, whether or not an HMO will be held liable for the conduct of non-member physicians should depend on the circumstances of each case.

Id.
In contrast to *Boyd* and *Decker*, *Raglin v. HMO Illinois, Inc.* held that neither the health insurer nor its HMO subsidiary could be held vicariously liable for the negligence of doctors under contract with them to provide medical services. In *Raglin*, the plaintiff sued the HMO alleging that her group model HMO was vicariously liable for the negligence of its contracted physicians. The court affirmed the trial court's decision and rejected the plaintiff's argument that the HMO's quality assessment and utilization guidelines amounted to sufficient control to impugn an agency relationship. In reaching this decision, the court also noted that the HMO specifically informed the plaintiff that it did not furnish medical care. Thus, the HMO could not be held vicariously liable for the negligence of its contracted physicians.

Therefore, a majority of courts will recognize ostensible agency as a viable cause of action in suits against HMOs. Moreover, because this theory does not require an actual employer-employee relationship, this theory offers the most flexibility for a plaintiff to assert negligence claims against an HMO. Thus, this theory will continue to be the most viable alternative for plaintiffs.

**B. Direct Liability—Corporate Negligence**

The established doctrine of corporate negligence provides that the health care organization, traditionally the hospital, owes an independent, nondelegable duty to its patients: (1) to exercise reasonable care in ensuring the physicians selected as members of the hospital staff are competent to maintain safe and adequate facilities and equipment; (2) to supervise all persons who practice medicine within its walls; and (3) to formulate, adopt and enforce adequate rules and policies to ensure quality care for

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74. See id. at 158 (holding that doctrine of respondeat superior does not apply because HMO was group model organization and rejecting claim based on ostensible agency because HMO did not exert requisite control over physicians).
75. See id. at 155.
76. See id. at 158 ("[T]he quality assessment program is really just a manner of tracking the independent medical groups to determine if they are complying with the rules and regulations of [the HMO].").
77. See id. (noting that HMO plays only an administrative role). The court stated that the HMO "does not review the contents of the documentation to assess the accuracy of the medical diagnoses or opinions, nor does it assume any responsibility for determining the correctness or appropriateness of the physician's medical services delivered." Id. Therefore, the HMO "does not [exert] the type of control necessary to impugn an agency relationship between the [HMO] and the physicians." Id. Moreover, the court found "no basis for finding that [the HMO] advertised or held itself out as exerting control over its physicians so that one might reasonably conclude that the physicians were the employees [of the HMO]." Id.
78. See id.
79. See Cooper, *supra* note 26, at 1274 (agreeing that absence of employee-employer relationship not significant in ostensible agency claims).
their patients. This doctrine was first introduced in the landmark case of Darling v. Charleston Community Memorial Hospital. In Darling, the plaintiff broke his leg during an amateur football game. Soon afterward, the plaintiff experienced great pain and his toes became swollen and discolored. Three days later, the defendant’s physician removed the cast from the plaintiff’s leg. Subsequently, the plaintiff had to be transferred to another hospital where the leg had to be amputated. The Illinois Supreme Court found the defendant hospital liable for breaching its duty to review the treatment and procedures of its independent contractor physicians.

Since Darling, the courts have applied the theory of corporate negligence to hospitals in several cases. Over the past ten years, courts have

80. See Purcell v. Zimbelman, 500 P.2d 335, 341 (Ariz. Ct. App. 1972) (stating that if department of surgery of hospital was negligent in supervising competence of its staff doctors, hospital would also be negligent); Darling v. Charlestown Community Mem’l Hosp., 211 N.E.2d 253, 258 (Ill. 1965) (finding hospital was not unfairly surprised when complaint amended to include claim based upon its failure to adhere to standards customarily required and followed by accredited hospitals in area); Thompson v. Mason Hosp., 591 A.2d 703, 707-08 (Pa. 1991) (“[The hospital] will be subject to corporate liability if it failed to uphold proper standard of care, if it had actual or constructive knowledge of defect or procedure which created harm, and if its negligence was substantial factor in bringing about harm to patient.”); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 170 (Wis. 1981) (“[Hospitals owe duty of ordinary care in selecting and maintaining only qualified members on their medical staff to insure quality care, diagnosis and treatment of their patients”).

The Health Care Quality Improvement Act of 1986 grants the HMOs qualified immunity for damages under a claim of corporate negligence when the HMO actually provides medical care. See 42 U.S.C. §§ 11101-11152 (1994). The statute, however, does not protect HMOs when they simply administer the delivery of medical care. Hence, the HMO may still be liable under a corporate negligence theory, regardless of the statutory qualified immunity.

81. 211 N.E.2d 253 (Ill. 1965).

82. Id. at 255.

83. See id.

84. See id.

85. See id. at 255-56. The leg had to be amputated because of dead tissue caused by swelling against the cast. See id.

86. See id. at 258 (holding that negligence verdict could have been sustained based on fact that nurses did not test for circulation in leg as frequently as necessary and hospital failed to review physician’s work or require consultation).

also suggested that this theory may be applicable to the negligence of HMOs.\textsuperscript{88} \textit{Wickline v. State}\textsuperscript{89} was one of the first cases to suggest the possibility of direct third-party payor negligence. In \textit{Wickline}, the plaintiff underwent surgery and experienced some complications.\textsuperscript{90} The HMO typically only provided for a ten-day hospital stay and, therefore, denied the request of the surgeon to extend the plaintiff's postoperative recovery.\textsuperscript{91} The plaintiff alleged in her complaint that as a result of not being able to stay in the hospital for the extended period of time, her leg became infected and eventually had to be amputated.\textsuperscript{92} Although the court did not impose liability on the defendant, it did opine:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions


\textsuperscript{88} See Noah, supra note 2, at 1233 (noting courts original reluctance to hold managed care organizations directly liable for malpractice and recent change in view).

\textsuperscript{89} 239 Cal. Rptr. 810 (Ct. App.), vacated, 727 P.2d 753 (Cal. 1986).

\textsuperscript{90} Id. at 812-13. The plaintiff, Wickline, was being treated for problems associated with her back and legs. \textit{See id.} at 812. Her treating physician admitted her to the hospital where she was diagnosed with Leriche's Syndrome, which is caused by an obstruction of the aorta leading to the legs. \textit{See id.} Wickline underwent surgery to treat this condition, but, because of circulatory problems in her right leg, she had to return to surgery later that day and then again five days later. \textit{See id.}

\textsuperscript{91} Id. at 814. Wickline was scheduled to be discharged on January 16, 1977, four days after her last surgery, but on that day, her physician concluded it was "medically necessary" that the plaintiff remain in the hospital for an additional eight days. \textit{See id.} at 815. To obtain an extension of health care benefits, the hospital and physician are responsible for furnishing the on-site HMO representative with the patient's diagnosis, significant history, clinical status and treatment plan. \textit{See id.} The representative then reviews the extension request, and has the option of either approving it without consultation or contacting an HMO consultant to make the decision to deny the extension. \textit{See id.} at 813-14. The on-site representative does not have the authority to reject the request outright or to authorize a lesser number of days than requested. \textit{See id.} at 814. The on-site representative that reviewed Wickline's request felt she could not approve it, so she contacted the HMO consultant. \textit{See id.} With the extension, the plaintiff was discharged on January 21, 1977. \textit{See id.} at 815.

\textsuperscript{92} See id. at 811. The plaintiff alleged:

Between January 6, 1977, and January 21, 1977, Doe I, an employee of the state of California, while acting within the scope of employment, negligently discontinued plaintiff's Medi-Cal eligibility, causing plaintiff to be discharged from Van Nuys Community Hospital prematurely and [while] in need of continuing hospital care. As a result of said negligent act, plaintiff suffered a complete occlusion of the right infra-renal-aorta, necessitating an amputation of plaintiff's right leg.

\textit{Id.}
result from defects in the design or implementation of cost containment mechanisms . . . .

In *Harrell v. Total Health Care, Inc.*, the Missouri Court of Appeals stated that a group model HMO owed a duty to its participants to investigate the competence of its panel members and to exclude physicians who presented a foreseeable risk of harm. In *Harrell*, the plaintiff consulted with a primary care physician for a urological problem. After an initial examination, the primary care physician referred the plaintiff to a specialist. This HMO-approved specialist negligently performed surgery on the plaintiff. The trial court eventually granted summary judgment in favor of the HMO based upon statutory immunity for a nonprofit organization. The appellate court, however, concluded that absent the statutory immunity, the plaintiff had otherwise established a cause of action against the HMO for negligent selection.

Another case suggesting that the theory of corporate negligence is applicable to an HMO for the early inpatient discharge of a patient is *Wilson v. Blue Cross*. In *Wilson*, the hospital released the decedent from a drug rehabilitation program after a brief stay. The physician recommended a stay that was several weeks longer than that permitted by the HMO. Several days after the decedent was released, he committed suicide. The court stated that it is possible for a plaintiff to maintain a cause of action against an HMO for negligence based upon principles of joint liability. Citing section 431 of the *Restatement (Second) of Torts*, the

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93. *Id.* at 819.
94. 781 S.W.2d 58 (Mo. Ct. App. 1989) (en banc).
95. *Id.* at 59.
96. *Id.*
97. *See id.*
98. *See id.*
99. *See id.* at 62.
100. *See id.* at 62-64.
102. *Id.* at 877-78. On March 1, 1983, Wilson was admitted to the hospital while suffering from severe depression, drug dependency and anorexia. *See id.* at 877. On March 11, 1983, the decedent's HMO, through its agents, informed Wilson that it would no longer pay for his hospital care, and the plaintiff was accordingly discharged. *See id.* at 877-78.
103. *See id.* at 877. When the decedent was admitted to the hospital, his treating physician determined that he needed three to four weeks of inpatient care. *See id.*
105. *See id.* at 877 (noting that "[b]ecause a triable issue exists as to whether the conduct of the decedent's insurance company and certain related entities was a substantial factor in causing the decedent's death," summary judgment was inappropriately granted). The court expressly reversed the grant of summary judgment for the HMO on a procedural defect, but "emphasize[d] that the reasons that warrant reversal of the order granting summary judgment entered on behalf of the hospital] also apply equally" to the physician and the HMO. *Id.* at 883 n.4.
court stated that "[t]he actors' negligent conduct is a legal cause of harm to another if (a) his [or her] conduct is a substantial factor in bringing about the harm, and, (b) there is no rule of law relieving the actor from liability." 106 Although the court held that the state did not depart from the customary standard of care in this case, it suggested that the payor implementing the utilization review could be liable to a patient if its conduct was a substantial factor in bringing about the injury. 107

Plaintiffs have also argued that the financial incentive to the HMO of reducing the amount of services provided should be a basis for applying corporate negligence to HMOs. The California Court of Appeals rejected this argument, however, in Pulvers v. Kaiser Foundation Health Plan. 108 In Pulvers, plaintiff, on behalf of her deceased husband, sued the HMO on the grounds of fraud claiming that the HMO fraudulently led them to believe they would receive the "best quality care." 109 The court granted defendant's nonsuit finding that there was no suggestion that individual doctors acted negligently or refrained from recommending diagnostic procedures that were generally accepted for the appropriate circumstance. 110

V. PREEMPTION AS A PRECLUSION TO SUITS AGAINST HMO

Many HMOs have attempted to exit malpractice lawsuits by arguing that such claims are preempted by the Employee Retirement Income Security Act (ERISA). 111 This is a particularly important tool because a successful preemption argument allows a defendant to have its case heard in

106. Id. at 883 (citing RESTATEMENT (SECOND) OF TORTS § 431 (1965)).
107. See id.
109. Id. at 394 (noting plaintiffs believed that, although doctors were paid salaries by nonprofit health plan, compensation amounts were fixed and did not include financial incentives rewarding conservative attitudes toward unnecessary tests and treatments). The court responded by finding such "incentive plans" to be not only recommended as a "means of reducing unnecessarily high medical costs, but they are specifically required" by the relevant statute. Id.
110. See id. ("We can see in the plan no suggestion that individual doctors act negligently or that they refrain from recommending whatever diagnostic procedures or treatments the accepted standards of their profession require."). The court also noted that the plan's cost containment incentives were statutorily required and supported by professional medical organizations. See id. The court, although considering the nature of the incentives, appeared to rely on the statutory authorization in deciding the case. See Noah, supra note 2, at 1236 n.78 (discussing Pulvers).
111. 29 U.S.C. §§ 1001-1461 (1994). ERISA's preemption clause states, in relevant part:
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. § 1144(a).
federal court and its financial liability limited to reimbursement for the negligent care.\textsuperscript{112} For example, in the recurring cases in which breast cancer is not detected because of the failure of the primary care physician to order a mammogram, the plaintiff's recovery would be limited to the cost of the mammogram, as opposed to traditional negligence damages, which include pain and suffering and lost wages. Accordingly, ERISA bars two traditional types of recovery available in tort actions—compensatory and punitive damages.\textsuperscript{113} The justification behind placing such drastic measures in the statute is that because many benefit plans are self-funded, it is the workers' money that would pay the damages.\textsuperscript{114}

In enacting ERISA, Congress sought to establish a comprehensive system of regulating employee welfare benefit plans that "through the purchase of insurance or otherwise" provide medical, surgical or hospital care, or benefits in the event of sickness, accident, disability or death.\textsuperscript{115} ERISA also "provides a detailed system of civil enforcement which limits who may file suit, the grounds for such suits and the relief to which a

\textsuperscript{112} See, e.g., Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 137-38 (1985) (noting that case was properly removed to federal court because state law claims were preempted by ERISA, and affirming district court's holding that "ERISA bars any claims for extraordinary contractual damages and punitive damages arising out of the original denial of plaintiff's claims for benefits").

\textsuperscript{113} See id. (holding that ERISA does not create compensatory or punitive damage remedies when administrator of plan fails to provide benefits due under that plan).

\textsuperscript{114} See Barry R. Furrow et al., The Law of Health Care Organization and Finance 501 (3d ed. 1997) (discussing purpose behind ERISA's bar of compensatory and punitive damages). Dean Furrow notes that:

ERISA . . . sees a zero sum game. The pot is only so big, and when it is empty it is empty. To fudge the rules to care for one beneficiary may result in the plan being unable to honor the legitimate claims of other beneficiaries. If one claimant who has been egregiously treated by the plan is permitted to recover extracontractual damages from its administrator, these damages will ultimately come out of the pockets of the other beneficiaries, who have themselves done nothing wrong. In a world of scarce resources, not everyone can be taken care of.

\textsuperscript{115} See 29 U.S.C. § 1002(1) (defining "employee welfare benefit plans" regulated by ERISA). ERISA specifically regulates any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

litigant is entitled." Most importantly, ERISA supersedes all state laws insofar as they “relate to any employee benefit plan” as defined in ERISA.

One court noted: “A rule of law relates to an ERISA plan if it is specifically designed to affect employee benefit plans, if it singles out such plans for special treatment, or if the rights or restrictions it creates are predicated on the existence of such a plan.” A state law may be preempted even though it has no such direct connection with ERISA plans if its effect is to restrict the choices of ERISA plans or if the ability of a plan to function simultaneously in a number of states would be impaired by states having such rules.

Courts faced with medical malpractice claims must decide whether the applicable state law “relates to” the plaintiff’s employment benefit plan in such a way that requires preemption. In determining whether state law claims are preempted “[t]he purpose of Congress is the ultimate touchstone.” Courts look to see whether the state law relates to an ERISA plan “in the normal sense of the phrase, [in that] it has a connection with or reference to such a plan.” Any connection may trigger preemption, and preemption is not limited to laws relating to the specific subjects covered by ERISA. The state law may be found to relate to a benefit plan even if it is “not specifically designed to affect such plans or the effect is only indirect.” The case law addressing this issue indicates that the trend is for courts to find claims of direct negligence against the HMO preempted by ERISA. The courts, however, are split as to whether


117. 29 U.S.C. § 1144(a) (1994); see Stroker, 1994 WL 719694, at *5 (discussing ERISA preemption of state law claims); Furrow et al., supra note 114, at 493 (“ERISA both preempts state laws that ‘relate to’ employee benefit plans, and provides exclusive federal court jurisdiction over [most] ERISA cases.”).


119. See id. at 1193.

120. See Stroker, 1994 WL 719694, at *5 (noting that “[c]onsideration of whether a law ‘relates to’ an employee benefit plan within the meaning of ERISA § 514(a) requires [the] court to apply a broad common-sense meaning of the term”).


123. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48 (1987) (emphasizing that “the preemption clause is not limited to ‘state laws specifically designed to affect employee benefit plans’” (quoting Shaw, 463 U.S. at 98)).


A. Claims of Direct Negligence

Courts agree that when a plaintiff seeks to hold an HMO liable for negligent administration of cost containment provisions of an employee benefit plan or with regard to the type and extent of benefits promised, ERISA preempts such claims brought under state law.\(^{126}\) One court noted:

\(^{126}\) Compare Dykema, 959 F. Supp. at 741-42 (remanding plaintiff’s case, alleging vicarious liability against HMO, to state court because ERISA did not preempt claim), Lancaster, 958 F. Supp. at 1149-50 (holding that vicarious liability against HMO for fraud and negligence were not preempted by ERISA), and Stroker, 1994 WL 719694, at *5 (holding that plaintiff’s claims “concerning [HMO’s] alleged vicarious liability for the actions of [its doctors] must survive ERISA preemption”), with Butler v. Wu, 853 F. Supp. 125, 129 (D.N.J. 1997) (concurring with reasoning adopted by other courts that held ERISA preempted vicarious liability claims against HMO), and Ricci v. Gooberman, 840 F. Supp. 316, 317 (D.N.J. 1993) (finding that “vicarious liability claims do relate to employee benefit plans and, as such, implicate ERISA”).

\(^{127}\) See Stroker, 1994 WL 719694, at *6 (finding allegations of HMO’s “direct negligence in failing to use due care in its administration of plaintiffs’ employee benefit plans are preempted by ERISA”); see also Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 187 (E.D. Pa. 1994) (“Claims against an ERISA plan party premised on a failure to provide promised benefits or a misrepresentation of what benefits would be provided are preempted.”); Elsesser, 802 F. Supp. at 1290-91 (finding plaintiffs’ allegations that HMO improperly instructed treating physician that it would not pay for treatment “clearly ha[d] a ‘connection with or reference to’ a benefit plan” and were, therefore, preempted).

It is important to note, however, that where the court finds that “plaintiffs’ claims are not claims ‘to recover [plan] benefits due . . . under the terms of [the] plan, to enforce . . . rights under the terms of the plan, or to clarify . . . rights to future benefits under the terms of the plan’ as those phrases are used in § 502(a)(1)(B) of ERISA” complete preemption is inapplicable and removal of such claims is improper. See Dukes v. United States Health Care Sys. of Pa., Inc., 57 F.3d 350, 351-52 (3d Cir. 1995). In Dukes, plaintiffs filed suit in state court against HMOs organized by U.S. Healthcare, claiming damages for injuries arising from the medical malpractice of HMO-affiliated hospitals and medical personnel. See id. at 351. The defendant sought to remove both cases to federal court based on ERISA preemption. See id. The district court found that the plaintiffs’ state law claims against the HMOs fell within the scope of section 502(a)(1)(B) of ERISA and that the complete preemption doctrine permitted removal. See id. at 355-56. On appeal, the Third Circuit held that the complete preemption doctrine did not apply and that this removal was improper. See id. The court held that when a claim merely attacks the quality of the benefits received, it falls outside of the scope of section 502(a)(1)(B) of ERISA. See id. at 356. In so holding, the court noted that
In these cases, the courts have found preemption because of the obvious connection between state negligence claims including, inter alia, allegations that an HMO was negligent in failing to pay a benefit claim, pre-approve a medical procedure, create adequate rules to guide the conduct of participating physicians, select qualified personnel for participation in its program and in setting the terms of the applicable benefits plans. \(128\)

Thus, cases which allege that the HMO was negligent in employing or contracting with negligent doctors, knew that the doctors were not qualified or competent, failed to use due care in selecting and overseeing the doctors and failed to formulate, adopt and enforce adequate rules and policies to insure quality care for patients will likely be preempted under ERISA. \(129\)

B. Ostensible Agency Claims Preempted by ERISA

Courts are divided on the issue of whether ERISA preempts medical malpractice claims against an HMO under a theory of ostensible agency. \(130\) Courts which hold that ERISA preemption is appropriate in such cases reason “that a determination of the existence of the ostensible agency relationship ‘relates to’ the employee benefit plan [because] it requires an assessment of what the benefit plan itself provides and whether the treatment provided by the doctor measured up to [the] performance level advertised under the benefit plan.” \(131\) In other words, “[t]he ques-

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129. See id. (listing specific assertions made by plaintiffs against HMO and finding all were preempted by ERISA); see also Kearney v. U.S. Healthcare, Inc., 859 F. Supp. 182, 188 (E.D. Pa. 1994) (dismissing plaintiff’s claims as preempted against HMO for “negligent selection of a particular primary care physician, for misrepresentation of available benefits and for breach of a contractual obligation to provide certain benefits” as well as malpractice claim against physician for “not testing, hospitalizing or referring decedent to a specialist because defendant [HMO] disallowed or discouraged such services”).
130. See Stroker, 1994 WL 719694, at *6 (“The courts, however, are divided on the issue of whether ERISA preempts a medical malpractice claim against an HMO benefits plan brought by a plan beneficiary under an ostensible agency theory.”). Compare Ricci, 840 F. Supp. at 317-18 (holding that vicarious liability claim against HMO for malpractice of affiliated physician alleged to be ostensible agent was preempted by ERISA), with Kearney, 859 F. Supp. at 188 (finding vicarious liability claim against HMO under theory of ostensible agency was not preempted by ERISA); Elsevier, 802 F. Supp. at 1290-91 (same); Independence HMO, Inc. v. Smith, 735 F. Supp. 983, 988 (E.D. Pa. 1990) (same).
tion is one of relating plan performance to plan promise. As stated by another court:

[T]he outcome of a vicarious liability claim arising from a health care provider's alleged malpractice ultimately depends on the relationship between the provider and the administrative plan under which he or she functions. Whether a doctor is an employee or an independent contractor, for example, will depend on factors such as the degree of control maintained over one's work and the method of payment. Each of these factors is defined by the contract between the provider and the HMO. Accordingly, it seems evident to this court that disputes involving such factors can fairly be characterized as "relating to" the governing employee benefit plan.

Thus, these courts have determined that when an HMO is alleged to be vicariously liable for the negligence of a plan physician, a plaintiff's claims will relate to the benefit plan and be preempted by ERISA because all such claims have one central feature in common: "the circumstances of the [plaintiff's] medical treatment under his employer's [medical] services plan."

Another reason espoused by courts finding preemption is one of public policy. Some courts note that a refusal to find preemption will cause both HMOs and providers to carry liability insurance, ultimately resulting in higher costs to the end user. This strikes at the very purpose of the legislation enacted by Congress regarding the HMOs: to provide low cost health care to the population.

In Corcoran v. United Healthcare, Inc., the Fifth Circuit held that a suit against an HMO for the erroneous medical decision of one of its physicians was preempted by ERISA. In Corcoran, the plaintiff's obstetrician recommended that she have complete bed rest during the final months of her pregnancy. Plaintiff's employer had a self-funded welfare benefit

135. See Dukes, 848 F. Supp. at 43 ("If an HMO . . . is obliged to act as a malpractice insurer for health care providers, higher cost will invariably be passed along to health care consumers."); Ricci, 840 F. Supp. at 318 ([S]uch a rule effectively requires that both the provider and the HMO carry liability insurance for the acts of the provider, resulting in higher costs that certainly trickle down to plan beneficiaries.").
137. 965 F.2d 1321 (5th Cir. 1992).
138. Id. at 1331 (holding that, although United gives medical advice, it only does so in connection with determination of what benefits are available).
139. Id. at 1332.
The plan, administered by the defendant, United Healthcare, required that participants obtain advance approval for overnight hospital admissions and certain medical procedures. Accordingly, the plaintiff applied to her employer for the benefits, but her request was denied. This prompted the obstetrician to write to her employer's medical consultant and explain that the plaintiff had several medical problems that placed her in a category of high-risk pregnancy. Plaintiff's employer again denied the disability benefits. Plaintiff's child was eventually stillborn.

The plaintiff and her spouse filed a wrongful death action alleging various acts of negligence by Blue Cross and United. In sustaining United Healthcare's motion for summary judgment based upon preemption, the court held:

We cannot fully agree with either United or the Corcorans. Ultimately, we conclude that United makes medical decisions—

140. See id. at 1323. The plaintiff was a member of the medical assistance plan (MAP) of her employer, South Central Telephone Company. See id. The MAP is a self-funded welfare benefit plan that provides medical benefits to eligible employees. See id. It is administered by Blue Cross and Blue Shield of Alabama pursuant to an administrative services agreement between Bell and Blue Cross. See id.

141. See id. The court noted: "Under a portion of the Plan known as the 'Quality Care Program' (QCP), participants must obtain advance approval for overnight hospital admissions and certain medical procedures ('pre-certification'), and must obtain approval on a continuing basis once they are admitted to a hospital (concurrent review) or plan benefits to which they otherwise would be entitled are reduced." Id. United Healthcare administers QCP pursuant to an agreement with Bell and performs cost containment services commonly known as "utilization review." See id. For further discussion of utilization reviews, see John D. Blum, An Analysis of Legal Liability in Health Care Utilization Review and Case Management, 26 Hous. L. Rev. 191, 192-93 (1989).

142. See Corcoran, 965 F.2d at 1322. The plaintiff applied to her employer, for temporary disability benefits for the remainder of her pregnancy, but the benefits were denied. See id. Following the terms of the plan, her physician sought precertification for her hospital stay from United. See id. at 1324. Despite the physician's recommendation, United determined that hospitalization was not necessary and instead authorized 10 hours per day of home nursing care. See id.

143. See id. at 1322.

144. See id. at 1324. Furthermore, unbeknownst to the plaintiff or her obstetrician, the employer's medical consultant solicited a second opinion on the plaintiff's condition from another obstetrician, Dr. Simon Ward. See id. In a letter to the medical consultant, Dr. Ward indicated that he had reviewed the plaintiff's medical records and suggested that the company would be at considerable risk denying her doctor's recommendation. See id. at 1322.

145. See id. at 1324. The plaintiff entered the hospital on October 3, 1989. See id. Because the defendant had not precertified her stay, she returned home on October 12, 1989. See id. On October 25, 1989, while no nurse was on duty, the fetus went into distress and died. See id.

146. See id. The plaintiffs sought damages for the lost love and affection of their unborn child. See id. Additionally, the plaintiff sought damages for the aggravation of a pre-existing depressive condition and the loss of consortium caused by such aggravation. See id.
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Deed, United gives medical advice—but it does so in the context of making a determination about the availability of benefits under the plan. Accordingly, we hold that the Louisiana tort action for the wrongful death of their child allegedly resulting from United’s erroneous medical decision is preempted by ERISA.147

Several other decisions are in accord with this line of reasoning. In Dukes v. United States Health Care Systems of Pennsylvania,148 Judge Ditter dismissed the plaintiff’s claim of ostensible agency on the basis of preemption because (1) any ostensible agency claim must be made on the basis of what the benefit plan provides and, therefore, is related to it and (2) the treatment received must be measured against the benefit.149

In Pomeroy v. Johns-Hopkins Medical Services,150 plaintiff was diagnosed with diplopia (double vision), a medical condition requiring surgery.151 The plaintiff’s HMO, Prudential Health Care Plan, refused to pay for the surgery.152 In September of 1990, the plaintiff was diagnosed with chronic back pain, severe depression and a facial tick.153 Once again, the plaintiff’s HMO refused to pay for proper and necessary medical treatment.154 The plaintiff alleged that as a result of the HMO’s refusal to provide the proper treatment, he became addicted to the prescription drug Percodan.155 The plaintiff also alleged that the HMO refused to pay for drug dependency treatment.156

In holding plaintiff’s claims preempted by ERISA, the court found the reasoning of the Dukes court persuasive:

[M]edical malpractice claims against an HMO, whether couched in direct or vicarious liability terms relates to the benefit plan. One who enrolls in an HMO is assured of the medical services of a given extent and quality. A malpractice claim asserts the services provided did not measure up to the benefit plan’s promised

147. Id. at 1331.
149. Id. at 43 (noting that court had strong reservations about holding HMOs liable for state law claims based on physician negligence because higher costs will inevitably result).
151. Id. at 111.
152. See id. (noting that plaintiffs became members of Prudential Health Care Plan, Inc. through employee benefits plan offered by one of their employers).
153. See id.
154. See id.
155. See id. The plaintiffs brought four counts against Prudential. See id. Count I was a claim brought expressly pursuant to ERISA to enforce their benefits rights and to clarify future benefits under the plan. See id. Counts II through IV were brought under the common law theories of medical malpractice, direct and vicarious negligence, and intentional infliction of emotional distress, respectively. See id.
156. See id.
quality. The question is one of relating plan performance to plan promise, and therefore preempted by ERISA.157

C. Ostensible Agency Claims Not Preempted by ERISA

Courts holding that claims based upon ostensible agency are not preempted by ERISA have offered several reasons for their holdings. The United States District Court for the Eastern District of Pennsylvania stated that there is

no question that state law vicarious liability claims are not designed to specifically impact employee benefit plans. Further, . . . while direct negligence claims may be said to be predicated on the existence of an employee benefit plan to the extent the claims concern the administration of a plan and plan benefits, a vicarious liability claim does not restrict the benefits, structure, administration or reporting requirements of employee benefit plans.158

In Kearney v. U.S. Healthcare, Inc.,159 the same district court argued that "[a] determination that a treating physician committed malpractice does not require an examination of the plan to decide whether the service provided was that which was promised."160 The court went on to state that what is required is evidence of what transpired between the patient and the physician and an assessment of whether in providing admittedly covered treatment or giving professional advice, the physician possessed and used the knowledge, skill and care usually had and exercised by physicians in his or her community or medical specialty.161 That one may refer to the contents of a plan to adduce evidence that it held out a particular person as its employee or agent to help sustain a cause of action does not implicate the concerns underlying ERISA preemption provisions.162

160. Id. at 187.
161. See id. at 188.
162. See id. (holding plaintiff's claims based on misrepresentation, direct negligence and breach of contract were preempted and finding claims based upon vicarious liability were not preempted); see also Dearmat v. Av-Med, Inc., 865 F. Supp. 816, 818 (S.D. Fla. 1994) (holding that medical malpractice claims brought against HMO based on vicarious liability were not preempted); Elsesser v. Hospital of Phila. College of Osteopathic Med., 802 F. Supp. 1286, 1290-91 (E.D. Pa. 1992) (holding that plaintiff's claims against U.S. Healthcare for negligent selection, re-
In *Independence HMO v. Smith*, the court found that a plaintiff's state medical malpractice claims brought against an HMO under a theory of ostensible agency had "nothing to do with any denial of her rights under the plan." The court stated that instead, the plaintiff sought redress for physical injuries in which the HMO's selection of an operating surgeon allegedly played a part.

In *Haas v. Group Health Plan, Inc.* the plaintiff suffered a punctured eardrum during a routine cleansing of the ear. The plaintiff sought to hold the HMO vicariously liable for the negligent acts of its employee or agent. The court found that the ERISA preemption did not apply to the state court vicarious liability and medical malpractice claims. The court concluded "that when an HMO plan elects to directly provide medical services or leads a participant to reasonably believe that it has, rather than simply arranging and paying for treatment, a vicarious liability medical malpractice claim based on substandard treatment by an agent of the HMO is not preempted.'

The amended complaint requested damages for pain and suffering, medical expenses and permanent disability. The court also stated that "[m]edical malpractice claims based on treatment do not require a court to determine if a promised benefit was actually provided, as such claims would be preempted; rather, the [c]ourt must..."
In *Smith v. HMO Great Lakes*, the plaintiff's claims against the defendant HMO were based upon garden variety professional malpractice and contractual relationships between the HMO and the treating physician. In holding that the plaintiff's claims were not preempted by ERISA, the court reasoned that the plaintiff's claims were not the functional equivalent of claims for benefits and were not based on obligations on the plaintiff's employee health care plan.

Courts holding that preemption is inapplicable to vicarious liability claims have addressed critics' public policy concerns by noting that, although a particular state law may increase the cost of operating the benefit plan, Congress never attempted preemption with regard to vicarious liability claims. As one court noted, "[i]f costs were determinative, employee benefit plans would be exempt from liability for virtually all state law torts."

VI. CONCLUSION

The developing case law provides an opportunity for plaintiffs' attorneys to assert a wide array of theories of negligence. Hence, counsel for the HMOs will continue to face the difficulty of defending broad attacks. Defense counsel will continue to have the benefit of the preemption defense, although recent decisions indicate that this may be a temporary refuge.

Most disconcerting to the defense bar, however, is that recent jury verdicts against HMOs reveal the public's discontent with the manner and control HMOs have on their receipt of health services. For example, a California jury, in holding a prominent HMO liable, awarded $89 million to a deceased patient's family for denying coverage for the cost of a breast cancer patient's bone marrow transplant, which the HMO argued was an decide if the services provided deviated from the applicable standard of care." *Id.* at 549.


172. *Id.* at 670 ("Plaintiff claims that defendants failed to properly care for and deliver [her baby] and that she suffers from severe disabilities as a result of fetal distress during the birth.").

173. *See id.* at 672. Because the court held that the plaintiff's state law claims were not preempted by ERISA, the case was remanded to the state court. *See id.*


175. *Id.*

176. *See Noah, supra* note 2, at 1244-45 ("Careful consideration of the preemption issue in several recent cases suggests that [managed care organizations] will be more vulnerable in the future to certain types of claims that fall outside of ERISA's preemptive scope."). Professor Noah argues that the narrowing of ERISA preemption of state law claims against MCOs combined with the increase in successful patient lawsuits "may leave these organizations scrambling to absorb costs without sacrificing quality care." *Id.*
experimental treatment.\textsuperscript{177} What is clear to the defense bar, however, is that holding HMOs liable for the medical negligence of its providers defeats the purpose of these organizations.
