

Table 1. Relevant Legal Claims Involving Managed Care Companies: Leading Cases

Type of Claim	Leading Cases (*)
<p>Medical liability</p> <ul style="list-style-type: none"> ▪ Corporate liability (direct liability for failure to select and properly oversee staff, correct quality related problems or use practice standards that are professionally appropriate) ▪ vicarious liability (liability under various agency theories for the negligence of a network provider) 	<p>In general</p> <ul style="list-style-type: none"> ▪ <u>Boyd v Albert Einstein Medical Center</u> 547 A. 2d 1229 (Pa. Super 1988): Under Pa. Law, HMOs are a form of health provider and can be vicariously liable for the negligent medical care of network physicians if a physician is shown to be negligent and if an agency relationship is proven. HMOs are hybrid entities that contract for the provision of health care and thus carry the attributes of both health providers and health insurers under state law. ▪ <u>Shannon v McNulty</u> 718 A. 2d 828 (Pa. Super., 1988): PA. Law recognizes HMOs as health providers for medical liability purposes and an HMO that allegedly failed to adequately manage a member's preterm labor care and oversee the performance of its physicians can be found directly and vicariously liable for the quality of care. ▪ <u>Petrovitch v Share Health Plan of Illinois</u> 719 N.E. 2d 756: Under Illinois law, an HMO can be vicariously liable where agency is proved for the negligence of its network physician in a failure to diagnose cancer. <p>Cases brought by ERISA-sponsored health plan members</p> <ul style="list-style-type: none"> ▪ <u>Dukes v U.S. Healthcare</u> 57 F. 3d 350 (3d Cir., 1995); cert. den., 116 S. Ct. 564 (1995): cases involving allegations by an ERISA plan member of professionally substandard provision of covered services in the context of a medical emergency constitute medical negligence cases governed by state law and lie outside of ERISA preemption. ▪ <u>Moscovitch v Danbury Hospital</u> 25 F. Supp. 2d 74 (D. Ct., 1998):* claims by an ERISA plan member related to the reasonableness of the medical judgement exercised by health plan medical staff in a psychiatric hospital discharge case amount to a quality of care claim that can be pursued under state law. ▪ <u>Pegram v Herdrich</u>, 120 S. Ct. 2143 (2000): Claims challenging the professional soundness of the medical judgement of managed care physician who delayed the performance of diagnostic tests are not the types of decisions that are considered "fiduciary" under ERISA. Thus, even though physician incentive plans cannot be challenged as a violation of ERISA's fiduciary duty standard, medical negligence by an HMO physician falls within the purview of state law. ▪ <u>Lazorko v Pennsylvania Hospital</u>, 2000 WL 1886619:* Allegations by an ERISA plan member that the physician incentive plan used by an HMO was a contributing factor to the physician's negligent decision to withhold medically necessary psychiatric care amounts to a direct medical negligence claim covered by state law ▪ <u>In re U.S. Health Care</u> 193 U.S. Healthcare 193 F. 3d 151 (3d Cir., 1999); cert. den. 120 S. Ct. 2687 (2000): Claims by an ERISA plan member that an HMO's treatment guidelines were professionally substandard and encouraged negligent care that led to the death of a newborn infant amounts to a direct medical negligence claim that can

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	<p>be pursued under state law.</p> <p>Cases brought by Medicaid beneficiaries</p> <ul style="list-style-type: none"> ▪ <u>Jones v Chicago HMO</u> 2000 WL 632790 (Ill, 2000): Under Illinois law an HMO can be held directly liable for failure to oversee the activities of a network physician in a Medicaid plan whose patient load exceeded professionally acceptable norms and contributed to the physician's failure to timely treat an infant. <p>Cases brought by Medicare beneficiaries</p> <ul style="list-style-type: none"> ▪ <u>Ardary v Aetna Health Plans</u> 98 F. 3d 496 (9th Cir., 1996): Claims of medical negligence against a Medicare HMO constitute claims under state law and are not preempted by Medicare.
<p>Americans with Disabilities Act</p> <ul style="list-style-type: none"> ▪ Accessibility of care ▪ Quality of care ▪ Content of coverage 	<p>Health care providers as public accommodations</p> <ul style="list-style-type: none"> ▪ <u>Bragdon v Abbott</u> 524 U.S. 624 (1998): Health care providers constitute a public accommodation under the ADA and therefore have a legal obligation to reasonably modify their practices to accommodate persons with disabilities (in this case, HIV) unless they can prove the existence of a direct threat. ▪ <u>Woolfolk v Duncan</u> 872 F. supp. 1381 (E.D. Pa., 1995): Health plan network providers constitute a public accommodation under the ADA and thus may not discriminate in the provision of care against persons with disabilities. <p>Physician incentive plans as violative of the ADA</p> <ul style="list-style-type: none"> ▪ <u>Zamora-Quesada v Humana Health Plan</u> 34 F. Supp. 2d 433 (W.D. Tex., 1998): An HMO may be liable under the ADA if it is demonstrated that its physician incentive plan discouraged physicians from serving persons with disabilities by failing to adjust for a sicker caseload or acted as an incentive for the withholding of medically necessary care. <p>The design of insurance contracts and the ADA</p> <ul style="list-style-type: none"> ▪ <u>Doe v Mutual of Omaha</u> 179 F. 3d 557 (1999); cert. den., 528 U.S. 1106 (1999) The ADA is not violated by across the board limits in health insurance content design, even where the limits target particular disabilities (in this case, lesser coverage for AIDS and AIDS-related conditions)
<p>Insurance coverage and utilization management liability</p> <ul style="list-style-type: none"> ▪ Bad faith breach of contract ▪ Fraud 	<p>In general</p> <ul style="list-style-type: none"> ▪ <u>Wickline v State of California</u> 239 Cal. Rptr. 810 (Cal. App., 1986); pet. for rev. dismissed 741 P. 2d 613 (Cal., 1987): Under California law, a health insurer can be held liable for the negligent design or administration of a utilization management scheme. However, the insurer's negligence will not excuse a health professional from liability where the professional negligently fails to intervene when the insurer withholds or terminates coverage in a manner that is inconsistent with

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<ul style="list-style-type: none"> ▪ Breach of good faith and fair dealing 	<p>professional standards.</p> <ul style="list-style-type: none"> ▪ <u>McEvoy v Group Health Cooperative of Eau Claire</u> 570 N.W. 2d 397 (Wis., 1997): * Under Wisconsin law an HMO like other insurers may be liable for bad faith breach of contract for a plan's refusal to authorize out of network services for a patient whose mental illness could not be competently treated by an in-network provider. ▪ <u>Wohlers v Bartgis</u> 969 P. 2d 949 (1999): An insurer who misrepresents and misleads members through deceptive description of covered services may be liable under Nevada law for bad faith breach of contract and breach of good faith and fair dealing.
<p>ERISA</p> <ul style="list-style-type: none"> ▪ Coverage design limits ▪ Claims for covered benefits ▪ Breach of fiduciary duty 	<p>Breach of fiduciary duty</p> <ul style="list-style-type: none"> ▪ <u>Pegram v Herdrich</u>: HMOs that build incentive plans into their design do not breach their fiduciary duty under ERISA, since the use of incentive plans is simply a matter of plan design; however, claims alleging professional medical negligence in health care decision-making by an HMO physician are actionable under state law. ▪ <u>Shea v Eisenstein</u> 208 F. 3d 712; cert. den. 121 S. Ct. 172 (2000) : Failure to disclose the terms of a physician incentive plan constitutes a breach of fiduciary duty under ERISA where the information was potentially material to a decedent's decision not to seek a second opinion regarding the need for heart surgery. <p>Claims for covered benefits</p> <ul style="list-style-type: none"> ▪ <u>Andrews Clarke v Fallon Health Plan</u> 984 F. Supp. 49 (D. Mass, 1998):* Where the facts of a wrongful death action against a health plan for the denial of coverage leading to a suicide on the part of a patient with mental illness and an addiction disorder show that the action is predicated on the denial of coverage rather than the quality of covered care, state law remedies are preempted under ERISA. ▪ <u>Bedrick v Travelers Insurance Co.</u> 93 F 3d 149 (4th Cir., 1996): where coverage is denied on medical necessity grounds, the denial can be considered an abuse of discretion under ERISA if it lacks an evidentiary basis. ERISA provides courts with the power to independently construe the terms of a coverage agreement when deciding a coverage case. <p>Coverage design</p> <ul style="list-style-type: none"> • <u>Jones v Kodak</u> 169 F. 3d 1287 (10th Cir., 1999):* When practice guidelines are incorporated directly into the terms of the contract, the guidelines limit coverage on a conclusive basis and as a matter of plan design, and a court is without the authority to hear a medical necessity based challenge.
<p>RICO</p>	<ul style="list-style-type: none"> ▪ <u>Maio v Aetna</u> 221 F 3d 472 (3d Cir., 2000): Failure to provide services in accordance with claims in member information materials does not constitute a racketeering violation under RICO

* Indicates that the case involves a patient with mental illness or addiction disorder-related condition.

Table 2. Relevant Legal Claims Brought Against Medicaid Agencies: Leading Cases

Type of Claim	Leading Cases(*)
Constitutional due process (beneficiaries)	<ul style="list-style-type: none"> ▪ <u>J.K. v Dillenberg</u> 836 F. Supp. 694 (D. Ariz., 1993) :* Reduction or termination of care to children with severe mental illness constitutes the type of action that triggers constitutional due process protections under Medicaid, including timely and adequate notice and a pre-termination hearing; HMOs are agents of the state and their actions thus constitute state action. ▪ <u>Daniels v Wadley</u> 926 F. Supp. 1305 (M.D. Tenn., 1996); vac. in part, 145 F. 3d. 1330 (6th Cir., 1997): Accord, Dillenberg ▪ <u>Rodriguez v Chen</u> CV-95-Tuc-RMB (D. Ariz., 1996): Accord, Dillenberg ▪ <u>Perry v Chen</u> CV 95-140-Tuc-RMB [reprinted at } CCH Medicare/Medicaid Guide para. 44,044: Accord, Dillenberg ▪ <u>Catanzano v Wing</u> 992 F. Supp. 593 (S.D. N.Y., 1998): Accord Dillenberg (case involves home health care)
Constitutional and statutory due process in selection and de-selection (MCOs)	<ul style="list-style-type: none"> ▪ <u>MedCare HMO v Bradley</u> 788 F. Supp. 1460 (N.D. Ill., 1992): Failure of a state agency to give an allegedly non-performing HMO timely notice and a pre-contract termination hearing constitutes a Constitutional due process violation and state may be enjoined from allowing members to disenroll. ▪ <u>Medco Behavioral Care Corp. v Iowa Department of Human Services</u> 553N.W. 2d 356 (1996);* State procurement laws are violated when a state Medicaid agency awards a managed care contract to an entity whose subsidiary designed the state's RFP. ▪ <u>Value Behavioral Health v Ohio Department of Mental Health</u> 966 F. Supp. 557 (S.D. Ohio, 1997)* Federal grants and contract regulations create a federal right of action in the case of HMOs who allege that a state's competitive contracting practices allegedly violate federal standards
Coverage design	<ul style="list-style-type: none"> ▪ <u>Rodriguez v City of New York</u> 197 F. 3d 611(2d Cir., 1999); cert. den. 148 L. Ed. 2d 104 (2000):* Across the board state plan limitations on the range of procedures covered under an optional class of Medicaid benefits are lawful, even where the coverage limitations apply to a specific diagnosis (in this case mental illness), because states are not obligated under federal law to cover all medically necessary procedures within a covered optional benefit class, as long as limitations are reasonable; in addition, non-discrimination prohibition under federal Medicaid law applies only to required benefit classes.
Administration of managed care obligations	<ul style="list-style-type: none"> ▪ <u>Frew v Gilbert</u> 109 F. Supp. 2d 579 (E.D. Tex. 2000):* injunction against continuing state failure to ensure adequate access to EPSDT services for Texas children, including children enrolled in the state's managed care system. Children with mental illness identified as particularly underserved.
ADA/Section 504	<ul style="list-style-type: none"> ▪ <u>Rodriguez v City of New York</u> 197 F. 3d 611(2d Cir., 1999); cert. den. 148 L. Ed. 2d 104 (2000):* Across the board state plan limitations on a covered optional benefit that are tied to a specific condition (in this case, mental illness) do not violate the ADA, because they are part of the plan design and thus apply equally to all beneficiaries.
Practice guidelines	<ul style="list-style-type: none"> ▪ <u>Massachusetts Eye and Ear Infirmary v Commissioner, Div. Of</u>

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	<u>Medical Assistance</u> 705 N.E. 2d 592 (Mass., 1999): Because Medicaid prohibits arbitrary limitations on covered services, a state may not use medical practice guidelines as irrebuttable evidence of coverage and must take individual medical circumstances into account.

* Signifies a case involving mental illness or addiction disorder

Table 3. Legal Claims Against Managed Care Organizations by Health Care Providers

Type of Claim	Case
<p>Selection and de-selection</p>	<ul style="list-style-type: none"> • <u>Stuart Circle v Aetna Health Management</u> 995 F. 2d 500 (4th Cir., 1993); cert. den. 510 U.S. 1003 (1993): Virginia “any willing provider” statute regulating PPO products offered by insurers constitutes a law that regulates insurance and is not preempted by ERISA. • <u>Washington Physician Services Association v Gregoire</u> 147 F. 3d 1039 (9th Cir., 1998); cert. den. 119 S. Ct. 1033 (1999): Washington State law prohibiting health insurance carriers from discriminating among classes of qualified health professionals in coverage policies constitutes a law that regulates insurance and thus is not preempted under ERISA in the case of insured plans. • <u>Harper v Healthsource of New Hampshire</u> 674 A. 2d 962 (N.H. 1996): while not void for public policy, an “at will” termination clause in a managed care provider contract is unenforceable under New Hampshire state insurance law requiring minimum fair procedure standards in provider selection and de-selection. • <u>Potvin v Metropolitan Life Insurance Co.</u> 997 P. 2d 1153 (2000) :In light of the substantial power to affect livelihood that insurers maintain over health professionals, California common law recognizes a right to fair procedure and makes invalid as a matter of public policy a contract at will clause.
<p>ADA</p> <ul style="list-style-type: none"> ▪ Discrimination against providers who treat patients with disabilities ▪ Discrimination against providers with disabilities 	<ul style="list-style-type: none"> • <u>Zamora-Quesada v Humana Health Plans</u> (see Table 1)