

Capitation as a Free-Standing Cause of Action in Medical Malpractice

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A "capitation plan" is a method many HMOs use to compensate their participating health care providers, whereby the providers are paid not according to the amount, or cost, of care they give, but simply by the number of patients they treat. Our law firm brought one of the first known cases alleging that the act of simply entering into a capitation plan, itself, is malpractice. This article reflects that experience.

1. THE CONFLICT OF INTERESTS PROBLEM WITH CAPITATION.

When a provider (whether it be a doctor or group) agrees to care for every patient it receives through its HMO for a fixed fee, no matter what the actual cost of that care ends up being, many of the insurance risks have been passed from the insurance company to the provider itself.

Capitation plans therefore create an inherent conflict of interest whereby the entity "paying" for a patient's treatment is now the same entity determining whether that patient should be allowed that treatment. Although the HMOs will argue that this is simply a system of "risk-sharing" or "cost-containment", justifiably placing "some of" the financial decisions of medical care with those who are in the best position to make them, it in actuality simply incentivizes doctors to maximize their profits by minimizing their care.

The AMA Code of Medical Ethics, Current Opinions, instructs:

Section 8.13 Managed Care:

(3) When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. **Efforts to contain health care costs should not place patients at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care...**

The line between "cost-effective delivery" and "the withholding of necessary care" is thin. Obviously, no doctor will admit that a capitation plan affects the quality of his care. But the terms of a capitation contract are clearly designed to affect both the doctor's decisions and, neces-

sarily, the patient's care, and in some cases that line will be crossed.

2. MOTIVATION IS RELEVANT (AND THE FINANCIAL INCENTIVES AND DIS-INCENTIVES OF THE CAPITATION PLAN ARE THEREFORE DISCOVERABLE) TO PROVE A TORT WAS COMMITTED.

There can be no argument that financial motives color and influence doctors' practice of medicine. The New England Journal of Medicine has reported that financial incentives in health care contracts led to 75 percent of the surveyed doctors "report[ing] that they are being pressured to see more patients each day; one-third of them believed the pressure was so intense that it compromised the quality of care. 57 percent said they were under pressure to avoid sending patients to specialists, nearly one-third in that group said patients were getting substandard treatment as a result. 28 percent complained that they were under pressure from the managed care operations to withhold information from patients about all their treatment options. As a result nearly one-third of those doctors said that patients don't get the best care."

Evidence that a doctor skimped on medical care because he was financially motivated to do so tends to prove the existence of malpractice: i.e., it makes determination of the action more probable or less probable than it would be without the evidence. Thus, such evidence is relevant, and therefore, should be admissible.

Evidence of "motive" is admissible to prove that an actor did (or didn't do) a specific act, provided it has a logical relation to the conduct charged "according to known rules and principles of human conduct." Prince-Richardson On Evidence, §4-503 ("Motive"). 11th Ed. (1995).

Furthermore, the use of evidence of motive, or "statements of intention", is not limited to cases where intent is itself an issue. "Such statements, when made under unsuspecting circumstances have also been admitted as some evidence that the purpose intended was attempted or accomplished." Prince-Richardson, On Evidence, §8-612 ("State of Mind - Intention").

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3. LEGAL PRECEDENT ALREADY HOLDS PROVIDERS AND HMOS ACCOUNTABLE FOR COMPROMISING CARE DUE TO THE FINANCIAL INFLUENCE OF THEIR CONTRACTS.

This is one of the rare areas where the plaintiffs' malpractice bar shares a common position with many medical societies and organizations. The American Medical Association has endorsed federal legislation in the form of a "Patient's Bill of Rights" that allows patients to sue their health insurers in tort for failing to provide necessary medical tests. A study in the *Journal of the American Medical Association*, 278(12): 1025-1026, Sept. 24, 1997, which showed that managed care is associated with an 8% increase in mortality and 9% increase in morbidity towards the end of life, diplomatically explained: "Managed care is designed to provide incentives to reduce the number of services, whereas traditional fee-for-service medicine provided incentives in the other direction, namely, to provide more services... More is not always better, but less care that is provided based on the health care provider's financial interest rather than patient welfare considerations is ethically questionable." "Ethical Issues in Managed Care" in the journal, *Oncology Issues*, 13(3): 25-27, 1998.

The U.S. Court of Appeals for the Seventh Circuit was more explicit, and less diplomatic, when it weighed the doctors' conflict between maximizing profits and optimizing care, and ruled the patient's favor. The court in *In Herdrich v. Lori Pegram, M.D., Carle Clinic Assoc., and Health Alliance Medical Plans Inc.*, No. 97-1070, 1998 U.S. App. Lexis 20189; 22 E.B.C. 1617, held: "incentives [to maximize profits by minimizing costly tests] can rise to the level of a breach [of duty] where, as pleaded here, the fiduciary trust between plan participants [patients] and plan fiduciaries [doctors] no longer exists - i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses."

Many states also impose liability on providers, and in some cases HMOs, for theories similar to capitation negligence. See, for instance, *Shea v. Esenstein*, No. 95-4029MN, (CT), holding that it is a breach of fiduciary duty for a health plan to withhold from a patient information about physician incentives to withhold medical care; *Neade v. Portes*, 1999 WL 179338, where Illinois' intermediate appellate court held that physicians owe their patients a duty to disclose HMO incentive plans; *Moore v. Regents of Univ. of Calif.*, 793 P2d 479 (Cal., 1990) holding that a reasonable patient would want to know about a physician's conflicts of interest as part of the informed consent process.

Other modern-thinking jurisdictions have already extended liability, and allowed discovery based on theories of capitation negligence, although not labeled as such. In *Lancaster v. Kaiser Foundation Health Plan*, 958 F. Supp. 1137 (E.D. Va., 1997), the plaintiff claimed that financial incentives influenced the plan physician to limit referrals for diagnostic tests. As a result, the plaintiff's child died of a brain tumor. The plaintiff was allowed to pursue the financial incentives as part of the theory of negligence against the doctor.

As the details of a capitation plan can be the basis of a general theory of negligence, the fact of a capitation plan should, in appropriate circumstances, be allowed to stand alone as its own cause of action.

4. PRACTICAL CONSIDERATIONS: DISCOVERY

Unless you are very familiar with each insurer in your state, it will be difficult to determine if a particular client was treated under a capitation plan until well into the discovery phase of a case.

If you believe that the doctor or medical group withheld or skimmed on medical care, causing an injury to your client, and if the client's insurer is an HMO, look for a capitation plan, conduct discovery, and move to add the cause of action to your complaint if necessary.

Consider demanding anything which will go to proving the defendant's motivation for his actions (or inactions). This includes:

- a complete copy of the member handbook, subscriber certificate, and subscriber contract governing the health insurance benefits and procedures available to the plaintiff.
- all contracts, documents, and records between (1) the HMO and any medical group/doctors, members, employees, or staff who treated the plaintiff, and (2) any medical group and any of its doctors, members, employees, or staff who treated the plaintiff, with respect to the formulas utilized to compensate the defendants for their medical care of the plaintiff for care rendered both within the group and by any outside health care providers.
- a complete copy of the applicable plan documents, whether or not a "capitation plan", including all actual billing and collection records for all charges incurred or collected on behalf of the plaintiff for all times that he was a patient of the defendant.
- the HMO's utilization-review file, the underwriting file, and any policy and procedure manuals.

- the depositions of the Utilization Review Manager, the members of the Board of Directors of the defendant group, the Officers of the defendant group, and the financial comptroller of the defendant group (regardless of the title by which the persons in that capacity may have been known).

5. REBUTTING THE "CONTRACT IS LEGAL" DEFENSE.

Capitation is grievously contrary to public policy and to ordinary common sense. Most states have already extended to doctors many specific protections as a result of the medical establishment's successful lobbying efforts to publicize alleged health-care "crises". It is no defense to a tort action, however, to exclaim, "the contract made me do it!" That a contract may be permissible under the law does not immunize a tortfeasor from liability for negligence to a third party arising from the execution of the contract's obligations. There is nothing in the U.S. Code, or any legislation that we are aware of, which protects doctors and medical groups from medical malpractice based on contracts with insurers that motivate the doctors and medical groups to give substandard care.

6. WILL THE COURTS UPHOLD THIS CAUSE OF ACTION?

We do not yet know. Our law firm in New York has brought the capitation negligence cause of action in six

different cases, but in only one was it actually litigated. There, the New York Supreme Court judge ruled that we were entitled to full discovery of the capitation plan, including the deposition of the HMO's utilization manager. The defendant appealed to the Appellate Division of the Supreme Court of the State of New York, Second Department. With the appeal perfected, and the maximum time delay gained at the expense of our dying client, the defendant successfully withdrew the appeal (despite our adamant objection), before the court could make what the defendant surely believed was going to be precedential "bad law".

Revealing these secret capitation contracts would be of immense import to millions of Americans insured with capitation plans, who are unaware that the agreements foster medical malpractice. The time has come, therefore, to hold the health care industry, and ultimately the insurers accountable for these practices.

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