Beyond HIPAA: Data Security Breach Laws Mandate Security and Written Electronic Health Data Management Policies

In the beginning, there were HIPAA privacy and security rules. Health plans and providers had to digest hundreds of pages of Joycean prose to determine how they were required to maintain confidentiality of medical information. Barely recovered from that experience, they stumbled into the recent amendments to the Federal Rules of Civil Procedure, in which pre-trial discovery of electronic health data would be the subject of court orders that could result in thousands of dollars spent to retrieve archived and/or deleted records and that could mean severe sanctions if relevant electronic health records were lost.

One way to avoid such penalties was by drafting and implementing document preservation and deletion policies that could proffer a legitimate business reason for deletion. Those entities that have resisted preparation of electronic document management policies will be left without an alternative, for a side effect of the legislative reaction to recent personal data security breaches has been statutory mandates for electronic data management policies.

New Jersey’s Identity Theft Prevention Act, signed into law on September 22, 2005, by Acting Governor Richard Codey, is a perfect example. Personal information covered by the statute includes medical information, and the law requires entities compiling such data to have written policies documenting their deletion procedures and, by extension, the preservation of electronic health information, to keep such data out of the hands of identity thieves. North Carolina Governor Mike Easley signed a similar bill on September 21. California’s statute predates both and requires that businesses that compile personal electronic data (including health data) post their electronic data privacy policy on their Web sites.

More states will follow New Jersey, California and North Carolina. Some, like New Jersey, will impose stiff penalties in the event of a security breach of an entity with no documented security policy. The time to prepare electronic document management policies is now.

—Submitted by Kenneth N. Rashbaum
Sedgwick New York

Medical Malpractice Reform in Illinois: Another Bite at the Apple

On August 25, 2005, Illinois joined a growing list of states that have passed medical malpractice reform legislation. Governor Rod Blagojevich, a Democrat and former Chicago trial lawyer, signed Senate Bill 475 (“S.B. 475”) into law in the midst of rising political pressures throughout the state. The comprehensive reform legislation is designed to address the growing concern that increasingly costly jury awards are the cause of expensive malpractice insurance, rising medical costs and an exodus of physicians from Illinois. This new law represents the second time in the last ten years that Illinois has enacted medical malpractice reform.

The passing of S.B. 475 comes at a time when the national debate for medical malpractice reform is at an all-time high. The American Medical Association has identified 20 states in a “full-blown medical liability crisis” and says another 24 are showing signs of trouble. The American Trial Lawyers Association counters that the focus should not be on limiting payable damages caused by irresponsible acts but on preventing injuries from occurring in the first place. In 2005, 48 states have introduced over 400 medical malpractice reform bills between the months of January and June, and 27 states have passed over 50 bills that have already been signed into law (National Conference of State Legislatures, Medical Malpractice Tort Reform, http://www.ncsl.org (June 30, 2005)). The reform measures in Illinois are similar to actions taken in other states.

The new tort reform falls into three categories: judicial reform, medical
discipline and insurance regulations. The most significant judicial reform involves caps on noneconomic damages ($500,000 for physicians, $1 million for hospitals). Other notable judicial reforms include elevated standards for experts certifying a lawsuit and testifying in court; Good Samaritan immunity for retired physicians providing free care at clinics; and a “Sorry Works” rule allowing doctors and hospitals to apologize for an adverse outcome without the apology being admissible in court. S.B. 475 also authorizes the use of annuities to pay for portions of certain medical care awards. If the annuity option is elected, the defendant would pay 20% of the present cash value of the future medical expenses up front and purchase an annuity to pay the remaining 80% of the cost.

S.B. 475 also provides Illinois officials with a greater ability to discipline physicians. The bill expands the Medical Disciplinary Board, doubles the number of medical investigators and doubles potential fines for violations of the Medical Practice Act to $10,000. The Illinois Department of Financial and Professional Regulation must also now post profiles of physicians on the Internet, including criminal history, disciplinary actions, history of licensure disciplinary actions in other states and medical litigation judgments, settlements and arbitration awards.

Finally, S.B. 475 amends several portions of the Illinois Insurance Code as it relates to medical liability insurers. For example, the changes transfer power from the Director of Insurance to the Secretary of Financial and Professional Regulation; increase the availability of rate review hearings; lower the standard for finding that rates are excessive; expand the entities required to report malpractice claims and suits; and require more detailed loss, actuarial and reserve filings.

It is uncertain if S.B 475 will survive judicial scrutiny. In 1995, the Illinois legislature enacted what many described at the time as the most comprehensive tort reform package in the United States. Among other things, that tort reform capped noneconomic damages at $500,000, abolished joint and several liability, called for defense-oriented jury instructions and limited punitive damages to three times economic damages. Such reform did not last long. In 1997, the Illinois Supreme Court in Best v. Taylor Machine Works, 179 Ill. 2d 367 (1997), found that the tort reform discriminated against the most seriously injured plaintiffs by precluding them from being made whole, while allowing a person sustaining less than $500,000 in noneconomic damages to be compensated in full. The court also ruled that the cap violated the separation of powers doctrine since it effectively gave the legislature the power to reduce excessive jury awards, a role traditionally reserved for the judiciary. In the end, the court held that the unconstitutional provisions could not be severed from the remainder of the statute and invalidated the entire statute.

Today, five of the seven current Illinois Supreme Court judges were elected to the court after the Best decision. Future challenges to this latest tort reform could therefore yield a different result. Only time will tell as Illinois trial lawyers plan their strategy to challenge S.B. 475.

—Submitted by David M. Goldhaber
Sedgwick Chicago

Humana Liable for Negligent Case Management

In a case likely to have wide-ranging implications for future HMO lawsuits in Texas, a San Antonio jury found Humana Health Plan of Texas liable for $4.2 million for negligently managing its members’ medical care. The lawsuit, brought by the family of Humana member Joan Smelik, alleged that her death was caused, in part, by Humana’s failure to properly manage her care. The verdict is noteworthy because it is the first significant verdict against an HMO in Texas subsequent to the U.S. Supreme Court’s decision in Aetna Healthcare, Inc. v. Davila. In Davila, the Supreme Court unanimously ruled that patients cannot sue under state tort law for an HMO’s refusal to pay for recommended medical treatment as such suits were found to be preempted by ERISA. In Smelik v. Humana, the plaintiffs successfully argued that their claims were based on Humana’s negligent case management rather than denial of benefits and, therefore, were not preempted by ERISA. The case proceeded to the jury under state law theories, resulting in a finding that Humana was 35% at fault. Humana has said it will appeal the verdict.

—Submitted by Michael C. Diksa
Sedgwick Dallas

ERISA Alert

Hospital State Law Breach of Contract Claims Not Preempted by ERISA §502(a)(1)(B)

In Pascack Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393 (3d Cir. 2004), cert. denied, 126 S.Ct. 336, 73 U.S.L.W. 3661 (U.S. Oct. 3, 2005) (No. 04-1452), the Third Circuit held that a hospital’s state law breach of contract claims against a union-sponsored employee welfare benefit plan were not preempted by ERISA §502(a)(1)(B). Plaintiff’s claims were originally brought in state court, but the defendant removed the suit to district court and moved for summary judgment, alleging that ERISA completely preempted the hospital’s contract claims. Plaintiff moved to remand. The Third Circuit vacated the removal and remanded the case to state court because (1) the hospital did not have standing to sue under ERISA §502(a) and (2) the hospital’s claims were based on a legal duty independent of ERISA (see Aetna Health Inc. v. Davila, 542 U.S. 200
The Plan’s petition for certiorari was denied on October 3, 2005.

Pasack Valley Hospital (the “Hospital”) sued Local 464A UFCW Welfare Reimbursement Plan (the “Plan”) in state court seeking reimbursement of full-billed charges for two of the Plan’s participants. The Hospital did not have a direct contract with the Plan but entered into a Network Hospital Agreement with MagNet, Inc., an independent consultant with an organized network of hospitals that agreed to accept discounted rates for medical services. MagNet, Inc., entered into a separate Subscriber Agreement with the Plan permitting its participants and beneficiaries to access MagNet, Inc.’s network of hospitals. The Subscriber Agreement provided that the Plan must pay for covered services within 30 days after receipt of a submitted claim or forfeit the discounted rate.

The Hospital alleged that the Plan failed to pay covered charges within 30 days for two of its participants and sought to recover its full rate for medical services as a third-party beneficiary to the Subscriber Agreement between the Plan and MagNet, Inc. Applying the well-pleaded complaint rule, the court determined that the Hospital’s complaint, on its face, did not present a federal question under ERISA. Since there was no proof of an assignment and the Hospital was neither a participant nor beneficiary under the Plan, the court concluded that the Hospital had no standing to sue in its own right for the recovery of benefits pursuant to ERISA §502(a). Notably, the court declined to decide whether an assignee has standing to sue under ERISA §502(a)(1)(B).

In Pasack Valley, the Plan did not dispute the eligibility of the two participants at issue or coverage of the Hospital’s services. Consequently, while the Hospital’s claims arose out of an ERISA-governed Plan, they did not involve the interpretation of the Plan’s terms. Rather, the only disputed issue was the amount or level of payment owed pursuant to the Subscriber Agreement, which the court classified as “independent of the plan itself.” Consequently, the court concluded that the Hospital’s claims were “predicated on a legal duty . . . independent of ERISA.” If eligibility and coverage had been disputed, the Plan could have argued that the claims were undeniably “relate[d] to” an ERISA Plan and therefore expressly preempted by ERISA §514(a). While the hospital’s breach of contract claims were held not to be preempted under §502(a)(1)(B), this does not preclude the possibility that the hospital’s state law breach of contract claims may be expressly preempted under ERISA §514(a) and may signal whether this affirmative defense will be strictly or liberally construed in future provider-payment litigation.

—Submitted by Colleen A. DeNoto
Sedgwick New York

Illinois Appellate Court Finds No Duty for Sleep-Deprived Resident’s After-Hours Auto Accident

How far will courts go to impose liability on a hospital for injuries caused by a sleep-deprived, off-duty resident? The Appellate Court of Illinois addressed this novel issue in Brewster v. Rush Presbyterian-St. Luke’s Medical Center, No. 98L8806 (Sept. 30, 2005). In this case, a first-year resident worked a 34-hour shift at the hospital and proceeded to drive home. She fell asleep at the wheel, causing an accident in which the plaintiff was injured. The plaintiff sued both the resident and the hospital.

In ruling on the hospital’s motion to dismiss, the court was faced with the issue of whether a hospital may owe a duty to a plaintiff injured by an off-duty resident allegedly suffering from sleep deprivation. The trial court dismissed the complaint, concluding that no such duty exists. Plaintiff appealed.

The appellate court affirmed, refusing to find that the hospital owed a duty to the plaintiff. The court relied on Kirk v. Michael Reese Hospital and Medi-
cal Center, 117 Ill.2d 507, 513 N.E.2d 387 (1987), where the Illinois Supreme Court ruled that, generally, no liability can be imposed on healthcare providers for injuries to non-patient third parties, absent some “special relationship” between the defendant (or the person causing injury) and the plaintiff. The Brewster court found the hospital’s role as employer of the resident did not create such a “special relationship.” The court also refused to extend liability to the hospital by creating a special exception under §§315-319 of the Restatement (Second) of Torts. It rejected the plaintiff’s argument that a hospital should face liability to third parties under the Restatement for the conduct of its residents working excessive hours at the behest of the hospital. The court also rejected plaintiff’s reliance on cases from other states where employers were held liable for injuries to a third party in an auto accident caused by an employee working excessive hours or because of other job-related “impairments.” The court found that the Illinois Supreme Court has not recognized this kind of liability.

Plaintiff argued that the hospital violated the Illinois Hospital Licensing Act (“Act”) by having its resident work excessive hours. The court rejected this argument, finding the Act was meant to combat problems associated with patient care. It did not create a private right of action in a third party. The court left open, however, the possibility that under different circumstances, there may be a private right of action. Similarly, the court chose not to address whether the case presented liability under the Act because it dealt with issues of internal staffing decisions. It left open the question as to the circumstances under which a hospital may have a duty to third persons for injuries caused by its overworked residents.

Whether the plaintiff will appeal this decision to the Illinois Supreme Court is uncertain. However, since courts in other states have held employers liable for actions by impaired, off-duty employees, we are certain that hospitals...
and other healthcare entities have not seen the last of these kinds of suits.

—Submitted by Carol J. Gerner and Fred A. Smith, III
Sedgwick Healthcare Chicago

Sedgwick Healthcare Attorneys Serving the Legal Community

Congratulations to New York partner Michael H. Bernstein, who has been admitted to practice before the U.S. District Court for the Eastern District of Pennsylvania.

2005 Articles, Media Mentions, Seminars and Sponsorships

For further information on the following listings, please contact Stephen Kimmerling at stephen.kimmerling@sdma.com or 212.898.4003.

ARTICLES

“An Overview of FEHBA and the Power of Its Preemption”
By Fred A. Smith, III, David M. Goldhaber
The Health Lawyer
October 2005

“State Law Challenges in Managed Care”
Managed Care Litigation (Chapter 4)
October 2005

“Current Trends in Midwest Tort Reform”
By Evan T. Smith, Erica Lewis Battaglia, Eileen Navarro
Paper presented during the Marsh Healthcare Forum & Client Roundtable
Chicago, IL
September 23, 2005

“Court Must Consider Whether to Allow Amended Complaint Asserting Claim Under §502(a)(3)”
By Michael H. Bernstein
Life, Health and Disability News
Summer 2005

MEDIA MENTIONS

“Hurricane Katrina Storms Onto ‘Hot Topics’ Seminar Agenda”
Evan T. Smith and Erica Lewis Battaglia noted as speakers at Sedgwick’s Third Annual Hot Topics Seminar for the Bermuda Insurance Market, which included discussion of Hurricane Katrina.
The Royal Gazette (Bermuda)
October 4, 2005

SEMINARS

“Understanding the New Revolution in Compliance & Litigation: Electronic Records Management & Discovery”
Co-hosted by Sedgwick and Kroll Ontrack Inc.
Kenneth N. Rashbaum and Scott D. Greenspan—Speakers
Keith M. Casto—Moderator
Los Angeles, CA: November 8, 2005
San Francisco, CA: November 9, 2005

“The Digital Maelstrom: Confidentiality, Preservation and Disclosure of Electronic Health Data”
Kenneth N. Rashbaum—Speaker
Columbia University’s Mailman School of Public Health
New York, NY
November 3, 2005

“Forensic Risk Management: Monitoring and Reporting Employee Misconduct”
Kenneth N. Rashbaum—Speaker
American Society for Healthcare Risk Management’s Annual Conference & Exhibition
San Antonio, TX
October 24, 2005

“Medical Malpractice: Is Tort Reform Working?”
Erica Lewis Battaglia—Speaker
Sedgwick’s Third Annual Hot Topics Seminar for the Bermuda Insurance Market
Pembroke, Bermuda
October 5, 2005

“A Comparison of State Efforts in the Midwest – Tort Reform”
Evan T. Smith—Panel Moderator
Marsh Healthcare Forum & Client Roundtable
Chicago, IL
September 23, 2005

“2005 Managed Care Seminar”
Michael H. Bernstein, Wayne B. Mason, Robin O’Connor, Kenneth N. Rashbaum—Speakers
Hartford, CT
September 22, 2005

SPONSORSHIPS

“Celebrate Montefiore 2005”
Sedgwick New York sponsored a Patron Table and a full-page ad in the souvenir journal for Montefiore Medical Center’s 2005 fundraising gala.
New York, NY
October 26, 2005

“New York Race for the Cure”
Jayne Jahre, Caryn Silverman and eight other Sedgwick New York women attorneys raised over $3,000 as participants in New York’s Race for the Cure, a 5K run in Central Park to raise money for breast cancer research.
New York, NY
September 25, 2005

About This Publication

Welcome to Sedgwick’s Healthcare Law Newsletter, a quarterly publication written by members of the Healthcare Practice Group at Sedgwick, Detert, Moran & Arnold LLP.

Healthcare Law Newsletter is available in hard copy by or e-mail. It is also available at www.sdma.com by clicking on “Sedgwick Updates.” If you would like to be added to our mailing list, correct your address, submit ideas for articles or other features or send information about notable cases, please send your request to david.humiston@sdma.com.

For more information about Sedgwick’s Healthcare Practice Group, please contact David M. Humiston (Los Angeles), Chair, Healthcare Practice Group, at david.humiston@sdma.com or 213.426.6900.

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