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Torts: The Death of Duty of Care

By Steve Cohen
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Take yourself back in time: imagine your torts professor, widely referred to as Professor Sadist, crafting the hypothetical for your final exam. At first glance it seems out of character: the issue spotting is too easy and the questions of liability too clear. The hypo is this:

Pat Patient is a North Carolina resident who visits her local doctor, complaining about pain in her leg. Dr. Feelgood reviews her medical history, examines her, takes an x-ray and tells Pat he sees nothing amiss. He prescribes the standard (insurance approved) protocol: six weeks of physical therapy twice a week, over-the-counter Aleve as needed, and hot compresses and cold-packs—whichever make her feel better. Ms. Patient complies diligently and returns to Dr. Feelgood six weeks later stating that the pain is worse. Dr. Feelgood, unable to diagnose the source of the pain—but knowing Ms. Patient had cancer of the cervix nine years earlier—orders an MRI.

But there is one more hurdle between prescribing the diagnostic test and Ms. Patient actually getting it: approval by her insurance company, known as prior authorization. So, Dr. Feelgood calls Mammoth Insurance and requests prior authorization for Ms. Patient's MRI. Ten days later, a letter arrives at both Dr. Feelgood's office and Ms. Patient's home denying the MRI as "not medically necessary."

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The letter is signed by both the insurance company and its utilization review subcontractor. It states that the criteria for approval of an MRI is predicated on completing six weeks of physical therapy (twice a week) and use of Aleve. The letter then explains to the doctor how he can appeal the denial.

Dr. Feelgood immediately contacts the utilization review company, which says on its website that "The strong evidence supporting our criteria allows us to make appropriate decisions on patients' behalf." It further states that it "want[s] to make sure the patient gets the right procedure" and provides "a chance to change the outcome and the path for people receiving these services."

Dr. Feelgood points out that not only has Ms. Patient completed the six weeks of physical therapy, Mammoth Insurance paid for it. "Still denied," says the utilization review rep, "but you may appeal." Dr. Feelgood appeals, provides proof of Ms. Patient's PT, and spends hours trying to get a qualified orthopedist from the utilization review company on the

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phone for for a peer-to-peer discussion of the case. The entire review process takes five weeks, and the insurance company reverses its denial.

Ms. Patient gets the MRI, and it shows a fast-growing sarcoma in her hip. When she sees the specialists at Best Cancer Hospital, they tell her, "Had you come to us a month sooner, we would have treated your cancer just with chemotherapy. We're still going to use chemo, but first we're going to amputate your leg, hip, and pelvis."

Any liability?

The U.S. Court of Appeals for the Second Circuit didn't think so. In its nonprecedential Summary Order in *Valentini v. GHI*, the court said that neither an insurance company nor its utilization review subcontractor owed Kathleen Valentini a duty of care. *Valentini v. Grp. Health Inc*., No. 22-157, 2023 WL 2027273 (2d Cir. Feb. 16, 2023).

Because of employers' desire to shift the cost of caring for their retirees to the federal government, hundreds of thousands of elderly and disabled New Yorkers may, within the next few years, suddenly be subjected to prior authorization.

The facts of Valentini are identical to the hypothetical in Pat Patient's. Mrs. Valentini's estate—because she died some nine months after her doctor's request for an MRI—sought to bring an action for negligence and medical malpractice premised on the alleged delayed diagnosis and treatment caused by the denial of the MRI.

The Second Circuit explained its reasoning: "Generally speaking, a duty of care exists "[w]henever one person is by circumstances placed in such a position with regard to another that [everyone] of ordinary sense…would at once recognize that if he did not use ordinary care and skill in his own conduct with regard to the circumstances [,] he would cause danger of injury to the person or property of the other." (Citing *Havas v. Victory Paper Stock Co.,* 49 N.Y.2d 381, 386 (1980).) And then noting, "none of the GHI defendants ever affirmatively treated Kathleen or affirmatively advised her as to the course of her treatment; rather, GHI and Emblem simply informed Kathleen and her doctor that they were "denying [her] request for coverage" of the MRI because eviCore had determined that it was "not [m]edically [n]ecessary" as defined by her insurance policy."

Not surprisingly, the Valentinis argued that the eviCore doctors did indeed affirmatively treat Kathleen when they stepped between her and her doctor—by first overruling and then delaying her doctor's prescribed course of treatment: the MRI.

What was surprising was how little case law existed in New York or the Second Circuit to rely on. The leading case is *Sommer* where a fire alarm company was deemed to owe a duty of care to its client when it failed to properly alert the fire department to a triggered alarm.

In *Sommer*, the New York Court of Appeals said it looks to "the nature of its services"—specifically whether they *implicate the "public interest" whether "failure to perform the service carefully and competently can have catastrophic consequences";* and on the manner in which the injury arose in this case and the resulting harm, both typical of tort claims." *Sommer v. Fed. Signal Corp*., 79 N.Y.2d 540 (1992).

But in *Valentini*, the Second Circuit noted that, "The New York Court of Appeals, though, 'has been hesitant to expand *Sommer* into the realm of insurance law.'" The court further noted that the additional tort duty in *Sommer* "arose from the very nature of [the fire-alarm company's] services—to protect people and property from physical harm"—and "the public interest in seeing [that service] performed with reasonable care."

By contrast, because "governing the conduct of insurers and protecting the fiscal interests of insureds [was] simply not in the same league as

the protection of the personal safety of citizens," the Court of Appeals refused to impose a tort duty for the allegedly negligent breach of a commercial-crime-liability insurance policy."

It further noted that, "Following that logic, at least one New York court [has] held that a health-care insurer does not owe a duty of care to an insured while conducting preauthorization utilization review." See *Logan v. Empire Blue Cross & Blue Shield,* 714 N.Y.S.2d 119, 121–23 (2d Dept. 2000).

The Valentinis were hoping that the Second Circuit would rely instead on another Second Circuit case called *Cicio*, which recognized the impact that prior authorization often has on an individual's access to healthcare.

In *Cicio*, the court said that prior authorization "must be treated as a mixed decision because it allegedly involved both an exercise of medical judgment and an element of contract interpretation." And it noted that, "These medical decisions have possibly dispositive consequences for the course of treatment that a patient ultimately follows." *Cicio v. Does,* 321 F.3d 83, 89 (2d Cir. 2003), cert. granted, judgment vacated sub nom. *Vytra Healthcare v. Cicio*, 542 U.S. 933, 124 S. Ct. 2902, 159 L. Ed. 2d 808 (2004).

And the Valentinis hoped that the Second Circuit would certify a question to the New York Court of Appeals as to the extent of the duty of care.

The Second Circuit did neither. Instead, it said, "And while we recognize that the New York Court of Appeals has not squarely decided whether a health insurer owes its insureds a duty of reasonable care when performing contractual obligations like the preauthorization utilization process, we find that we are nevertheless able to "predict"—based on *Sommer, New York University,* and other decisions by New York courts—"how the Court of Appeals would answer [that] question."

Thus, a question of accountability remains largely unanswered; one that affects tens of thousands of New Yorkers every year. Significantly, that estimate of prior authorization's impact is neither rhetorical nor puffery.

In April 2022, the U.S. Department of Health and Human Services released a damning report revealing "widespread and persistent problems related to inappropriate denials of services and payment" caused by [Medicare Advantage] prior authorization requirements. (*See* U.S. Dept. of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, April 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf).

The report noted "millions" of unwarranted denials each year, which are so routine and unjustified that 75% of denials that get appealed are eventually reversed—but only after causing a dangerous delay in care.

While Medicare Advantage plans—which serve the elderly and thus many of the most medically vulnerable—are among the most egregious offenders of prior authorization, the impact is not limited to those on Medicare.

Medical practices report completing, on average, 45 prior authorizations per physician per week. And the American Medical Association, which has been surveying doctors regularly about the impact of prior authorization recently reported that 94% of respondents reported that prior authorization requirements caused delays in necessary treatment, and, as a result, 33% reported "serious adverse events" that required medical intervention, 19% reported a life-threatening event, and 9% reported a serious disability or permanent bodily damage.

Significantly, the potential impact of prior authorization is likely to grow exponentially within the next few years. That is because employers—both municipal and private—are trying to force retirees (for whom they have pension and healthcare obligations) out of traditional Medicare and into Medicare Advantage

programs. Why? Because the federal government pays for almost all of the cost of Medicare Advantage plans; whereas former employers typically have to pay the cost of "supplemental" insurance plans that cover the 20% of medical expenses not covered by traditional Medicare.

But traditional Medicare and Medicare Advantage, although they sound alike, are very different. The biggest difference is that traditional Medicare imposes virtually no prior authorization on patients—requiring only motorized wheelchairs, hospital beds, and some experimental drugs to be subjected to prior authorization review.

Medicare Advantage plans, which are for-profit plans run by private insurers are notoriously rife with prior authorization hurdles and abuses. As a result, many doctors who treat patients under traditional Medicare refuse to participate in Medicare Advantage plans: they don't want often unqualified insurer-employed doctors to second-guess their care of their patients; and they don't want to endure the cost or hassle of dealing with denial-happy reviewers.

Yet because of employers' desire to shift the cost of caring for their retirees to the federal government, hundreds of thousands of elderly and disabled New Yorkers may, within the next few years, suddenly be subjected to prior authorization. And the lack of accountability of insurance companies and their prior authorization subcontractors—should they overrule a doctor's recommendations and the patient be adversely affected—will become a very real and growing problem. Given the *Valentini* decision, that accountability—to say nothing of liability—is at worst non-existent and at best uncertain.

Which brings us back to Professor Sadist's grading of the exam. It is well established that there can be no medical malpractice in the absence of a physician-patient relationship. See *Heraud v. Weissman*, 276 A.D.2d 376, (1st Dept. 2000). Clearly Kathleen Valentinni was never seen by the utilization review company's doctors. But the New York Court of Appeals has said that where the conduct "constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment" then it is malpractice. *Bleiler v. Bodnar,* 65 N.Y.2d 65, 72, (1985). Yet in denying Kathleen Valentini's request that the Second Circuit certify the question of duty-of-care, it instead chose to "predict" how the Court of Appeals would answer.

So, with hundreds of thousands of elderly and disabled New Yorkers potentially about to be subjected to prior authorization, there are at least two ways to address the problem of no accountability. The first is for the New York State Legislature to hold hearings and deal with the vacuum by statute.

The second is for the Court of Appeals to do what the U.S. Supreme Court did recently in a voting rights case and send up a "bat signal" that it wants the issue to come before the Court. New Yorkers need one or the other. For as the Court of Appeals said in *Sommer*, some questions are "simply not in the same league as the protection of the personal safety of citizens."

Very simply, how can adequate access to healthcare *not be* "protection of the personal safety of citizens"? There are few issues more fundamental to the safety of citizens than the prompt access to healthcare—unimpeded by an insurance company which chooses to step between a doctor and her patient and practice medicine.